ÖKK

General Insurance Conditions (GIC)

ÖKK FAMILY FLEX

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1. Insurance fundamentals

1.1 Insurance provider

The insurance provider is ÖKK Versicherungen AG, Landquart (hereinafter referred to as the insurer).

1.2 Common Provisions

The ÖKK UNO Common Provisions (ÖKK UNO CP) are an integral part of the provisions of this insurance product. If the provisions of this insurance product differ from the ÖKK UNO CP, the provisions of this insurance product take precedence over the ÖKK UNO CP.

1.3 Purpose

The insurance provides benefits for inpatient or outpatient treatment in the case of illness, accident and maternity as well as emergencies abroad.

The insurance provides benefits for preventative measures, aids, dental treatments, alternative treatment methods, transport costs, search, rescue and recovery operations, optional medications, natural remedies, spa treatments, domestic assistance outside the hospital and pays a breastfeeding allowance.

The insurance pays benefits further to compulsory health care insurance (BASIS). Of the maximum costs, the maximum share payable is the portion which is not covered by a social insurance (incl. BASIS with another insurer).

The insurance provides benefits before any other insurance policies concluded with the insurer in accordance with the VVG. Retentions are deducted for every insurance.

1.4 Conditions for receiving benefits

The insurance provides benefits if the treatment is medically necessary and is carried out by people who are recognised to do so by the insurer.

The insurance provides benefits for inpatient treatment if it is carried out in a list or contractual hospital. The treatment must be carried out by service providers who are recognised to do so in accordance with KVG.

1.5 Geographical scope

Unless otherwise specified, the insurance provides benefits in Switzerland.

1.6 Conclusion of insurance

The insurance can be concluded until the person turns 60 years of age.

2. Outpatient treatment

2.1 Medical treatment in the case of an emergency abroad

The insurance provides benefits for medical treatment in the event of emergencies abroad during temporary stays abroad.

2.2 Non-medical psychotherapy

2.2.1 Scope of benefits

The insurance pays 50% of the costs up to CHF 1,000 per calendar year for the treatment of mental disorders by qualified psychotherapists, who are not physicians and who have a cantonal license to practise independently.

2.2.2 Conditions for receiving benefits

The insurance provides benefits after the cost guarantee request has been approved by the independent medical examiner.

The insurance does not pay benefits in case of psychotherapy treatment which is carried out for the purpose of self-realisation, personal development or for learning purposes, and also not in case of parallel treatments with other psychologists or psychiatrists.

2.3 Thermal bath

The insurance pays 50% of the costs for a maximum of twelve entrance fees for the medically prescribed visits per calendar year.

2.4 Sterilisation

The insurance provides benefits totalling 50%, up to CHF 1,000, for vasectomies and the sterilisation of adults.

3. Inpatient treatment

3.1 Acute treatment

3.1.1 Conditions for receiving benefits

The insurance provides benefits if the insured person is in need of hospital care within the meaning of BASIS insurance.

3.1.2 Scope of benefits

The insurance provides benefits to cover the costs of a hospital stay over and above the benefits provided by BASIS. The deductible for BASIS applies.

The insured person chooses the hospital ward with the corresponding cost sharing amount before being admitted to hospital.

3.1.3 Insured hospital ward and deductibles

The insured person can choose from the following wards:

Treatment on:	Cost-sharing amount per calendar year:
General ward	nil
General ward with comfort twin-bedded room	10%, up to CHF 200
General ward with comfort single-bedded room	10%, up to CHF 200
General ward comfort family room (only for childbirth)	10%, up to CHF 200
Semi-private ward	15%, up to CHF 1,500
Semi-private ward family room (only for childbirth)	15%, up to CHF 1,500

For childbirth in a list or contractual hospital, the cost-sharing amount does not apply for a comfort room on the general ward (single, twin, family room).

The deductible for families where all family members live within the same household is limited to CHF 3,000 per calendar year. The deductibles can be adapted to the development of costs.

The insurance provides benefits up to CHF 200 per day for the additional costs in a comfort room on the general ward (single, twin, family room) or in the family room on the semi-private ward.

3.2 Inpatient rehabilitation

If medical treatment is carried out in a rehabilitation clinic recognised by the insurer, the insurance provides benefits for up to 60 days per calendar year in accordance with the conditions for hospital treatment (section 3.1.3).

3.3 Psychiatric treatment

In the event of an inpatient stay at a psychiatric clinic, or psychiatric treatment in an acute-care hospital or special clinic, the insurance pays for up to 90 days every three calendar years on the insured ward in accordance with the conditions for hospital treatment (section 3.1.3).

