General Insurance Conditions (GIC)

ÖKK LIVE product line

Edition 2023

ÖKK

General Insurance Conditions ÖKK LIVE product line

Edition 2023

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

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

ÖKK BASIS

ÖKK Kranken- und Unfallversicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Insurer

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

1.2 Legal basis

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

1.3 Purpose

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

2. Insurance

2.1 Insured persons

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

2.2 Acceptance process

2.2.1 Application

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

2.2.2 Insurance policy and GIC

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

2.3 Duration of insurance

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

2.4 Change of residence

2.4.1 General provisions

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

2.4.2 Moving abroad

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

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

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

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

2.5 Accident cover

2.5.1 Suspension of accident cover

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

2.5.2 Withdrawal from accident insurance

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

2.6 Change to forms of insurance

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

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

2.7 End of insurance

2.7.1 General provisions

Insurance shall end upon

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

2.7.2 Termination

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

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

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

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

2.7.3 Consequences of insurance ending

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

Insured persons shall meet their financial obligations to the insurer.

3. Benefits

3.1 General conditions relating to insurance benefits

3.1.1 Eligibility to claim benefits

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

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

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

In particular, the benefits cover

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

3.1.3 Benefits abroad

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

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

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

3.1.4 Conditions for receiving benefits

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

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

3.1.5 Invoicing, reimbursement

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

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

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

3.1.6 Loss mitigation and duty of cooperation

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

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

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

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

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

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

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

3.2 Outpatient treatment

3.2.1 Duration of benefits

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

3.2.2 Service providers

In particular, service providers include:

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

3.2.3 Scope of benefits

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

3.2.4 Choice of service provider

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

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

3.2.5 Medications

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

3.2.6 Analyses

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

3.2.7 Aids

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

3.2.8 Alternative medicine

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

3.2.9 Medical prevention

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

3.3 Inpatient treatment

3.3.1 Hospital

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

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

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

ÖKK BASIS provides benefits for medically required treatment and emer-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.3 Exceptions

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

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

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

5. ÖKK BASIS ECOPLAN

5.1 Purpose

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

5.2 Principle

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

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

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

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

5.3 Exceptions

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

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

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

6. Cost sharing

6.1 Standard cost sharing

6.1.1 Deductible and excess

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

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

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

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

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

6.1.2 Excess for medications

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

6.1.3 Hospital contribution

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

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

6.2 Optional deductible

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

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

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

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

7. Premiums

7.1 Determining the premium

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

7.2 Premium reductions

Reduced premiums apply for insured persons

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

7.3 Reduced premiums

The individual reduced premiums comply with Art. 65 KVG.

7.4 Premium exemptions during military and civilian service

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

7.5 Premium payment

7.5.1 Due date and payment period

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

7.5.2 Payment fees

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

7.5.3 Default of payment

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

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

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

7.5.4 Pledging and assignment

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

8. Administrative contract

8.1 General provisions

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

8.2 Alternative conditions

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

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

In particular, alternative conditions relate to

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

9. Administration of justice

9.1 Decision

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

9.2 Appeal

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

9.3 Cantonal insurance tribunal

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

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

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

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

9.4 Legal force

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

9.5 Legal protection

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

10. Final provisions

10.1 Changes

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

10.2 Entry into force

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

Common Provisions

ÖKK Versicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Principle

Supplementary and additional insurance policies are offered in accordance with these ÖKK LIVE General Insurance Conditions (hereinafter referred to as ÖKK LIVE GIC).

1.2 Insurance providers

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

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

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

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

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

1.3 Scope of insurance

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

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

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

1.4 General Insurance Conditions

Unless special conditions have been agreed in an individual contract, the ÖKK LIVE GIC govern the insurance relationship. The Common Provisions of the ÖKK LIVE GIC (hereinafter referred to as ÖKK LIVE 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 LIVE CP, the provisions of the individual insurance products take precedence over the ÖKK LIVE CP.

1.5 Conditions for framework contracts/collective insurance policies

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

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

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

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

1.6 Insurance Contract Act

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

2. Insurance options

2.1 Insurance products

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

Basic module
- ÖKK START

Supplementary modules
- ÖKK HOSPITAL Benefit levels: FLEX MINI, FLEX, SEMI-PRIVATE, PRIVATE, GLOBAL
- ÖKK NATURE Benefit levels: MINI, MIDI, PLUS
- ÖKK PREVENTION
- ÖKK SMILE Benefit levels: 1,000, 1,500, 3,000, 5,000
- ÖKK PARENTS

Additional products
- ÖKK HOSPITAL PRIVATE ACCIDENT
- ÖKK TOURIST
- ÖKK PROTECT
- ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ILLNESS
- ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ACCIDENT
- ÖKK COMPENSA
- ÖKK GIA DAILY ALLOWANCE

2.2 Combinations

The above-mentioned insurance products (basic module, supplementary modules, additional products) can be combined with each other.

The ÖKK START basic module is required for the following insurance products:
- ÖKK NATURE (MINI, MIDI, PLUS)
- ÖKK PREVENTION
- ÖKK SMILE (1,000, 1,500, 3,000, 5,000)
- ÖKK PARENTS

2.3 ÖKK OPTION 5/10

ÖKK OPTION offers guaranteed upgrade and expansion options in the future. With ÖKK OPTION, insured persons are able to conclude certain products within the agreed duration of the option (subject to the waiting period) without having to undergo another health check.

2.3.1 Conclusion of the option for the ÖKK START basic module

The ÖKK START basic module can be reserved for an option duration of five or ten years for an option fee.

Requirements for concluding the option:
In order to conclude the option, the health check must be passed; this is performed based on the details provided in the health declaration for the ÖKK START basic module. The provisions in section 4.1 apply mutatis mutandis.

2.3.2 Conclusion of options for supplementary modules and additional products

Persons with an active ÖKK START basic module (or this module guaranteed under an option) can reserve the following insurance products for an option duration of five or ten years for an option fee:

- ÖKK HOSPITAL (FLEX MINI, FLEX, SEMI-PRIVATE, PRIVATE, GLOBAL)
- ÖKK HOSPITAL PRIVATE ACCIDENT
- ÖKK NATURE (MINI, MIDI, PLUS)
- ÖKK SMILE (1,000, 1,500, 3,000, 5,000)

Requirements for concluding the option:

- An active ÖKK START basic module (or this module guaranteed under an option); and
- A successfully passed health check, which is performed based on the details provided in the health declaration for the insurance product covered by the option. The provisions in section 4.1 apply mutatis mutandis.

2.3.3 Exercising the option

The option can be exercised as of the first day of any month following prior written notification to the insurer. The option can be exercised up to 31 December of the year in which the insured person turns 60 years of age.

The option for supplementary modules and additional products can only be exercised if the option for the ÖKK START basic module is exercised at the same or the person is already actively insured with ÖKK START.

The waiting period stipulated in the policy applies from the time the option is exercised. The waiting period refers to the period of time from when the option is exercised until the start of the insurance. The waiting period does not count towards the minimum duration of the respective insurance product.

Any qualifying periods within the insurance product do not begin until the waiting period has expired.

2.3.4 Duration of the option

The option can be concluded for a duration of five or ten years.

The option can be renewed following the expiry of the selected option duration; the requirements stipulated in sections 2.3.1 and 2.3.2 apply in this regard.

2.3.5 Termination of option

Options may be terminated as of 31 December of each year subject to a written notice of termination received by no later than 30 September of said year. The termination provisions in section 5.1 apply mutatis mutandis.

This possibility of termination also applies within the waiting period of the option.

In the event of termination, the option to conclude the relevant insurance product without undergoing another health check expires.

The option also expires in the following cases:

- if the maximum option duration (five or ten years) is reached;
- if the insured person terminates the ÖKK START basic module or their option, or if ÖKK START expires for another reason (unless the ÖKK START basic module is guaranteed under an option in accordance with section 2.3.1); and
- upon reaching the age limit (i.e. on 31 December of the year in which the insured person turns 60 years of age).

2.3.6 Option fee

A fee is charged for each insurance product guaranteed under an option (option fee).

The option fee must also be paid during the waiting period. After this has expired, the premium tariff of the insurance product that the option guarantees shall apply.

The option fee is no longer charged once the option ends.

2.4 Selected insurance products

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

3. Insured persons

3.1 Individual insurance

The persons listed in the insurance policy are insured.

3.2 Framework contract/collective insurance

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

The collective contract specifies the group of insured persons.

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

4. Start and duration of insurance

4.1 Process for concluding insurance

4.1.1 Application

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

Persons without capacity to act may only be represented by their legal representatives.

4.1.2 Obligation to provide information

If, when completing the application, incorrect or incomplete information is provided, the insurer may terminate the contract within four weeks of becoming aware of the breach of the disclosure obligations.

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

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

The insurer may demand a doctor's certificate or, at its cost, a medical examination.

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

4.1.4 Right of revocation

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

This deadline is deemed to have been met if the policyholder notifies the

insurer of the revocation or sends its revocation declaration by post on the last day of the revocation period.

4.2 Start of insurance

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

4.3 Duration of insurance

4.3.1 General provisions

The duration of the respective insurance products is based on the provisions of the ÖKK START basic module as well as the conditions of the individual supplementary modules.

The additional products can each be concluded for a period of one year.

4.3.2 Longer duration of insurance

If supplementary modules are concluded in addition to the ÖKK START basic module (combination as per section 2.1), the duration of insurance for the ÖKK START basic module is based on the duration of insurance of the most recently concluded supplementary module.

4.3.3 Timing of conclusion of insurance

Insurance may be concluded at any time, even during the calendar year. In such cases, premiums are calculated based on the remaining duration of insurance up to the primary expiry date of 31 December of a calendar year.

4.3.4 Extension of insurance

The insurance contract is automatically extended by one year after the expiry of the agreed duration of insurance, 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 to adjust the insurance contract with a higher level of coverage and applications for products requiring a health declaration are considered to be applications for a new insurance contract.

If the policyholder wishes to reduce the insurance cover, the termination provisions apply.

4.4.2 Changes on the part of the insurer

If, after the insurance is concluded, there are far-reaching changes to the framework conditions for insuring 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. Policyholders have 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

An application can be made to suspend insurance in all or individual active insurance products provided it can be proved there is equivalent insurance cover in place.

The insurer reserves the right to reject the suspension application.

During the period of suspension, a reduced premium may be charged.

4.5.2 Duration and scope of suspension

After having submitted an application, the period of suspension begins no earlier than the start of the month after the grounds for suspension arise.

The suspension must be requested for at least three months, and can be concluded for a duration of up to six years. It is possible to apply for a further extension of the suspension period.

If the insurer does not agree to an extension of the suspension period, the insurance cover is reactivated in full if this is requested within 30 days. If the insurance cover is not reactivated within this deadline, the insurance lapses until further notice.

If the grounds for suspension cease to apply, the insurance cover is reactivated in full if this is requested within 30 days. If the insurance cover is not reactivated within this deadline, the insurance lapses until further notice.

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

5. End of insurance

5.1 Termination by the policyholder

5.1.1 Standard termination

The insurance / an insurance product may be terminated following the expiry of the insurance duration as of 31 December of each year subject to a written notice of termination received by no later than 30 September of said year. This remains subject to any termination provisions in the individual insurance products to the contrary.

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. In such cases, the premium will be owed up until the termination of the contract.

5.1.3 Receipt of notice of termination

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

5.1.4 Collective contract

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

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

5.1.5 Framework contract

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

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

5.2 Termination by the insurer

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

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

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

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

5.3 Other grounds for termination

The insurance also lapses in the following cases:

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

6. Benefits

6.1 Definition of terms

6.1.1 Illness

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

6.1.2 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) Eardrum injuries.

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

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

6.1.3 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 360 days (qualifying period) at the time of the birth or, if she previously had equivalent insurance with another insurer, provided this insurance was concluded at least 360 days before the birth (and there is confirmation of this).

6.1.4 Birth defects

Birth defects are those illnesses that exist following birth.

6.1.5 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.

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

6.1.6 Psychiatric clinics

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

6.1.7 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.

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

6.1.8.1 List hospital

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

6.1.8.2 Contractual hospital

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.

6.1.8.3 Other hospital

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

6.1.9 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.

6.1.10 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

In principle, the insurance applies for benefits in Switzerland and, in the event of emergency treatment, abroad. The provisions of the individual insurance products concerning geographical scope take precedence.

6.2.2 Period of benefits

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

The key date in this regard is the date of treatment or the sate on which the insured benefit was first received.

6.3 Insured benefits

6.3.1 Scope of benefits

The insurance covers benefits as per the coverage listed on the insurance policy and in accordance with the provisions of the individual insurance products.

6.3.2 Economical treatment

Treatments are covered provided they are effective, expedient, economical and medically necessary. This means that the costs of medical and therapeutic treatments are covered if they are limited to the extent that they are in the interests of the insured person and are necessary for the purpose of treatment. The effectiveness of the treatment must be backed by scientific methods (with the exception of complementary medicine).

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 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.

6.3.3 Treatment from recognised medical service providers

Treatments from medical service providers are insured if they are recognised in accordance with the KVG. Benefits from other persons or institutions are insured if this is provided for in the individual insurance products.

6.4 Benefit restrictions

6.4.1 Pre-existing illnesses and accidents

The insurer may exclude illnesses and consequences of accidents from the insurance cover if they exist/existed at the time the insurance is/was concluded.

This restriction of cover is communicated to the insured person in writing.

If an insured person has opted to conclude ÖKK OPTION supplementary modules, the regulations set out in section 2.3 apply.

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; and
d) if a treatment's aim is not to remedy a health problem or the consequences thereof. 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, terrorist acts, unrest, and similar events, and during military service abroad;
k) in the event of illnesses and accidents resulting from warlike events that had broken out more than 14 days previously;
l) in the event of illnesses and accidents resulting from actively participating in fights, brawls or other acts of violence or from actively participating in punishable actions or attempts to do so;
m) for the consequences of earthquakes and other natural catastrophes;
n) in the event of health impairments resulting from large-scale industrial emergencies or impairments caused by nuclear energy;
o) 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;
p) for statutory and agreed cost-sharing amounts from compulsory health care insurance;
q) in the event of epidemic diseases;
r) as a consequence of abusing alcohol, medication or other drugs;
s) in the event of health impairments resulting from recklessness, i.e. if the insured person exposes themselves to a considerable risk without taking or being able to take any measures that could reduce this risk to a reasonable level. This does not include rescue operations in aid of persons. In terms of this provision, recklessness includes in particular the participation in races or training with motor vehicles; and
t) if the insured person's health is damaged intentionally, also as a suicide attempt or self-harm;
u) for cosmetic treatments and operations.

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

6.4.3 Benefit restrictions

Benefits are restricted:

a) if notification obligations or other duties are breached in the event of a claim;
b) in the event of grossly negligent causation of the impairment; and
c) if the supporting documentation required to assess an insurance claim is not provided within four weeks, despite a written reminder being sent. The provisions under Art. 45 VVG shall apply (absence of fault or no influence on scope of benefit).

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

7.1 Notification obligation

The insured person must notify the insurer of their benefits claims in due time in accordance with the provisions of the individual insurance products. The insurer must be notified of the occurrence of an accident within ten days.

The notification must be made truthfully. If benefits are claimed, the insurer must be provided with all information that contains the required medical and administrative details. Only detailed original invoices are accepted.

7.2 Reduction of damage

Insured persons must do everything in their power that can help to reduce the damage, in particular that is conducive to curing their condition, and desist from any action which may delay this.

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 obtain information.

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

The insured person must provide the insurer with information about all benefits received from third parties in the event of illness, accident, disability and maternity. Upon request, the insurer must be provided with bills from third parties.

For persons without capacity to act, 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 determining in a premium tariff for each insurance product.

8.1.2 Level of premiums

The level of the premiums is determined in line with the risk entailed.

The insurer may stipulate a minimum premium. This is specified in the policy and applies for each insured person per insurance year.

Premium adjustments resulting from a change of the risk group are carried out 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.

For options on insurance products (ÖKK OPTION, see section 2.3), a reduced premium will be charged compared to that charged for active insurance cover.

8.1.3 Premium discount

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

Children and young adults who live in the same household as at least one parent and are insured with the insurer on the same family policy are eligible for the discount.

To receive the family discount, the child/young adult and the parent in question must have the following insurance cover with the insurer:
- compulsory health care insurance;
- ÖKK START; and
- at least one supplementary module in accordance with section 2.1.

The ÖKK START basic module and the supplementary modules may not be guaranteed with ÖKK OPTION.

The family discount is granted on the insured supplementary modules in accordance with section 2.1.

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

8.2 Adjustment of premium tariffs and cost-sharing amounts

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

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

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

For ÖKK SMILE, the first three age groups are as follows: 0 to 3, 4 to 5 and 6 to 10.

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

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

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

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

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

An adjustment of the tariff resulting from a change in the place of residence is not deemed to be a premium adjustment.

8.3 Premium payment

8.3.1 Due date

Premiums are to be paid in advance. Premiums are to be paid without interruption, even in the event of illness, accident, pregnancy and maternity, or an inability to work or if the entitlement to benefits is suspended.

8.3.2 Reminder 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. Even if premiums are subsequently paid, the insured person has no entitlement to benefits for illnesses, accidents and their consequences which occurred while the obligation to provide benefits was suspended.

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

8.4 Other payment provisions

8.4.1 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.

8.4.2 Pledging and assignment

Claims against the insurer may not be pledged or assigned without the consent of the latter.

8.4.3 Payment of benefits

Unless otherwise agreed between the insurer and service providers, the insured person owes the service providers the relevant costs.

If there are different contracts and tariffs in place between the insurer and service providers, the insurer pays the service providers directly. If the insurer pays the service providers directly, the insured person must reimburse the insurer the agreed cost-sharing amount within 30 days of the invoice being received.

