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## Insurance Conditions (IC) BeneFit PLUS Insurance – Special Forms of Compulsory Health Insurance

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

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### Introduction

The legal entity specified in the policy provides the insurance benefits and is referred to as the “insurer”. All terms used in the text to refer to persons are to be understood as gender-neutral.

### General Provisions

#### 1 Basis of the insurance

BeneFit PLUS insurance is a special form of compulsory health care insurance with a limited choice of service providers within the meaning of the Federal Health Insurance Act of 18 March 1994 (KVG) and the Health Insurance Ordinance (KVV). Cover is provided for the financial consequences of illness, maternity and accident. Risk of accident is included if it is listed in the policy. The provisions 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, which have been issued in addition to the legal provisions, shall be applicable for the execution of this insurance.

BeneFit PLUS insurance encompasses various options for selecting a service provider. For all of these options, the insured person is obliged to comply with the agreed restrictions in the choice of service provider and the integrated care and management measures.

#### 2 Insured person

The insurance covers the person specified in the insurance policy.

#### 3 Scope of insurance

The benefits guaranteed under BeneFit PLUS insurance are based on the scope of benefits under compulsory health care insurance, taking into account the restrictive conditions for benefits claims (Sections 16–20).

By signing the insurance application, the insured person confirms that they are in agreement with the restrictive conditions.

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



## Start, Alteration and End of Insurance

### 4 Taking out the insurance

BeneFit PLUS insurance can be taken out by anyone who meets the legal requirements, confirms their agreement with the restrictions to the choice of a coordinating service provider set out in these Insurance Conditions and with the measures stipulated, and is resident in the BeneFit PLUS insurance service area. This shall be subject to the provisions regarding alteration of the insurance (Section 7). Admission into the BeneFit PLUS insurance shall not be extended to persons who have been excluded from this insurance product (Section 23) for a certain time period.

When taking out BeneFit PLUS insurance, the insured person selects a coordinating service provider from the range offered by the insurer for the service area in which the insured person's legal residence is located.

### 5 Suspension of accident cover

Insured persons with compulsory insurance for occupational and non-occupational accidents may apply to suspend the accident cover. The suspension takes effect from the first day of the month following the application.

If the compulsory accident insurance cover ceases, the insured person must report this to the insurance company within one month.

### 6 Choice of annual deductible

The 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 in the official customer magazine and on the insurer's homepage.

### 7 Alteration of the insurance

If medical treatment by the coordinating service provider is or becomes impossible (in particular if the insured person has to stay in a nursing home and is treated by one of its doctors, moves away from the service area of the coordinating service provider selected, spends time abroad, or if the coordinating service provider withdraws from the insurer's health care system, etc.), the insurer shall be entitled to cancel the BeneFit PLUS insurance cover without giving prior notification with effect from the end of a calendar month, subject to a 30-day notice period.

The insured person may, if they move away from the service area, or if the coordinating service provider withdraws from a service area or is absent for an extended period of time, select a new coordinating service provider from the range offered by the insurer for the service area in question. This selection must be made within 30 days of written notice of the change of residence or notification of the withdrawal or absence of the coordinating service provider being given. If the insured person fails to exercise this right of selection within the given deadline, this shall automatically result in transferral of the insured person to the insurer's compulsory health care insurance.

In justified cases, the insured person may switch coordinating service provider and choose a new coordinating service provider from the range offered by the insurer. The application – including details of the reasons for the switch – must be submitted in writing directly to the insurer before use has been made of any of the services of the newly selected service provider.

### 8 Cancellation by the insured person

The BeneFit PLUS insurance may be terminated with effect from the end of a calendar year, subject to a three-month notice period, or upon notification of a new premium, subject to a one-month notice period with effect from the end of the month before the new premium becomes valid. Notice of termination must be submitted in writing and shall result in the transfer of the insured person to the newly selected compulsory health care insurance. This is subject to the relevant legal provisions.

### 9 Suspension by the insurer

The insurer may suspend the BeneFit PLUS insurance or a module of the BeneFit PLUS insurance with effect from the end of a calendar year subject to a two-month notice period.

