The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd, Helsana Accidents Ltd and Progrès Insurance Company Ltd.

Helsana

Version dated 1 January 2021

Insurance Conditions (IC)
PREMED-24 Insurance – Special Form of Compulsory Health Insurance

in accordance with the Federal Health Insurance Act (KVG) of 18 March 1994

List of Contents

Translation: Only the original German text approved by the Swiss Supervisory Authority is binding.

Introduction

All terms used in the text to refer to persons are to be understood as gender-neutral.

The legal entity specified in the policy provides the insurance benefits and is referred to as the "insurer".

General Provisions

1 What is PREMED-24 Insurance?

PREMED-24 Insurance is a special form of compulsory health care insurance that offers a limited choice of benefit providers under the terms of the Federal Health Insurance Act of 18 March 1994 (KVG) and the Health Insurance Ordinance (KVV).

2 What are the principles behind PREMED-24 Insurance?

The insured person or a third person acting on their behalf contacts the medical advice helpline should they require medical treatment from a medical service provider (physician, chiropractor, midwife, hospital, etc.).

The medical advice helpline does not provide diagnostic or therapeutic services, but offers medical advice and recommendations for the next course of action to be taken and, if necessary, for the consultation of a medical service provider at the insured person's option, depending on the seriousness of the illness and the acuteness of the problem.

If a medical follow-up check by the treating physician or a transfer to another medical service provider is needed, the insured person must contact the medical advice helpline again.

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3 What is the legal basis of this insurance?

3.1 PREMED-24 Insurance is a special form of compulsory health care insurance with a limited choice of medical benefit providers within the meaning of the Federal Act on the General Part of Social Insurance Law of 6 October 2000 (ATSG), the provisions of the KVG and its implementation provisions and these Insurance Conditions. Insofar as these conditions do not state otherwise, the Insurance Conditions for Compulsory Health Care Insurance shall apply.

3.2 These Insurance Conditions contain only those provisions which apply in addition to the legal provisions mentioned in Section 3.1.

4 Who is covered by the insurance?

The insurance covers the persons specified in the insurance policy.

Taking out /Terminating/Discontinuing the Policy

5 Who can take out this policy?

Anybody can take out PREMED-24 Insurance in line with the legal provisions. Admission shall not be extended to persons who have been excluded from this insurance product (Section 17) for a certain time period.

6 How and when can I terminate the policy?

A transfer from PREMED-24 Insurance to compulsory health care insurance is possible with effect from the end of a calendar year subject to a three-month notice period. This must be done in writing and shall result in the insured person's transfer to the compulsory health care insurance of the insurer or of another health insurer. Changing insurer during the calendar year for legal reasons is excepted.

7 Can the insurer suspend PREMED-24 Insurance?

The insurer can suspend PREMED-24 Insurance with effect from the end of a calendar year subject to a two-month notice period.

Premiums and Co-Payments

8 What conditions apply regarding premiums and co-payments?

8.1 Under Premed-24 insurance, a discount can be granted on the premium for compulsory health care insurance. The current valid premium rate shall be applicable.

8.2 Insured persons may choose to pay higher annual deductibles in return for reduced premiums. Details are regulated in the relevant provisions issued by the Federal Government and are published on the insurer's homepage and issued with the annual policy enclosures.

8.3 If the insurance relationship begins or ends during a calendar month, the premium is charged exactly to the day.

8.4 As a general rule, premiums shall be charged on a monthly basis, shall be payable in advance and shall be due on the first day of each month. If different payment periods have been agreed upon, the premiums shall always be due on the first day of the relevant period.

8.5 If premiums are outstanding, the insured person's attention shall be drawn to this fact by means of a reminder of the consequences of late payment and a deadline shall be set by which the outstanding premiums are to be paid. If payment is not received within this subsequent period, debt enforcement proceedings shall be instituted to recover the premiums.

8.6 In the event that payments are made directly by the insurer to the medical service provider, the insured person shall be obliged to repay any agreed annual deductibles and/or co-payments to the insurer within 30 days of invoicing. If the insured person fails to fulfil this obligation to pay, Section 8.5 shall apply accordingly.

8.7 Charges such as reminder charges and collection charges arising as a result of outstanding premiums and co-payments of medical costs shall be borne by the insured person.

8.8 Where payment in instalments has been agreed, a charge shall be levied in the event that payments are outstanding. The amount of this charge shall be determined in accordance with the amount outstanding and the agreed repayment period.

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Rights and Obligations

9 What must I do in the event of illness or accident?
The insured persons must follow their doctor's orders, and must do everything in their power to aid their recovery and refrain from doing anything which would delay it.