Remuneration agreements between billers and insured persons are not binding for the insurer. An entitlement to benefits only exists within the scope of the tariff recognised by the insurer for the corresponding service provider.

Any benefits obtained wrongfully are reclaimed by the insurer.

8.4.4 Statute of limitations

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

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

9. Third-party benefits

9.1 Subsidiarity

9.1.1 General provisions

If a third party is liable for a reported illness or accident 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.

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

9.1.3 Multiple insurance policies

If more than one private insurer is obliged to provide benefits, a calculation is performed to determine how much each private insurer would have to pay if they were solely liable for providing benefits. This also applies if the other private insurers only have a subsidiary obligation to provide benefits.

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

9.1.4 Waiver of benefits

If insured persons wholly or partially waive their right to benefits vis-à-vis third parties without the consent of the insurer, the obligation to provide benefits under these ÖKK LIVE GIC no longer applies. The capitalisation of an entitlement to benefits is also considered to be a waiver of benefits.

9.2 Social insurance

No benefits are covered that are paid out under social insurance schemes. Any claim to benefits must be reported to the relevant social insurance office.

9.3 Advance payment of benefits and recourse

Unlike for social insurance schemes, an advance payment of benefits can be made if the insured person is also insured with third parties. A requirement is that the insured persons must have made reasonable efforts to enforce their claims without success and is willing to assign their claims against third parties to the insurer within the scope of the benefits provided.

9.4 Overinsurance

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

10. Data protection

10.1 Legal basis

The data of insured persons is processed in accordance with the provisions of the Federal Act on Insurance Contracts (VVG) and the Federal Act on Data Protection (FADP).

10.2 Purpose of processing data

The insurer processes data (e.g. personal information, information on a person's health, checking the information provided in applications, collecting money owed, settling benefits) in order to execute the insurance contract in accordance with the VVG. In addition, it may use the data for regulatory evaluations as well as for personal customer consultations and to assist customers.

The insurer may also analyse the data using mathematical and statistical methods in order to improve the quality of products and services based on these findings and to inform insured persons of this.

The insurer is therefore expressly permitted, for the above-mentioned purposes, to process personal and contractual data (excl. sensitive personal data within the meaning of the Data Protection Act, in particular) as well as the client profile using information from the basic and supplementary insurance provided by the companies of the ÖKK Group and its outsourcing partners exclusively in the area of supplementary insurance.

The insurer treats the information it receives with the highest confidentiality.

10.3 Forwarding of data to third parties for processing

The insurer can fully or partially transfer responsibility for data processing to a third party (e.g. computer centre, outsourcing partner). Here the insurer shall ensure that the data is only processed in such a way as it is permitted to do itself.

In other cases, the insurer may only provide information to third parties with the consent of insured persons.

10.4 Data storage

The insurer carefully stores the data and puts in place appropriate technical and organisational measures to protect it from unauthorised access.

10.5 Right to information

Insured persons have the right to request information from the insurer about the data processed. Such requests must be in writing and contain sufficient proof of identity (copy of ID/passport).

11. Notifications

The insurer must be notified in writing of any changes to the personal circumstances of insured persons that are material with regard to the insurance (e.g. change of place of residence) within 30 days.

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

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

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

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

12. Formal requirements

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

13. Place of jurisdiction

In the event of any disputes arising out of insurance policies in accordance with these ÖKK LIVE 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 START

ÖKK Versicherungen AG, Edition 1.1.2019

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK START provides benefits for outpatient and inpatient treatments in the event of illness, accident and maternity as well as in case of emergencies abroad in addition to compulsory health care insurance under the Health Insurance Act (KVG). ÖKK START provides benefits before any other insurance policies concluded with the insurer in accordance with the VVG. Of the total costs, a maximum of the amount not covered by other social insurance schemes will be covered. If more than one private insurance policy is in place, benefits are provided subsidiary to other insurers. If the insurance conditions of other private insurers also contain this subsidiarity clause, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP.

The cost-sharing amount to be covered under compulsory health care insurance, including the daily contribution towards the costs of a hospital stay, is not insured.

ÖKK START provides benefits with respect to
- medical and dental treatments;
- non-medical psychotherapy;
- vasectomies and sterilisation;
- optional medications;
- inpatient treatments;
- emergencies abroad;
- aids;
- transport, search, rescue and recovery operations;
- treatments in health resort; and
- domestic workers.

1.4 Conditions for receiving benefits

1.4.1 Outpatient benefits

ÖKK START provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP.

1.4.2 Inpatient benefits

ÖKK START provides benefits if the treatment is medically necessary and is carried out on the general ward of a list or contractual hospital. The treatment must be carried out by service providers who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP. In other hospitals, benefits are only insured in the event of acute treatments within the scope of section 2.4.1.4.

1.5 Geographical scope

Unless otherwise specified, ÖKK START provides benefits in Switzerland.

1.6 Conclusion of the insurance

ÖKK START can be concluded until the person turns 60 years of age.

1.7 Duration of insurance

The term of ÖKK START insurance is one year and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

If supplementary modules are also concluded in addition to the ÖKK START basic module, the duration of the insurance is extended in accordance with section 4.3.2 ÖKK LIVE CP.

2. Insurance benefits

2.1 Non-medical psychotherapy

2.1.1 Conditions for receiving benefits

ÖKK START provides benefits after the cost guarantee request has been approved by the insurer.

ÖKK START does not provide benefits for psychotherapy for the purpose of self-realisation, personal development or learning purposes. ÖKK START does not provide benefits for parallel treatments at further psychologists or psychiatrists.

ÖKK START does not provide benefits for couple's therapy for problems with interpersonal relationships.

2.1.2 Scope of benefits

ÖKK START provides benefits totalling 50%, up to CHF 1,000 per calendar year, for non-medical psychotherapeutic treatment, provided the psychotherapist has received cantonal approval to run an independent practice.

2.2 Vasectomies and sterilisation

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

2.3 Optional medications

ÖKK START provides benefits totalling 90%, up to CHF 20,000 per calendar year, for medically prescribed (by KVG doctors) medication that does not appear on the List of Medications with Tariff (LMT), the List of Specialities (LS) in accordance with KVG or the insurer's negative list.

The insurer's negative list includes the following:
- all preparations on the list of pharmaceutical products for special application (LPPA);
- life-style preparations; and
- new medication yet to be classified by the FOPH.

2.4 Inpatient treatment

2.4.1 Acute treatment

2.4.1.1 Conditions for receiving benefits

ÖKK START provides benefits if the insured person is in need of hospital care within the scope of compulsory health care insurance.

2.4.1.2 Scope of benefits

ÖKK START provides benefits to cover the costs of stay on a general ward of a list or contractual hospital in Switzerland over and above the benefits provided under compulsory health care insurance.

2.4.1.3 Treatment on a more expensive hospital ward

If the treatment is carried out on a more expensive ward than the general ward, costs are only covered up to the amount that would have been incurred on the general ward. If these costs cannot be determined, ÖKK START provides a flat rate of CHF 30 per day.

2.4.1.4 Treatment in other hospitals

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

2.4.2 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic (in institutions recognised by the insurer in accordance with sections 6.1.8.1 and 6.1.8.2 ÖKK LIVE CP), ÖKK START covers the full costs for 90 days within a period of three calendar years in accordance with the conditions for acute treatment (section 2.4.1.2).

If the treatment lasts longer, the following daily flat rates are paid for treatment on the corresponding ward: from 91st to 180th day, the actual costs, up to CHF 20 per day.

These benefits are provided for up to 180 days within a period of three calendar years.

2.4.3 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer (in accordance with sections 6.1.8.1 and 6.1.8.2 ÖKK LIVE CP), ÖKK START covers the full costs for up to 60 days per calendar year in accordance with the conditions for acute treatment (section 2.4.1.2).

2.5 Emergencies abroad

2.5.1 Medical treatment in the event of emergencies abroad

ÖKK START provides benefits for medical outpatient treatment in the event of emergencies abroad during temporary stays abroad.

2.5.2 Inpatient treatment in the event of emergencies abroad

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

2.5.3 Procedure in the case of hospital stays

In the case of inpatient treatment, a cost guarantee request must be submitted to the insurer immediately, at the latest within 10 days of being admitted to hospital.

2.6 Aids

2.6.1 Visual aids

ÖKK START provides up to CHF 80 per calendar year for glasses lenses and contact lenses for the purposes of vision correction.

ÖKK START also provides benefits if the glasses lenses and contact lenses are bought abroad.

2.6.2 Other aids

ÖKK START provides benefits totalling 50%, up to CHF 300 per calendar year, for medically prescribed (by KVG doctors) aids for which no benefits are provided under compulsory health care insurance.

The aids must be recognised by the insurer. A list of these is available on request. The costs for operating, maintaining and repairing aids are not insured.

2.7 Transport costs, rescue and recovery operations in emergencies

2.7.1 Scope of benefits

ÖKK START provides benefits for

- medically necessary emergency transport to the nearest suitable hospital;
- repatriation to a suitable hospital in the canton of residence for inpatient treatment; and
- rescue and recovery operations

totalling up to CHF 50,000 per calendar year.

For repatriation from abroad, ÖKK START only provides benefits if the repatriation is organised via the insurer's emergency call centre.

ÖKK START provides benefits for transport by air, if this is necessary for medical or technical reasons.

2.7.2 Excess

The excess is CHF 100 per case.

2.7.3 Search activities

ÖKK START provides benefits for search activities of up to CHF 20,000 per calendar year in addition to the benefits for rescue or recovery.

2.7.4 Third-party benefits

There is no insurance cover for costs that are covered by patronage or membership of an air rescue service or similar organisations.

2.8 Travel expenses

ÖKK START provides benefits totalling 90%, up to CHF 100 per calendar year, for travel expenses on public transport between the place of residence and place of treatment, if the treatment cannot be provided in the place of residence or within a radius of 30 kilometres.

In addition to the above costs, ÖKK START provides benefits totalling 90%, up to CHF 300 per calendar year, for travel expenses on public transport between the place of residence and place of treatment for insured persons undergoing dialysis, radiotherapy or chemotherapy, if the treatment cannot be provided in the place of residence or within a radius of 30 kilometres.

2.9 Balneotherapy and convalescent therapy

2.9.1 Convalescent treatments

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

The insured person is free to choose from the medically run convalescent facilities recognised by the insurer. The insurer maintains a list of these convalescent facilities, which is available on request.

2.9.2 Balneotherapy treatments

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

The insured person is free to choose from the medically run spas recognised by the insurer. The insurer maintains a list of these spas, which is available on request.

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

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

2.9.3 Other convalescent treatments

On request, a flat rate up to the amount of the balneotherapy contribution can be paid in accordance with section 2.9.2 for other medically prescribed convalescent treatments (treatments that do not fall under section 2.9.1 or 2.9.2). This applies for convalescent treatments in spas or convalescent homes that are not on the list in the Health Care Benefits Ordinance (KLV).

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

2.9.4 Procedure in the case of convalescent stays

The medical prescription for a convalescent stay must be submitted to the insurer two weeks before entering the convalescent facility together with the diagnosis. If the stay in the convalescent facility is interrupted, partial treatment costs can only be covered if the interruption was a result of illness or other compelling reasons and a medical certificate was obtained from the doctor at the convalescent facility.

2.9.5 Thermal baths

ÖKK START provides benefits totalling 50% of the costs, up to 12 entries per calendar year, for medically prescribed thermal baths.

2.10 Domestic assistance

2.10.1 Principle

Directly after an inpatient stay in hospital as well as after a home birth or outpatient birth, if medically prescribed, ÖKK START makes contributions towards domestic assistance outside of the hospital, provided the insured person's domestic and family circumstances require this.

2.10.2 Scope of benefits

ÖKK START provides up to CHF 40 per day, max. CHF 400 per calendar year, towards the costs of a recognised domestic assistance provider.

No benefits are paid if the insured person is staying in a care home.

2.10.3 Service providers

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

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

2.11 Dental treatments

2.11.1 Check-ups and prophylaxes

ÖKK START provides up to CHF 60 per calendar year for dental check-up incl. x-rays or dental prophylaxes for children and young adults up to the age of 25.

2.11.2 Orthodontic treatment

After a qualifying period of 3 years from the start of the insurance, ÖKK START provides benefits totalling 70%, up to CHF 10,000 per calendar year, for the orthodontic of children and young adults up to the age of 25 in accordance with the recognised tariff.

2.11.3 Wisdom teeth

ÖKK START provides benefits totalling 90% for the extraction of wisdom teeth on an outpatient basis.

2.11.4 Treatment abroad

ÖKK START also provides benefits if the treatment is carried out in a country neighbouring Switzerland. Neighbouring countries are those countries that share a border with Switzerland.

2.11.5 Tariff

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff". ÖKK START provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

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

2.11.6 Procedure after dental treatment

The insurer must be sent the detailed original invoice by no later than 30 days after the invoice date.

ÖKK HOSPITAL

ÖKK Versicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK HOSPITAL provides benefits for inpatient treatments in the event of illness, accident and maternity as well as in case of emergencies abroad.

ÖKK HOSPITAL also provides benefits towards the costs of transport, search, rescue and recovery activities.

ÖKK HOSPITAL provides benefits in addition to compulsory health care insurance under the Health Insurance Act (KVG). Of the total costs, a maximum of the amount not covered by other social insurance schemes or the ÖKK START basic module will be covered. If more than one private insurer has an obligation to pay benefits, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP.

The cost-sharing amount to be covered under compulsory health care insurance, including the daily contribution towards the costs of a hospital stay, is not insured.

1.4 Conditions for receiving benefits

ÖKK HOSPITAL provides benefits if the treatment is medically necessary and is carried out in a list or contractual hospital. The treatment must be carried out by service providers who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP. In other hospitals, benefits are only insured in the event of acute treatments within the scope of section 2.1.4.

1.5 Geographical scope

Unless otherwise specified, ÖKK HOSPITAL provides benefits in Switzerland.

1.6 Conclusion of the insurance

ÖKK HOSPITAL can be concluded until the person turns 60 years of age.

1.7 Duration of insurance

The term of ÖKK HOSPITAL insurance is three years and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

1.8 Insurance options

ÖKK HOSPITAL offers the following benefit levels:

ÖKK HOSPITAL FLEX MINI:	General or semi-private ward in Switzerland; in accordance with tariff recognised by the insurer; with corresponding cost-sharing amount
ÖKK HOSPITAL FLEX:	General, semi-private or private ward in Switzerland; in accordance with tariff recognised by the insurer; with corresponding cost-sharing amount
ÖKK HOSPITAL SEMI-PRIVATE:	Semi-private ward in Switzerland (twin room); in accordance with tariff recognised by the insurer
ÖKK HOSPITAL PRIVATE:	Private ward in Switzerland (single room); in accordance with tariff recognised by the insurer
ÖKK HOSPITAL GLOBAL:	Private ward worldwide (single room)

For all benefit levels, benefits in other hospitals (non-list/contractual hospitals) are only insured for acute treatments within the scope of section 2.1.4).

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

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

Information on any maximum tariffs set by the insurer can be requested from the insurer.

1.9 Accident cover

Accident cover can be excluded.

2. Insurance benefits

2.1 Acute treatment

2.1.1 Conditions for receiving benefits

ÖKK HOSPITAL provides benefits if the insured person is in need of hospital care within the scope of compulsory health care insurance.

2.1.2 Scope of benefits

In the event of hospital stays, ÖKK HOSPITAL covers the costs of the insured hospital ward in accordance with the chosen benefit level (section 1.8).

For treatments on a semi-private or private ward, there is a free choice of doctor.

2.1.3 Treatment on a more expensive hospital ward

If a person insured with ÖKK HOSPITAL SEMI-PRIVATE or ÖKK HOSPITAL FLEX MINI is treated on a more expensive ward than the one insured, costs are only covered up to the amount that would have been incurred on the insured ward. If these costs cannot be determined, ÖKK HOSPITAL provides a flat rate of CHF 90 per day.

2.1.4 Treatment in other hospitals

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

For ÖKK HOSPITAL FLEX MINI / ÖKK HOSPITAL FLEX / ÖKK HOSPITAL SEMI-PRIVATE / ÖKK HOSPITAL PRIVATE:	the additional costs that would have been incurred in a list hospital in the canton of residence compared to the general and the insured and chosen hospital ward
For ÖKK HOSPITAL GLOBAL:	all costs covered

2.1.5 Costs of inpatient treatment in the event of childbirth

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

If the newborn is not insured with the insurer, the mother's ÖKK HOSPITAL insurance covers the uncovered costs over and above any other insurance policies of the child.

2.1.6 Second medical opinion

The insured person may obtain a second opinion from another doctor or specialist at the cost of the insurer prior to a planned operation.

2.2 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic (in institutions recognised by the insurer), ÖKK HOSPITAL covers the full costs for 90 days within a period of three calendar years in accordance with the conditions for acute treatment (section 2.1.2).

If the treatment lasts longer, the following daily flat rates are paid for treatment on the corresponding ward:

	from 91st to 180th day / per day
ÖKK HOSPITAL FLEX MINI:	CHF 50
ÖKK HOSPITAL FLEX:	CHF 50
ÖKK HOSPITAL SEMI-PRIVATE:	CHF 50
ÖKK HOSPITAL PRIVATE:	CHF 70
ÖKK HOSPITAL GLOBAL:	CHF 90

These benefits are provided for treatment on the insured ward for up to 180 days within a period of three calendar years.

If the treatment is carried out on a cheaper ward than the one insured, the benefits are based on the options for the ward on which the treatment is carried out.

