2022 edition

Compulsory health insurance

Terms and Conditions of Insurance (TC)
callmed 24

2022 edition

Terms and Conditions of Insurance (TC) callmed 24 in accordance with the Federal Law on Sickness Insurance (KVG)

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Purpose of the insurance

Compulsory health insurance covers the costs of diagnosis and treatment in the case of illness, accident and maternity under the Federal Law on Sickness Insurance (KVG). Policyholders can take out health insurance with a standard or optional franchise. They can take out compulsory health insurance with a free choice of doctor or as an alternative insurance model in the form of a special type of insurance with a limited choice of service providers.

1 Basic information about the insurance

1.1 Statutory provisions and cantonal law

This insurance policy is based on the provisions of the Federal Act on General Aspects of Social Security Law of 6 October 2000 (ATSG), the Federal Law on the Supervision of Social Health Insurance of 26 September 2014 (KVAG), the Federal Law on Sickness Insurance of 18 March 1994 (KVG) and the implementing provisions belonging thereto as well as these Terms and Conditions of Insurance (TC). Swiss law and cantonal law take precedence over these Terms and Conditions of Insurance (TC).

1.2 Application to insurance companies in the Sympany Group

As the health insurer, the legal entity named in the policy provides the insurance benefits and is here inafter referred to as the “insurer”.

1.3 How the alternative insurance model works

callmed 24 is an alternative insurance model in the context of compulsory health insurance in accordance with the Federal Law on Sickness Insurance (KVG).

By taking out a **callmed 24** insurance policy, the insured person agrees to consult the telemedical centre (hereinafter referred to as the “coordinating service provider”) before receiving any medical treatment and/or nursing care. The coordinating service provider is the insured person’s first point of contact for all medical concerns. It is available 24 hours a day, 365 days a year to provide advice on health problems and issues obligatory instructions as regards the next course of action in terms of treatment (in particular referrals to other medical service providers).

2 Subject of the insurance

The people specified in the policy are insured against the economic consequences of illness, maternity and accident. The accident risk is covered if it is specified on the insurance policy.

3 General obligations

The insured person must follow the doctor’s instructions, do everything to aid recovery and refrain from anything that might delay it.

4 Liability resulting from medical treatment

Liability for diagnostic and therapeutic services lies solely with the service providers treating the insured person.

5 End of the insurance

The insurance ends:

a) when cancelled,
b) when the policyholder moves abroad, except when the insurance obligation continues to apply,
c) in the event of death.

6 Termination by the insurer

The insurer may terminate the **callmed 24** insurance policy as of the end of a calendar year subject to a two-month notice period or change the insurance product with the same notice period.

As of the date of termination, the insured person can choose to switch either to another special type of insurance with a limited choice of service providers or to compulsory health insurance with a free choice of doctor. The insured person shall be made aware of the options at the same time as the insurer terminates the policy.

If the insured person fails to exercise their right of choice by the end of the notice period, this will automatically result in them being switched to compulsory health insurance with a free choice of doctor.

7 Accident cover

The accident cover against work-related and non-work-related accidents can be excluded if evidence of full compulsory accident cover under the Federal Law on Accident Insurance (AIL) is produced. The exclusion takes place as of the first day of the month following the application. Accident cover is included as soon as the accident cover under AIL ends. The insured person must inform the insurance company immediately when the insurance cover under AIL lapses.

8 Obligation to report to and notify the insurance company

8.1 Reporting an accident

If accident benefits are claimed, the accident notification form must also be completed and sub-

mitted. The accident notification must be sent to the insurer no later than ten days after the accident occurred.

8.2 Cooperation of the insured person
The insured person must provide the insurer with all the information needed to evaluate a claim for benefits, free of charge. This also includes the decisions of other social insurance organisations and supporting documents from any private insurance companies.

8.3 Authorisation to share information
The insured person must authorise all people and organisations, i.e. employers, doctors, hospitals, therapists, insurance companies and public authorities, to provide the information needed to evaluate a claim for benefits.

8.4 Failure to uphold the obligation to notify the insurance company
The insured person is responsible for any negative consequences arising as a result of breaching the reporting and notification obligations.

