FAVORIT BESTCARE

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

Version 2024, valid as of 1 January 2024

BECAUSE HEALTH IS EVERYTHING SWICA

SUPPLEMENTARY CONDITIONS FOR FAVORIT BESTCARE.

The General Insurance Conditions (GIC) for healthcare and daily allowance insurance under the KVG apply in full to these supplementary conditions. In the event of any contradictions, the SC 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 civil-law domicile lies within the catchment area of the selected insurance providers with a limited choice of service provider (special form of insurance). The above provision is subject to special legal arrangements and the right to reallocate an insured person due to breach of contract. The special forms of insurance may not be available in all 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 (if the insured person is moved to a care home, for example, or temporarily lives in another country), the insurer has the right to switch the insured person to the insurer's standard healthcare insurance by giving 30 days' notice to the start of a calendar month.
3. If the insured person relocates out of the catchment area for the selected insurance type, the insurer will transfer the insured person to the insurer's standard healthcare insurance at the beginning of the month following the relocation. The insurer must be notified of the relocation out of the catchment area for the selected insurance type within one month. Insured persons who relocate to an area with another insurance type with limited choice of service provider have the right to 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 insured persons may choose, within 30 days of being prompted to do so in writing by the insurer, to switch to a service provider in the selected insurance type or to transfer to the insurer's standard healthcare insurance. If the insurer is not notified of a new service provider within the specified period, the switch to the insurer's standard healthcare insurance will take place automatically at the start of the following month.
5. If the contract with the service provider or the service provider's network is terminated by the insurer, the selected insurance type will lapse at the end of the year. Unless the insurer receives notification of a change to the special forms of insurance pursuant to Art. 11 para. 2 of the GIC, the insured person(s) will be automatically transferred to the insurer's standard healthcare insurance on 1 January of the following year.
6. Insured persons with special forms of insurance are eligible for reduced premiums.

ART. 2 EXCEPTIONS TO LIMITED CHOICE OF SERVICE PROVIDER

Free choice of service provider applies for the following treatments and investigations for all special forms of insurance, unless otherwise specified in the relevant supplementary conditions:

a. Gynaecological examination and treatments
b. Visits to the paediatrician, up to the child's 18th birthday
c. Eye examination by an ophthalmologist
d. Temporary stays abroad of up to six months
e. Emergencies

Any follow-up consultations or treatment that may be needed following an emergency consultation must be administered within the limited choice of service provider available under the relevant special form of insurance.

ART. 3 CONSEQUENCES OF BREACHES OF CONTRACT

1. If the obligations arising from a particular special form of insurance are not complied with, the insurer may reduce benefits to 50% of the amount that would be due otherwise (following deduction of the statutory co-payments). The insurer may carry out investigations to establish whether any obligation has been breached.
2. In the event of repeated breaches of contract, the insured person shall be excluded from the special form of insurance and transferred to the standard healthcare insurance with effect from the start of the following month after having been informed accordingly.
3. The insured person cannot switch back to a special form of insurance within twelve months of being reallocated.

ART. 4 MEASURES RELATING TO INTEGRATED CARE AND CARE MANAGEMENT

When suffering from 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. Such measures may involve a disease or chronic care management programme, the services of the insurer's care managers, or choosing from among special service providers. The insurer shall determine the programmes and the service providers who administer them. Consent to participation in the integrated care and care management programmes will be agreed in writing with the insured person.

II. SCOPE

ART. 5 PURPOSE OF THE INSURANCE MODEL

1. FAVORIT BESTCARE healthcare insurance is a special form of insurance with limited choice of service provider.
2. The insurance carrier is SWICA Healthcare Insurance Ltd.
3. The FAVORIT BESTCARE insurance model is based on a limited choice of service providers who deliver their services using digital applications and technical solutions (Art. 8, 9 and 10 of the SC below). The insured person can choose between several treatment paths (Art. 7 of the SC below) which are intended to ensure more efficient and coordinated care.

