HMO PROVITA

SUPPLEMENTARY INSURANCE CONDITIONS (SIC) FOR INSURANCE WITH LIMITED CHOICE OF SERVICE PROVIDER UNDER THE KVG.

Version 2020, valid as of 1 January 2020

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

I General

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

1. These insurance types are available to individuals who meet the statutory enrolment conditions and whose place of work or civil-law domicile lies within the catchment area of the selected insurance with limited choice of service provider (special form of insurance). 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 type 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 type, 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 type. Insured persons who relocate to an area with another insurance type with limited choice of service provider can continue their cover by choosing another insurance model with limited choice of service provider in a new selected insurance type.
4. If the selected service provider in the selected insurance type terminates the contract with the Insurer, the affected insured persons can switch to a service provider in the selected insurance type 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 type of cover 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. 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. HMO PROVITA healthcare insurance is a special form of insurance with limited choice of service provider.
2. Persons insured under a HMO PROVITA plan agree to have all treatments and examinations administered by a HMO Health Centre or to have such a Centre refer them to a third party.
3. The insurance carrier is PROVITA Gesundheitsversicherung AG.
4. The HMO PROVITA plan is based on the principle whereby the doctors of the HMO Health Centres provide comprehensive medical care. Under a HMO PROVITA 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 HMO Health Centre. The doctor of the partner practice will refer the person to another specialist or hospital if necessary.
5. The insured person must always first consult his HMO Health Centre in connection with all treatments and examinations (the exceptions laid out in Art. 2 are reserved). If necessary, the Centre 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 his HMO Health Centre as soon as possible. Any follow-up consultations must be arranged through the HMO Health Centre. The emergency doctor or hospital can administer further treatment for as long as necessary if the HMO Health Centre has given its consent.
7. If the insured person's HMO Health Centre 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 HMO Health Centre in advance about this and get its consent.
8. Admission to a hospital or day clinic must be arranged through an HMO Health Centre or with its consent, except in emergencies.
9. By choosing the HMO PROVITA insurance model, the insured person authorises the HMO Health Centre 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 HMO Health Centre, 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 HMO Health Centre.

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