2.3 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, ÖKK HOSPITAL covers the full costs for up to 60 days per calendar year in accordance with the conditions for acute treatment (section 2.1.2).

2.4 Benefits abroad

2.4.1 Emergencies

ÖKK HOSPITAL covers the costs for emergency inpatient treatment in an acute-care hospital during temporary stays abroad up to the full costs incurred on the insured hospital ward.

Benefits are only provided for as long as the insured person cannot reasonably be repatriated.

2.4.2 Elective treatments abroad

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

2.4.3 Procedure in the case of hospital stays

In the case of inpatient treatment, a cost guarantee request must be submitted to the insurer immediately, at the latest within 10 days of being admitted to hospital.

In the case of elective inpatient treatments, a cost guarantee request must be submitted to the insurer in advance.

2.5 Transport costs, rescue and recovery operations in emergencies

2.5.1 Scope of benefits

Contributions from ÖKK HOSPITAL are made towards the costs of

- medically necessary emergency transport to the nearest suitable hospital;
- repatriation to a suitable hospital in the canton of residence for inpatient treatment; and
- rescue and recovery operations

as follows:

ÖKK HOSPITAL FLEX:	CHF 30,000 per calendar year
ÖKK HOSPITAL SEMI-PRIVATE:	CHF 30,000 per calendar year
ÖKK HOSPITAL PRIVATE:	CHF 30,000 per calendar year
ÖKK HOSPITAL GLOBAL:	CHF 100,000 per calendar year

For repatriation from abroad, ÖKK HOSPITAL only provides benefits if the repatriation is organised via the insurer's emergency call centre.

ÖKK HOSPITAL provides benefits for transport by air, if this is necessary for medical reasons.

2.5.2 Search activities

ÖKK HOSPITAL provides benefits in the benefit levels ÖKK HOSPITAL FLEX, ÖKK HOSPITAL SEMI-PRIVATE, ÖKK HOSPITAL PRIVATE and ÖKK HOSPITAL GLOBAL for search activities of up to CHF 10,000 per calendar year, in addition to the costs of rescue or recovery.

2.5.3 Third-party benefits

There is no insurance cover for costs that are covered by patronage or membership of an air rescue service or similar organisations.

2.6 Travel expenses

ÖKK HOSPITAL FLEX, ÖKK HOSPITAL SEMI-PRIVATE, ÖKK HOSPITAL PRIVATE and ÖKK HOSPITAL GLOBAL provide benefits totalling 90%, up to CHF 300 per calendar year, for travel expenses on public transport between the place of residence and place of treatment, if the treatment cannot be provided in the place of residence or within a radius of 30 kilometres.

In addition to the above costs, ÖKK HOSPITAL FLEX, ÖKK HOSPITAL SEMI-PRIVATE, ÖKK HOSPITAL PRIVATE and ÖKK HOSPITAL GLOBAL provide benefits totalling 90%, up to CHF 300 per calendar year, for travel expenses on public transport between the place of residence and place of treatment for insured persons undergoing dialysis, radiotherapy or chemotherapy, if the treatment cannot be provided in the place of residence or within a radius of 30 kilometres.

2.7 Reimbursement in the benefit levels ÖKK HOSPITAL SEMI-PRIVATE, ÖKK HOSPITAL PRIVATE and ÖKK HOSPITAL GLOBAL

ÖKK HOSPITAL SEMI-PRIVATE, ÖKK HOSPITAL PRIVATE and ÖKK HOSPITAL GLOBAL provide a reimbursement to insured persons aged 16 and over if they choose a cheaper hospital ward in an acute-care hospital in Switzerland. The insurer must be notified of the insured person's choice to receive treatment on a cheaper ward.

ÖKK HOSPITAL SEMI-PRIVATE:	general ward: CHF 300 per day
ÖKK HOSPITAL PRIVATE / ÖKK HOSPITAL GLOBAL:	general ward: CHF 400 per day semi-private ward: CHF 200 per day

The amounts may be adjusted in line with the development of hospital costs. If the amounts are reduced, the right to withdraw in accordance with section 8.2 ÖKK LIVE CP applies.

2.8 Cost-sharing in the benefit levels ÖKK HOSPITAL FLEX MINI and ÖKK HOSPITAL FLEX

2.8.1 Scope of cost-sharing

The insured person chooses the ward before admission. This choice determines the cost-sharing amount.

The following cost-sharing amounts are charged for the level ÖKK HOSPITAL FLEX MINI:

Treatment on:	Cost-sharing amount per calendar year:
General ward	none
Semi-private ward	35%, up to CHF 4,500

This cost-sharing amount also applies for maternity.

The following cost-sharing amounts are charged for the level ÖKK HOSPITAL FLEX:

Treatment on:	Cost-sharing amount per calendar year:
General ward	none
Semi-private ward	15%, up to CHF 1,500
Private ward	25%, up to CHF 4,500

This cost-sharing amount also applies for maternity.

The statutory cost-sharing amount under compulsory health care insurance is also charged.

2.8.2 Maximum cost-sharing amount for families

If two or more people listed on the same insurance policy are insured in the benefit levels ÖKK HOSPITAL FLEX MINI or ÖKK HOSPITAL FLEX, it is possible to reclaim cost-sharing amounts from the insurer that in total exceed the amount of CHF 4,500 per calendar year.

ÖKK

ÖKK HOSPITAL PRIVATE ACCIDENT

ÖKK Versicherungen AG, Edition 1.1.2018

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits in the event of an accident for inpatient treatments, travel for medical treatment, search activities and transport costs.

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits in addition to health care insurance under the Health Insurance Act (KVG). Of the total costs, a maximum of the amount not covered by other social insurance schemes will be covered. If more than one private insurance policy is in place, benefits are provided subsidiary to other insurers. If the insurance conditions of other private insurers also contain this subsidiarity clause, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP. If there are additional insurance policies held with the insurer that provide benefits for outpatient or inpatient treatment, the benefits from these insurance policies take precedence over those provided by ÖKK HOSPITAL PRIVATE ACCIDENT.

The cost-sharing amount to be covered under compulsory health care insurance, including the daily contribution towards the costs of a hospital stay, is not insured.

1.4 Conditions for receiving benefits

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP.

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits for inpatient treatment if it is carried out in a list or contractual hospital. Benefits are not provided for psychiatric treatment in any case.

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits up to the amount of the additional costs incurred on a private ward compared to the general ward of a list hospital in the insured person's canton of residence if the treatment is carried out in a hospital that is neither a lost nor contractual hospital. In the event of emergency, the full costs are covered.

An accident and its consequences are insured if the accident occurred during the term of insurance cover.

1.5 Geographical scope

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits in Switzerland and, in the event of emergency, worldwide.

1.6 Conclusion of the insurance

ÖKK HOSPITAL PRIVATE ACCIDENT can be concluded until the person turns 60 years of age.

1.7 Duration of insurance

The term of ÖKK HOSPITAL PRIVATE ACCIDENT insurance is one year and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

2. Insurance benefits

2.1 Inpatient treatment

2.1.1 Acute treatment

In the event of hospital stays, ÖKK HOSPITAL PRIVATE ACCIDENT covers the costs of a private ward.

2.1.2 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, ÖKK HOSPITAL PRIVATE ACCIDENT covers the full costs for up to 60 days per calendar year in accordance with the conditions for hospital treatment (section 2.1.1).

2.1.3 Benefits abroad

2.1.3.1 Emergencies

ÖKK HOSPITAL PRIVATE ACCIDENT covers the costs for emergency inpatient treatment in an acute-care hospital during temporary stays abroad up to the full costs incurred on a private hospital ward.

Benefits are only provided for as long as the insured person cannot be repatriated for medical reasons.

2.1.3.2 Procedure in the case of hospital stays

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

2.2 Transport costs, rescue and recovery operations in emergencies

2.2.1 Scope of benefits

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits for

- medically necessary emergency transport to the nearest suitable hospital;
- repatriation to a suitable hospital in the canton of residence for inpatient treatment; and
- rescue and recovery operations

totalling up to CHF 50,000 per calendar year

For repatriation from abroad, ÖKK HOSPITAL PRIVATE ACCIDENT only provides benefits if the repatriation is organised via the insurer's emergency call centre.

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits for transport by air, if the transport is necessary for medical or technical reasons.

2.2.2 Search activities

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits for search activities of up to CHF 10,000 per calendar year in addition to the costs for rescue or recovery.

2.2.3 Third-party benefits

There is no insurance cover for costs that are covered by patronage or membership of an air rescue service or similar organisations.

2.3 Travel expenses

ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits totalling 90%, up to CHF 300 per calendar year, for travel expenses on public transport between the place of residence and place of treatment, if the treatment cannot be provided in the place of residence or within a radius of 30 kilometres.

2.4 Medical treatment for the consequences of accidents

2.4.1 Treatment by doctors not subject to the KVG

For treatments by doctors not subject to the KVG, ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits in accordance with the KVG tariff.

2.4.2 Private consultations with hospital doctors not subject to KVG

For outpatient private consultations with senior university hospital consultants not subject to the KVG, ÖKK HOSPITAL PRIVATE ACCIDENT provides benefits in accordance with the recognised tariff.

2.5 Aids

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

The costs of aids replacing a body part or bodily function are covered. However, this only applies if the aid is damaged in connection with an accident that requires hospital treatment.

Up to CHF 30,000 per calendar year is covered.

ÖKK NATURE

ÖKK Versicherungen AG, Edition 1.1.2018

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK NATURE provides benefits for outpatient alternative medical treatments, medical treatments abroad and natural remedies, and reimburses benefits for visual aids and laser eye treatment.

ÖKK NATURE provides these benefits in addition to compulsory health care insurance under the Health Insurance Act (KVG). Of the total costs, a maximum of the amount not covered by other social insurance schemes or the ÖKK START basic module will be covered. If more than one private insurance policy is in place, benefits are provided subsidiary to other insurers. If the insurance conditions of other private insurers also contain this subsidiarity clause, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP.

Cost-sharing amounts from compulsory health care insurance are not insured.

1.4 Conditions for receiving benefits

ÖKK NATURE provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP.

1.5 Geographical scope

ÖKK NATURE provides benefits in Switzerland and, where specified, abroad.

1.6 Conclusion of the insurance

ÖKK NATURE can be concluded until the person turns 60 years of age.

1.7 Duration of insurance

The term of ÖKK NATURE insurance is three years and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

1.8 Insurance options

ÖKK NATURE offers the following benefit levels:

- ÖKK NATURE MINI
- ÖKK NATURE MIDI
- ÖKK NATURE PLUS

2. Insurance benefits

2.1 Alternative medical treatment

2.1.1 Recognised therapy methods

Within the scope of the chosen benefit level, ÖKK NATURE provides the following benefits per calendar year for outpatient alternative medical treatments:

ÖKK NATURE MINI	80%, up to CHF 1,000 (with a deductible of CHF 300)
ÖKK NATURE MIDI	80%, up to CHF 5,000 (with a deductible of CHF 300)
ÖKK NATURE PLUS	80%, up to CHF 10,000 (with a deductible of CHF 300)

ÖKK NATURE PLUS also provides benefits if the treatment is carried out in a country neighbouring Switzerland. Neighbouring countries are those countries that share a border with Switzerland.

Benefits are covered provided the therapy method (e.g. sub-sections of traditional Chinese medicine, naturopathic practices) and the therapist or doctor are recognised by the insurer. The insurer maintains lists for this purpose, which are available on request.

No benefits are paid for parallel alternative medical treatments that are not expected to be beneficial.

The maximum entitlement to benefits per calendar year is calculated from the residual amount in excess of the deductible.

2.1.2 Other therapeutic methods

ÖKK NATURE also reimburses the following benefits per calendar year for other outpatient alternative medical treatment carried out by qualified personnel:

ÖKK NATURE MINI	no benefits
ÖKK NATURE MIDI	50%, up to CHF 500
ÖKK NATURE PLUS	50%, up to CHF 1,000

ÖKK NATURE PLUS also provides benefits if the treatment is carried out in a country neighbouring Switzerland. Neighbouring countries are those countries that share a border with Switzerland.

If ÖKK NATURE PLUS is concluded and maintained together with ÖKK HOSPITAL GLOBAL, ÖKK NATURE PLUS provides benefits worldwide.

This remains subject to the medical indication being verified and the therapists/doctors being qualified by the insurer.

No benefits are paid for parallel alternative medical treatments that are not expected to be beneficial.

2.1.3 Non-insured treatment

ÖKK NATURE does not provide benefits for wellness, lifestyle and preventative treatments.

2.2 Elective medical treatment abroad

ÖKK NATURE provides the following benefits per calendar year for outpatient conventional medical treatments by doctors abroad:

ÖKK NATURE MINI	no benefits
ÖKK NATURE MIDI	no benefits
ÖKK NATURE PLUS	80%, up to CHF 5,000 (with a deductible of CHF 300)

The maximum entitlement to benefits per calendar year is calculated from the residual amount in excess of the deductible.

2.3 Natural remedies

ÖKK NATURE reimburses the following benefits per calendar year for phytotherapeutic, homeopathic and anthroposophical remedies as well as Oligosol, provided it does not appear on the insurer's negative list:

ÖKK NATURE MINI	80%, max. CHF 300
ÖKK NATURE MIDI	80%, max. CHF 2,000
ÖKK NATURE PLUS	80%, max. CHF 4,000

The negative list is available from the insurer on request.

ÖKK NATURE PLUS also provides benefits if the remedy is obtained in a country neighbouring Switzerland. Neighbouring countries are those countries that share a border with Switzerland.

If ÖKK NATURE PLUS is concluded and maintained together with ÖKK HOSPITAL GLOBAL, ÖKK NATURE PLUS provides benefits worldwide.

2.4 Visual aids

In addition to ÖKK START, ÖKK NATURE also reimburses the following benefits per calendar year for glasses lenses and contact lenses for the purposes of vision correction.

ÖKK NATURE MINI	no benefits
ÖKK NATURE MIDI	CHF 80
ÖKK NATURE PLUS	CHF 200

Benefits can be accumulated for a period of two years if no benefits were claimed in the insured benefit level in the previous year.

ÖKK NATURE also provides benefits if the glasses lenses and contact lenses are bought abroad.

2.5 Laser eye treatment

ÖKK NATURE provides a one-time benefit of up to CHF 500 in the ÖKK NATURE PLUS benefit level after a qualifying period of three years. This applies for laser eye treatment for the purposes of vision correction for adults aged 18 and above.

ÖKK NATURE also provides benefits if the treatment is carried out abroad.

ÖKK PREVENTION

ÖKK Versicherungen AG, Edition 1.1.2018

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK PREVENTION provides contributions towards gynaecological preventative examinations, check-ups and inoculations. Contributions are also available from a health account for selected preventative measures.

ÖKK PREVENTION provides these benefits in addition to compulsory health care insurance under the Health Insurance Act (KVG). Of the total costs, a maximum of the amount not covered by other social insurance schemes or the ÖKK START basic module will be covered. If more than one private insurance policy is in place, benefits are provided subsidiary to other insurers. If the insurance conditions of other private insurers also contain this subsidiarity clause, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP.

Cost-sharing amounts from compulsory health care insurance are not insured.

1.4 Conditions for receiving benefits

ÖKK PREVENTION provides benefits for outpatient treatments carried out by people who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP.

1.5 Geographical scope

Unless otherwise specified, ÖKK PREVENTION provides benefits in Switzerland.

1.6 Conclusion of the insurance

ÖKK PREVENTION can be concluded until the person turns 60 years of age.

1.7 Duration of insurance

The term of ÖKK PREVENTION insurance is three years and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

2. Insurance benefits

2.1 Gynaecological preventative examinations

ÖKK PREVENTION covers 90% of the costs of a gynaecological preventative examination under the KVG at the KVG tariff, provided no benefits have been paid from compulsory health care insurance for a corresponding preventative examination in the current calendar year.

2.2 Check-up

ÖKK PREVENTION provides benefits totalling 90% of the costs, up to CHF 300 per calendar year, for medical check-ups (declared as such on the invoice by the doctor providing treatment).

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

2.3 Inoculations

ÖKK PREVENTION provides benefits totalling 90% of the costs, up to CHF 200 per calendar year for medically recognised inoculations, provided no benefits have been paid from compulsory health care insurance for this.

2.4 Health account

ÖKK PREVENTION provides benefits totalling 50% of the costs, up to CHF 300 per calendar year, for selected preventative measures in the areas of nutrition, movement, family and other prevention. The individual preventative measures recognised by the insurer in each area are specified on a list maintained by the insurer, which is available at any time.

The contribution towards individual recognised preventative measures within an area may be limited.

If preventative measures from various areas are used, ÖKK PREVENTION provides a maximum total amount of CHF 500 per calendar year.

ÖKK

ÖKK SMILE

ÖKK Versicherungen AG, Edition 1.1.2018

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK SMILE provides benefits for dental treatment and prophylactic measures.

ÖKK SMILE provides these benefits in addition to compulsory health care insurance under the Health Insurance Act (KVG) or accident insurance under the Accident Insurance Act (UVG). Of the total costs, a maximum of the amount not covered by other social insurance schemes or the ÖKK START basic module or cantons and municipalities will be covered. If more than one private insurance policy is in place, benefits are provided subsidiary to other insurers. If the insurance conditions of other private insurers also contain this subsidiarity clause, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP.

Cost-sharing amounts from compulsory health care insurance are not insured.

1.4 Conditions for receiving benefits

ÖKK SMILE covers medically necessary dental measures, scientifically recognised diagnostic and therapeutic measures, provided the treatment is economical.

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

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

1.5 Geographical scope

ÖKK SMILE provides benefits if the treatment is carried out in Switzerland or a country neighbouring Switzerland. Neighbouring countries are those countries that share a border with Switzerland.