ART. 6 CO-PAYMENT

Co-payment arrangements are based on Art. 20 of the GIC and the statutory provisions. The insurer may waive the right to demand co-payment wholly or in part in accordance with the information regarding FAVORIT BESTCARE on its website.

ART. 7 TREATMENT PATHS

1. In the event of a new health problem or the recurrence of a health problem after completion of a treatment or investigation, the insured person may contact one of the following first points of contact for a consultation, which are offered by the service providers under their treatment contract:

a) The digital symptom checker app offered by the telemedicine partner santé24 (see Art. 8 of the SC)
b) The telemedicine partner santé24, assisted by a telemedicine device (see Art. 9 of the SC)
c) A FAVORIT BESTCARE partner pharmacy (according to the directory on the SWICA website).

Irrespective of the first point of contact chosen, the insured person is subsequently obliged to contact a FAVORIT BESTCARE partner practice (according to the directory on the SWICA website) for any treatments and investigations.

2. Instead of choosing a first point of contact for a consultation in accordance with Art. 7 para. 1 of the SC, the insured person can also contact a FAVORIT BESTCARE partner practice (according to the directory on the SWICA website) directly.
3. Under a FAVORIT BESTCARE plan, the insurer pays the legally stipulated insurance benefits, in particular for outpatient and inpatient treatments, provided that these are administered or prescribed by a doctor from a FAVORITBESTCAREpartner practice. The doctor from the FAVORIT BESTCARE partner practice will refer the insured person to a third party (such as a specialist, hospital or care home) if necessary.

4. If the insured person's FAVORIT BESTCARE partner practice refers them to a third party who then orders further treatments, investigations, surgery, or care, the insured person must inform or have someone inform the FAVORIT BESTCARE partner practice of this in advance and obtain its consent.
5. If an insured person needs to be hospitalised in an emergency or undergo emergency treatment, he/she must inform or have someone inform their FAVORIT BESTCAREpartner practice at the earliest possible opportunity. Any follow-up consultations required after emergency treatment must be carried out in a FAVORITBESTCAREpartner practice. The emergency doctor or hospital can administer further treatment for as long as necessary if the FAVORIT BESTCAREpartner practice has given its consent.

ART. 8 DIGITAL SYMPTOM CHECKER APPLICATION

1. The digital symptom checker application offered by the telemedicine partner santé24 (referred to below as the "SymptomCheck app") is one of the possible first points of contact under Art. 7 para. 1 of the SC, and provides recommendations for what to do next in the event of a health problem. The insured person has to answer questions about their health condition in the SymptomCheck app. The insured person is not obliged to follow any recommendations provided by the SymptomCheck app. The SymptomCheck app is free to use.
2. To use the SymptomCheck app, the insured person has to install the app on an app-enabled mobile device (such as a smartphone). When registering, the insured person has to provide their core data to enable a user account to be set up in the SymptomCheck app. This is used in particular to identify the insured person and to enable later identification by santé24. The insured person may be asked by SWICA to provide this data when first setting up the SymptomCheck app. The SymptomCheck app only collects the data the insured person enters into the app. The insured person has to provide information about their condition and their health problem in as much detail as possible to enable the SymptomCheck app to provide recommendations for the next steps. Especially sensitive data such as health data or data about the insured person's personal life may be collected during this process. If the insured person is not satisfied with the recommendation from the SymptomCheck app, the data can be sent to santé24. No data is transferred without the consent of the insured person. At the request of the insured person, a telemedicine device pursuant to Art. 9 para. 3-5 of the SC may also be connected to the SymptomCheck app. Further information about data processing can be found in the SymptomCheck app's conditions of use and data protection provisions.

