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

Helsana

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

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

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

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 models for selecting a service provider. For all of these models, the insured person is obliged to comply with the agreed restrictions in the choice of service provider and with 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 benefit claims (Sections 17 – 21). By signing the insurance application, the insured person confirms that they are in agreement with the restrictive conditions.

4 Insurance models

The insured person can choose one of the following models with relevant coordinating service providers:
– “Telmed” Medical advice helpline or telemedicine advice service
– “General practitioner” Coordinating general practitioner or coordinating group practice
– “Flexmed” In addition to the chosen general practitioner, the insured person can opt for other coordinating service providers. The supplemental provisions are applicable for this model.

Start, Alteration and End of Insurance

5 Taking out the insurance

BeneFit PLUS insurance can be taken out by anyone who meets the legal requirements and who confirms their agreement with the restrictions on the choice of coordinating service provider set out in these Insurance Conditions and with any stipulated measures that may be applicable. This shall be subject to the provisions regarding alteration of the insurance (Section 8). 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 shall select a coordinating service provider from the options offered by Helsana.

6 Suspension of accident cover

Insured persons with compulsory insurance for occupational and non-occupational accidents may apply to suspend the accident cover.

If the compulsory accident insurance cover (UVG) ceases, the insured person must report this to Helsana within one month.

7 Choice of annual deductible

The insured person 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 Helsana website and issued with the annual policy enclosures.

8 Alteration of the insurance

If medical treatment by the coordinating service provider is not possible, or becomes impossible, the insured person shall be transferred to the compulsory health care insurance of Helsana, in particular if the insured person has to stay in a nursing home and is treated by one of its doctors or changes their place of residence or habitual residence by moving abroad.

If the coordinating service provider is no longer included in the options offered by Helsana, the insured person shall be required by Helsana to select a different general practitioner within 30 days. Upon expiry of this 30-day period, the insured person shall transfer to the Helsana compulsory health care insurance.

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

9 Cancellation by the insured person

The BeneFit PLUS insurance may be terminated with effect from the end of a calendar year 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 transferral of the insured person to the newly selected compulsory health care insurance. This is subject to the relevant legal provisions.

10 Suspension by Helsana

Helsana may suspend the BeneFit PLUS insurance or a model 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 the Helsana compulsory health care insurance with effect from the date of the suspension. The notification of the suspension shall also include details of the options available to the insured person.

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 Helsana's compulsory health care insurance.

Suspension of the “Flexmed” model automatically results in a switch to the “General practitioner” model (provided that this model has not been suspended).

Premiums and Co-Payments

11 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.

12 Premium discount

Under all the BeneFit PLUS insurance models, a discount may be granted on the premium for compulsory health care insurance. The current valid premium rate shall be applicable.

13 Co-payment of medical costs

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 and are published on Helsana's website and issued with the annual policy enclosures.

In the event that payments are made directly to the service provider by Helsana, the insured person is obliged to repay any agreed annual deductibles and/or co-payment to Helsana within 30 days of invoicing. If the insured person does not fulfil this obligation to pay, section 11 shall apply accordingly.

14 Charges

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 to the insured person by Helsana.

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 Helsana

15 Notifications, change of residence and payments

Notifications to Helsana must be directed to the address stated in the policy. Notifications and payments from Helsana shall be considered valid if sent to the last address or payment address provided by the insured person. Additional information and binding notifications, such as in relation to amendments to these Insurance Conditions, shall be published on the Helsana website and issued with the annual policy enclosures.

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

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 account, payments will be made via outpayment order (OSR) and the accruing charges will be deducted from the amount credited.

16 Due dates of benefits

Entitlement to benefits commences at the time of treatment.

Rights and Obligations of the Insured Person

17 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, the representative designated by the coordinating service provider).

Taking into account the insured person's individual situation and any integrated care measures (Section 20), 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.

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

18 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.

19 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. 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.

20 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 Helsana, 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 coordinating service provider or Helsana 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 Helsana or by 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, or the coordinating service provider shall draw their attention to this.

21 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.

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, Helsana 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 Helsana. In particular, Helsana 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, Helsana 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 Helsana's compulsory health care insurance.

24 Data protection and data handling

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 about the insured person shall be exchanged between Helsana and the coordinating service providers as part of administering the BeneFit PLUS insurance. This processing and disclosure of data shall be restricted to the extent required for the limited choice of service provider and cost-effective care, in particular for assessing the insured person's entitlement to benefits and for calculating benefits.

In addition, the coordinating service providers and 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 insurances and in particular for reviewing whether the insured person has complied with their obligations.

In the event of a switch to another coordinating service provider, any necessary personal data shall be forwarded to the new coordinating provider. This shall mean that the previous coordinating service provider is released from its professional confidentiality obligation for the purposes of this disclosure.

25 Disputes

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

26 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.

27 Effective Date

These Insurance Conditions come into force on 1 January 2024. They replace the Insurance Conditions Edition 1 January 2021.

Supplemental provisions applying to the "Flexmed" BeneFit PLUS model

A. The "Flexmed" model gives the insured person the choice, before making use of any medical treatment, of contacting their chosen general practitioner, the telemedicine advice service or another coordinating service provider recognised by Helsana.

B. If the insured person opts for the "Flexmed" insurance model, they shall choose a general practitioner from the options offered by Helsana.

C. Within the meaning of Section 17, the insured person shall be obliged, prior to making use of any medical services, to contact the coordinating service provider in the form of their chosen general practitioner, the telemedicine advice service or a recognised partner of Helsana.

D. Should the telemedicine advice service or the recognised coordinating partner order treatment by a general practitioner, this treatment must be performed by the chosen general practitioner.

E. In the interest of providing an optimal course of treatment and potential savings in benefit costs, Helsana may, on an ongoing basis, analyse the billing and benefits data of the previous 4 years in addition to the data handling measures specified in Section 24 for the purpose of the measures set out in Section 20. On the basis of its findings, it may then issue an order to the insured person or via the coordinating service provider for the relevant measures to be taken, or inform insured persons of appropriate options without any obligation.

F. Insofar as these supplemental provisions do not contain any contrary rules or principles, the BeneFit PLUS Insurance Conditions shall apply.