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

Helsana

Edition 1 January 2014

General Insurance Conditions (AVB) for Supplementary Health Insurance (KZV)

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

General Provisions

1 Introduction
The present General Insurance Conditions form the basis for all supplementary health insurance plans, whose content is regulated in the Additional Insurance Conditions (ZVB).

2 Insurer
Helsana Supplementary Insurances Ltd provides the insurance benefits in its capacity as party to the insurance contract in relation to the insured persons and is referred to as “insurer”.

3 Insured persons
The insurance covers the persons listed in the policy.

4 Basis of contract
Unless the contract conditions contain a provision to the contrary, the insurance contract is subject to the regulations of the Federal Act on Insurance Contracts (VVG).

Scope of Insurance

5 Subject of insurance
5.1 Cover is provided by the supplementary insurance to the compulsory health care insurance within the framework of the conditions set out below as well as in accordance with the Additional Insurance Conditions (ZVB) for the financial consequences of illness, maternity and accident during the period whilst the insurance is in force.

5.2 In the insurance policy it is stated which insurance plans have been taken out and if Special Insurance Conditions (BVB) apply.

6 Geographical scope of cover
Unless specified otherwise the insurance cover applies worldwide.

HEL-00007-en-1218-0007-40938

Definitions

7 Definitions of illness, accident and maternity

7.1 Illness is any impairment to physical, mental or psychological health which is not due to an accident and which requires medical examination or treatment and/or results in incapacity to work.

7.2 Pregnancy and delivery are equivalent to illnesses, providing the mother has been insured for illness with the insurer for at least 365 days as at the date of delivery and the insurance cover for pregnancy benefits has not been excluded.

7.3 Accident is any unexpected and involuntary injury to the human body resulting from an extraordinary external cause which is harmful to physical, mental or psychological health or which leads to death.

7.4 Physical injuries considered as accidents are equated with accidents according to the Federal Accident Insurance Act (UVG).

8 Recognised service providers

8.1 Recognised service providers are deemed to be those persons and institutions that are recognised as such by the legislation on health insurance.

8.2 Deviations from Section 8.1 are regulated in the ZVB.

Start and End of Insurance

9 Start and duration of insurance

9.1 The insurance cover commences as soon as the insurer has notified the applicants that the insurance application has been accepted, no earlier, however, than on the date stated in the policy.

9.2 The minimum period of insurance is 1 year. The insurance period runs from 1 January to 31 December respectively. For insurance policies concluded during the calendar year, the premium for the remaining duration of the insurance year will be charged. The insurance is tacitly extended by one further year on the expiry date and after each following insurance year.

9.3 The insurance expires
a) on the death of the insured person;
b) on attainment of the agreed retirement age up to which the insurer guarantees insurance cover;
c) on cancellation by the policyholder following expiry of the contractually agreed period of notice;
d) in the event of a temporary period of more than 5 years abroad, in the absence of any agreement to the contrary;
e) in the event of the person relocating their place of residence abroad, fundamentally at the end of the calendar year in the absence of any agreement to the contrary;
f) in the daily allowance insurance, on cessation of gainful employment, no later than on reaching the age of 70.

10 Cancellation by the policyholder

10.1 The insurance can be terminated in writing by the policyholder for each individually insured person after the insurance has been in force continually for one year, giving a three-month period of notice to the end of a calendar year.

10.2 The notice of cancellation is deemed to have been issued within the stipulated period if it has been received by the insurer no later than on the last day of the month prior to the commencement of the three-month period of notice.

10.3 After each claim for which the insurer must render a payment, the policyholder can cancel the relevant insurance policy within 14 days following payment of the claim amount or from the corresponding date of notification. The insurance cover expires 14 days after the receipt of this notification by the insurer.

11 Waiver of cancellation and amendment of the General Insurance Conditions (AVB) and Additional Insurance Conditions (ZVB)

11.1 The insurer expressly waives its statutory right to cancel the contract on expiry and to withdraw from the contract in the event of a claim. It reserves the right to withdraw from the policy in the case of behaviour constituting a breach of its conditions.