1.6 Conclusion of the insurance

ÖKK SMILE can be concluded until the person turns 60 years of age.

Any pre-existing conditions, such as non-filled or missing teeth, misaligned teeth or jaw abnormalities, at the time the insurance was concluded are not insured. This benefit restriction is communicated to the insured person in writing.

The most recent dental check-up or treatment may not be more than one year before the start of the insurance.

1.7 Duration of insurance

The term of ÖKK SMILE insurance is three years and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

1.8 Insurance options

ÖKK SMILE offers the following benefit levels:

- ÖKK SMILE 1,000
- ÖKK SMILE 1,500
- ÖKK SMILE 3,000
- ÖKK SMILE 5,000

2. Insurance benefits

2.1 Dental treatments

Within the scope of the chosen benefit level, ÖKK SMILE covers the costs of dental treatment including laboratory costs. No benefits are provided for dental hygiene products.

Benefit level	Maximum entitlement to benefits per calendar year
ÖKK SMILE 1,000	50 % up to CHF 1,000
ÖKK SMILE 1,500	75% up to CHF 1,500
ÖKK SMILE 3,000	75% up to CHF 3,000
ÖKK SMILE 5,000	75% up to CHF 5,000

2.2 Check-ups and prophylaxes

In addition to ÖKK START, ÖKK SMILE provides benefits for check-ups incl. x-rays and for prophylaxes the actual costs up to CHF 100 per calendar year.

2.3 Qualifying period

Insured persons are entitled to benefits from ÖKK SMILE

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

The qualifying period also applies for increases in insurance.

Benefits for prophylaxes and check-ups are not subject to a qualifying period.

2.4 Procedure after dental treatment

The insurer must be sent the detailed original invoice by no later than 30 days after the invoice date. The duration of treatment and the single benefits provided must be indicated on the invoice.

ÖKK PARENTS

ÖKK Versicherungen AG, Edition 1.1.2018

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1. Insurance fundamentals

1.1 Insurance providers

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK PARENTS provides selected benefits in relation to giving birth and looking after the child.

ÖKK PARENTS provides these benefits in addition to compulsory health care insurance under the Health Insurance Act (KVG). Of the total costs, a maximum of the amount not covered by other social insurance schemes or the ÖKK START basic module will be covered. If more than one private insurance policy is in place, benefits are provided subsidiary to other insurers. If the insurance conditions of other private insurers also contain this subsidiarity clause, the coordination rules apply as per section 9.1.3 ÖKK LIVE CP.

Cost-sharing amounts from compulsory health care insurance are not insured.

1.4 Conditions for receiving benefits

ÖKK PARENTS provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer in accordance with section 6.3.3 ÖKK LIVE CP.

1.5 Geographical scope

Unless otherwise specified, ÖKK PARENTS provides benefits in Switzerland.

1.6 Conclusion of the insurance

ÖKK PARENTS can be concluded until the person turns 60 years of age.

1.7 Duration of insurance

The term of ÖKK PARENTS insurance is three years and the contract is automatically extended by one year, unless it is terminated by the policyholder subject to the standard notice period.

2. Insurance benefits

2.1 Maternity

2.1.1 Antenatal courses

ÖKK PARENTS provides benefits totalling up to CHF 200 per pregnancy for antenatal courses run by a specialist (incl. pregnancy and post-natal courses).

2.1.2 Nursing allowance (breastfeeding)

ÖKK PARENTS provides benefits totalling CHF 150 per child, provided the mother breastfeeds her child for ten weeks.

2.1.3 Birth in a birth house

In the event of a birth in a birth house recognised by the insurer that does not appear on a cantonal hospital list, the following benefits are provided: 90%, up to CHF 1,000 per birth.

The insurer maintains a list of recognised birth houses, which is available on request.

2.1.4 Domestic assistance following birth

2.1.4.1 Principle

In addition to ÖKK START, ÖKK PARENTS provides contributions towards the costs of medically prescribed domestic assistance.

The contributions are made instead of the benefits stipulated in section 2.3.

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

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

2.1.4.2 Birth in a hospital

Following a hospital birth, the following amount is paid: up to CHF 60 per day, a maximum of CHF 600 per calendar year.

2.1.4.3 Home birth

In the event of a home birth or following an outpatient birth, the following amount is paid: up to CHF 60 per day, a maximum of CHF 840 per calendar year.

2.1.5 Family room

In the case of a birth in a list or contractual hospital, ÖKK PARENTS provides benefits totalling up to CHF 200 per day towards the additional costs of a family room or a one- or two-bed room that is used as a family room.

2.2 Rooming-in

If a child up to 12 years of age receives inpatient treatment, ÖKK PARENTS provides benefits from the parent's insurance of up to CHF 150 per day for one parent to stay in the child's room.

If a parent insured with the insurer receives inpatient treatment, ÖKK PARENTS provides benefits of up to CHF 150 per day for one child up to the age of 12 to stay in the parent's room.

2.3 Domestic assistance

2.3.1 Principle

Directly after an inpatient stay in hospital, if medically prescribed ÖKK PARENTS (in addition to ÖKK START) makes contributions towards domestic assistance outside of the hospital, provided the insured person's domestic and family circumstances require this.

2.3.2 Scope of benefits

If the insured person is responsible for the care of at least one child up to the age of 12, ÖKK PARENTS provides benefits towards the costs of a recognised domestic assistance provider of up to CHF 40 per day, a maximum of CHF 600 per calendar year.

No benefits are paid if the insured person is staying in a care home.

2.3.3 Service providers

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

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

2.4 Childcare service

2.4.1 Principle

ÖKK PARENTS provides contributions towards childcare and nursing services for children up to the age of 12 if the services are provided by a partner recognised by the insurer.

The insurer maintains a list of recognised partners, which is available on request.

2.4.2 Conditions for receiving benefits

ÖKK PARENTS provides benefits if the child requires childcare or nursing as a result of acute illness or accident. The benefits provided are limited exclusively to childcare and nursing carried out by the mandated specialist.

Insured persons are entitled to benefits if they are the child's legal guardian and they are engaged in gainful activity during this time.

2.4.3 Scope of benefits

ÖKK PARENTS provides benefits of up to CHF 30 per hour, a maximum of CHF 600 per calendar year.

ÖKK TOURIST

ÖKK Versicherungen AG
Coop Rechtsschutz AG
Helvetia Swiss Insurance Company Ltd
Edition 1.1.2022

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INSURANCE FUNDAMENTALS

1. Insurance providers

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

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

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

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

2. Common Provisions

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

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

3. Purpose

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

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

The following conditions apply with regard to the insurance cover.

4. Insurance options

The following modules can be concluded within ÖKK TOURIST:

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

5. Conclusion of the insurance

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

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

6. Insured persons

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

6.1 Individual insurance

The person listed in the insurance policy is insured.

6.2 Family insurance

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

7. Start, duration and end of insurance

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

8. Dissolution of the collective contract

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

9. Cost sharing

No cost sharing applies to benefits provided under ÖKK TOURIST.

TREATMENT COSTS & PERSONAL ASSISTANCE

1. Conditions for receiving benefits

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

2. Geographical scope

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

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

3. Period of benefits

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

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

4. Insurance benefits

4.1 Treatment costs

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

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

The cover extends to illness, accident or premature birth at the habitual local tariffs or the contractually agreed tariffs. A birth is regarded as premature if it is unforeseen and takes place more than six weeks before the medically attested expected birth date.

The statutory cost share applicable to Switzerland is not insured.

4.2 Transport, search, rescue and recovery operations

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

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

4.3 Trips for visiting purposes and additional travel costs

4.3.1 Trips for visiting purposes

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

4.3.2 Additional return trip

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

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

4.4 Amount of coverage

4.4.1 ÖKK TOURIST 50/100

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

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

4.4.2 ÖKK TOURIST 250/500

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

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

4.5 Services

4.5.1 Payment advances to hospitals

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

4.5.2 Notification of people at home

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

4.5.3 Referral to hospitals and doctors abroad

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

4.5.4 Medical advice from doctors

If an insured person requires medical assistance while travelling and this cannot be obtained at the place they are staying, the doctors at the ÖKK emergency call centre provide medical advice. This advice only represents a recommendation, and in no way should be considered a diagnosis.

4.6 Exclusion of benefits

There is no entitlement to insurance benefits:

a) for illnesses and consequences of accidents that existed before embarking on the journey;
b) if the insured person travelled abroad for the purposes of receiving treatment or care, or giving birth;
c) if the ÖKK emergency call centre has not given its prior approval for search operations, repatriation, visitation or additional return trips; the provisions under Art. 45 VVG shall apply (absence of fault or no influence on scope of benefit);
d) in the case of participation in warlike actions, unrest, and similar events, and during military service abroad;
e) in the case of illnesses and accidents resulting from warlike events that had broken out more than 14 days previously;
f) in the case of illnesses and accidents resulting from active participation in punishable actions, fights or other acts of violence;
g) in the case of grossly negligent causation of the illness or accident, in particular as a result of misusing alcohol, medication or other drugs;
h) in the case of health impairments resulting from recklessness, i.e. if the insured person exposes themselves to a risk without taking or being able to take any measures that could reduce this risk to a reasonable level. This does not include rescue operations in aid of persons. In terms of these provisions, recklessness includes in particular the participation in races or training with motor vehicles; and
i) if the insured person's health is damaged intentionally, also as a consequence of suicide, a suicide attempt or self-harm.

If the emergency transportation or repatriation is not possible as a result of external factors, such as strike action, turmoil, acts of violence, large-scale industrial emergencies, radioactivity, natural disasters, epidemic illnesses or force majeure, there is no right to demand that these be organised or performed.

5. Obligations in the event of a claim

5.1 Notification of ÖKK emergency call centre

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

5.2 Release from duty of professional secrecy

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

5.3 Making a claim

The insured person must submit their claim for benefits to the insurer immediately and make available all information that contains the required medical and administrative details. Only detailed original invoices are accepted. If the invoice details are insufficient and additional information is not provided upon request, the level of benefits to be provided is determined at the insurer's discretion.

5.4 Deduction of rail or flight tickets

Unused rail or flight tickets must be automatically returned to the insurer. If useless tickets are sold or reimbursed by a third party, the amounts received in this respect will be deducted from the insurance benefits. If this obligation is not met, the insurer may reclaim an amount determined at its discretion from the insured person or offset this amount against the claim for benefits.

6. Third-party benefits

6.1 Social insurance

No benefits are covered that are paid out under social insurance (KV, UV, IV, MV, AHV, AVI etc.). Any claim to benefits must be reported to the relevant social insurance office.

If an insured person does not have compulsory health care insurance under KVG or equivalent coverage in the Principality of Liechtenstein, benefits are provided by the insurer as if this cover were in place.

6.2 Existing insurance policies with the insurer

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

6.3 Air rescue service and similar organisations

If the insured person is a member (donor) of an air rescue service or similar organisations, costs are only covered to the extent that these organisations have not provided benefits. This remains subject to other contractual agreements in place.

TRAVEL LEGAL PROTECTION

1. Geographical scope

The insurance cover applies worldwide outside of Switzerland and the Principality of Liechtenstein.

2. Period of benefits

The insurance cover applies for the duration of the insurance specified in the insurance policy.

Legal protection is provided for disputes arising during the duration of the insurance specified in the insurance policy. Cases are deemed to have occurred at the time of the breach of the law; for insurance-law-related cases, at the time of the insured event.

3. Insured capacities

The insured person has legal protection in their capacity as

a) the owner, driver or renter of a motor vehicle;
b) a sportsperson, pedestrian, cyclist, motorist or passenger in any form of transport;
c) the renter of a holiday property;
d) an attendee of a course at a foreign school;
e) the contractual party to a travel contract;
f) the victim of a violent crime; and
g) the holder of a credit card.

4. Insured travel legal protection claims

The following legal protection claims are insured:

a) claims for extra-contractual compensation for damage against the perpetrator/the perpetrator's liability insurance due to a physical injury or damage to property caused;
b) legal disputes with an insurer, health insurer or pension fund in relation to an event abroad;
c) representation in proceedings brought by criminal or administrative authorities resulting from a negligent breach of foreign legislation. In the event of an official investigation due to a premeditated crime, the costs will only be covered if the insured person is acquitted or the proceedings are suspended; and
d) legal disputes arising from the following contracts under the Swiss Code of Obligations (exhaustive list), provided the insured person is affected in a capacity in accordance with section 3 above:
   – Tenancy contract
   – Repair contract
   – Freight contract
   – Contract of carriage
   – Travel contract
   – School contract
   – Credit card contract.

5. Insurance benefits

The following benefits are provided in the insured legal protection cases:

a) protection of the insured person's legal interests by the legal service of Coop Rechtsschutz;
b) payment of up to CHF 300,000 (CHF 100,000 outside Europe) per case unless a specific benefit restriction applies, in particular the
   – costs of appointed lawyers and mediators;
   – costs of appointed experts;
   – costs of legal proceedings and court costs charged to the insured person;
   – procedural costs payable to the other party;
   – travel expenses for necessary appearances before a foreign court of up to CHF 5,000;
   – translation costs of up to CHF 5,000; and
   – bail money in order to avoid custodial remand of up to CHF 100,000. This benefit is only provided in advance and must be reimbursed to Coop Rechtsschutz.

No benefits are paid for:

a) fines;
b) compensation for damage and settlements;
c) costs which a liable third party is required to cover;
d) costs for public notarisations and register entries; and
e) costs for official authorisations, permits and inspections.

The insured person must reimburse to Coop Rechtsschutz the procedural and party compensation granted to them in the amount of the benefits they receive.

6. Exclusions

No legal protection is provided:

a) in legal protection cases for insured persons in the same family policy;
b) in direct or indirect relation to a crime being intentionally committed;
c) in legal protection cases that were intentionally caused as well as any resulting disputes/proceedings under civil or administrative law;
d) in relation to lawyers, mediators, appraisers and experts who are acting or acted for an insured person in an insured legal protection case;
e) in relation to claims assigned to an insured person as well as claims transferred to insured persons as heirs; and
f) in claims against Coop Rechtsschutz or any of its executive bodies.

7. Reporting a legal protection case

The occurrence of a legal protection case must be reported to the insurer immediately, and on its request, in writing. The insurer immediately forwards the case to Coop Rechtsschutz to be processed.

The insured person must assist Coop Rechtsschutz in processing the legal protection case, provide it with the necessary powers of attorney and information, and forward any notifications they receive, in particular from authorities, with no delay.

In the case of a culpable breach of these obligations, Coop Rechtsschutz may reduce the benefits it provides by the amount of the additional costs it incurs as a result. In the case of a serious breach, the insurer may refuse to pay any benefits.

8. Processing a legal protection case

Having consulted the insured person, Coop Rechtsschutz takes the measures required to safeguard its interests.

If it is necessary to involve a lawyer, in particular in court or administrative proceedings or in the case of conflicts of interest, the insured person is free to choose a lawyer. If Coop Rechtsschutz disagrees with the insured person's choice, the latter may propose three further lawyers, which may not belong to the same law firm. Coop Rechtsschutz must accept one of these three lawyers.

Before appointing the lawyer, the insured person must obtain consent from Coop Rechtsschutz as well as a cost guarantee.

If there is no valid reason for changing lawyers, the insured person must bear any costs resulting from this change.

9. Process in the case of differences of opinion

In the case of differences of opinion, particularly in cases Coop Rechtsschutz believes have no chance of success, the insured person may request that arbitration proceedings be initiated. Both parties jointly appoint a person as the arbitrator. Furthermore, this process is based on the provisions governing arbitration in the Swiss Code of Civil Procedure (ZPO).

If an insured person takes legal action at their own cost, contractual benefits will be provided if the result in the main proceedings is more favourable than the assessment of Coop Rechtsschutz.

10. Place of jurisdiction

In the event of any disputes arising out of this travel legal protection insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (Coop Rechtsschutz AG, Aarau).

CANCELLATION COSTS

1. Geographical scope

The insurance cover applies worldwide.

2. Period of benefits

The insurance cover applies for the period specified in the insurance policy.

The cover begins when the insurance is concluded or, in the case of existing insurance cover, when the travel service is booked and ends when the insured travel service ends (check-in, boarding the booked means of transport etc.).

3. Insured events

Insurance cover is provided if the insured person cannot make use of, has to prematurely cancel or has to extend a booked travel service as a result of one of the events listed below, provided the event occurs after the insurance is concluded/the travel service is booked:

a) unforeseen serious illnesses, injuries, pregnancy complications or death of
   - an insured person;
   - a person travelling with the insured person;
   - a person not travelling with the insured person, but to whom the latter is extremely close;
   - the insured person's deputy at their place of work, meaning that the insured person must be present there;

b) strikes (except in the case of active participation) on the planned route of travel abroad;

c) unrest of any kind or force majeure at the destination of travel if this could specifically endanger the life and/or property of the insured person and there is an official travel warning in place issued by the Swiss authorities for the destination of travel and if it is therefore impossible or unreasonable to continue the trip or stay;

d) serious damage to the property of the insured person at their place of residence as a result of fire, natural hazards, theft or water damage, meaning that they must be present in their homes;

e) the outage or delay – both as a result of technical defects or personal accidents – of the means of public transport to be used to travel to the official point of departure (airport, train station, port or coach terminal) in the country of residence;

f) if, within 30 days before departure,
   - the insured person unexpectedly starts a new permanent job with a new employer (promotions etc. are excluded); or
   - the employment contract of the insured person is terminated by the employer through no fault of their own; and

g) theft of tickets, passport or identity cards.

If the person who triggers the cancellation because of an insured event is neither related to nor related by marriage to the insured person, there is only an entitlement to benefits if the insured person would be obliged to embark upon the trip alone.