3.4 Emergencies abroad

The insurance provides benefits in the event of emergencies abroad for inpatient treatment on the general ward of an acute-care hospital during temporary stays abroad in accordance with the conditions for hospital treatment (section 3.1.3), provided a return journey to Switzerland is not possible for

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medical reasons. A cost guarantee request must be submitted to the insurer immediately, at the latest within 10 days of being admitted to hospital.

3.5 Balneotherapy and convalescent therapy

3.5.1 Convalescent therapy

The insurance provides benefits for medically prescribed convalescent treatments following hospital stays of CHF 50 per day, for up to 21 days per calendar year.

The insured person is free to choose from the medically run convalescent facilities recognised by the insurer.

3.5.2 Balneotherapy

The insurance provides benefits of CHF 30 per day, up to 21 days per calendar year.

The insured person is free to choose from the medically run spas recognised by the insurer.

The insurer may require an examination be carried out on admission by the doctor at the convalescent facility as well as a final check-up with a final report from the referring doctor.

3.5.3 Other cures

At the request of the independent medical examiner, the insurance may pay a flat rate up to the amount of the balneotherapy contribution for other medically prescribed convalescent treatments if there is a special medical indication.

3.5.4 Procedure in case of convalescent stays

The medical prescription (together with the diagnosis) for a convalescent stay must be submitted to the insurer two weeks before entering the convalescent facility.

If the treatment is interrupted, partial costs will only be taken over if the interruption was caused by illness or other compelling reasons and if this is certified by the physician administering the treatment.

3.6 Domestic assistance

3.6.1 General provisions

If, in the event of accident or illness, a hospital stay can be avoided or shortened, the insurance makes contributions towards domestic assistance outside of the hospital, provided the insured person's domestic and family circumstances require this.

3.6.2 Scope of benefits

The insurance provides up to CHF 50 per day, max. CHF 1,000 per calendar year, towards the costs of a recognised domestic assistance provider. Benefits are provided even if an agreement does not exist between the service provider and the insurer.

If the insured person is responsible for the care of a child up to twelve years of age, the insurance pays up to CHF 100 per day, up to a maximum of CHF 2,000 per calendar year.

In case of stay in a nursing home, no benefits are paid.

3.6.3 Service providers

A person who works in the insured person's household on a professional basis or for an organisation contractually recognised by the insurer is recognised as a domestic assistance provider.

Assistance provided by relatives of the insured person is recognised if the relative can provide evidence of a loss of earnings.

3.7 Childcare service

3.7.1 General provisions

The insurance provides contributions towards childcare and nursing services for children up to the age of twelve.

This requires a contractual agreement between the insurer and a childcare service recognised by the insurer.

3.7.2 Conditions for receiving benefits

The benefit will be paid if the child requires care of nursing as consequence of acute illness or accident. The provision of benefits is limited to special personnel of the organisation recognised by the insurer.

Children whose legal guardian or parent(s) is/are gainfully employed during the time when childcare is provided have a claim for this benefit.

3.7.3 Scope of benefits

The insurance provides up to CHF 30 per day, max. CHF 600 per calendar year, towards the costs of childcare and nursing services.

3.8 Rooming-in

If a child up to twelve years of age receives inpatient treatment, the insurance provides benefits from the child's insurance for one parent to stay in the child's room.

If a parent receives inpatient treatment, the insurance provides benefits from the parent's insurance for one child up to twelve years of age to stay in the parent's room.

4. Maternity

4.1 Costs of inpatient treatment

If the newborn child does not have their own insurance, the insurance of the mother will cover the uncovered costs of the child in the hospital on the insured ward in accordance with the conditions for hospital treatment (section 3.1.3).

4.2 Birth in a birth house

The insurance pays benefits of up to CHF 2,000 per birth in the case of childbirth in a birth house approved by the insurer, which is not listed on a cantonal hospital list.

4.3 Domestic assistance after childbirth

4.3.1 General provisions

The insurance pays contributions towards the costs of medically prescribed domestic assistance by personnel acknowledged by the insurer.

The contributions shall be paid in lieu of the benefits pursuant to section 3.6.

Contributions are also paid if this assistance is provided by family members of the insured person and the family members suffer a demonstrable loss of earnings as a result.

4.3.2 Scope of benefits in case of childbirth in hospital

The insurance provides up to CHF 100 per day, max. CHF 700 per calendar year, after childbirth in a hospital.