11.2 The insurer is entitled to amend the General and Additional Insurance Conditions (AVB and ZVB) on one of the grounds listed below:
a) increase in the number or establishment of new types of service providers;
b) developments in modern medicine;
c) establishment of new or more cost-intensive forms of treatment such as operating techniques, drugs and the like;
d) changes in benefits in the compulsory health care insurance.

11.3 If the General or Additional Insurance Conditions are adapted on the basis of the conditions set out in Section 11.2 during the course of the insurance, the new conditions shall apply for the policyholder and the insurer. The insurer shall notify the policyholders of these adaptations in writing. Policyholders who are not in agreement with these adaptations can cancel the corresponding insurance from the date the adaptation comes into effect. If the insurer receives no notice of cancellation within 30 days this shall be deemed as acceptance of the new rules governing the insurance policies.

Premiums and Co-Payments

12 Premium setting

12.1 The premiums are fundamentally adjusted according to the age of the insured person.

12.2 The premiums for insured persons aged over 65 are a maximum of three times the premium for 30 year-old insured persons and a maximum of four times the premium for 30 year-old insured persons for those aged over 70.

12.3 If a change in place of residence results in a premium adjustment then the premium will be adjusted with effect from this date.

13 Premium payment

13.1 The premiums are due for payment in advance for the period of insurance.

13.2 If the policyholder fails to meet their payment obligation, they will be requested in writing to effect payment for the entire period of the insurance within 14 days after the reminder is sent, irrespective of any agreed instalment payments, with reference made to the consequences of failing to effect payment. If the reminder is unsuccessful in producing payment, the obligation to render benefits ceases on expiry of the reminder period.

13.3 No claims for benefits can be made for illnesses, accidents and the consequences thereof which occur whilst the obligation to render benefits is suspended, even in the event of premiums being subsequently paid.

14 Repayment of deductibles and excess

14.1 Where payments are made directly to the service provider by the insurer, the policyholder is obligated to refund the agreed annual deductibles and/or excesses to the insurer within 30 days of production of invoice.

14.2 If the policyholder fails to meet their payment obligation Sections 13.2 and 13.3 AVB shall apply accordingly.

15 Premium reimbursement

15.1 If the premium has been paid in advance for a set period of insurance and the contract is cancelled for legal or contractual reasons before the end of this period, the insurer will reimburse the premium for the unused part of the period paid.

15.2 There is no entitlement to repayment if the contract has been in effect for less than one year and the contract was terminated by the policyholder.

16 Change of the premium rates, deductibles and excess

The insurer can amend premium rates, deductibles or excess as a result of a change of age group, the development of costs or the claims experience, as well as on account of adaptation to the scope of cover each year. The insurer shall notify the policyholders of these changes in writing. Policyholders who are not in agreement with the new arrangement can cancel the corresponding insurance policies with effect from the date of the change. If the insurer receives no notice of cancellation within 30 days following receipt of the notification of change, the change shall be deemed to have been accepted.

Obligations of the Insured Person

17 Obligations on inclusion in the insurance and during its term

17.1 The applicant must provide truthful and complete information relevant to the risk assessment on the application form, insofar as they are aware of or should be aware of such information at the time the insurance policy is signed. If such information is concealed or misrepresented, the insurer is entitled to cancel the entire contract in writing within four weeks after it has learned of the breach of the obligation of disclosure. The cancellation is deemed to take effect once it has been received by the policyholder.

17.2 If the insurance policy is cancelled, the insurer's duty to provide benefits also lapses for losses that have already occurred and whose occurrence or scope was influenced by the misrepresentation or concealment of significant information relevant to a risk. If the benefits have already been paid, the insurer is entitled to a reimbursement.

17.3 The applicants and the insured persons must release the medical practitioners treating them, or who have treated them, from their duty to maintain confidentiality in respect of the insurer, and authorise them to provide all information requested by the insurer.

17.4 If the insured person changes their address or professional occupation, the insurer must be notified in writing without delay.

18 Obligations in the event of a claim

18.1 The insured person must do everything to promote recovery and refrain from anything that delays it. In particular, they must follow the instructions of the doctor and the nursing personnel.