10 What are my obligations as an insured person?
The insured person shall be required to contact the medical advice helpline before arranging a medical visit. Prior contact with the medical advice helpline shall also be required for follow-up examinations and transfers to other medical service providers (Section 2).

11 Are there exceptions to these obligations?
Prior contact with the medical advice helpline is not necessary when abroad. No prior contact with the medical advice helpline is required for gynaecological examinations.

For ophthalmological treatment, as well as for the first pair of glasses/contact lenses after the policyholder's 19th birthday, the policyholder must first contact the medical advice helpline. Any subsequent adjustments can be carried out directly by the ophthalmologist/optician and do not require any prior recommendation from the medical advice helpline.

12 As an insured person, what should I do in an emergency?
Prior contact with the medical advice helpline is not necessary for emergency consultations that require obvious urgency. An emergency is when the person themselves or a third person deems the condition of the person is life threatening or requires direct treatment. Even outside of practice opening hours, a new or recurrent health problem shall not be necessarily classed as an emergency. Should a follow-up examination or treatment be necessary after the emergency treatment, the obligations stated under Section 7 shall apply.

13 What do I have to do in case of chronic illness?
In case of chronic illness, the insured person shall be required to contact the medical advice helpline every third month. The treating physician must confirm whether the insured person suffers from a chronic illness or not. For all other health problems which cannot be defined as chronic, the obligations under Section 10 shall apply.

14 What rights and obligations must be observed with regard to the insurance card?

14.1 The insured persons shall receive an insurance card. This card shall serve as proof of insurance for medical service providers. If appropriate agreements exist, it shall also entitle the insured person to the receipt of benefits, such as obtaining prescription medicines free of charge from pharmacies.

14.2 The insurance card shall remain valid throughout the duration of the insurance cover. It may not be lent or transferred or made accessible to third parties in any manner whatsoever. If the insurance card is lost or is mislaid by the insured person in any other way, the insurer must be informed of this without delay. Upon expiry of the insurance cover, the insured person must destroy the insurance card immediately.

14.3 If the insurance card is misused, the person to whom the insurance card was issued shall be liable for all damages incurred by the insurer. In particular, the insurer must be reimbursed for the insurance benefits wrongly obtained and the associated charges met by the person liable. This does not apply in situations where the insured person is not culpable.

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15 What conditions apply to notifications and payments?

15.1 Notifications to the insurer must be directed to the address stated in the policy. Notifications and payments from the insurer shall be considered valid if sent to the last address or payment address provided by the insured person.

15.2 In case of a change of address, the insurer must be informed immediately in writing. If a change in residence leads to a change in premium, the insurer will adjust the premium on the first day of the following month.

15.3 The insured person has various options for paying premiums and co-payments without incurring any charges. Any charges arising from payments made at the post office counter may be passed on by the insurer to the insured person.

15.4 Payments to a postal or bank account in Switzerland are made free of charge. A charge of CHF 3.00 can be deducted for transfers to accounts abroad. If the person does not have a bank or a post account, payments will be made via outpayment order (OSR) and the accruing charges will be deducted from the amount credited.

15.5 Additional information and binding notifications, for example, in relation to amendments to these Insurance Conditions, shall be published on the insurer's homepage and issued with the annual policy enclosures.

16 What are the rules regarding due dates of benefits?

Entitlement to benefits shall commence at the time of treatment.

Breach of Obligations

17 What are the consequences of breaches of these Insurance Conditions?

Should these Insurance Conditions be breached, the insurer may exclude the policyholder from PREMED-24 Insurance for a period of at least 12 months, subject to 30 days' notice with effect from the end of a calendar month. Exclusion must be done in writing giving details of the breaches of contract. This will result automatically in the transfer of the insured person to the compulsory health care insurance provided by the insurer.

Miscellaneous

18 Which data from the medical advice helpline will be passed to the insurer?

The insurer receives from the medical advice helpline the personal data that it requires to ensure the correct deployment of PREMED-24 benefits, in particular the information required to check the insured person's observance of the obligation to contact the medical advice helpline. The medical advice helpline shall act in accordance with the data protection regulations of the Social Insurance Act (ATSG), the Health Care Insurance Act (KVG) and the Data Protection Act (DSG).

19 How is liability settled?

The liability for therapeutic and diagnostic services shall be borne solely by the provider of services as chosen by the policyholder.

20 What is the procedure in the event of a dispute?

If an insured person is not in agreement with a decision made by the insurer, they may request a written ruling. This ruling shall include an explanation about rights of appeal.

21 When do these Insurance Conditions come into force?

These Insurance Conditions come into force on 1 January 2021. They replace the version of the Insurance Conditions for PREMED-24 Insurance dated 1 Juli 2016.

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