4.3.3 Scope of benefits in case of homebirth or outpatient childbirth

The insurance provides up to CHF 100 per day, max. CHF 1,200 per calendar year, after a home birth or outpatient birth.

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4.4 Antenatal courses

The insurance will pay benefits of CHF 200 per pregnancy towards the costs of an antenatal course (incl. pregnancy and post-natal courses) if the class is held by a skilled specialist.

4.5 Nursing allowance

The insurance pays a breastfeeding allowance of CHF 250. The nursing mother's allowance is paid where the mother breastfeeds her child for ten weeks.

5. Prevention

5.1 Check-up examinations

The insurance pays 90% of the costs, up to CHF 300 per calendar year, for medical check-up examinations.

The description of a check-up is available from the insurer on request.

5.2 Gynaecological preventative examinations

The insurance covers 90% of the costs of a gynaecological preventative examination under the KVG at the KVG tariff per calendar year, provided no benefits have been paid from BASIS for a corresponding preventative examination in the current calendar year.

5.3 Health account

5.3.1 Scope of benefits

The insurance pays 50%, up to CHF 200 per calendar year per area, for the costs of selected preventative measures in the areas designated by the insurer of family, nutrition, movement and other prevention.

The contribution paid by the insurance for individual approved preventative measures may be limited.

If, in one year, several preventative measures from different areas are used, the insurance will pay up to CHF 500 per calendar year.

5.3.2 Conditions for receiving benefits

The preventative measures and courses must be recognised by the insurer.

A list of the individual preventative measures recognised by the insurer is available from the insurer on request.

5.4 Vaccination

The insurance provides benefits totalling 90% of the costs, up to CHF 200 per calendar year, for medically recognised inoculations.

6. Aids

6.1 Visual aids

The insurance pays up to CHF 200 per calendar year towards the costs of glasses lenses and contact lenses required for vision correction.

6.2 Other aids

Upon medical prescription, the insurance may pay 50% of the costs of a necessary aid appropriate to insured person's state of health for which no benefit is paid under BASIS, up to CHF 250 per calendar year. The benefit is paid for aids which improve the use of restricted bodily functions, are economical and comply with the state of the state of the art of medical research. The insurer designates the recognised aids.

What is not insured are costs that arise due to operation, maintenance and repair of these aids.

7. Dental treatment

7.1 Wisdom teeth

The insurance provides benefits totalling 90% for the extraction of wisdom teeth.

If this is effected as inpatient treatment, the costs will be taken over up to the amount of the contractually fixed tariffs of the general ward in the canton of residence.

7.2 Additional benefits for children and young adults

The insurance also provides the following benefits for children and young people up to 25:

- the costs of a check-up incl. x-ray up to CHF 60 per calendar year,
- 70% of the costs of orthodontic treatment pursuant to approved rate.

The benefits for orthodontic treatment will be provided if an insurance duration of at least three years (qualifying period) is given.

The insurer does not stipulate qualifying period provided at least one parent is also insured under an equivalent previous insurance policy with the insurer

7.3 Community benefits

The insurance offsets its benefits against benefits provided by the cantons and municipalities. The insurance subsequently provides the relevant benefits.

7.4 Service providers and tariff

Dental benefits are determined on the basis of the applicable SSO (Swiss Dental Association) dental tariff. There are two tariff structures: the "KVG tariff" and the "revised UVG/MV/IV dental tariff".

The insurance provides benefits at the respective maximum social insurance tariff (tax point value and tax points) of the tariff structure used by the service provider.

7.5 Treatment abroad

The insurance also provides benefits if the treatment is carried out in a country neighbouring Switzerland. Neighbouring countries are countries which have a joint border with Switzerland.

8. Alternative medicine

The insurance provides benefits for alternative medical treatments.

The insurance provides benefits totalling 70% of the costs, up to CHF 10,000 per calendar year, provided the therapy method (e. g. sub-sections of traditional Chinese medicine, naturopathic practices) and the therapist or doctor are recognised by the insurer.

The insurer designates the approved forms of therapy as well as the therapists and physicians. The insurer keeps a list of recognised therapy methods.

The insurance pays 50% of the costs, up to CHF 1,000 per calendar year, for further alternative medical treatments carried out by qualified persons.

The insurance does not provide benefits for therapy methods, treatments and therapists that are listed on the insurer's negative list.

If the alternative medicine treatment is carried out in a neighbouring country of Switzerland, it is insured at the same conditions. The verification by the medical examiner of the medical indication and the qualification of physicians and therapists remains reserved.

