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HMO Health Insurance

HMO Health Insurance Supplementary Regulations and Special Insurance Terms and Conditions for Supplementary Insurances for HMO-Insured Persons

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Special Insurance Terms and Conditions for Supplementary Insurances for HMO-Insured Persons

HMO Health Insurance Supplementary Regulations

I. General Provisions

1 Principles

1.1 HMO Health Insurance is a special form of mandatory health care insurance with a limited choice of service providers. The HMO health organisation ensures the comprehensive care and treatment of HMO-insured persons in all matters of health.

1.2 HMO-insured persons agree to have all treatments and examinations performed by the designated HMO health organisation or to allow their HMO health organisation to refer them to a third party. In this way, HMO-insured persons contribute to the provision of costconscious medical care.

1.3 The benefits guaranteed by HMO Health Insurance are determined by the scope of benefits of mandatory health care insurance while taking into consideration the limiting provisions concerning the drawing of benefits (Art. 7 et seqq.).

1.4 Data protection is guaranteed with HMO Health Insurance.

1.5 The insurance provider and the HMO doctor shall provide each other with the information necessary to effect this special form of insurance. They will both have access to all invoices that the other has received. This data is evaluated within the framework of HMO Health Insurance. The insurance provider may engage a third-party specialist for this as long as the insurance provider binds that third party to the duties regarding data protection.

2 Area of Validity

2.1 The limiting provisions concerning the drawing of benefits within the framework of HMO Health Insurance also apply to any other supplementary insurances held with the insurance provider. The relevant insurance terms and conditions of supplementary insurances shall apply.

2.2 As long as no contrary regulations are included in these provisions, the provisions in the statutes and in the mandatory health care insurance regulations of the insurance provider apply.

II. Insurance Relationship

3 Taking Out Insurance

3.1 HMO Health Insurance may be taken out by all insured persons whose place of residence according to Swiss civil law is in the corresponding regional HMO service area. HMO Health Insurance is always taken out for the first day of the following month.

3.2 When taking out HMO Health Insurance, HMO-insured persons choose a regional HMO health organisation as long as a choice exists. It is possible to change at a later date to another HMO health organisation (Art. 13).

3.3 If family doctor care is not possible through the HMO health organisation (e.g. if the treatment of the insured person cannot be influenced by the HMO doctor), HMO Health Insurance may not be taken out.

4 Cancellation

4.1 It is possible to change to another form of insurance or to another insurance provider with effect at the end of a calendar year, subject to a three-month cancellation period.

4.2 In the event of a move out of the HMO service area, the exit from HMO Health Insurance and the change to mandatory health care insurance take effect on the first day of the following month.

4.3 If family doctor care is no longer possible through the selected HMO health organisation (e.g. if the medical treatment of the insured person can no longer be influenced by the HMO doctor), the insurance provider is entitled to exclude the HMO-insured persons from HMO insurance, effective at the end of a calendar month, subject to a 30-day period of notice. This shall result in an automatic change to the insurance provider's mandatory health care insurance. The right to grant HMO Health Insurance in the future remains reserved. This rule also applies to insured persons that stay abroad for more than three months as well as to those that repeatedly violate the regulations.

III. Premiums and Cost Sharing

5 Premiums

HMO-insured persons receive a discount on the mandatory health care insurance premium. The applicable premium tariff shall prevail.

6 Cost Sharing

The charging of the deductible and retention fee for outpatient and inpatient treatment and the contribution to the costs of a hospital stay are effected in accordance with the legal provisions of mandatory health care insurance and the relevant insurance terms and conditions of the insurance provider. The HMO premium (standard premium minus the discount in accordance with Art.5) forms the basis for the calculation of the premium reduction for insurance with optional deductible.

IV. Rights and Duties of HMO-Insured Persons

7 Treatment and Care by the HMO Health Organisation Doctor

7.1 HMO-insured persons always first consult their HMO doctor or the doctor's replacement from the HMO organisation for all treatments. Gynaecological precautionary examinations and obstetrical assistance, examinations at the ophthalmologist solely for a prescription for glasses or contact lenses are excluded. When necessary, the HMO doctor ensures the provision of suitable treatment and care from other doctors or paramedical personnel.

7.2 If HMO-insured persons directly resort to direct outpatient or inpatient treatment outside of an emergency situation without previous orders from their HMO doctor, they themselves shall bear all associated costs.

7.3 HMO-insured persons shall inform the doctor or therapist that they consult outside of the HMO organisation that they are covered by HMO insurance.

8 Emergency Treatments

8.1 In an emergency situation, HMO-insured persons consult their HMO health organisation; should this not be available, they consult the regional emergency organisation in the place of residence or, where appropriate, the place where they are staying.

8.2 If an emergency necessitates hospital admission or treatment by an emergency doctor, HMO-insured persons are obligated to inform their HMO health organisation themselves or via proxy as soon as possible and to submit a certificate from the emergency doctor.