The insured person may choose either to switch to another special form of insurance or to compulsory health care insurance with effect from the date of the suspension. The notification of the suspension provided by the insurer shall also include details of the options available.

If the insured person fails to exercise this right of selection before the end of the notice period, this shall automatically result in the transferral of the insured person to the insurer's compulsory health care insurance.



## Premiums and Co-Payments

### 10 Premiums

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

As a general rule, premiums shall be charged on a monthly basis, are payable in advance and are 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.

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.

### 11 Premium discount

Under all the variants of the BeneFit PLUS insurance, a discount may be granted on the premium for compulsory health care insurance. The current valid premium rate shall be applicable. The effect of the deductible and the co-payment on the benefits awarded to the insured person, as well as the contribution to the cost of a hospital stay, can be found in the relevant federal regulations, the official customer magazine, or on the insurer's website.

### 12 Co-payment of medical costs

In the event that payments are made directly by the insurer to the service provider, the insured person is 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 10 shall apply accordingly.

### 13 Charges

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.

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 according to the amount outstanding and the agreed repayment period.

## Rights and Obligations of the Insurer

### 14 Notifications and payments

Notifications sent to the insurer must be directed to the address stated in the policy. Policyholders shall receive notifications and payments from the insurer at their most recent reported address in Switzerland. Additional information and binding notifications, for example, in relation to amendments to these Insurance Conditions, shall be published on the insurer's homepage, in the customer magazine and issued with the annual policy enclosures. Payments to the insured person shall be transferred free of charge to their postal or bank account. If the insured person requires payment via money order (ASR), the appropriate charges shall be passed on in full to the insured person.

### 15 Due dates of benefits

Entitlement to benefits commences at the time of treatment.



## **Rights and Obligations of the Insured Person**

### **16 Restriction in the choice of service provider**

Insured persons are obliged, before making use of any medical services or treatment, to always contact their chosen coordinating service provider first (or, if applicable, a representative designated by the coordinating service provider).

Taking into account the insured person's individual situation and any integrated care measures (Section 19), the coordinating service provider shall determine the optimal and adequate course of treatment (including in particular referrals to and/or instructions to consult other doctors or medical practitioners). Any prescribed course of treatment shall be binding for the insured person. If any unforeseen changes occur that affect the course of treatment, or if the timeframe originally planned for the treatment proves insufficient, the insured person shall be obliged to contact the coordinating service provider again. This shall apply in particular to chronic illnesses.

### **17 Exceptions from the restriction in the choice of service provider**

It is not necessary to take up prior contact with the coordinating service provider for gynaecological check-ups or obstetric care.

For ophthalmological treatment, as well as for the first pair of glasses/contact lenses, the insured person must first contact the coordinating service provider. Any subsequent adjustments may be carried out directly by an ophthalmologist/optician and do not require any prior recommendation from the coordinating service provider.

Dental treatment may be performed directly by a dentist and does not require a referral from the coordinating service provider.

### **18 Emergencies**

In an emergency, the insured person should attempt to reach their coordinating service provider whenever possible. If the coordinating service provider cannot be reached, the insured person should contact the emergency physician or the regional emergency organisation at the person's place of residence or location, as applicable.

An emergency is considered to exist when the affected person or a third person deems the affected person's condition to be life-threatening or to require immediate treatment. Even outside of practice opening hours, a new or recurrent health problem shall not necessarily be classed as an emergency.

If an emergency necessitates hospitalisation or treatment by an emergency physician, the insured person shall be obliged to inform, or to have someone else inform, their coordinating service provider as soon as possible, and to provide the coordinating service provider with certification from the emergency physician.

The insured person must contact the coordinating service provider beforehand to arrange any subsequent check-ups as necessary. With the agreement of the coordinating service provider, further treatment may also be performed by the emergency physician for as long as necessary.

### **19 Integrated care and management measures**

If integrated care planning proves necessary for the treatment of a specific (in particular a chronic or potentially chronic) illness, the insured person shall be obliged to undergo special integrated care measures. These may include a disease management programme, case management or the selection of a special service provider. The insured person shall be informed of these measures by the insurer, the coordinating service provider or a third-party service provider and shall be obliged to comply with them.

