

Mandatory basic health insurance

pursuant to the Swiss Federal Health
Insurance Act (KVG/HIA)

Insurance carrier: Sanitas Grundversicherungen AG

January 2009 edition
Amended 2022

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Basic

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Overview of insurance

Mandatory basic health insurance (basic insurance) covers the costs of treatment in the event of illness, accident and maternity within the scope of the Swiss Federal Health Insurance Act (KVG/HIA). It can be taken out with a regular or elective deductible, and in the form of a special alternative insurance model.

The general terms of insurance contain the general terms for the basic insurance plan called "Basic". These also apply to the alternative insurance models, subject to any divergent provisions laid down in the supplementary terms applicable to the individual insurance model.

Scope of insurance

1 Basis of insurance

- 1 If any matter is not dealt with specifically in these general terms of insurance, the Swiss Federal Health Insurance Act (KVG/HIA) and the Swiss Federal Act on the General Part of Social Insurance Law (ATSG/GSSLA) in conjunction with the related ordinances shall apply.
- 2 Federal law and cantonal law, in that order, have precedence over these general terms of insurance.
- 3 The respective supplementary terms also apply when taking out an alternative insurance model (a special form of mandatory basic health insurance).
- 4 In this document the masculine form refers to both genders.

2 Object of insurance

Sanitas Grundversicherungen AG (hereinafter "Sanitas") insures the economic consequences of illness, maternity and accidents. The coverage includes the risk of accident if this is specified in the insurance policy.

3 Definitions

- 1 Illness is defined as any impairment to physical, mental or psychological health that is not the consequence of an accident and which requires a medical examination or treatment or results in incapacity to work.
- 2 Maternity includes pregnancy and childbirth and the mother's postnatal recovery period.
- 3 An accident is defined as the sudden, unintentional, harmful influence of an exceptional external force on the human body, resulting in the impairment of physical, mental or psychological health, or death. Occupational illnesses and accident-like events are deemed to be equivalent to an accident.

4 Geographic coverage

Geographic coverage is governed by the provisions of the Swiss Federal Health Insurance Act (KVG/HIA).

Benefits

5 Scope of benefits

The benefits stipulated in the law will be paid.

6 Cost share

The cost share paid by the insured comprises the following:

- Deductible
- Copayment (percentage of claim)
- Hospital copayment

7 Cessation of entitlement to benefits

No benefits will be paid for the costs of treatment and measures that are not effective, expedient or economical; the effectiveness of the treatment or measure must be scientifically proven.

8 Third-party benefits

- 1 The insured person must inform Sanitas without delay as per Art. 28 ATSG/GSSLA of all benefits provided by third parties (e.g. accident, liability, military or disability insurance) as well as of any agreements regarding lump-sum settlements if Sanitas is liable to pay benefits for the same insurance claim.
- 2 If Sanitas pays benefits on behalf of a third party, the insured person must assign his claims to Sanitas to the amount of the benefits Sanitas is obliged to pay.
- 3 Agreements between the insured person and third parties are not binding on Sanitas.

9 Liability

Liability for therapeutic and diagnostic services lies exclusively with the healthcare providers chosen by the insured person.

Obligations and establishment of claims

10 General obligations

The insured person is obliged to comply with the instructions of doctors or other healthcare providers and must endeavour to ensure that the treatment is economical.

11 Establishment of claims

- 1 When benefits are claimed, detailed original invoices must be submitted to Sanitas within five years of the date of invoicing. Any entitlement to claim benefits expires once this period has elapsed.
- 2 If the establishment of claims includes medical prescriptions, original copies of these prescriptions must be submitted.
- 3 When accident benefits are claimed, the accident report form must also be submitted.

12 Foreign invoices

Foreign invoices and documents must be submitted in German, French, Italian or English. Invoices and documents in any other language must be accompanied by a translation. The rules set down in the agreements with EU and EFTA states on the free movement of persons take precedence.