4. Insurance benefits

4.1 Principle

The entitlement to benefits is determined based on the event that triggered the cancellation, premature disruption or extension of the travel services. Neither previous nor subsequent events are taken into account.

4.2 Cancellation costs

Upon occurrence of the insured event, the insurance covers the cancellation costs actually incurred (excl. security and airport taxes). In total, this benefit is restricted to the price of the travel service/the insured amount.

Excessive or repeated processing fees are not insured.

4.3 Additional costs

The insurance reimburses the additional costs for any delayed start, premature cancellation or extension of travel if the travel service cannot be made use of, has to be prematurely cancelled or has to be extended as at the scheduled time as a result of the insured event.

Additional costs to extend the trip are reimbursed for a maximum of seven days.

If a claim is made for additional costs, there is no entitlement to any cancellation costs.

4.4 Unused travel services

The insurance reimburses the pro rata costs of unused travel services (excl. costs of the originally booked return journey) if the travel has to be interrupted prematurely. This benefit is restricted to the price of the travel service/the insurance amount specified in the insurance policy.

4.5 Amount of coverage

The benefits for cancellation costs or additional costs for any delayed start or premature cancellation of travel are limited to CHF 20,000 per event and person / CHF 50,000 per event and family.

Additional costs to extend the trip are limited to a maximum of CHF 700 per person, or up to CHF 1,000 if using a hire car, irrespective of how many people use the car.

Benefits included in the leisure cover (day trips, training courses, concert tickets, ski passes, entry fees for runs etc.) are limited to CHF 500 per person and event.

4.6 Exclusion of benefits

Benefits are excluded:

a) if the service provider (travel company, lessor, organiser etc.) cancels the agreed service or would have to have cancelled them for objective reasons (this particularly applies for package holidays);

b) if the event had already occurred or was foreseeable at the time the insurance was concluded or the travel service booked;

c) if the complaint giving rise to the cancellation, disruption or extension of the trip was a complication or consequence of a medical operation or treatment that was already planned at the time the insurance began/the travel service was booked;

d) if an illness or the consequences of an accident, an operation or a medical procedure already existed at the time the travel was booked and had not healed by the date of travel;

e) in the event of cancellation, disruption or extension of the trip without medical indication or if the certificate of incapacity to work had not been issued at the time the inability to travel could first possibly be identified or if it was obtained on the basis of a telephone consultation;

f) if a cancellation as a result of an psychological or psychosomatic complaint:
   – cannot be justified on the basis of a psychiatrist's findings and a certificate issued by said psychiatrist on the day of the cancellation; and
   – cannot additionally be justified by people in employment relationship by providing a 100% absence confirmation from their employer for the duration of the medically certified inability to travel;
g) if the appraiser (expert, doctor etc.) who makes the findings is a direct beneficiary or is related/married to the insured person;
h) for events resulting from orders by public authorities (arrest, entry or exit bans, closure of borders and/or airspace, quarantine etc.);
i) which the insured person brings about in relation to suicide, self-mutilation or attempts thereof;
j) in the case of cancellation, travel disruption or travel extension resulting from warlike events or terrorism;
k) in the case of cancellation, travel disruption or travel extension due to events involving ionising radiation of any type, in particular the transmutation of atomic nuclei;
l) if the event that gave rise to the cancellation, travel disruption or travel extension is a result of deliberate or grossly negligent acts or omissions or is a result of a failure to exercise the customary level of due care;
m) if an event that gave rise to the cancellation, travel disruption or travel extension was caused when under the influence of alcohol, drugs, narcotics or medication;
n) if the event that gave rise to the cancellation, travel disruption or travel extension arose while intentionally committing criminal acts or attempting to do so;
o) if additional costs are claimed for the premature cancellation or extension of a trip without these costs having first been approved by the ÖKK emergency call centre; and
p) in the case of epidemics and pandemics as well as the consequences of those. This has no impact on the benefits covered for the insured events as definitely listed in this document.

4.7 Chronically ill persons

The chronically ill must obtain confirmation in the form of a medical certificate that they are able to travel immediately prior to booking a travel service.

If an insured person suffers from a chronic illness, but there appears to be no concern regarding the travel service upon conclusion of the insurance/booking of the travel service because of said illness, the insurance pays the insured costs incurred if the travel service has to be cancelled due to an unforeseeable, serious acute deterioration of this illness or if the insured person dies as a result of the chronic illness.

4.8 Assignment of claims

Once ETI makes a claim payment, the insured person automatically assigns their entire claim resulting from the insurance contract to ETI.

4.9 Liability of insurer

ETI only provides insurance cover to the extent that it is not in breach of any sanctions or restrictions under UN resolutions and is not in breach of any trade or economic sanctions imposed by Switzerland, the European Union or the United States of America, and in the event of claims or other benefits, is only liable to this extent.

5. Obligations regarding conduct while travelling

When assessing whether a journey to a country is feasible or not due to a strike, unrest, war, terror attacks etc., only the applicable recommendations and travel warnings issued by the Swiss authorities must be considered. First and foremost, this is the Federal Department of Foreign Affairs (FDFA) and the Federal Office of Public Health (FOPH).

6. Obligations in the event of a claim

The place of booking (travel agency, transport company, lessor etc.) must be notified immediately upon occurrence of the event.

Furthermore, in the event of a claim, the insurer must be notified immediately. The insurer immediately forwards the case to ETI to be processed.

The ÖKK emergency call centre must always be contacted before cancelling or extending a trip.

In the case of accident or illness, a doctor must be contacted immediately, who must be informed about the travel plans and whose instructions must be followed. The insured/entitled person must release the doctors treating them from their duty of professional secrecy to the insurer.

The following documents must be submitted to ETI, among others:
– the booking confirmation/invoice for the travel service as well as the invoices for the cancellation/additional travel costs (original copies);
– a detailed medical certificate/death certificate or any other official certificates; and
– a copy of the insurance policy.

7. Claims against third parties

If the insured/entitled person is reimbursed by a liable third party or their insurer, no reimbursement is due on the basis of this contract. If ETI is requested to make settlement instead of the liable third party, the insured person has to assign their liability claims to ETI up to the amount of the costs.

In the case of multiple insurance policies (voluntary or compulsory insurance), ETI provides its benefits on a subsidiary basis unless the insurance conditions of the other insurer also contain a subsidiarity clause. In this case, the statutory rules covering duplicate insurance cover shall apply. In the event of a claim, the insured/entitled person shall fully disclose and make accessible any existing insurance cover and authorise ETI to make any claims.

If there are multiple insurance policies in place with licensed companies, the costs shall only be reimbursed once overall.

8. Place of jurisdiction

In the event of any disputes arising out of this cancellation cost insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (European Travel Insurance, Basel).

LUGGAGE

1. Geographical scope
The insurance cover applies worldwide.

2. Period of benefits
The insurance cover applies for the duration of the insurance specified in the insurance policy, and for as long and so often as the insured items are taken outside the insured person's permanent residence.

The insurance cover also applies for travel on public transport for as long as the insured items are in the custody of a transport operator.

3. Insured items
All items taken on the journey by the insured persons for their own person necessity are insured.

Sporting equipment, wheelchairs and prams/pushchairs are only covered by the insurance during travel on public transport and for as long as these items are in the custody of the transport operator.

4. Uninsured items
The insurance does not cover the following:

a) Cash and tickets (subject to section 6.1 d);
b) All types of securities, certificates and documents (subject to section 6.1 g);
c) Software;
d) Precious metals, precious stones and pearls;
e) Stamps;
f) Commercial goods and commercial samples;
g) Items of artistic or collector's value;
h) Musical instruments;
i) Surf boards;
j) Motor vehicles, trailers, caravans, boats and aircraft, including all accessories;
k) Items covered by special insurance;
l) Items bought or received as gifts during the period of travel (e.g. souvenirs) that are not personal travel necessities; and
m) Items that are taken on the journey that are not personal travel necessities (gifts, goods for third parties etc.).

5. Insured events
The following events are insured:

a) Theft and burglary
b) Robbery
c) Damage and destruction
d) Loss during travel on public transport; and
e) Delayed delivery (at least six hours) by public transport.

When camping, these events are only insured within official campsites.

6. Insurance benefits
6.1 Scope of benefits
The insurance reimburses the following:

a) in the case of total loss/write-off of insured items, the fair value; the fair value is the item's original purchase price less depreciation of at least 10% per year from the date of purchase; in total, however, a maximum of 60%;
b) in the case of partial damage, the costs of the repairs, up to a maximum of the fair value;
c) for all valuable items, up to 50% of the insurance amount;
d) cash and tickets only in the event of robbery; in such cases, up to 20% of the insurance amount, up to CHF 1,000; for replacement tickets, up to CHF 2,000;
e) breakages, up to 20% of the insurance amount;
f) glasses, contact lenses, prosthetics and wheelchairs, up to 20% of the insurance amount;
g) in the event of theft/loss of a passport, identity card, driving licence, vehicle registration documents and similar document as well as keys, the replacement costs;
h) in the event of theft/loss of credit cards and mobile telephones, the organisation (but not the costs) of having them blocked;
i) if luggage is delivered late via public transport, the costs of absolutely necessary purchases of up to CHF 1,000 per person and up to CHF 4,000 per family/per insurance confirmation and event. Insured persons are not entitled to any reimbursements when travelling back to their place of residence;
j) for non-valuable items left in a closed vehicle, boat or tent, up to 50% of the insurance amount, up to CHF 2,000 per insured journey under individual insurance policies and up to CHF 5,000 under family insurance policies.

6.2 Amount of coverage
Benefits are limited to the insured amount, up to CHF 4,000 per person and up to CHF 10,000 per family/insurance confirmation and event.

6.3 Exclusion of benefits
Benefits are excluded for loss/damage:

a) resulting from wear and tear, damage inflicted by the insured person, weather damage, insufficient or unsatisfactory quality or packaging of the items;
b) resulting from neglect, inattention, loss, dropping or negligence;
c) to items left in a publicly accessibly location outside the insured person's sphere of location, even if for just a short period of time;
d) to items whose value is not deemed sufficient for the item to be kept safe;
e) to valuable items left in a vehicle, boat or tent or handed over to a transport operator for transport, and for as long as these items are in the custody of the transport operator;
f) to items left in vehicles, boats or tents overnight (from 10 p.m. to 6 a.m.);
g) resulting from warlike events or terrorism;
h) due to events involving ionising radiation of any type, in particular the transmutation of atomic nuclei;
i) caused by deliberate or grossly negligent acts or omissions or is a result of a failure to exercise the customary level of due care;
j) arising while intentionally committing criminal acts or attempting to do so.

6.4 Assignment of claims

Once ETI makes a claim payment, the insured person automatically assigns their entire claim resulting from the insurance contract to ETI.

6.5 Liability of insurer

ETI only provides insurance cover to the extent that it is not in breach of any sanctions or restrictions under UN resolutions and is not in breach of any trade or economic sanctions imposed by Switzerland, the European Union or the United States of America, and in the event of claims or other benefits, is only liable to this extent.

7. Obligations regarding conduct while travelling

When they are not being used or worn, valuable items must:

- be handed over to the place of accommodation or a guarded cloakroom for safekeeping; or
- be stored in a locked room that is not accessible to the general public and kept under separate lock and key; bags of any kind, beauty and attaché cases, and jewellery boxes are not considered sufficient for this purpose.

Travel advice issued by the Federal Department of Foreign Affairs (FDFA) on the respective destination, in particular crime there and the associated precautionary measures to be taken, must be taken into consideration and followed.

8. Obligations in the event of a claim

In the event of a claim, the insurer must be notified immediately. The insurer forwards the case to ETI to be processed.

The insured person must

a) in the case of theft or robbery, request from the nearest police station that an official investigation be carried out and that the incident be recorded (police report, report of loss of air ticket etc.);
b) in the event of damage, delayed delivery or loss while the luggage is being transported by the responsible body (hotel management, tour leader, transport company etc.), immediately have the causes, circumstances and extent of the damage be confirmed in a report and request compensation from said body; and
c) after returning from the trip, immediately notify ETI in writing and provide justification for the claim.

The following documents must be submitted to ETI, among others:

a) the original copy of the relevant report (police report, report of loss of air ticket etc.);
b) the original confirmation, receipts purchase confirmations; and
c) a copy of the insurance policy.

Damaged goods must be made available to ETI.

9. Place of jurisdiction

In the event of any disputes arising out of this luggage insurance, the claimant may choose to have their case heard before the court at their place of residence in Switzerland or the insurer's registered office (European Travel Insurance, Basel).

ÖKK PROTECT

Coop Rechtsschutz AG, Edition 1.1.2022

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1. Insurance fundamentals

1.1 Insurance provider

The insurer is Coop Rechtsschutz AG, Entfelderstrasse 2, 5000 Aarau (hereinafter referred to as the insurer).

ÖKK Versicherungen AG (hereinafter referred to as ÖKK) has concluded a collective insurance contract as a policyholder with Coop Rechtsschutz AG as the insurer to provide health-legal protection.

The insured person has a direct right of claim against Coop Rechtsschutz AG. ÖKK accepts no liability for any claims arising out of this legal protection insurance.

ÖKK Kranken- und Unfallversicherung AG, Landquart (hereinafter referred to as ÖKK KUV AG) shall be entitled to take all actions on behalf and for the account of ÖKK.

1.2 Common Provisions

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

1.3 Geographical scope

The insurance cover applies worldwide.

1.4 Period of benefits

Legal protection is provided for disputes arising during the duration of the insurance. Cases are deemed to have occurred at the time of the breach of the law; for insurance-law-related cases, at the time of the insured event. If this insurance is dissolved, the entitlement to legal protection also expires for cases occurring after this time.

1.5 Insured persons

Persons who have concluded an ÖKK PROTECT policy with ÖKK are insured.

The following persons are also insured:

- all persons who are insured at ÖKK under a joint policy with the aforementioned person; and
- children and young persons up to the age of 18 who live in the same household as the aforementioned person and are insured at ÖKK.

If an insured person dies as a result of an insured event, their legal successors are insured for this case.

1.6 Start, duration and end of insurance

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

If a person fulfilling the conditions for ÖKK PROTECT leaves the joint policy, they remain insured with ÖKK PROTECT. However, the insured person has the right to withdraw within three months of being notified of this.

1.7 Dissolution of the collective contract

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

2. Scope of coverage

2.1 Contract fundamentals

The content of the contract is based on these ÖKK PROTECT General Insurance Conditions, the Federal Act on Insurance Contracts (VVG), the Federal Law on the Supervision of Insurance Companies (VAG) as well as the Ordinance on the Supervision of Private Insurance Companies (AVO).

2.2 Insured disputes

The following disputes are insured in relation to an insured person's health being damaged:

- disputes related to liability law (e. g. with medical service providers, with vehicle owners following traffic accidents), in particular:
  - enforcing claims for damages resulting from incorrect treatments;
  - the obligation to provide information to the insured person regarding the potential impact of medical treatment;
  - incorrect information being provided or the refusal to provide information, in particular concerning
    - the inspection of examination documents;
    - the surrender of x-ray images; and
  - a failure to carry out examinations.
- disputes related to insurance law (e. g. with liability, accident, health, disability insurance providers).

2.3 Subsidiarity

There is only an entitlement to legal protection if and to the extent that the benefits have to be provided by another insurer. The principle of subsidiarity does not apply to disputes with medical service providers and their liability insurers.

2.4 Non-insured disputes

The insurance does not cover the following:

- cases that are not expressly listed;
- cases that occurred before this insurance entered into force;
- disputes of the insured person with Coop Rechtsschutz AG and/or its executive bodies and representatives;
- cases related to:
  - psychiatric and psychotherapeutic treatments;
  - fees and invoices (excluding those related to the non-provision of benefits);
  - ÖKK premium calculations; and
  - defending claims for damages.

3. Insurance benefits

The insurer provides the following benefits:

- protection of the insured person's legal interests by the legal service of Coop Rechtsschutz;
- payment up to CHF 250,000 (or CHF 50,000 for cases other than Europe and countries bordering on the Mediterranean) per case for:
  - the costs of appointed lawyers
  - the costs of appointed experts
  - the costs of legal proceedings and court costs charged to the insured person
  - the costs of collecting the compensation promised to the insured person
  - the procedural costs imposed upon the insured person and payable to the other party.

The following will not be paid:

- compensation for damage
- the costs which a liable third party is required to cover.

Court costs and legal fees promised to the insured person are to be assigned to the insurer.

4. Legal protection cases

4.1 Reporting a legal protection case

The occurrence of a legal protection case must be reported to the insurer/ÖKK immediately, and on their request, in writing. The insured person must assist the insurer in processing the legal protection case, provide them with the necessary powers of attorney and information, and forward to the insurer any notifications they receive, in particular from authorities, with no delay. In the case of a culpable breach of these obligations, the insurer may reduce the benefits it provides by the amount of the additional costs it incurs as a result. In the case of a serious breach, the insurer may refuse to pay any benefits.

4.2 Processing a legal protection case

Having consulted the insured person, the insurer takes the measures required to safeguard the latter's interests. If it is necessary to involve a lawyer, in particular in court or administrative proceedings or in the case of conflicts of interest, the insured person is free to choose a lawyer. If there is no valid reason for changing lawyers, the insured person shall bear any costs resulting from this change.

4.3 Process in the case of differences of opinion

In the event of a difference of opinion about the next steps to be taken, particularly in cases the insurer believes have no chance of success, arbitration proceedings will be initiated at the request of the insured person. Both parties jointly appoint a person as the arbitrator. Furthermore, this process is based on the provisions governing arbitration in the Swiss Code of Civil Procedure (ZPO). If an insured person takes legal action at their own cost, contractual benefits will be provided if the result in the main proceedings is more favourable than the assessment of the insurer.