The insured person shall be obliged to inform the co-ordinating service provider or the insurer of any planned hospital treatment (either outpatient or inpatient) at least 10 days in advance.

Insured persons shall be obliged to obtain medication, laboratory services, assistive devices, etc. from cost-effective sources (e.g. mail order pharmacies). They shall be informed of the source they must use by their insurer or the coordinating service provider.

Insured persons shall be obliged to choose to be treated with the most cost-effective medication available to treat their condition, which may be a generic medicine or a cost-effective original medicine. Should insured persons purchase medication for which a more cost-effective alternative is available, the insurer or the coordinating service provider shall draw their attention to this.



**20 Duty to mitigate losses**

The insured person 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.

**21 Notifications**

Notifications sent to the insurer must be directed to the sender address stated in the policy or to the insurer's headquarters.

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. In the event of delayed notification, the insurer shall be entitled to adjust the premiums with retroactive effect from the date on which the change would have been made if notification had been provided in good time.

**22 Insurance card**

The insured person shall receive an insurance card. This card shall serve as proof of insurance for 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.

The insurance card shall remain valid throughout the duration of the insurance cover. It may not be lent or transferred nor otherwise made accessible to third parties. If the insurance card is lost or otherwise mislaid by the insured person, the insurer must be notified to this effect without delay. Upon expiry of the insurance cover, the insured person must destroy the insurance card immediately.

If the insurance card is misused, the person to whom the insurance card was issued shall be liable for any damages incurred by the insurer. In particular, the insurer must be reimbursed for any 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.

**Violation of Obligations**

**23 The consequences of breaching the obligations**

In the event of a breach of the obligations set out in these Insurance Conditions, the insurer shall be entitled – if it is deemed proportionate – to exclude the insured person from the Benefit PLUS insurance cover for at least 12 months with effect from the end of a calendar month and subject to a 30-day notice period, and/or not to assume the costs of services that were not provided or prescribed by the coordinating service provider or that contradict the latter's instructions.

Notification of the exclusion or refusal to meet costs shall be given in writing and shall provide details of the conduct that was in breach of the obligations.

Exclusion from the Benefit PLUS insurance cover shall automatically result in the transferral of the insured person to the insurer's compulsory health care insurance.

**Insurance Options**

**24 Selectable coordinating service providers**

The insured person can choose from the following options:

- Medical advice helpline or telemedicine advice service
- Coordinating general practitioner or coordinating group practice



## Miscellaneous

### 25 Impact on supplementary insurance

The restrictive conditions for benefits claims under BeneFit PLUS insurance may also apply to supplementary insurance concluded with the insurer, in which case the relevant insurance conditions of the corresponding supplementary insurance shall be applicable.

### 26 Data protection and data handling

Data protection

Data handling shall take place in accordance with the data protection provisions of the Federal Act on the General Part of Social Insurance Law (ATSG), the provisions of the Federal Health Insurance Act (KVG) and the Data Protection Act (DSG).

Data handling

Upon taking out the BeneFit PLUS insurance cover, the insured person gives their consent that the insurer, the coordinating service provider or third parties, acting on the service provider's behalf, may exchange treatment and invoicing details relating to their entire health care, provided that these are required for processing the BeneFit PLUS insurance and in particular for reviewing whether the insured person has complied with their obligations. The insured person also gives their consent to the processing of these details by the insurer. In the event of a switch to another coordinating service provider, the insured person gives their consent that this information may be forwarded to the new coordinating service provider in writing and simultaneously releases the previous coordinating service provider from its professional confidentiality obligation for the purposes of this disclosure.

### 27 Disputes

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

### 28 Liability

The liability for therapeutic and diagnostic services shall be borne solely by the service providers (e.g. physicians, therapists, medical advice helpline) treating the insured person.

### 29 Effective date

These Insurance Conditions come into force on 1 July 2016. They replace the Insurance Conditions, version dated 1 January 2014.