13 Assignment and pledging of benefits

The insured person may neither assign nor pledge claims on Sanitas without the permission of Sanitas, except in cases where claims are assigned to healthcare providers.

Commencement and end of insurance coverage

14 Commencement of insurance

Commencement of coverage is governed by the provisions of law. Sanitas issues an insurance policy document as confirmation of insurance coverage.

15 Amendments to the insurance

- 1 The deductible can be adjusted annually as of 1 January; the periods of notice stipulated in point 17 below must be adhered to if switching to a lower deductible.
- 2 Accident coverage can be excluded if it can be shown that the insured person is insured for accidents (occupational and non-occupational) under the Swiss Federal Law on Accident Insurance (UVG/LAA). The exclusion will take effect on the first day of the month following written application at the earliest.
- 3 Accident coverage will be included immediately once accident coverage under the Swiss Federal Law on Accident Insurance (UVG/LAA) expires. Sanitas must be notified of the expiration of accident insurance within 30 days.

16 Suspension

Mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/HIA) will be suspended for insured persons who become eligible for military insurance for more than 60 consecutive days. Sanitas must be notified at least 8 weeks before the insured person commences military service. If Sanitas is not notified until after this deadline, coverage will be suspended with effect from the next possible date, but in any case no later than 8 weeks after notification. Sanitas will refund any premiums already paid or credit them against subsequent premiums. For his part, the insured person is obliged to notify Sanitas if his military service comes to an end prematurely. In this case, the duration of the suspension will be reduced accordingly.

17 Termination of insurance

- 1 An insured person switching to another insurer may terminate his insurance with effect from 31 December or, provided that he has neither an elective deductible nor an alternative insurance model, with effect from 30 June; in both cases termination is subject to 3 months' notice.
- 2 An insured person may also terminate his insurance with effect from the end of the month before a newly announced premium takes effect; in this case termination is subject to one month's notice.
- 3 Coverage ends once confirmation of coverage has been received from the new insurer.

18 End of insurance coverage

Coverage ends

- if coverage is terminated as per 17 above;
- if the insured person is no longer subject to mandatory health insurance;
- in the case of cross-border commuters as per Art. 7 para 4 of the Health Insurance Ordinance (KVV/HIO)
- in the case of insured persons who are not subject to Swiss social security legislation pursuant to Art. 9 of the Health Insurance Ordinance (KVV/HIO);
- on the death of the insured person.

Premiums

19 Payment of premiums and due dates

- 1 Premiums are due on the first day of the month in question. Payments may be made on an annual, semiannual, quarterly, bimonthly or monthly basis, with the insurance year beginning on 1 January. If bills are sent to an address outside Switzerland, payments may only be made on an annual, semiannual or quarterly basis.
- 2 If the insurance is terminated prematurely, the premium due for the unused period of insurance will be refunded.
- 3 The insured may not offset premiums due against benefits due.

20 Payment reminders and consequences of default in payment

- 1 If, despite receiving a reminder, the insured person fails to pay due premiums or cost shares and an application for continuation has been filed as part of debt enforcement proceedings, Sanitas shall suspend payment of benefits to the insured person until the outstanding amounts, including reminder fees, interest on arrears and debt enforcement costs, have been paid in full. At the same time, Sanitas shall inform the cantonal authority responsible for monitoring compulsory insurance that the benefits have been suspended.
- 2 If the insurance is terminated as per point 17, the switch to the other insurer is only possible once the outstanding amounts, including reminder fees, interest on arrears and debt enforcement costs, have been paid in full.
- 3 If, despite a reminder and information on the consequences of defaulting on payment, an insured person resident in an EU or EFTA state subject to the agreement on the free movement of persons still owes premiums or cost shares, payment of benefits will be suspended until the outstanding amounts are paid in full.
- 4 Sanitas will charge reasonable fees and interest on arrears for payment reminders and debt enforcement proceedings.

Miscellaneous

21 Acceptance of the insurance policy

If the content of the insurance policy or the supplements thereto do not coincide with the agreements reached, the policyholder must ask for a correction within four weeks of receipt of the policy, failing which the contents of the policy shall be deemed to have been approved by them.