9 Rights and obligations relating to third-party benefits
The insured person is obliged to inform the insurer immediately about any third-party benefits (e.g. accident, third-party liability, military or disability insurance) and settlement agreements if it must pay benefits in the same insurance case. The insured person may not waive third-party benefits wholly or partially without the insurer's express permission. If another health, accident or social insurance provider reduces its benefits for reasons which also entitle the insurer to reduce benefits, it will not reimburse the shortfall caused by the reduction.

10 General benefit conditions
10.1 Contacting coordinating service providers
The insured person shall contact the coordinating service provider regarding health problems before beginning any treatment. The coordinating service provider will advise the insured person on their medical concerns and set out the best course of treatment. The insured person must follow the instructions.

10.2 Timeframe for further treatments
If medical treatment is advised during the consultation, the coordinating service provider will agree a timeframe with the insured person during which the treatment will take place with a service provider of their choice. In the case of follow-up checks and referrals to other service providers, further consultation with the coordinating service provider is required. If the agreed timeframe is insufficient for treatment to be completed, the insured person will contact the coordinating service provider again before the time limit expires.

10.3 Conduct in the event of commitment to bear costs
The coordinating service provider must also be informed about the treatment if the insurer has agreed to bear the costs.

11 Obligation to be subject to special measures regarding integrated care
If holistic care planning is required in the event of a specific (particularly chronic or potentially chronic) illness, the insured person shall be obliged to be subject to special measures regarding integrated care, such as disease management (an organised, patient-centred, multi-component approach to holistic health care).

The insured person shall be made aware of the 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 also be obliged to consider obtaining medication, laboratory work, aids, etc. from cost-effective sources (e.g. mail-order pharmacies). They shall be informed by the insurer or the coordinating service provider of the source to be considered in each case. The insured person shall be obliged to be treated with the medication that is effective, appropriate and most cost-effective in treating the condition. This may be a generic product, a biosimilar or a cost-effective branded preparation.

If the insured person obtains a medication for which a more cost-effective alternative is available, the insurer or the coordinating service provider shall make them aware of this.

12 Exceptions
12.1 Ophthalmologist, gynaecologist, paediatrician, dentist
The insured person may have examinations and treatments performed at ophthalmologist, gynaecologist and dental practices without notifying their chosen coordinating service provider beforehand. Treatment by paediatricians is excluded from the obligation to inform the coordinating service provider until the insured person reaches the age of 16.

12.2 Emergencies

In an emergency, the coordinating service provider is to be contacted. If this is not possible, the insured person can consult the local emergency service on duty or hospital. In such cases, the insured person shall be obliged to notify or have the coordinating service provider notified as soon as possible and submit confirmation of emergency treatment to the coordinating service provider.

12.3 Definition of an emergency

An emergency is when a person's condition is considered life-threatening by themselves or by third parties or there is an immediate need for treatment.

13 Lists with preferred service providers

The insurer reserves the right to provide the coordinating service provider with a list of preferred service providers from which the coordinating service provider and the insured person must together choose a service provider for further treatment. The insurer must compile this list fairly and without prejudice. This list shall be made available by the insurer when this provision is applied.

14 Violation of the conditions of the alternative insurance model

If the insured person ever receives non-emergency treatment from service providers other than the coordinating service provider, the insurer must inform them of their failure to comply with and violation of contractual provisions. This shall also apply in the event of non-compliance with the special measures defined in section 11.

Moreover, in the event of a violation of the obligations under these Terms and Conditions of Insurance, the insurer reserves the right to exclude the insured person from all alternative insurance models for at least 12 months and at most 24 months as of the first of the following month and/or to reclaim costs for benefits that were not performed or ordered by the coordinating service provider or contradict its instructions. The exclusion or refusal to pay shall be communicated in writing (by post or digitally), providing details of the breach of duty. Exclusion from the **callmed 24** insurance model will automatically result in the insured person being switched to compulsory health insurance with a free choice of doctor.

