FAVORIT TELMED

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

Version 2020, valid as of 1 January 2020

BECAUSE HEALTH IS EVERYTHING SWICA

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 fr 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. FAVORIT TELMED healthcare insurance is a special form of insurance.
2. Persons insured under a FAVORIT TELMED plan agree to always first call the santé24 health advice helpline for a consultation before any treatments or examinations and to have any such treatments and examinations administered only by a KVG-approved service provider.
3. The insurance carrier is SWICA Healthcare Insurance Ltd.
4. The FAVORIT TELMED plan is based on the principle whereby the insured person first seeks advice by phone before consulting a service provider. Under a FAVORIT TELMED plan, the Insurer covers the statutorily prescribed benefits for outpatient and inpatient treatments and examinations, provided that the insured person consulted santé24 before going to a doctor or hospital and that the treatments and examinations are administered by a KVG-approved service provider. The specialists at santé24 provide no diagnoses or therapies; they make recommendations instead. The decision on which further steps to take rests with the insured person.
5. When experiencing a new health problem or when symptoms recur following completion of a treatment or an examination, the insured person must always contact santé24 before the first visit to a doctor or hospital (except in case as defined in Art. 2). Third parties can also obtain advice by phone on behalf of the insured person, provided the insured person has given his express consent.
6. Any follow-up consultations after an emergency treatment must be arranged through santé24 in advance.
7. Admission to a hospital or day clinic must be arranged through santé24 in advance, except in emergencies.
8. In addition to the exceptions mentioned in Art. 2, there is no need to get health advice by phone regarding consultations and follow-up treatment for six months after this matter has been discussed with santé24.
9. In amendment to the general exceptions, the obligation to hold an advisory consultation with santé24 in advance applies also to paediatric visits by children after the 12th birthday.
10. By choosing the FAVORIT TELMED insurance model, the insured person authorises santé24 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 santé24, 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.
11. Consultations by santé24 are free of charge. The insured person pays the standard phone rates for the call. santé24 records and archives its calls. In case of a dispute, the recordings can be used as evidence. The Insurer cannot access this information directly without the insured person's authorisation.

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