18.2 If claims are being made for insurance benefits, all invoices from hospitals, doctors, medical personnel, etc., must be sent to the insurer. Only original invoices will be acknowledged. In addition, the insurer can request medical certificates, reports, documents etc. from the insured person.

18.3 The insurer must be notified of admittance to an emergency hospital or a psychiatric clinic without delay and no later than after five days. If a payment undertaking is demanded, notification to this effect must be made prior to admittance. Additional payment conditions are governed by the respective conditions of the individual insurance policies.

19 Breach of the disclosure obligations

19.1 If, in a claim event, there is a breach of the disclosure obligations, the insurer can refuse to pay the benefits or set their level at its discretion.

19.2 These legal disadvantages do not apply if the breach of the disclosure obligation is to be considered as of a no-fault nature on the basis of the circumstances.

20 Payment obligation

The insured persons are basically fee debtors in relation to the service providers. However, they accept contracts to the contrary between the insurer and the service providers, which include direct payment to the service providers.

Restriction in the Insurance Cover

21 Benefit exclusions

21.1 There is no insurance cover for:

a) illnesses, accidents and the consequences thereof which existed prior to the insurance policy being concluded;
b) illnesses, accidents and the consequences thereof on expiry of the insurance even if benefits were rendered during the term of the insurance;
c) costs of ineffective, inappropriate or uneconomic treatment. Medical measures which are not restricted to the interests of the insured person and to the extent required for the purpose of treatment are deemed uneconomic. The effectiveness of treatment must be proven on the basis of scientific methods;
d) cosmetic treatments and operations;
e) dental treatments, unless cover is expressly provided for in individual insurance policies;
f) illnesses and accidents as a result of special risks. Special risks are deemed to be:
   fa) participation in riots and upheavals;
   fb) foreign military service;
   fc) participation in armed conflicts, acts of terrorism, deliberate criminal actions or attempts to carry out criminal actions;
   fd) participation in brawls and fights, unless the insured person was injured by the fighters as an innocent bystander or in an attempt to help a defenceless person;
   fe) dangers into which insured persons put themselves by strongly provoking others;
g) illnesses and accidents as a result of risks. Risks are deemed to be actions which expose the insured person to great danger, without taking or being able to take the necessary precautions which would limit the risk to a reasonable degree.
   Rescue operations in favour of other persons are insured, even if they can be regarded as risks;
h) illnesses and accidents as a result of war-like events:
   ha) in Switzerland or the Principality of Liechtenstein;
   hb) abroad, unless the insured persons fall ill or suffer an accident within 14 days of the war or armed conflict breaking out in the country in which they are staying and the outbreak of war in that country took them by surprise;
i) damage to health as a result of ionising radiation and damage caused by nuclear energy;
k) illnesses and accidents due to the abuse of alcohol, medication, drugs and chemicals;
l) organ transplants for which the Swiss Association for General Duties of Health Insurers, Solothurn (SVK) has agreed flat-rate payments. This also applies for clinics without any agreed flat-rate payments;
m) statutory and agreed contributions towards costs on the part of the compulsory health care insurance;
n) self-mutilation, suicide or attempted suicide.

21.2 The right is reserved to make further benefit exclusions in accordance with the conditions of the individual insurance policies.

22 Subsidiarity and third-party benefits

22.1 All benefits in accordance with these General and Additional Insurance Conditions will be rendered respectively after the rendering of benefits by social insurers. If other private insurers are liable to provide benefits, the insurer shall render benefits based on its insured amount in proportion to the total of the insured amounts.

22.2 If liable third parties have an obligation to provide benefits for the consequences of illness or accident, the insurer only guarantees to provide its benefits subject to Section 23 AVB, providing the third parties have rendered their benefits and only to the extent that the insured person gains no profit, taking into account the benefits provided by third parties.

23 Advance payments and right of recourse

23.1 The insurer can render benefits in advance on the condition that the insured persons transfer their claims against liable third parties to it up to the amount of the benefits rendered by it and providing the insured persons undertake not to act in any way which would jeopardise the assertion of any right of redress from third parties.