9 Treatments by a Specialist

If HMO-insured persons are referred to a specialist by their HMO doctor and this specialist recommends further treatment or surgical intervention for the HMO-insured persons, the HMO-insured persons are obligated to inform their HMO doctor of this beforehand, either themselves or via proxy, and to obtain the HMO doctor‘s approval.

10 Hospital Admission

Admissions into hospitals or semi-inpatient institutions must be prescribed by the HMO doctor or with his approval (with the exception of emergencies as per Art. 8). The HMO doctor determines the need for hospital care and admits the HMO-insured persons into the hospital.

11 Spa Cures

Admissions into health spas must be prescribed by the HMO doctor or with his approval, provided that the entitlement to insurance benefits is asserted.

12 Duty to Notify in the Event of Accidents

HMO-insured persons shall report accidents and related treatments to their HMO doctor even if these are covered by accident insurance in accordance with the Swiss federal law on accident insurance (UVG/LAA/LAINF).

13 Changing HMO Health Organisations

In justified cases, HMO-insured persons may change HMO health organisations for the first day of the following month. They communicate this to their current HMO health organisation and to their insurance provider.

14 Right to Access Records

By taking out HMO Health Insurance, HMO-insured persons agree to grant their HMO doctor access to all treatment and billing information pertaining to their medical care. When changing to another HMO health organisation, they agree to this information being forwarded to the new HMO health organisation and release the HMO doctor from professional confidentiality for this purpose.

V. Final Provision

15 Entry into Force

15.1 These supplementary regulations were adopted by the Administrative Board on 25 October 1996 and enter into force on 1 January 1997.

15.2 The changes from 27 October 2000 (Arts. 1.4, 1.5, 3.3, 4.1, 4.3, 7.1, 7.3, 12 and 15) enter into force on 1 January 2001.

15.3 The change from 19 September 2003 (Art. 4.1) enters into force on 1 October 2003.

15.4 The changes from 16 September 2005 (Arts. 3.1, 4.2 and 11) enter into force on 1 January 2006.

15.5 The changes from 4 May 2007 (use of the new term "HMO health organisation" throughout the supplementary regulations) enter into force retroactively on 1 January 2007.

Please note:

Insured persons covered by HMO Health Insurance have the option of taking out supplementary insurances with CONCORDIA Insurences Ltd according to the Swiss federal law on insurance contracts (VVG/LCA). With respect to supplementary insurances for HMO insured persons, the subsequent Special Insurance Terms and Conditions are always applicable in addition to the General Insurance Terms and Conditions and the Additional Insurance Terms and Conditions.

Special Insurance Terms and Conditions for Supplementary Insurances for HMO-insured persons

I. General Provisions

1 Principles

1.1 Insured persons covered by HMO Health Insurance have the option of taking out supplementary insurance. However, insurances that are supplementary to HMO Health Insurance may only be taken out in conjunction with an existing HMO Health Insurance policy at CONCORDIA Swiss Health and Accident Insurance Ltd or with an insurance provider that offers CONCORDIA Insurances Ltd
supplementary insurances.

1.2 Supplementary insurances for HMO-insured persons are regarded as special forms of insurance with a limited choice of service providers. The applicable rights and duties of insured persons covered by HMO Health Insurance are also mandatorily applicable for supplementary insurances. In the event of a change to mandatory health care insurance, the special rights and duties of HMO-insured persons no longer apply.

2 Area of Validity

As long as no contrary regulations are included in these Special Insurance Terms and Conditions, the provisions of the HMO Health Insurance supplementary regulations and the relevant General and Additional Insurance Terms and Conditions for supplementary insurances apply.

II. Benefits

3 Principle

3.1 The benefits of HMO supplementary insurances are determined by the Additional Insurance Terms and Conditions of the corresponding supplementary insurance that are applicable.

3.2 The limiting provisions concerning the drawing of benefits and on the choice of service providers (Arts. 7–13 of the HMO Health Insurance supplementary regulations) also apply when HMO-insured persons draw benefits from the supplementary insurances.

III. Premiums and Cost Sharing

4 Premiums

HMO-insured persons receive a discount on the premium of the supplementary insurance that has been taken out. The applicable premium tariff shall prevail.

5 Cost Sharing

The charging of deductibles and retention fees for outpatient and inpatient treatment is determined by the applicable General and Additional Insurance Terms and Conditions for supplementary insurance.

The following abbreviations, with corresponding translations in German, French, Italian and English, are used in these Regulations:

UVG/LAA/LAINF
UVG: Bundesgesetz über die Unfallversicherung
LAA: Loi fédérale sur l'assurance-accidents
LAINF: Legge federale sull'assicurazione contro gli infortuni
Swiss federal law on accident insurance

VVG/LCA
VVG: Bundesgesetz über den Versicherungsvertrag; Versicherungsvertragsgesetz
LCA: Loi fédérale sur le contrat d'assurance
LCA: Legge federale sul contratto d'assicurazione
Swiss federal law on insurance contracts

CONCORDIA
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CONCORDIA
Bundesplatz 15
6002 Lucerne
Phone 041 228 01 11
www.concordia.ch
info@concordia.ch

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