22 Data capture and processing

- 1 Sanitas ensures compliance with the data protection provisions of Swiss law, namely the Swiss Federal Law on Data Protection (DSG/LPD), and in particular Art. 33 of the Federal Act on the General Part of the Social Insurance Law (ATSG/GSSLA) and Art. 84 ff. of the Swiss Federal Health Insurance Act (KVG/HIA).
- 2 Within the limits of the statutory provisions, Sanitas may obtain information required for the provision of insurance coverage, process this information electronically, and forward it to third parties for processing.

23 Payment of benefits

- 1 Sanitas will pay benefits to a postal or bank account. If other forms of payment are requested, Sanitas may charge a fee to cover the extra expense involved. Payments will be made to addresses in Switzerland, or to addresses in EU or EFTA states provided that the insured person lives in the country in question and is subject to the agreement on the free movement of persons.
- 2 If Sanitas owes fees to a healthcare provider on the basis of contracts, Sanitas will pay benefits directly to the healthcare provider and invoice the insured person for his share of the costs.
- 3 Sanitas may offset benefits against its claims on the insured person provided that the payment of benefits has not been suspended as per Art. 20 para. 1 of these general terms of insurance.

24 Notifications/contact address

- 1 Sanitas must be notified in writing of changes to names or addresses/contact addresses within 30 days. If Sanitas is not informed of these changes, all correspondence sent to the last known address shall be considered to be legally effective.
- 2 Insured persons who are absent from Switzerland for more than three months must provide Sanitas with a contact address in Switzerland. This does not apply to changes in civil law domicile to an EU or EFTA state, provided that the insured person is subject to the agreement on the free movement of persons.
- 3 The delivery address for notifications or proofs of claim is the address specified on the insurance policy.

25 Amendments to the general terms of insurance

- 1 Amendments to these general terms of insurance and to the supplementary terms of the alternative insurance models, as well as all other binding notifications, shall be communicated to the insured person in writing or published in the customer magazine.

26 Compulsory insurance requirements in EU and EFTA states

Insured persons domiciled in an EU or EFTA state who are covered by the agreement on the free movement of persons are obliged to notify Sanitas of any changes related to the compulsory insurance requirement within 30 days.

27 Legal recourse

- 1 If an insured person does not agree with a decision made by Sanitas he may, within a reasonable period, demand that Sanitas issue a written decision including reasons and an explanation of rights of appeal.
- 2 An objection to a written decision may be lodged with Sanitas within 30 days. Sanitas shall review this objection and issue a written appeal decision including reasons and an explanation of rights of appeal.
- 3 An appeal against this ruling can be lodged with the competent cantonal insurance court within 30 days. The competent court is the insurance court in the canton of residence of the insured person or the third party lodging the complaint.
- 4 An appeal may also be lodged if Sanitas fails to issue a written decision or ruling in response to a request that has been made.
- 5 An appeal against the ruling of a cantonal insurance court may be filed with the federal court pursuant to the Swiss Federal Supreme Court Act.

CallMed

Basic insurance with initial consultation by phone

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Overview of insurance

CallMed is an alternative insurance model, i.e. a special form of mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/HIA).

When taking out the CallMed plan, the insured person declares that he is prepared to consult the medical advice centre before medical treatment. This centre is available to insured persons around the clock, 365 days a year. It advises insured persons on health problems and gives recommendations for the further course of treatment. The insured person is at all times free to choose any healthcare provider required within the scope of the KVG/HIA.

Insurance model regulations

1 Basis of insurance

If any matter is not dealt with specifically in these supplementary terms, the general terms of insurance for the Basic standard plan for basic insurance apply.