15 Change of insurance due to amended framework conditions

If the coordinating service provider cannot or can no longer provide medical treatment (in particular, in the event of a stay in a care home and treatment by its doctor, etc.), the insurer shall be entitled to cancel the **callmed 24** insurance policy without prior notice as of the first of the following month. This will automatically result in the insured person being switched to compulsory health insurance with a free choice of doctor.

16 Payment details

The insurer pays out benefits to the insured person's specified post office or bank account. If the insured person fails to specify an account, the insurer may invoice them for a flat rate charge to cover expenses per benefit statement.

17 Fees

17.1 Reminder and debt collection fees

In addition to the costs involved in debt collection proceedings, the insurer may also invoice insured persons who default on payments for appropriate processing costs, handling costs, reminder costs and interest on arrears.

17.2 Payment in instalments

If payment in instalments is agreed during debt collection proceedings, the insurer may invoice the insured person an instalment fee for the additional administration involved.

18 Duty of confidentiality

The insurer's employees are bound by a legal duty of confidentiality.

19 Administration of justice

19.1 Order

If an insured person does not agree with a decision made by the insurer, the insurer shall issue a written substantiated order including instructions for the right to appeal within 30 days of being requested to do so.

19.2 Objection

An objection to the order issued by the insurer can be raised within 30 days of its delivery. The insurer shall review the objection and issue a written substantiated decision on the objection including instructions for the right to appeal.

19.3 Appeal procedure

An appeal against the decision on the objection issued by the insurer can be filed with the cantonal insurance court within 30 days of its delivery.

Appeals can be filed by parties who are affected by the contested order or the decision on the objection and who have a legitimate interest in them being overturned or changed.

The responsible insurance court is the one for the canton in which the insured person or third party filing the appeal resides. The insurance court can also be called upon if the insurer does not issue an order or decision on the objection within the allocated time.

If the insured person or third party filing the appeal lives abroad, the responsible insurance court is the one for the canton in which their last place of residence in Switzerland was located or the canton in which their last Swiss employer resides. If it is not possible to determine a responsible court in either of these ways, the insurance court for the canton of Basel-Stadt shall be the responsible court.

20 Legal force

The order or decision on the objection issued by the insurer shall become legally valid if no appeal is filed within the allocated time. Legally binding orders regarding monetary payments are equivalent to enforceable court judgements according to Art. 80 of the Swiss Debt Enforcement and Bankruptcy Act (SchKG).

21 Legal protection

In disputes about fees between the insured person and service providers according to the KVG, the insurer may, at the insured person's request, take over representation of the insured person in the responsible courts at its own expense insofar as the legal request does not seem futile.

22 Data protection

In particular, insured persons' data is processed in accordance with the applicable legal data protection provisions of the Federal Act on Data Protection of 19 June 1992 (DSG, SR 235.1),Art. 33 of the Federal Act of 6 October 2000 on General Aspects of Social Security Law (ATSG, SR 830.1) and Art. 84, 84a and 84b of the Federal Law on Sickness Insurance of 18 March 1994 (KVG, SR 832.10). As regards insurance relationships with international relevance, data is processed in accordance with the applicable provisions (e.g. GDPR [EU] 2016/679 of 27 April 2016).

By taking out the **callmed 24** insurance model, the insured person consents to the insurer, the coordinating service provider or third parties acting on its behalf sharing treatment, diagnosis and invoice data relating to the insured person's complete medical care with each other, insofar as this data is required for the processing of the **callmed 24** insurance policy and, in particular, for verifying the compliance of the insured persons with their obligations (quality assurance and ensuring the best course of treatment). This includes statistical analyses of **callmed 24**. The insured person also consents to this data being processed by the insurer. The data shall be stored in physical or electronic form.

In the event of a change of coordinating service provider, the insured person shall give consent to this information being passed on to the new coordinating service provider in written and electronic form and at the same time release the current coordinating service provider from its professional secrecy obligations as regards the disclosure of this data.

Detailed information on data protection can be found on the insurer's website.

23 Interpretation

The German version of these Terms and Conditions of Insurance is the original. The versions in English, French and Italian are translations. In case of discrepancies, the German version shall prevail.

24 Entry into force

These rules come into force on 1 January 2022 and replace all previous rules and terms and conditions regarding compulsory health insurance under statutory law.

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