23.2 If the insured persons make any agreement with liable third parties, in which they partly or wholly waive their claims to insurance benefits or compensation, without the insurer's consent, their entitlement to benefits from the insurer becomes null and void.

24 Offsetting

24.1 The insurer can offset any due payments with claims against the insured persons.

24.2 The insured persons have no offset rights against the insurer.

25 Pledging and assigning of benefits

Benefits cannot be pledged nor assigned to third parties to legal effect without the consent of the insurer.

26 Fee rates of service providers

The insurer recognises the valid fee rates set out in the Swiss social insurance. Subject to conditions to the contrary in the Additional Insurance Conditions.

27 Fee arrangements

Fee arrangements between invoice issuer and insured persons are not binding on the insurer. A claim to benefits exists only within the framework of the fee rates recognised by the insurer for the corresponding service provider.

Miscellaneous

28 Insurance card

28.1 The persons insured under specific supplementary health insurance policies are provided with the insurance card. This is used as proof for service providers that the insurance policies have been concluded. Providing the corresponding agreements are in force, the card also entitles them to obtain benefits such as medications.

28.2 The insurance card is valid for 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. Once the insurance cover has expired, the insured person must immediately destroy the insurance card.

28.3 If the insurance card is misused, the person to whom the insurance card has been issued is liable for the losses incurred by the insurer. In particular, the insurer must be reimbursed for the insurance benefits wrongly obtained and the associated costs met by the person liable. Subject to action where no blame is attached as understood by Article 45 VVG.

29 Notices

29.1 Notices to the insurer must be directed to the address stated in the policy.

29.2 Policyholders receive notices from the insurer at their most recent reported address in Switzerland.

29.3 Additional information for example in relation to amendments to these Insurance Conditions, are published on the insurer's homepage together with the annual policy enclosures.

30 Data protection

For detailed explanations on the use of personal data by Helsana Supplementary Insurances Ltd we refer to the Privacy Policy. This is published at www.helsana.ch/data-protection.

30.1 Helsana Supplementary Insurances Ltd and the other companies belonging to the Helsana Group use the personal information pertaining to their insured persons not only for the purposes of processing contracts and providing personal advice and assistance to patients, but also with the aim of making ongoing improvements to the quality of the products and services they offer to their existing, potential and former insured persons. The insurer can also commission the data processing.

In order to respond in the best possible manner to the varying and individual needs of insured persons and to ensure that the products and services offered by Helsana Supplementary Insurances Ltd and companies belonging to the Helsana Group or partner companies (in particular those listed on the insurer's website) are both cost effective and of interest to existing, potential and former insured persons, the data are evaluated using mathematical and statistical methods so as to compile needs-oriented customer groups.

Helsana Supplementary Insurances Ltd and the other companies belonging to the Helsana Group are therefore expressly authorised to inspect any health insurance files that may exist in relation to basic and/or supplementary insurance policies and to process them for the purposes mentioned exclusively in the area of supplementary insurance.

30.2 The members of the Helsana Group are Helsana Insurance Company Ltd, Helsana Supplementary Insurances Ltd, Helsana Accidents Ltd, Progrès Insurance Company Ltd, Helsana Investment Ltd and Procare Providence Ltd.

30.3 The current partner companies of Helsana Supplementary Insurances Ltd can be found on the insurer's website.

30.4 Helsana Supplementary Insurances Ltd and the Helsana Group are subject to particularly stringent data protection guidelines. In principle, no personal information is therefore passed on the third parties outside the Helsana Group. The only exception to this are cases where the disclosure of data is expressly prescribed or allowed by a legal provision.

30.5 Personal data are processed and stored in a database or kept on paper only for as long as required by legal or contractual provisions. The personal data are then destroyed.

31 Place of jurisdiction

Jurisdiction for lawsuits arising from the insurance contract lies either with the courts at the Swiss place of residence of the insured persons and the beneficiaries or at the registered offices of the insurer.

32 Special cancellation right

For insurance coverage that is in effect before 1 January 2008, the policyholder has the right to waive Sections 10.3, 11.3 and 16 of these General Insurance Conditions (AVB) and cancel the entire policy.