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Version 2014

Supplementary Insurance Conditions (ZVB)
PRIMEO Supplementary Health Care Insurance for Outpatient Benefits

List of Contents

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

General

1 Purpose

1.1 PRIMEO Supplementary Health Care makes payments towards the costs for outpatient treatment that are not covered by compulsory health care insurance.

1.2 Benefits from this insurance policy are paid out if they are claimed for medical purposes and are deemed necessary.

Benefits

2 Free choice of doctor for outpatient treatment

2.1 PRIMEO covers the costs for the free choice of doctor for outpatient treatment. The insurer shall also pay out any additional costs incurred in relation to the free choice of doctor for outpatient treatment or outpatient births.

2.2 For there to be an entitlement to a given benefit, a contractual agreement (tariff contract) covering this benefit must be in place between the insurer and the relevant service provider.

2.3 The insurer keeps a list of those institutions at which doctors can be chosen for outpatient treatment and births (i.e. where there is an entitlement to benefits). This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested (homepage).

3 Overnight stays and comfort benefits

3.1 For overnight stays in a clinic or hotel that are not medically required and are taken by the insured person on the night directly before/after a treatment that is paid for by compulsory health care insurance or this insurance policy, the insurer shall make a contribution of up to CHF 400 per treatment up to a maximum of CHF 1,200 per calendar year.

3.2 For comfort benefits provided as part of outpatient treatment, the insurer covers the costs at the level specified in the agreement with the relevant service provider. Comfort benefits include thorough care from non-medical personnel, accommodation in a separate recovery zone (e.g. one- or two-bed room), separate refreshments as well as special services (e.g. WLAN, print media, telephone).

3.3 For there to be an entitlement to a given benefit, a contractual agreement (tariff contract) covering this benefit must be in place between the insurer and the relevant service provider.

3.4 The insurer keeps a list of those service providers that offer comfort benefits. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested (homepage).

4 Implants

For implants that are used during outpatient treatment and are not paid for or are not fully paid for by compulsory health care insurance, the insurer shall cover up to 90% of the cost of the benefits not covered by compulsory health care insurance, up to a total of CHF 5,000 per calendar year.

5 Innovative forms of diagnosis and treatment

5.1 The insurer shall cover up to 90% of the costs (up to a maximum of CHF 5,000 per calendar year) that are not covered by compulsory health care insurance in relation to effective, innovative outpatient forms of diagnosis and treatment.

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5.2 The insurer keeps a list of those innovative forms of diagnosis and treatment for which benefits may be claimed together with the service providers that offer them. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested (homepage).

6 Transport

6.1 For transport costs the insurer covers a maximum of CHF 500 per calendar year, taking into account section 22 AVB.

6.2 There is only an entitlement for the reimbursement of costs for transport to/from a service provider recognised under compulsory health care insurance if the transport was related to treatment that is paid for under compulsory health care insurance or this insurance policy.

7 Aids and equipment

For necessary aids and equipment that are medically prescribed in accordance with the aids and equipment list (MiGeL, appendix 2 of the Ordinance on Health Care Benefits) and that exceed the limits specified in the aids and equipment list (MiGeL), the insurer shall pay up to CHF 5,000 per calendar year to cover the benefits that are not covered in full under compulsory health care insurance.

8 Outpatient treatment abroad

8.1 In the case of specific, scientifically recognised and appropriate outpatient treatment at a hospital abroad, the insurer shall cover the costs by issuing a guarantee for payment. However, this may also take the form of the insurer issuing a guarantee for payment to cover only part of the desired treatment.

8.2 In order to make use of other benefits under these ZVB (overnight stays and comfort benefits, implants, innovative forms of diagnosis and treatment, transport, aids and equipment, check-ups and hotlines) abroad, the relevant requirements/limits shall apply.

9 Check-ups

9.1 The insurer shall pay up to CHF 1,700 per three calendar years towards the costs of check-ups.

9.2 For there to be an entitlement to a given benefit, a contractual agreement (tariff contract) covering this benefit must be in place between the insurer and the relevant service provider.

9.3 The insurer keeps a list of those institutions where there is an entitlement to benefits. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested (homepage).

10 Hotlines

10.1 The insurer shall pay a maximum of CHF 300 per calendar year towards the costs incurred in relation to the use of hotlines and/or online services that are subject to a charge for medical treatment from a service provider that is recognised by Helsana.

10.2 The insurer keeps a list of service providers recognised with respect to this benefit. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested (homepage).

10.3 These costs will be reimbursed upon presentation of the corresponding telephone bills/invoices for online services.

Insurance Plan Options

11 Special condition for special types of insurance

For insured persons who have obtained other special forms of insurance under compulsory health care insurance pursuant to the KVG (e.g. HMOs, other general practitioner models or insurance models with limited choice of service providers), the limiting conditions for a benefits claim set forth in the relevant General Insurance Conditions apply to this insurance as well.

Miscellaneous

12 Premium setting

12.1 Premiums are calculated based on the age and gender of the insured person. Insured persons are assigned to the age group that corresponds to their current age.

12.2 Section 12.2 of the General Insurance Conditions (AVB) for Supplementary Health Insurances does not apply to the PRIMEO product.