

Favorit Sante

Supplementary Conditions (SC) for insurance with limited choice of service provider under the KVG

Version 2025, valid as of 1 January 2025

SWICA

Supplementary Conditions Favorit Sante

The General Insurance Conditions (GIC) for healthcare and daily benefits insurance under the KVG apply in full to these SC.
In case of any contradictions, the SC take precedence over the GIC.

I. General

Art. 1 Insurance purchase, change of insurance plan, and premiums

1. These insurance plans are available with limited choice of service provider (special form of insurance) to individuals who meet the statutory enrolment conditions. Special provisions and the right to reallocate an insured person due to contract violations are reserved. The special forms of insurance may not be available in certain regions.
2. If the selected service provider is no longer able to provide medical treatment under the selected insurance plan for reasons relating to the insured person (e.g. transfer to a nursing home, a temporary stay abroad), the insurer has the right to switch the insured person to ordinary healthcare insurance with the insurer by observing a thirty-day period from the beginning of a calendar month.
3. If the insured person moves out of the catchment area of the selected insurance plan, the insurer will transfer the insured person to ordinary healthcare insurance with the insurer at the beginning of the month following the month of relocation. The insurer must be notified within one month if the insured person moves out of the catchment area of the selected insurance plan. Insured persons who relocate to an area with another insurance plan with limited choice of service provider can continue their cover by choosing another insurance plan with limited choice of service provider.
4. If the selected service provider in the selected insurance plan terminates the contract with the insurer, the affected insured persons can switch to a service provider in the selected insurance plan within 30 days from when the insurer prompted them to do so in writing or to ordinary healthcare insurance from the insurer. The switch to ordinary healthcare insurance with the insurer takes place automatically at the beginning of the following month, unless the insurer is notified of the new service provider by the given deadline.
5. If the contract between the insurer and the service provider or its network is terminated, the selected plan expires at the end of the year. Unless notification is issued about a change in the special forms of insurance in accordance with Art. 11 para. 2 of the GIC, this will result in an automatic switch to the insurer's ordinary healthcare insurance as of 1 January of the following year.
6. If the selected insurance plan is no longer offered, once this insurance plan lapses, the insured person will be automatically transferred to a comparable insurance plan with limited choice of service provider and also retaining the selected excess, or if there is no comparable insurance plan available, to a standard plan from the insurer. The insured person can also exercise their right to terminate their cover in accordance with Art. 7 KVG, or, taking the legal deadlines into account, select another one of the insurer's insurance plans.
7. Insured persons with special forms of insurance are eligible for premium reductions.

Art. 2 Exceptions to limited choice of service provider

Free choice of service provider applies to all special forms of insurance that cover the following treatments and examinations, unless contrary Supplementary Conditions apply:

- a) Gynaecological examinations and treatments
- b) Visits to the paediatrician, up to the eighteenth birthday
- c) Eye examinations by an ophthalmologist
- d) Stays abroad of up to six months
- e) Emergencies
Further emergency consultations or follow-up treatment that may be needed must be administered within the limited choice of service provider available under the special forms of insurance.

Art. 3 Consequences of contract violations

1. If the obligations arising from a particular special form of insurance have been violated, the insurer can reduce benefits by 50% of the amount that would be due otherwise (following deduction of the statutory co-payments).
2. In the case of repeated contract violations, the insured person is excluded from the special form of insurance and switched to ordinary healthcare insurance effective from the beginning of the following month and after having been informed accordingly.
3. Changing back to a special form of insurance is possible at the earliest twelve months after the switch in the following calendar year.

Art. 4 Measures on integrated care and care management

When facing a specific illness (especially a chronic or potentially chronic one), the insured person must undergo special measures involving integrated care at the request of the insurer. These can, for example, involve disease or chronic care management programmes, the services of the insurer's care managers, or the choice of special service providers. The insurer determines the programmes and service providers who administer them. Any agreement to participate in an integrated care and care management programme must be agreed with the insured person in writing.

II. Scope

Art. 5 Purpose

1. Favorit Sante healthcare insurance is a special form of insurance with limited choice of service provider.
2. Persons insured under a Favorit Sante plan agree to have all treatments and examinations administered by a Sante partner practice or to have such a practice refer them to a third party.
3. The insurance carrier is SWICA Healthcare Insurance Ltd.
4. The Favorit Sante plan is based on the principle whereby the doctors of the Sante partner practices provide comprehensive medical care. Under a Favorit Sante plan, the insurer pays the statutorily prescribed benefits for outpatient and inpatient treatments and examinations, provided they are administered or prescribed by a doctor from a Sante partner practice. The doctor of the Sante partner practice will refer the person to another specialist or hospital if necessary.
5. The insured person must always first consult the Sante partner practice in connection with all treatments and examinations (the exceptions laid out in Art. 2 are reserved). If necessary, the partner practice ensures that another doctor or hospital provides proper treatment.
6. If an insured person must be hospitalised or undergo emergency treatment, he must contact or have someone contact the Sante partner practice as soon as possible. Any follow-up consultations must be arranged through the Sante partner practice. The emergency doctor or hospital can administer further treatment for as long as necessary if the Sante partner practice has given its consent.
7. If the insured person's Sante partner practice refers him to a specialist who then recommends further treatments and examinations or an operation, the insured person must inform or have someone inform the Sante partner practice in advance about this and get its consent.
8. If required, doctors from a Sante partner practice will provide a referral to a third party (e.g. a specialist, hospital or nursing home).

9. By choosing the Favorit Sante insurance model, the insured person authorises the Sante partner practice to access all the information necessary under this model about the diagnoses, treatments, and invoices concerning his or her medical care. This form of insurance also requires information exchanges among the Sante partner practice, the insurer, and any third parties involved in providing the service. Such information pertains to the invoices of the insured person. In particular, such information is shared with specialists, hospitals, and other persons and institutions involved in providing the medical and administrative services for the purpose of managing the insurance contract or when changing to another Sante partner practice.