

Favorit Start

Supplementary Conditions (SC) for insurance with limited choice of service provider under the KVG

Version 2027, valid from 1 January 2027

SW/CA

Supplementary Conditions for Favorit Start

The General Insurance Conditions (GIC) for healthcare and daily allowance insurance under the KVG apply in full to these SC. In the event of any contradictions, the SC take precedence over the GIC.

I. General

Art. 1 Insurance purchase, change of insurance plan, and premiums

1. This insurance plan with limited choice of service provider (special form of insurance) is available to individuals who meet the statutory enrolment conditions. 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 plan 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 plan, 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 plan within one month. Insured persons who relocate to an area with another insurance plan with limited choice of service provider can continue their cover by choosing another insurance plan with limited choice of service provider.

4. If the contract between the selected service provider and the insurer is terminated, the insured person may choose, within 30 days of being prompted to do so in writing by the insurer, to switch to a new service provider under the selected insurance model or to transfer to the insurer's standard healthcare insurance. If the insured person does not respond 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 selected insurance plan is no longer offered, once this insurance plan lapses, the insured person will be automatically transferred to a comparable insurance plan with limited choice of service provider and also retaining the selected excess, or if there is no comparable insurance plan available, to the standard health insurance model from the insurer. The insured person can also exercise their right to terminate their cover in accordance with Art.7 KVG, or, taking the legal deadlines into account, select another one of the insurer's insurance plans.
6. Insured persons with special forms of insurance may be 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) Temporary stays abroad of up to six months
- c) 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

In the event of a violation of the obligations applying to the insurance with limited choice of service provider (e.g. failure to comply with the requirements of the service provider, failure to contact the telemedicine centre), the insurer may exclude the insured person from the selected insurance with limited choice of service provider following a second warning, with effect from the beginning of the next calendar month. This automatically results in a transfer to the standard health insurance model. The insurer may impose a waiting period of twelve months before the insured person can switch back to a policy with limited choice of service provider.

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.

In addition to SWICA, the santé24 telemedicine partner (referred to below as "santé24") may require the insured person to participate in a patient care programme (such as care management or disease management) if they have a chronic or potentially chronic illness or are undergoing treatment. If the insured person refuses in any manner to participate in a proposed patient care programme, SWICA may impose the sanctions provided for in Art. 3.

II. Scope

Art. 5 Purpose of the insurance model

1. Favorit Start 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 Start insurance plan is based on a limited choice of service providers. In the event of a health problem, the insured person undertakes to use the digital symptom check application provided by SWICA (referred to below as the "Symptom-Check app") first. This will then specify the treatment path. The insured person must answer questions about their health condition truthfully and in full in the app. The purpose of using the Symptom-Check app first is to ensure 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 Start on its website.

Art. 7 Treatment paths

1. In the event of a new or recurring health problem after completion of a treatment or examination, the insured person is obliged to consult the first point of contact specified below for advice.
2. Insured persons aged 17 or over are obliged to use the SymptomCheck app provided by santé24 (see Art. 8 of the SC). Upon completion of the symptom check, the insured person will receive instructions as to whom to contact for further treatment. This may, in particular, be a consultation through santé24, a consultation with a family doctor, a consultation in a pharmacy, self-treatment or going to the emergency department.
3. Insured persons aged 16 or under or their legal representatives, as well as persons who do not have a mobile device capable of using the application, are obliged to consult santé24 by telephone.
4. If the SymptomCheck app is not available (undergoing maintenance, or similar), santé24 must be contacted by telephone.
5. The insurer pays the statutory insurance benefits from Favorit Start, in particular for outpatient and inpatient treatments, provided that these were carried out by a doctor listed in the Favorit Start directory on the basis of an instruction from santé24. Where necessary, these doctors will arrange a referral to a third party (e.g. specialist, hospital, care home).

6. If a doctor listed in the Favorit Start directory refers the insured person to a third party who then orders further treatments, investigations, surgery, or care, the insured person must inform or have someone inform santé24 of this and obtain its consent in advance by telephone or by means of the online form.
7. If an insured person needs to be hospitalised in an emergency or undergo emergency treatment, he/she must inform or have someone inform santé24 by telephone or by means of the online form at the earliest possible opportunity. If a follow-up consultation is necessary following emergency treatment, this must be carried out by a doctor from the Favorit Start directory. Further treatment can be administered for as long as necessary, including by the emergency doctor or in hospital, provided that santé24 has given its consent.
8. The Favorit Start directory is updated at the beginning of each year. Amendments during the year are made only in exceptional circumstances, such as if a doctor ceases practising, a practice is closed, in cases of death or in similar circumstances.

Art. 8 Digital symptom checker application

1. The SymptomCheck app is the first point of contact for all insured persons aged 17 or over in accordance with Art. 7 para. 2 of the SC. The insured person must answer the relevant questions about their state of health truthfully and in full in the SymptomCheck app and must then authorise the release of the data to santé24. 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 instructions for the next steps. Particularly sensitive data such as health data or data about the insured person's personal life may be collected during this process. The consent of the insured person is required for the transmission of data from the SymptomCheck app to santé24. The conditions of use and the data protection provisions of the SymptomCheck app contain further information on data processing.

Art. 9 Telemedicine benefits

1. santé24 advises the insured person and determines whether and which medical treatments should be carried out. If santé24 concludes that medical treatment is necessary, it determines the appropriate medical treatment (including the number of consultations within a period defined by it). santé24 may also provide medical treatment itself.
2. By purchasing the Favorit Start insurance plan, the insured person agrees to grant santé24 access to the diagnostic, treatment and invoicing data relating to their medical care that is necessary for this insurance plan. This form of insurance also requires data to be shared between santé24, the insurer and any third parties needed to provide the healthcare. This includes all relevant data pertaining to the medical care of the insured person (e.g. patient documentation, contract data, invoice data, etc.). This data will in particular be disclosed to specialists, hospitals and other persons and institutions involved in the provision of medical and organisational services, for the purpose of executing the insurance contract.
3. 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 may be used as evidence. The insurer has no access to this information unless authorised by the insured person.

Art. 10 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 (in accordance with Art. 8 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.

Art. 11 mySWICA customer portal

The insured person is obliged to register in the mySWICA customer portal and to utilise this portal to carry out all processes specified by the insurer that can be handled via the customer portal. In particular, the insured person is obliged to submit all invoices via the mySWICA customer portal and to receive premium and benefit statements exclusively via the mySWICA customer portal. If the insured person fails to comply with this requirement, sanctions will be imposed in accordance with Art. 3 of the SC.