2 Duties under the insurance model

- 1 Before undergoing medical treatment, the insured person contacts the medical advice centre by phone. The centre gives the insured person medical advice and recommends the optimum course of treatment, which must be given due consideration by the insured person in the subsequent course of action.
- 2 If medical treatment is indicated on the basis of the consultation, the medical advice centre and the insured person agree a window during which treatment from a healthcare provider of the insured person's choice is to take place. This also applies to any referrals to additional healthcare providers that might be necessary. If the window is not going to allow sufficient time for the treatment, the insured person contacts the medical advice centre again before it has elapsed.

3 Exceptions to compulsory consultation

- 1 In emergencies it is not necessary to contact the medical advice centre before treatment. If the insured person receives treatment, the medical advice centre must be notified as soon as possible, but within ten days of the commencement of treatment at the latest.

An emergency is defined as a situation where the condition of the insured is deemed by the insured himself or by a third party to be life-threatening or requiring immediate treatment.

- 2 In the following cases it is not necessary to contact the medical advice centre:
 - Gynaecological check-ups
 - Maternity examinations, including childbirth
 - Vaccinations
 - Dental treatment

4 Violation of the compulsory consultation

- 1 If the insured person does not initially contact the medical advice centre before undergoing medical treatment, Sanitas shall transfer the insured person to the Basic standard plan for basic insurance after issuing a single reminder. The transfer will take effect from the first day of the month following written notification by Sanitas.
- 2 If the insured person repeatedly fails to pay due attention to the medical advice centre's recommended further course of treatment, Sanitas reserves the right to transfer him to the Basic standard plan for basic insurance.
- 3 The insured person may not transfer back to CallMed for 2 years following the transfer.

Amendments to the insurance

5 Amendments to insurance initiated by the insured person

- 1 An insured person may transfer from the standard Basic insurance plan to CallMed with effect from the beginning of any month.
- 2 A transfer from CallMed to the standard Basic insurance plan or another alternative insurance model is possible only with effect from 1 January. The periods of notice stipulated in point 17 of the general terms of insurance apply.

6 Amendments to insurance initiated by Sanitas

- 1 Sanitas transfers the insured from CallMed to the standard Basic insurance plan
 - if the insured person can no longer meet the telephone consultation requirement before seeking medical treatment;
 - if the insured person spends more than three months abroad;
 - if the insured person violates the compulsory consultation requirement as per point 4 above.

With the exception of the provision stipulated in point 4 para 1, the transfer shall be made on the first day of the month, subject to thirty days' notice.

- 2 Sanitas may suspend CallMed with effect from the end of a calendar year, subject to 2 months' notice. Thereupon, with effect from 1 January of the following year, the insured person will be transferred to the standard Basic insurance plan or, if the insured person desires, to another alternative insurance model.

CareMed

Basic insurance with choice of family doctor

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Overview of insurance

CareMed is an alternative insurance model, i.e. a special form of mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal).

When taking out CareMed insurance, the insured person declares that he is prepared to consult his chosen family doctor for medical treatment. This doctor is the insured person's first point of contact for all medical matters. If required, the family doctor will refer the insured person to specialists, auxiliary medical personnel or hospital for further treatment.

Insurance model regulations

1 Basis of insurance

If any matter is not dealt with specifically in these supplementary terms, the general terms of insurance for the Basic standard plan for basic insurance apply.

2 Duties under the insurance model

- 1 When taking out CareMed, the insured person chooses a family doctor and notifies Sanitas of his choice.
- 2 If he requires medical treatment, the insured person consults his chosen family doctor. The coordinating doctor conducts the necessary examination and treatment himself or, if required, refers the insured person to another healthcare provider.
- 3 If the chosen family doctor is not available (e.g. on holiday), the insured person consults his deputy. If the family doctor is absent for a longer period, the insured person may choose another family doctor for the duration of the absence. The insured person notifies Sanitas of this following the first consultation at the latest.
- 4 If the family doctor stops practising, the insured person chooses a new family doctor and notifies Sanitas accordingly following the first consultation at the latest.
- 5 In justified cases, the insured person may change his chosen family doctor. In this case he notifies Sanitas at the latest before the first consultation with the new family doctor.