5. Place of jurisdiction

The place of jurisdiction is agreed as the Swiss place of residence of the insured person or Aarau.

ÖKK

ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ACCIDENT

SOLIDA Versicherungen AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Insurance provider

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

ÖKK Versicherungen AG (hereinafter referred to as ÖKK) has concluded a collective insurance contract with SOLIDA as the insurer to provide insurance cover in the event of death or disability caused by accident.

Customers of ÖKK may submit an application to ÖKK to be insured with SOLIDA against the financial consequences of death or disability.

Customers of ÖKK do not have a contract in place with SOLIDA. Under the Insurance Contract Act, however, if an insured event occurs, insured persons have a direct claim against SOLIDA for the benefits it insures. ÖKK accepts no liability for claims resulting from this accident insurance policy.

ÖKK Kranken- und Unfallversicherung AG, Landquart (hereinafter referred to as ÖKK KUV AG) shall be entitled to take all actions on behalf and for the account of ÖKK.

1.2 Common Provisions

The Common Provisions (CP) of the ÖKK UNO or ÖKK LIVE product lines specified in the insurance confirmation shall apply. The CP shall apply mutatis mutandi for this collective insurance. They are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the CP, the provisions of this insurance product take precedence over the CP.

1.3 Geographical scope

The insurance cover applies worldwide. If the insured person moves abroad, the insurance ends with the calendar year in which they move (unless the insurance has been suspended).

1.4 Period of benefits

An accident and its consequences are insured if the accident occurred during the term of insurance cover.

1.5 Conclusion of the insurance

The insurance can be concluded until the person turns 65 years of age.

1.6 Age of insured person

The age of the insured person for the purpose of the insurance policy is the difference between the calendar year and their year of birth.

1.7 Insured persons

Individuals who have registered for the accident insurance in accordance with these GIC and have received the insurance confirmation are insured.

1.8 Start, duration and end of insurance

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

1.9 Changes to insurance

It is possible to increase the insurance amount until the insured person turns 65 years of age.

1.10 Dissolution of the collective contract

The insurance cover ends if the collective insurance contract between the insurer and ÖKK Versicherungen AG is dissolved. The insured person must be notified in writing of the dissolution of this contact by no later than one month before the termination of the insurance cover.

1.11 Contractual amendments

If the GIC are amended from the following calendar year, the new insurance conditions apply for the contractual partner of ÖKK. ÖKK shall provide notification of any amendments by no later than 30 days before the end of the calendar year. The contractual partner has the right to terminate the contract as of the end of the current calendar year. Due notice shall be deemed to have been given if it is received by ÖKK by no later than the last day of the calendar year. If the contractual partner fails to provide ÖKK with due notice of termination, they are deemed to have accepted the amendment(s).

2. Scope of coverage

The insurance covers all occupational and non-occupational accidents, including occupational diseases, provided there was an obligation to pay compensation for them at the time they occurred in accordance with the Swiss Federal Accident Insurance Act (UVG, Art. 6–9).

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

The following conclusive list of physical injuries are considered equivalent to accidents, provided they were not primarily caused by illness or attrition: bone fractures, dislocations of joints, meniscal tears, muscle tears, pulled muscles, tendon tears, ligament lesions and eardrum injuries.

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

The following are also considered to be accidents:
- health impairments caused by involuntarily breathing gases or vapours, or unintentionally consuming poisonous or corrosive substances;
- drowning; and
- the following health impairments, provided the insured person sustains them on an involuntarily basis and they are caused by an insured accident event: frostbite, heatstroke, sunstroke and health impairments caused by ultraviolet radiation, excluding sunburn.

The following are also not considered to be accidents: illnesses of all types, in particular infectious diseases, asbestos-related damage, effects of ionising radiation, damage caused by treatment or examination measures that were not required as a result of an insured accident and procedures carried out to the person's own body.

3. Insurance amounts

3.1 Level of insurance amounts

The insurance amounts listed in the insurance confirmation apply.

3.2 Maximum insurance amounts

3.2.1 Maximum insurance amounts for children

The maximum insurance amount for the death of a child up to the age of 15 is CHF 20,000.

The statutory death lump-sum payment from this and other insurance policies is a maximum of CHF 2,500 for children who are under two and a half years of age and a maximum of CHF 20,000 for children who are under twelve years of age.

3.2.2 Maximum insurance amounts in old age

The maximum insurance amounts for insured persons aged 66 (see section 1.6) and above are CHF 20,000 in the event of death and CHF 100,000 in the event of disability.

Higher insurance amounts are automatically reduced to the maximum insurance amounts as of the start of the next calendar year.

The progression for disability insurance does not apply.

4. Death endowment policy

4.1 Beneficiaries

If the accident causes the death of the insured person immediately or within five years of the date of the accident, the insurer shall pay the insured amount upon death provided accident insurance was in place at the time of the accident

- to the surviving spouse/registered partner;
- if there is no surviving spouse, to the children, adoptive children and step-children in equal amounts;
- if there are none of the above, to the parents in equal amounts;
- if there are none of the above, to the siblings in equal amounts.

Spouses and children from a marriage that took place after the accident have no entitlement to any benefits.

In amendment of the above regulation, the insured person may notify ÖKK in writing that they wish to designate a beneficiary/exclude persons entitled to the benefits. Such a declaration may be revoked or amended at any time in writing.

If there are none of the above-mentioned beneficiaries, the insurer reimburses the costs of the funeral, but no more than 10% of the insurance amount, up to CHF 10,000.

The insurance benefits are owed irrespective of whether the insured event caused a loss of assets (fixed-sum insurance policy).

4.2 Double death benefit

If the same accident results in the death of both parents or registered partners, the insurer pays double the death lump-sum benefit of each insured parent/registered partner in equal parts to the minor or long-term incapacitated children, step children or adoptive children who are in need of support.

4.3 Deduction of disability lump-sum payment

Any disability lump-sum payment already paid out for the same accident is deducted from the death lump-sum payment.

5. Disability endowment policy

5.1 Principle

If the accident results in an insured person suffering a disability that according to medical theory is likely to be of an enduring nature, the insurer pays the insurance amount agreed for the disability provided accident insurance was in place at the time of the accident:

- the full insurance amount for cases of full disability;
- part of the insurance amount corresponding to the degree of disability for cases of partial disability.

The final degree of disability is calculated based on the condition of the insured person that has been recognised as likely to persist. However, the insurer may have the degree of disability conclusively determined five years or more after the accident. This will determine the current degree of disability at the time the assessment is carried out. Any changes to the degree of disability that subsequently occur, i. e. relapses and long-term consequences, are no longer insured. When determining the degree of disability, any inability to work arising as a result of the event is not taken into consideration.

Only the insured person is entitled to the disability lump-sum payment.

5.2 Full disability

Full disability is considered to be:

- the loss of or inability to use both arms or hands;
- the loss of or inability to use both legs or feet, or the simultaneous loss of an arm or hand and a leg or foot;
- full paralysis; and/or
- complete blindness.

5.3 Partial disability

In the case of partial disability, the proportion of the insurance amount for full disability is paid in line with the degree of disability. The degree of disability is calculated according to the following scale:

Loss of or complete inability to use the following:

– Upper arm	70%
– Lower arm	65%
– Hand	60%
– Thumbs with metacarpal joint	25%
– Thumbs, metacarpal joint intact	22%
– End joint of the thumb	10%
– Index finger	15%
– Middle finger	10%
– Ring finger	9%
– Little finger	7%
– Leg above the knee	60%
– Leg below the knee	50%
– Foot	45%
– Big toe	8%
– Toe	3%
– Sight of one eye	30%
– Sight of the second eye for people with one eye	50%
– Hearing in both ears	60%
– Hearing in one ear	15%
– Hearing in one ear if hearing in the other ear had already been completely lost prior to the accident occurring	30%
– Sense of smell	10%
– Sense of taste	10%
– Kidney	20%
– Spleen	5%
– Extremely painful, severe functional restrictions to spinal column	50%

In the event of a partial loss of or partial inability to use a body part, the degree of disability that applies shall be reduced accordingly.

If it is not possible to determine the degree of disability using the applicable scale, it shall be determined in line with the guidelines for determining the loss of bodily functions in accordance with the Federal Law on Accident Insurance (UVG) and the Swiss Federal Ordinance on Accident Insurance (UVV).

In the event of a simultaneous loss of or inability to use multiple body parts as a result of the same accident, the degree of disability is usually calculated by adding together the percentages. However, the degree of disability cannot exceed 100%. In the event of an insured person losing all the fingers on one hand, only the disability lump-sum payment for the loss of the corresponding hand is paid out.

5.4 Severe disfigurements

With respect to persisting, severe disfigurements of the human body resulting from an accident (aesthetic damage, e. g. scars) for which no disability lump-sum payment is due, but which however, make the insured person's social circumstances more difficult, the insurer pays up to the following percentages of the insurance amount agreed in the event of disability:

– 10% for facial disfigurement
– 5% for disfigurement of other body parts that are usually visible.

Benefits paid with respect to aesthetic damage shall also be limited to CHF 20,000.

There shall be no progressive payments.

5.5 Pre-existing physical defects

If pre-existing physical defects (with the exception of the loss of an insured person's second eye or the hearing in their second ear) aggravate the consequences of the accident, this shall not result in a higher benefit being paid. If, prior to the accident, the insured person had already completely or partially lost the limb / organ or use thereof, the pre-existing degree of disability, as calculated in line with the aforementioned principles, is subtracted from the final degree of disability.

If pre-existing illnesses or infirmities that were not initially sustained as a result of the accident significantly aggravate the consequences of the accident, the insurance benefits are proportionally reduced; this is done at the time the degree of disability is determined and not when the disability lump-sum payment is determined.

5.6 Reimbursement in the case of disability

In the case of a disability of more than 25%, the reimbursement increases progressively up to 350% of the insurance amount.

Degree of disability (%)	Reimbursement (%) insured amount	Degree of disability (%)	Reimbursement (%) insured amount
1	1	29	37
2	2	30	40
3	3	31	43
4	4	32	46
5	5	33	49
6	6	34	52
7	7	35	55
8	8	36	58
9	9	37	61
10	10	38	64
11	11	39	67
12	12	40	70
13	13	41	73
14	14	42	76
15	15	43	79
16	16	44	82
17	17	45	85
18	18	46	88
19	19	47	91
20	20	48	94
21	21	49	97
22	22	50	100
23	23	51	105
24	24	52	110
25	25	53	115
26	28	54	120
27	31	55	125
28	34	56	130
57	135	79	245
58	140	80	250
59	145	81	255
60	150	82	260
61	155	83	265
62	160	84	270
63	165	85	275
64	170	86	280
65	175	87	285
66	180	88	290
67	185	89	295
68	190	90	300
69	195	91	305
70	200	92	310
71	205	93	315
72	210	94	320
73	215	95	325
74	220	96	330
75	225	97	335
76	230	98	340
77	235	99	345
78	240	100	350

6. Benefit restrictions

6.1 Principle

The conditions regarding benefit restrictions in the CP as per the insurance confirmation do not apply.

6.2 Exclusion of benefits

There is no entitlement to insurance benefits:

a) as a result of war, civil war or war-like situations;
   – in Switzerland, the Principality of Liechtenstein or any neighbouring countries;
   – in other foreign countries unless the accident occurs within a period of 14 days of such events initially occurring in the country in which the insured person is staying and the outbreak of the hostilities is unexpected;
b) as a result of an earthquake in Switzerland and the Principality of Liechtenstein;
c) as a result of entering into extraordinary dangers. This includes the following:
   – foreign military service;
   – participating in acts of war or acts of terror;
   – involvement in fights and brawls unless the insured person was injured by those fighting as an innocent bystander or as a result of going to a defenceless person's aid;
   – risks the insured persons takes by seriously provoking others;
   – the consequences of disturbances of all kinds unless the insured person can prove that they did not actively participate in such acts on the side of the perpetrators or incite them to further violence;
d) as a result of intentionally or consciously committing criminal acts, attempting to do so, or participating in them;
e) as a result of the effects of ionising beams or damage caused by nuclear energy;
f) for accidents in which the insured person has a blood alcohol concentration of two parts per thousand or more unless there is clearly no causal relationship between the insured person's intoxication and the accident;

g) as a result of recklessness (actions by which the insured person exposes themselves to a considerable risk without taking or being able to take any measures that could reduce this risk to a reasonable level);
h) as a result of suicide or health impairments to the insured person's own body that the insured person caused to themselves intentionally or in a state of full or partial diminished responsibility;
i) as a result of intentionally consuming or injecting medications, drugs or chemical products;
j) as a result of medical or surgical procedures that were not necessitated by an insured accident;
k) when using aircraft as a military pilot, other military crew member or Parachute Reconnaissance Company member;
l) when undertaking military parachute jumps;
m) when undertaking air travel if the insured person intentionally breaches official regulations or is not in possession of official pieces of identification and authorisations; and
n) for the statutory and regulatory cost-sharing amounts of the insured person under compulsory health care insurance.

6.3 Benefit reductions

6.3.1 Gross negligence

The insurer waives its right to reduce the benefits in the case of the insured accident being caused as a result of gross negligence.

6.3.2 Non-accident-related factors

If non-accident-related factors impact the progression of an insured accident, the insurer only pays a part of the agreed benefits that is determined on the basis of a medical assessment. Here the non-accident-related factors are already deducted at the time the degree of disability is determined and not when the disability lump-sum payment is determined.

6.3.3 Breach of obligations in the event of a claim

In the case of a culpable breach of the obligations by the insured person, the benefits may be reduced.

6.3.4 Further benefit reductions

Any further benefit reductions are based on the UVG provisions (Art. 37–39) applicable at the time of the accident or the onset of the illness.

6.4 Death caused by beneficiary

If a person causes the death of the insured person as a result of intentionally or consciously committing criminal acts, attempting to do so, or participating in them, this person shall have no claim to any payments resulting from the death.

If a beneficiary causes the death of the insured person due to gross negligence, the benefits they receive will be reduced; in particularly serious cases, they may be refused.

7. Retraining costs

If professional retraining is required as a result of an accident for which the insurer has paid benefits, the insurer will cover the appropriate costs for this, up to 10% of the insured disability amount.

8. Fees

The conditions regarding premiums and payments in the CP as per the confirmation apply mutatis mutandi.

The fee for the cover is calculated according to the age group of the insured person and the level of the insurance amounts. In each case, the fee remains guaranteed for one calendar year. There is no tariff guarantee.

The age groups are 0 to 3 years, 4 to 15 years, 16 to 20 years and 21 to 65 years. The last age group contains older people.

9. Process for making a claim

An accident that is likely to trigger the insurer's obligation to provide benefits must be reported to ÖKK immediately.

A death must be reported immediately, within ten days at the latest.

The insured person must undergo the examinations and follow the instructions of the doctors appointed by the insurer at its cost.

If any entitlement is lost as a result of non-compliance, the insured person must provide the insurer with any information requested concerning previous and current medical conditions as well as the accident and how treatment is progressing within 30 days of such a written request being made. The insured person and the beneficiary must substantiate their claims to costs with doctor's certificates. These may also be obtained by the insurer.

The insured person must release any doctors who have treated them following an accident or illness from their duty of professional secrecy so that they can provide any information requested by the insurer.

If the insured person or beneficiary culpably fail to meet one of these obligations, the insurer may reduce the benefits by the amount by which they would have been reduced had this obligation been duly met in good time, unless the insured person or beneficiary proves that their conduct contrary to the contract had no impact on the consequences of the accident or the establishment thereof.

10. Notifications to the insurer

All notifications and disclosures are to be made to ÖKK. The insurer recognises these notifications and disclosures as if they had been made to it. All notifications on the part of the insurer are duly sent to the last known address in Switzerland of the insured person or beneficiary.

11. Place of performance and place of jurisdiction

Besides Zurich as the place of jurisdiction, for all disputes arising out of this contract, the insurer acknowledges the place of jurisdiction to be the Swiss place of residence of the insured person or beneficiary. The insurer fulfils its obligations at the domicile of the insured person or beneficiary.

12. Applicable law

Furthermore, the current provisions of the Federal Act on Insurance Contracts (VVG) apply to this insurance policy.

ÖKK

ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ILLNESS

Squarelife Insurance AG, Edition 1.1.2023

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1. Insurance fundamentals

1.1 Principles

The principles of the contract "ÖKK RISK CAPITAL IN THE EVENT OF DEATH OR DISABILITY CAUSED BY ILLNESS" comprise the individual application, the insurance confirmation, the Common Provisions (CP) and the General Insurance Conditions (KTI GIC) covering risk capital insurance in the event of death or disability caused by illness as well as, on a subsidiary basis, the provisions of the Federal Act on Insurance Contracts (VVG).

1.2 Purpose and content of the insurance policy

The purpose of this risk capital insurance is to protect the insured person against the financial consequences of death or disability caused by illness.
The content of this risk capital insurance policy comprises a one-time lump-sum benefit to cover the financial consequences of death or disability caused by illness.

1.3 Common Provisions

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

1.4 Contractual parties and contractual relationship

ÖKK Versicherungen AG (hereinafter referred to as ÖKK) has concluded a collective insurance contract as a policyholder with Squarelife Insurance AG, 9491 Ruggell, Liechtenstein (hereinafter referred to as Squarelife).

Under this contract, insured persons have a direct right of claim against ÖKK (Art. 95a VVG in conjunction with Art. 98 VVG).

1.5 Insured persons

Individuals who are residents of Switzerland may be insured.

1.6 Insurance year

The insurance year begins on 1 January and ends on 31 December.

1.7 Age of insured person

The age of the insured person for the purpose of the insurance policy (actual age) is the difference between the calendar year and their year of birth.