If no improvements can be expected, no payments will be made for parallel alternative medical treatments.

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9. Medications and remedies

9.1 Optional medications

The insurance provides benefits totalling 90% of the costs of medically prescribed medication that does not appear on the List of Medications with Tariff (LMT), the List of Specialities (LS) in accordance with KVG or the insurer's negative list.

9.2 Natural remedies

The insurance provides benefits totalling 90% of the costs of phytotherapeutic, homeopathic and anthroposophic treatments and Oligosol, provided that they are not covered by BASIS and are not included on the insurer's negative list (NL).

10. Transport costs, search, rescue and recovery costs

10.1 Transport costs, rescue and recovery operations in emergencies

10.1.1 Scope of benefits

The insurance provides benefits towards the following costs:

- of medically required emergency transports to the nearest appropriate hospital in useful means of transport,
- repatriation to a suitable hospital in the insured person's canton of residence for inpatient treatment; and
- of rescue and recovery operations

of an aggregate amount of up to CHF 50,000 per calendar year.

Transports in aircrafts will be taken over if they are inevitable for medical or technical reasons.

10.1.2 Excess

The insured person has to bear CHF 100 per case.

10.1.3 Third-party benefits

If a membership (patronage) with an air rescue service or similar organisation is given, the insurance will pay benefits if no benefits are provided by these organisations. Differing contractual agreements remain reserved.

10.2 Search operations

In the case of search operations, in addition to the costs of the rescue or recovery, the insurance pays up to CHF 20,000 per calendar year.

10.3 Travel expenses

For regular medical treatment outside a radius of 30 kilometres from the place of residence, the insurance reimburses 90% of the costs of public transport, up to CHF 100 per year.

The insurance also provides benefits totalling 90%, up to CHF 300 per calendar year, for insured persons undergoing dialysis, radiation or chemotherapy.

11. CASAMED variant

11.1 General provisions

The following additional provisions apply to persons who are insured with the insurer under BASIS with the CASAMED option.

11.2 General practitioner principle

The insurance provides benefits pursuant to the general practitioner principle. These benefits must be provided, prescribed or organised by the CASAMED general practitioner with whom the insured person is registered.

Telemedical institutions may be approved by the insurer as CASAMED general practitioners.

11.3 Exceptions from the general practitioner principle

The insurance pays contributions to the costs of routine treatments carried out by ophthalmologists, gynaecologists and paediatricians without consulting the CASAMED general practitioner. If these physicians prescribe further treatments or operations or carry them out, the CASAMED general practitioner is to be consulted.

The insurance pays contributions to the costs of alternative medicine treatments, preventative measures within the scope of the health account, birth preparation, breastfeeding allowance, transport, search, rescue and recovery, and dental check-ups without consulting the CASAMED general practitioner.

11.4 Hospitals

The insurer may designate hospitals which are exclusively entrusted with the care of persons insured with CASAMED.

11.5 Other specialists

The insurer may designate other specialists instead of the CASAMED general practitioner who may provide, prescribe or arrange the benefits.

11.6 Preventative measures, alternative medicine, non-compulsory pharmaceuticals

The insurer may authorise the CASAMED general practitioner or the designated specialists to provide other preventative measures, alternative medical treatments, optional medications or natural remedies, or to prescribe or arrange such treatments.

11.7 Further service providers

The insurer may designate other service providers such as chemists, therapists, medical supply stores or similar service providers to which medical treatment or supplies for CASAMED insured persons are exclusively entrusted.

11.8 Emergencies

The insurance covers emergency cases irrespective of the general practitioner principle. The verification by the medical examiner of the medical indication remains reserved.

11.9 Exclusion of benefits, exclusion from CASAMED variant

11.9.1 Exclusion of benefits

If the insured person seeks treatment from a service provider not eligible, all costs are to be borne by the insured person, except in the definitively listed exceptions.

11.9.2 Exclusion CASAMED variant

The insurer can transfer the insured person from the CASAMED option to the ordinary insurance option in the case of repeated conduct in breach of the regulations.

11.10 Benefits processing

11.10.1 Flat-rate payment

The insurer may agree with the CASAMED general practitioner that the benefits are paid on a flat rate basis.

11.10.2 Prescribed benefits

In the case of prescribed benefits, the insurer may require evidence from the insured person or from the CASAMED general practitioner, before reimbursement of the costs, that the service was in fact performed according to the general practitioner principle.

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