ART. 9 TELEMEDICINE BENEFITS

1. santé24 is one of the first points of contact as per Art. 7 para. 1 of the SC. Via santé24, the insured person can discuss their health problem with a doctor or medical specialist on the phone. The insured person is not obliged to follow any recommendations provided by santé24.
2. The advice provided by santé24 is free of charge. The insured person pays for the call at the standard rate. santé24 records and archives its calls. In the event of a dispute, the recordings can be used as evidence. The insurer has no access to this information unless authorised by the insured person.
3. santé24 may use a telemedicine device during these consultations as a diagnostic tool and for treatment recommendations. When the insurance is purchased, every insured person or household will be provided with a telemedicine device free of charge which they can use to carry out medical examinations on themselves. santé24 decides when the telemedicine device must be used, based on the medical indication.
4. Use of the telemedicine device requires the installation and use of the SymptomCheck app (for user registration; see Art. 8 of the SC for the SymptomCheck app) and the telemedicine app (for collection of data via the telemedicine app and transfer of the data generated by the insured person to santé24) on an app-enabled mobile device (such as a smartphone). Use of this application is free.
5. Upon installation, the telemedicine app automatically requests the necessary user data (core data) from the SymptomCheck app and sends this to santé24 to identify the insured person. The telemedicine device connects to the telemedicine app. This allows the data generated by the telemedicine device to be sent by the insured person via the telemedicine app to santé24, for the purpose of performing the treatment contract in particular. To enable santé24 to advise the insured person and provide recommendations, the insured person must provide as much detailed information as possible and must use the telemedicine device in accordance with the instructions of the telemedicine device itself and those of santé24. Especially sensitive data such as health data or data about the insured person's personal life may be collected during this process. The conditions of use and data protection provisions of the telemedicine app contain further information on data processing.

6. If the insured person does not wish to use the telemedicine device and the necessary digital apps, they can choose another first point of contact in accordance with Art. 7 para. 1 of the SC or a direct consultation with the FAVORIT BESTCARE partner practice. If the insured person does not have an app-enabled mobile device (such as a smartphone), santé24 will not require them to use the telemedicine device.

ART. 10 DIGITAL PLATFORM FOR SHARING DATA

1. To ensure the coordinated provision of medical care, the insured person agrees to grant santé24, the FAVORIT BESTCARE partner pharmacies, the FAVORIT BESTCARE partner practices and any third parties necessary for the provision of medical or organisational services, access to the necessary diagnostic, treatment and billing data relating to their medical care via the digital data-sharing platform offered by the service providers ("data-sharing platform"). The insurer only has access to the data of relevance for billing.
2. To enable the sharing of data between the service providers, the insured person must install and use the app provided by the service providers for this purpose ("data-sharing app") on an app-enabled mobile device (such as a smartphone). The insured person can agree to the sharing of data between the service providers involved (see Art. 10 para. 3 of the SC below) on a case-by-case basis via the app. Use of the data-sharing platform and the data-sharing app is free of charge.
3. After installing the data-sharing app, the insured person can request their core data from the insurer. This core data is used by the service providers that use the data-sharing platform to identify the insured person. If the insured person contacts a service provider (irrespective of the treatment path selected), the data provided by the insured person, including especially sensitive data such as health data or data about their personal life, will be collected by the service provider as part of the treatment contract, in particular to document the consultation. The insured person then decides on a case-by-case basis whether to allow the disclosure of this data by the service provider to any other service providers via the data-sharing platform. This is done by specifying in the data-sharing app which data may be made available to which service provider. The conditions of use and the data protection provisions of the data-sharing app contain further information on data processing.
4. Insured persons who do not have an app-enabled mobile device (such as a smartphone) and are unable to use the functionality of the data-sharing app (particularly for booking appointments with service providers and accessing health information/medical records) can use the santé24 service instead.

ART. 11 SUPPLEMENTARY DATA PROTECTION PROVISIONS

The terms of use, general terms and conditions, special conditions, data protection provisions and other terms and conditions of the various providers apply in connection with the use of the SymptomCheck app, the telemedicine device and the data-sharing app (in accordance with Art. 8, 9 and 10 of the SC). Depending on the system and mobile app, data processing consent may be required as data may be processed by third parties or outside Switzerland.

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