1.8 Acceptance into insurance

The applicant must complete and submit the application truthfully and in full. It is not possible to accept an applicant into the insurance in all cases.

If an application is made to be accepted into the insurance within 90 days of being born, no health check is required.

2. Application

2.1 Start of insurance cover

ÖKK shall give the contractual partner written notice of the day on which the insurance cover shall commence. This date shall be no earlier than the date specified on the insurance confirmation, provided the insured person is fully able to work at the time the insurance cover begins.

2.2 Application

The applicant must complete, sign and submit to ÖKK the application truthfully and in full. The insured person or their legal representative must answer the questions relating to health and other risk factors truthfully and in full.

2.3 No insurance cover

No insurance cover is provided if the claim stems from an illness, an infirmity or the consequences of an accident that existed before the insurance cover began.

In addition, no insurance cover is provided for small children during their first 90 days of life or for claims which are the result of an illness, an infirmity or the consequences of an accident during these first 90 days.

2.4 Discontinuation of insurance cover

The insurance cover is discontinued if the insured person engages in military service for peace-keeping purposes in areas of conflict (e.g. UN Blue Helmets or OSCE Yellow Caps).

2.5 Geographical scope of insurance cover

The insurance cover applies worldwide.

3. Start, duration and end of insurance

3.1 Start and duration of insurance

The insurance begins no earlier than the insured person's birth and no later than their 60th birthday (maximum entry age).

The term of the insurance contract ends no later than on the 65th birthday of the insured person (expiry age).

This insurance policy may be concluded at any time before the insured person reaches the maximum entry age and at any time during the calendar year. Cover can be applied for to commence on the first day of any month.

3.2 Changes to the insurance

The sum insured may be increased within the parameters of the predetermined age categories and sums insured at any time before the insured reaches the maximum entry age; ÖKK is under no obligation to accept an application to do so.

3.3 Suspension of insurance

It is not possible to suspend the insurance.

3.4 End of insurance

The insurance shall end
- upon the death of the insured person;
- upon payment of a death benefit in the event of a fatal illness as per section 4.5.3;
- if the insured person becomes fully disabled; or
- when the person reaches the expiry age on the day after their 65th birthday.

The insurance shall end prematurely
- upon the withdrawal or termination by the contractual partner of ÖKK;
- upon termination as a result of breaches of disclosure obligations (Art. 6 ff. VVG), withdrawal in the event of a partial claim (Art. 42 VVG) or termination for good cause (Art. 35b VVG);
- if the contractual partner of ÖKK or the insured person ceases to reside in Switzerland or spends a period of time abroad of more than 12 months; or
- in the cases stipulated by law, in particular if there are outstanding fees.

Furthermore, the insurance shall expire if the collective insurance contract between ÖKK and Squarelife is dissolved. The contractual partner must be notified in writing of the dissolution of this contact by no later than two months before the expiry of the insurance cover.

4. Benefits

4.1 Overview of benefits

Under the insurance cover, ÖKK pays beneficiaries the following benefits in the event of death or disability as a result of illness:

- In the event of death: death lump-sum payment
- In the event of occupational disability presumed permanent (disability): disability lump-sum payment

4.2 Definition of terms

4.2.1 Disability

Disability is the inability to work as a result of illness which is expected to be permanent. It is recognised by the insurer

- if, cumulatively, the insured person's inability to work is not expected to improve significantly from continued medical treatment; and
- if the insured person will still be unable to work despite rehabilitation measures being taken; and
- if it has existed for a period of at least 12 months.

If the disability has been established before 24 months have expired, the insurer may recognise it earlier.

4.2.2 Illness

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

4.2.3 Inability to work

An inability to work is the full or partial inability to carry out reasonable work in a person's previous profession or area of work caused by an impairment of their physical, mental or psychological health.

4.2.4 Occupational disability

Occupational disability is the complete or partial loss of the insured person's ability to pursue gainful employment or self-employment in the relevant, balanced labour market as a result of an impairment of their physical, mental or psychological health that remains after reasonable treatment and rehabilitation.

The insured person is considered occupationally disabled if they are incapable of pursuing their profession or any other reasonable gainful employment and therefore suffers a loss of earnings as a result of impairment of physical or mental health which is diagnosed by a medical practitioner.

Occupational disability is deemed to be permanent if the insured person can prove that continued medical treatment cannot be expected to result in a significant improvement in their ability to work and that such occupational disability is likely to last throughout their life.

4.2.5 Reasonableness

An activity is deemed reasonable if it reflects the insured person's former permanent occupation and their previous position in life, even if they require retraining to obtain the necessary knowledge.

4.3 Insurance amounts

4.3.1 Level of insurance amounts

The insurance amounts listed in the insurance confirmation apply.

4.3.2 Minimum insurance amounts

The minimum insurance amount for a death lump-sum payment or disability lump-sum payment is CHF 10,000.

The maximum statutory death lump-sum payment is CHF 2,500 for children under the age of 2½ years.

4.3.3 Maximum insurance amounts

The maximum insurance amounts depend on the age of the insured person as per the following table.

Death

Age category	Maximum insurance amount Death (CHF)
0–12* years*	20,000*
13–20 years	300,000
21–65** years	500,000

* The maximum statutory death lump-sum payment is CHF 2,500 for children under the age of 2½ years.

** Up to expiry age as per sections 3.1 and 3.4

Disability

Age category	Maximum insurance amount Disability (CHF)
0–20 years	300,000
21–60 years	500,000
61–65** years	100,000

** Up to expiry age as per sections 3.1 and 3.4

If the insured person reaches a higher age category, the insurance amounts are automatically reduced to the maximum insurance amount in that new age category and the fees are adjusted accordingly. In all other cases, the insurance amounts remain unchanged.

4.3.4 Superseding causes

If the insured person dies before the disability lump-sum benefit is paid, only the insured death benefit is paid out.

4.4 Disability lump-sum payment

4.4.1 Entitlement to disability lump-sum payment

The insured person is entitled to the agreed disability lump-sum payment if they suffer an occupational disability that is likely to be permanent before reaching the expiry age.

4.4.2 Time of entitlement to disability lump-sum payment

The insurer pays out the disability lump-sum payment at the earliest after a waiting period of 24 months. The waiting period commences on the day on which the insured person first consults a doctor about the illness that led to their inability to work and the doctor confirmed that the insured person is at least 40% incapacitated.

In the event of a relapse or the insured person once again becoming unable to work within 12 months after the end of a period of an incapacity already reported and due to the same medical problem, no further waiting period applies.

If benefits have been paid under Swiss Federal Disability Insurance before the end of the waiting period or if the permanent inability to work is deemed to be permanent before the end of the waiting period or if a diagnosis has been received that will with absolute certainty result in disability in accordance with section 4.4.3, the insured disability lump-sum payment may be partially or completely paid out at an earlier date.

The insurer decides this on a case-by-case basis.

4.4.3 Diagnoses resulting with absolute certainty in disability

In the event of a diagnosis that will with absolute certainty result in disability, the insurer makes an immediate partial payment of up to CHF 20,000 as an advance payment of the disability lump-sum payment without having to observe the waiting period.

A diagnosis that will with absolute certainty result in disability is deemed to have been made when the medical specialists providing treatment determine that this is the case and the expert mandated by the insurer confirms the diagnosis.

Benefits from this insurance policy are only provided in the event of the below-listed diagnoses that will with absolute certainty result in disability (exhaustive list):
- Total loss of sight
- Total loss of hearing
- Multiple sclerosis from Expanded Disability Status Scale level 3.5
- Parkinson's disease from stage 3 on the Hoehn and Yahr scale
- Dementia
- Paraplegia
- Tetraplegia
- Amputation of at least one hand or both legs above the knee

4.4.4 Assessment basis for the calculation of the disability lump-sum benefit

The lump-sum benefit is determined on the basis of the insured disability lump-sum payment, the age of the insured person at the beginning of the waiting period, i.e. at the time their incapacity was first medically confirmed, and the insured person's degree of occupational disability determined by the insurer.

4.4.5 Grading of the disability lump-sum benefit

The disability lump-sum benefit is graded and determined in accordance with the degree of occupational disability of the insured person.
- If the degree of occupational disability is deemed to be between 70% and 100%, the insured person is entitled to the full disability lump-sum payment.
- If the degree of occupational disability is deemed to be at least 40% but less than 70%, the insured person is entitled to a disability lump-sum payment in proportion to the degree of disability determined.
- If the degree of occupational disability is deemed to be less than 40%, the insured person has no entitlement to a disability lump-sum payment.

4.4.6 Changes in the degree of occupational disability

If the degree of occupational disability changes after a disability lump-sum has been paid out, there is no adjustment in benefits to reflect the new degree of occupational disability.

4.4.7 Calculation of the degree of occupational disability for gainfully employed adults

For gainfully employed people, the degree of occupational disability is determined based on the loss of earnings suffered by the insured person. In principle, ÖKK recognises the degree of disability legally determined by the Swiss Federal Disability Insurance.

For gainfully employed people with a regular income, the degree of occupational disability is based on the income subject to state pension deductions (AHV) earned in the month preceding the start of the waiting period. For gainfully employed people with fluctuating or irregular income, the loss of earnings is based on the average income subject to state pension deductions (AHV) earned over the two calendar years preceding the start of the waiting period.

For self-employed people, the degree of occupational disability is based on either the average income subject to state pension deductions (AHV) earned in the two calendar years preceding the start of the waiting period or on the actual loss of earnings suffered by the insured person in the two preceding financial years. The income earned from gainful employment prior to the occurrence of the occupational disability is compared with that which the insured person has earned since the occurrence of occupational disability or that which they could have earned in a balanced labour market; the difference expressed as a percentage of the former income is deemed to be the degree of occupational disability.

4.4.8 Calculation of the degree of occupational disability for unemployed/partially employed adults

For people with no gainful employment and those who completely or partially stop working for reasons unrelated to health, the degree of occupational disability is determined on the basis of an activity comparison. The activity comparison measures, weights and compares the activities and tasks of the insured person before the illness occurred with those after its occurrence. The activities and tasks carried out prior to the occurrence of the occupational disability are set in proportion to those which can still be carried out following the occurrence of the occupational disability. An inability to be active in the former field of activity or work is treated as an occupational disability. The difference, expressed as a percentage of the former activities, is the degree of occupational disability. In principle, ÖKK recognises the degree of disability legally determined by the Disability Insurance (IV).

For people in part-time gainful employment, the degree of occupational disability is determined in accordance with the combined method of Swiss Disability Insurance (IV).

4.4.9 Calculation of the degree of occupational disability for infants and children

The occupational disability of infants and children is measured according to the degree to which the insured person will be incapable of taking on employment. For children who have not yet entered into any professional training, the occupational disability is measured according to whether and to what extent the insured person will later be able to carry out a professional activity. The degree of occupational disability reflects the presumed reduction in income attributed to the reduced capacity to work in relation to the income based on the annual median income ascertained in the Earnings Structure Survey conducted by the Swiss Federal Statistical Office.

For children currently in professional training, the assessment is based on the income that would have been earned in the relevant labour market following completion of the professional training. The degree of occupational disability reflects the presumed reduction in income attributed to the reduced capacity to work in relation to the income based on the annual median income ascertained in the salary structure survey conducted by the Swiss Federal Statistical Office and relevant for the profession for which the training has begun.

4.5 Death lump-sum payment

4.5.1 Entitlement to death lump-sum payment

If the insured person dies during the term of the insurance cover, there is an entitlement to a death lump-sum payment.

The insurer waives its legal right to reduce the death lump-sum benefit if the death of the insured person was a result of the latter's gross negligence.

4.5.2 Basis for the calculation of the death lump-sum benefit

The death lump-sum benefit is calculated on the basis of the insured death lump-sum payment and the age of the insured person at the time of death.

4.5.3 Fatal illness

If a serious illness with a likely life expectancy of up to 12 months is diagnosed for an insured person after the start of the insurance and at least 12 months before the end of the insurance, the insurer shall pay the insurance amount valid at the time of the diagnosis for the death while the insured person is still alive provided that the medical specialists providing treatment determine that this is the case and the expert mandated by the insurer confirms the diagnosis and provided there are no restrictions in these KTI GIC, CP or applicable legal regulations that would prevent this happening.

The insurance cover ends upon payment of the insurance amount for the serious illness with a likely life expectancy of up to 12 months. For the purpose of this contract, a "serious illness with a likely life expectancy of up to 12 months" is deemed to be an advanced, quickly developing, terminal illness, as a result of which the insured person has a likely life expectancy of up to 12 months as diagnosed by the medical specialists providing treatment and confirmed by the expert mandated by the insurer.

If the insured person culpably contracts a serious illness with a likely life expectancy of up to 12 months (irrespective of whether they were of sound mind at the time), the insurer is not obligated to provide insurance benefits.

4.5.4 Beneficiaries

Unless otherwise stipulated with regard to the payment of the death lump-sum benefit, the following persons, in descending order, shall be entitled to the benefits:

- in the case mentioned in section 4.5.3, the insured person;
- if they die, the spouse or registered partner of the insured person;
- if there are none of the above, the children of the insured person;
- if there are none of the above, the parents of the insured person;
- if there are none of the above, the other heirs of the insured person, to the exclusion of the community.

The contractual partner may change the order of beneficiaries at any time prior to the insured person's death, exclude beneficiaries or designate other beneficiaries, provided they have not previously put in place an irrevocable list of beneficiaries. Legal entities can also be named as a beneficiary. Any changes to the beneficiaries must be communicated in writing.

4.6 Exclusions of insurance benefits

4.6.1 In the event of an accident

There is no entitlement to benefits upon death or occupational disability as a result of illness if the insured event was a result of an accident as defined by the CP applicable as per the insurance confirmation. Occupational illnesses within the meaning of the UVG likewise do not give rise to any entitlement to benefits in the event of death or occupational disability as a result of illness.

4.6.2 Accident-like physical injuries

There is no entitlement to benefits in case of death or occupational disability as a result of illness in case of physical injuries deemed similar to accidents.
The following are considered accident-like physical injuries and not illnesses:

- health impairments and their consequences caused by involuntarily breathing gases or vapours, or unintentionally consuming poisonous or corrosive substances;
- the physical injuries considered equivalent to accidents that are listed in the CP and are applicable as per the insurance confirmation, provided they were not primarily caused by illness or attrition;
- frostbite, heatstroke, sunstroke and health impairments caused by ultraviolet radiation and their consequences, excluding sunburn, and involuntary drowning.

4.6.3 Intentional self-inflicted occupational disability

There is no entitlement to benefits for occupational disability if the insured person intentionally causes their occupational disability or illness (e.g. self-harm, attempted suicide). This also applies if the insured person takes the action leading to their occupational disability but was not mentally competent to judge their action.

The insurer waives its legal right to reduce the disability lump-sum benefit if the occupational disability of the insured person was a result of the latter's gross negligence.

4.6.4 Prenatal bodily injuries, birth defects and their consequences

There is no entitlement to disability or death benefits if the insured person's occupational disability or death is a result of prenatal bodily injuries, birth defects or their consequences.

4.6.5 Suicide and injury as a result of attempted suicide

There is no entitlement to death benefits if the insured person commits suicide within three years of the application or if the insured person dies of injuries as a result of attempted suicide committed within three years of the application. This also applies if the insured person is not competent to judge their actions or has a reduced capacity to make judgements at the time the action is taken which leads to their death.

4.6.6 Ionising beams and damage caused by nuclear energy

There is no entitlement to death or disability benefits if the insured person becomes ill as a result of exposure to the effects of ionising beams from nuclear energy.

4.6.7 Other benefit exclusions

Furthermore, there is no entitlement to insurance benefits in the cases listed in section 6.4.2 of the CP (benefit exclusions).

4.7 Reduced entitlement to insurance benefits

4.7.1 Concurrence of multiple causes

In the event that a number of different causes coincide, the insurer recognises partial claims that are not covered by accident or military insurance.

4.7.2 Concurrence of disability and death lump-sum benefits

In the event of death, the disability lump-sum payment already made to the insured person is deducted from the death lump-sum payment.

4.7.3 Other benefit restrictions

Furthermore, benefit restrictions apply in the cases listed in section 6.4.3 of the CP (benefit restrictions).

4.7.4 Verification of insurance claim

The standard documents to be submitted to verify the claim are as follows:

In the event of death:

- Extract from the family register/medical certificate of death/official certificate of death.

In the event of occupational disability:

- Medical certificate/medical records/IV decree/IV files/AHV statement/annual salary statement, payslips and accounts.

The insurer is entitled to demand further information and evidence and to make further enquiries of its own; it may also require that the insured person be examined by its independent medical examiner. The insured person's doctor is released from their duty of medical confidentiality in their dealings with ÖKK and the insurer.

4.7.5 Payment of insurance benefits

The insurance benefits are paid out when the beneficiaries have submitted all documents required for the verification and assessment of the claim and on the condition that the verification of the claim has a positive outcome.
Insurance benefits fall due after four weeks have passed from the time when the insurer received all documentation and information that were sufficient to prove to them the accuracy of the claim; in case of disability, this is no earlier than the end of the waiting period, however. The fee must be paid up until this time.

The insurance benefits are paid in Swiss francs (CHF) into an account designated by the beneficiary at a bank in Switzerland or the Swiss Post Office.

5. Obligations of the insured person

5.1 Disclosure obligation and health check

All facts material to the determination of risk must be listed truthfully and in full on the application to the extent and as they are known or should be known. If such facts are incorrectly listed or omitted, ÖKK may terminate the contract in writing within four weeks of becoming aware of the breach of the disclosure obligation. The notice of termination enters into effect on being received by the contractual partner.

If the contract is dissolved by means of termination, the obligation to provide benefits shall also expire in respect of claims already made, to the extent the occurrence or scope of which were related to the non-disclosed/incorrectly disclosed material risk factors. There is a right for any benefits that have already been paid out to be reimbursed. There is no right for fees paid for the cover to be reimbursed.

5.2 Process for making a claim

The insured person must immediately report any illness that is likely to trigger an obligation to pay benefits.

A death must be reported immediately, within ten days at the latest.

The documents required to verify and assess the claim must also be submitted without delay.

5.3 Duty of cooperation in the event of illness

The insured person has an obligation to cooperate and to mitigate loss. The insured person grants the insurer the authority to request files and information from hospitals, doctors, government offices, insurance companies, social security institutions and third parties, and to release these institutions from their duty of confidentiality.

The insured person shall without delay provide the insurer with all information requested regarding their previous and present state of health and the course of the illness.

The insurer reserves the right to require the insured person to undergo an examination by a physician designated by it. The insured person must undergo the examinations and follow the instructions of the doctors appointed by the insurer at its cost.

If the beneficiary fails to meet any of these obligations, there is no entitlement to benefits and the insurer is authorised to refuse to pay benefits unless the injury is considered to be non-culpable under the circumstances or the beneficiary can prove that the injury had no impact on the occurrence of the feared event and the extent of benefits owed by the insurer. In any case, the obligation to pay the fee for the cover continues to exist.

5.4 Notifications and disclosures

All notifications and disclosures are to be made to ÖKK and are only legally effective if they are sent in writing via e-mail or by post.

6. Fee

The fee for the cover is calculated according to the age group of the insured person and the level of the insurance amounts. In each case, fees remain guaranteed for one calendar year. There is no tariff guarantee.

The age groups are 0 to 3 years and 4 to 15 years. The age groups then span 5 years, i.e. 16 to 20, 21 to 25 etc. The last age group is 61 to 65.

7. Special provisions

7.1 Military service

Active service – without warlike activities – in order to safeguard Swiss neutrality or to maintain public order within Switzerland are deemed military service during times of peace and are covered by this insurance policy. In the event that Switzerland engages in war or warlike activities, the relevant provisions issued by the Federal Council apply.

7.2 Place of performance

The place of performance is the beneficiary's place of residence in Switzerland. If there is no such place of residence, the legal domicile of ÖKK is deemed to be the place of performance.

7.3 Place of jurisdiction and applicable law

In the event of a dispute arising from this contract, the beneficiaries may choose either their place of residence in Switzerland or the legal domicile of ÖKK as the place of jurisdiction. The contract is exclusively subject to Swiss law.

ÖKK COMPENSA

ÖKK Versicherungen AG, Edition 1.1.2022

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1. Insurance fundamentals

1.1 Insurance provider

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

1.2 Common Provisions

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

1.3 Purpose

ÖKK COMPENSA (insurance against loss of earnings for individuals under VVG) is provided in accordance with the provisions of the Swiss Federal Law on Insurance Contracts.

It is used to cover the loss of earnings caused by an inability to work as a result of illness, accident or birth.

ÖKK COMPENSA is also offered to persons who are not in gainful employment.

2. Geographical scope

2.1 General

The insurance cover applies worldwide.

2.2 Inability to work while abroad

In the event of private holiday travel abroad, the insured daily allowances are paid only during hospital stays These rules likewise apply to cross-border workers outside Switzerland and away from their place of residence. This does not apply to stays abroad for professional reasons.

2.3 Stays abroad while unable to work

If an insured person who is unable to work and entitled to benefits travels abroad without the consent of the insurer, there is no entitlement to benefits during the stay abroad. This restriction does not apply to cross-border workers when they are present in Switzerland.

3. Conclusion of the insurance

3.1 Conditions of acceptance

Self-employed, employed and non-active persons (housewives and househusbands, people in education and family members working in a family company who do not receive a salary in cash) can be accepted into ÖKK COMPENSA provided that:

- they are at least 15 and not more than 60 years old;
- they are fully capable of working when the application is made; and
- they reside in Switzerland.

3.2 Doctor's certificate

The insurer may demand a doctor's certificate or an examination by its independent medical examiner. It may designate the doctor and bears the costs.

3.3 Transfer from collective insurance policy

The GIC of the ÖKK LOSS OF EARNINGS INSURANCE for businesses (VVG) apply to transfers from collective insurance policies to individual insurance policies.

Cross-border workers can transfer from the collective daily allowance insurance to this individual insurance if they continue to work in Switzerland immediately after ceasing to belong to the group daily allowance insurance and cannot transfer to another group daily allowance insurance policy or are deemed to be unemployed within the meaning of the Federal Law on Compulsory Unemployment Insurance (AVIG) and are entitled to daily allowances from unemployment insurance.

3.4 AHV retirement age

Insured persons who remain in gainful employment after reaching the AHV retirement age may apply for their insurance to continue. However, this arrangement cannot continue beyond their 70th birthday.

4. Termination

4.1 Extraordinary termination

If the insured person has equivalent insurance against loss of earnings with a new employer under a new situation in employment law, termination is possible, by derogation from ordinary notice, with the approval of the insurer by giving one month's notice to the end of a month.

4.2 Other grounds for termination

In addition to the grounds for termination mentioned in the CP applicable as per the policy, the insurance lapses in the following cases:

a) if the self-employed insured person stops working;
b) if the company's headquarters are transferred abroad, with the exception of regions of foreign countries close to Switzerland's border;
c) on retiring – however, the insured person may apply for the insurance to continue until the age of 70; and
d) on moving abroad, unless the new place of residence is in a region of a foreign country close to Switzerland's border.

The insurer may withdraw from the contract within four weeks

e) if the insured person repeatedly and seriously infringes rulings of the insurer or instructions given by a doctor; or
f) in the event of a breach of disclosure obligations or in the event of attempted or successful insurance fraud.

5. Insurance options

The following insurance options may be selected:

- Daily allowance in case of illness
- Daily allowance in case of accident
- Daily allowance in case of illness and accident

These insurance options can be taken out with different benefit durations.

6. Scope of insurance

6.1 Amount of the insured daily allowance

The amount of the insured daily allowance is agreed between the insured person and the insurer.

6.2 Basis of assessment for the daily allowances

The daily allowance is calculated as one 365th of the insured loss of income in any one year. The calculated daily allowances are paid for every calendar day.

6.3 Maximum cover

6.3.1 Insurable daily allowance

The amount of the insurable daily allowance is limited to CHF 200,000 per year. For persons who transfer from a collective insurance contract of the insurer, the daily allowance is limited to CHF 250,000 per year.

6.3.2 Self-employed persons

Insured persons whose income is derived from self-employment may, over and above their income subject to AHV payments, additionally insure provable ancillary expenses according to the last contribution ruling.
These expenses are costs which relate directly to the insured person, are directly connected to their work and continue to be incurred during their inability to work, in particular fixed costs for business rents, motor vehicles, insurance, machine depreciation etc.

6.3.3 Employees

Insured persons whose income is derived from gainful employment by a third party may take out insurance in an amount equivalent to the gross salary liable for AHV contributions.

6.3.4 Non-active persons

Housewives and househusbands, people in education and family members working in a family company who do not receive a salary in cash may take out insurance up to the amount of the simple AHV maximum pension

6.3.5 Unemployed persons

The maximum cover for unemployed persons corresponds to the loss of unemployment insurance.

6.4 Accident cover

Accident cover can be included in the insurance or insured separately.

6.5 Childbirth

The daily sickness allowance includes cover for loss of earnings as a result of childbirth.

6.6 Start of benefits and waiting periods

The insurer offers daily allowance insurance policies with different benefit starting dates.

The entitlement to benefits begins after the expiry of the waiting period. The waiting period begins on the first day of the insured person's inability to work as per the medical certificate, but no earlier than three days before the first medical treatment. Waiting periods of up to and including 21 days are recalculated for each case of illness or accident. Longer waiting periods apply once each calendar year only.

Waiting days are days on which an inability to work of at least 25% exists.

The insurer pays the daily allowance according to the chosen start of benefits after the entitlement to draw benefits begins for the days on which a medically certified inability to work exists.

On reaching the AHV retirement age, an agreed waiting period of 60 days or more is converted into a waiting period of 30 days.

6.7 Adjustment of the insurance

6.7.1 Adjustment for inflation

The insured person may ask for their insurance to be adjusted in line with the annual rate of inflation according to the national consumer price index. The insurer approves this adjustment without any risk assessment provided that no inability to work has existed in the past two years and no daily allowance has been drawn. Adjustments are possible for the last two completed calendar years.

The insured person may also request at any time for their insurance to be adjusted in line with real wage trends at the conditions applicable to higher insurance amounts.

6.7.2 Unemployed persons

Unemployed persons may convert their insurance with an appropriate premium adjustment, regardless of their state of health, into insurance with a 30-day waiting period. The amount of the insured daily allowance is reduced to the level of unemployment insurance at the beginning of unemployment.

7. Insurance benefits

7.1 Conditions for receiving benefits

7.1.1 Inability to work

An inability to work exists if the insured person is wholly or partially unable by reason of illness, accident or childbirth to perform their previous or other reasonable employment activity.

A partial inability to work exists if there is at least a 25% inability to work.

7.1.2 Medical certificate

For daily allowances to be paid, a medical certification of the insured person's inability to work is required. The certificate must be issued by a physician or a chiropractor who is approved by the insurer (in accordance with section 6.1.9 ÖKK LIVE CP or section 6.1.11 ÖKK UNO CP).

Medical certificates and illness or accident reports may not be backdated by more than 3 days.

7.2 Scope of benefits

7.2.1 General

The benefits are determined according to the agreed scope of insurance and the existing insurance conditions.

7.2.2 Self-employed and inactive persons

In the case of self-employed persons and persons not in active employment, the insurer pays the agreed daily allowances

7.2.3 Employees

In the case of persons in gainful employment, the total daily allowances paid out must not exceed the loss of earnings of the insured person.

7.2.4 Partial inability to work

In the event of partial inability to work of at least 25%, the daily allowance is reduced accordingly.

For unemployed persons with an inability to work of more than 25% and a maximum of 50%, one half of the daily allowance is paid; the full daily allowance is paid in the case of an inability to work of more than 50%.

7.2.5 Accident

If the accident risk is insured, the benefits in the event of accident are paid on the same scale as in the event of illness.

7.2.6 Childbirth

Daily allowances for childbirth are paid on the condition that prior to the birth, equivalent cover was in place for an uninterrupted period of at least 270 days with the insurer or a different insurer (qualifying period for maternity).

Insured persons who gave up their gainful employment more than 8 weeks prior to the birth or who do not receive maternity benefits pursuant to the Loss of Earnings Compensation Act (LECA) are not considered to be gainfully employed.

In the event of birth, ÖKK COMPENSA will pay benefits in addition to the maternity benefits according to the LECA up to the agreed daily allowance sum.

7.3 Duration of benefits

7.3.1 Principle

For illness and accident combined, the insured daily allowance is paid out for a maximum of 730 or 365 days. The duration of benefits is listed in the insurance policy and measured according to the particular insurance claim.

Illness or the consequences of accidents are treated as a new insurance claim if the insured person has been able to work for an uninterrupted period of 12 months since the end of the last benefit payments.

The agreed waiting period counts towards the maximum duration of benefits. Days of partial inability to work count as full days for the purpose of calculating the duration of benefits.

7.3.2 Childbirth

The entitlement to insurance benefits starts on the day of birth.

If a daily allowance was insured in the same amount for at least three full insurance years prior to the birth, the maximum duration of benefits is 16 weeks, i.e. in addition to maternity compensation under the LECA, two additional weeks at the rate of the insured daily allowance for birth. The duration of benefits for a shorter insurance period is 8 weeks.

In the case of childbirth, the same waiting period applies as in the case of illness. The waiting period counts towards the duration of benefits for childbirth regardless of illness or accident. If the waiting period counted towards the duration of benefits because of complications during pregnancy, no further waiting period is counted with respect to the childbirth allowance.

Childbirth allowances count towards the maximum duration of an insurance claim.

7.3.3 AHV retirement age

In the event the insurance being continued at AHV retirement age, there is an entitlement to the insured daily allowance for 90 days; for persons transferring from a collective insurance of the insurer, for 180 days, but no later than the insured person's 70th birthday.

7.3.4 Unemployed persons

Unemployed persons receive the insured daily allowance at the latest until the end of the maximum period of payment in accordance with the provisions of the Swiss Federal Act on Compulsory Unemployment Insurance and Insolvency Compensation.

7.3.5 Transfer from collective insurance policy

For insured persons who have left the group of insured persons under a collective insurance policy and were insured under the scaled cover according to the General Insurance Conditions for insurance against loss of earnings for businesses (VVG), the maximum duration of benefits is 365 days.

7.4 Benefit restrictions

7.4.1 Exclusion of benefits

In addition to the excluded benefits mentioned in the CP applicable as per the policy, there is no entitlement to insurance benefits:

a) for consequences of accidents and occupational illnesses which are to be covered by a different insurer;
b) if a certificate of inability to work was issued by a doctor or chiropractor not recognised by the insurer;
c) if the insured person deliberately receives or seeks to receive benefits in an unlawful manner;
d) if the insured person's degree of inability to work is less than 25%;
e) for employees for the duration of unpaid leave; or
f) following termination of the insurance contract with the exception of periodic benefit obligations within the meaning of Art. 35c VVG.

7.4.2 Benefit restrictions

In addition to the benefit restrictions mentioned in the CP applicable as per the policy, benefits may be reduced:

a) if the illness or consequences of an accident are only partially the cause of the inability to work;
b) if the insured person repeatedly and seriously infringes rulings of the insurer or instructions given by a doctor;
c) if the insured person declines a medical check-up by the independent medical examiner required by the insurer; or
d) if the insured person refuses to perform another reasonable employment activity.

The provisions under Art. 45 VVG shall apply.

7.4.3 Reimbursement obligation

The insured person must refund to the insurer any benefits obtained in error or wrongfully.

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

8.1 Notification obligation

The insured person must inform the insurer within five days of every inability to work which may give rise to an entitlement to a daily allowance and state whether this is due to an accident or illness. In the case of agreed waiting periods of more than 21 days, the notification of inability to work must be given no later than one week before any claim to benefits is made.

The certificate issued by the doctor or chiropractor must be presented to the insurer at the latest ten days after the beginning of the inability to work, or in the case of waiting periods exceeding 21 days, with the notification of the inability to work.

Subject to Art. 45 VVG, if the insured person fails to comply with these requirements without providing sufficient reason, the insurer only grants benefits from the date on which the report is received. Medical certificates and illness or accident reports may not be backdated by more than three days.

Employees must provide evidence of a loss of earnings which is not otherwise covered.

If the degree of inability to work is reduced, the insurer must be notified of this fact without delay.

8.2 Obligation to provide information

In the event of an accident, the insured person must make available to the insurer all the necessary information on the reasons for the accident and any third parties involved in the accident.

In the event of frequent short absences within a short period of time, the insurer is entitled to require the insured person to visit a doctor on the first day of the inability to work.

The insurer may verify the inability to work and the uncovered loss of earnings in every case and make appropriate checks if necessary.

The obligations to provide information apply in accordance with the CP applicable as per the policy.

9. Premiums and payments

9.1 Level of premiums

The level of the premiums is determined in line with the risk entailed, for example based on the insured person's age, place of residence, benefits drawn or industry in which they work. Persons who are transferred from the loss of earnings insurance for businesses to an individual insurance policy form a separate risk group.

In addition, the CP applicable as per the policy apply with regard to determining premiums, paying the premiums, payment default and adjusting the premiums.

9.2 No-claims discount (NCD)

9.2.1 Principle

A premium discount is granted if no claims are made.

9.2.2 Observation period

The observation period runs from 1 September (or the start of the insurance policy) to 31 August of the following year. The processing date of the daily allowance statement is the determining factor for the calculation of benefits in the observation period.

9.2.3 Discount levels

The following discount levels/premiums apply:

Discount level	Premium
0	100%
1	64%

The discount levels can be adjusted in line with changes in costs.

9.2.4 Adjustment of level if benefits are drawn

If the insured person has claimed benefits during an observation period, the discount level will be adjusted to level 0 on 1 January of the following year unless the insured person is already at this level.

9.2.5 Adjustment of level if no benefits are drawn

If the insured person has not claimed any benefits for three consecutive observation periods at discount level 0, they will be adjusted to discount level 1 on 1 January of the fourth year.

9.2.6 Change of insurance cover

The discount level is maintained in the event of any change of insurance cover within ÖKK COMPENSA.

9.3 Payment of benefits

9.3.1 Payment of daily allowances

The daily allowance is paid out on the basis of a medical certificate when the person concerned becomes fit for work again. If the inability to work lasts for more than one month, the daily allowance is generally paid out monthly.

9.3.2 Daily allowances for childbirth

Childbirth allowances for employed and self-employed women are only payable after the statement of maternity compensation pursuant to LECA has been submitted to the insurer.

10. Third-party benefits

10.1 Employed persons and unemployed persons

Days with partial benefits following a reduction because the benefits are payable by a third party count as whole days for the calculation of the period of benefits in the waiting period.

Furthermore, the regulations governing third-party benefits apply in accordance with the CP applicable as per the policy.

The insured person assigns to the insurer any claims on the social security scheme for additional payments, in the event that the insurer has made advance payments.

10.2 Self-employed persons

For self-employed persons, the scope of benefits corresponds to the agreed daily allowance amounts.

Furthermore, the regulations governing third-party benefits apply in accordance with the CP applicable as per the policy, with the exception of the regulations governing overinsurance.

The insured person assigns to the insurer any claims on the social security scheme for additional payments, in the event that the insurer has made advance payments.

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