3 Exceptions to compulsory consultation with family doctor

- 1 In emergencies it is not necessary to seek treatment with the chosen family doctor. However, following initial treatment by another healthcare provider, any further treatment or follow-up checks should be conducted by the family doctor, if possible.

An emergency is defined as a situation where the condition of the insured is deemed by the insured himself or by a third party to be life-threatening or requiring immediate treatment.

- 2 The following examinations and treatments may be conducted directly by an accredited specialist without consulting the chosen family doctor:
 - Gynaecological check-ups
 - Maternity examinations, including childbirth
 - Periodic eye check-ups
 - Dental treatment

4 Violation of obligation to consult the family doctor

- 1 If the insured person claims medical benefits from healthcare providers without first consulting his family doctor, Sanitas will transfer the insured person to the Basic standard plan for basic insurance after issuing a single reminder. The transfer will take effect from the first day of the month following written notification by Sanitas.
- 2 The insured person may not transfer back to CareMed for 2 years following the transfer.

Amendments to the insurance

5 Amendments to insurance initiated by the insured person

- 1 An insured person may transfer from the standard Basic insurance plan to CareMed with effect from the beginning of any month.
- 2 A transfer from CareMed to the standard Basic insurance plan or another alternative insurance model is possible only with effect from 1 January. The periods of notice stipulated in point 17 of the general terms of insurance apply.

6 Amendments to insurance initiated by Sanitas

- 1 Sanitas transfers the insured from CareMed to the standard Basic insurance plan:
 - if it is no longer possible for the chosen family doctor to administer medical treatment;
 - if the insured person spends more than three months abroad;
 - if the insured person violates the obligation to consult the family doctor as per 4 above.

With the exception of the provision stipulated in 4 above, the transfer shall be made on the first day of the month, subject to thirty days' notice.

- 2 Sanitas may suspend CareMed with effect from the end of a calendar year, subject to 2 months' notice. Thereupon, with effect from 1 January of the following year, the insured person will be transferred to the standard Basic insurance plan or, if the insured person desires, to another alternative insurance model.

Miscellaneous

7 Data capture and processing

- 1 In taking out CareMed insurance, the insured person authorises his chosen family doctor or a third party authorised by his chosen family doctor to view treatment and billing information connected with his medical care.
- 2 Sanitas is entitled to pass on information necessary for the provision of CareMed coverage to the insured person's chosen family doctor or a third party authorised by his chosen family doctor in compliance with the relevant professional confidentiality and data protection requirements.

NetMed

Basic insurance with choice of coordinating family doctor

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Overview of insurance

NetMed is an alternative insurance model for mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/HIA). Within NetMed there are several models (variants) with different premium discounts. On taking out NetMed, the insured person chooses a family doctor who works in a network of physicians recognised by Sanitas (coordinating doctor). To this end, Sanitas concludes cooperation agreements with networks of physicians.

The family doctors are assigned to a NetMed variant. This assignment depends on the network with which the family doctor is affiliated and it may change at the start of a calendar year. The assignments can be seen online (www.sanitas.com) or requested from Sanitas.

The insured person agrees to consult the coordinating doctor for every medical treatment. The coordinating doctor is responsible for the end-to-end treatment and care of the insured person in all health matters. If required, the coordinating doctor will refer the insured person to specialists, auxiliary medical personnel or a hospital.

Insurance model regulations

1 Basis of insurance

If any matter is not dealt with specifically in these supplementary terms, the general terms of insurance for the Basic standard plan for basic insurance apply.

2 Duties under the insurance model

- 1 When taking out NetMed insurance, the insured person chooses a family doctor working in a network of physicians (hereinafter referred to as the “coordinating doctor”) and notifies Sanitas of his choice. Sanitas has a list of the coordinating doctors that it recognises. This list is updated periodically; it is available for inspection at Sanitas, and excerpts from the list can be provided on request.
- 2 If the insured person requires medical treatment, he consults his chosen coordinating doctor. The coordinating doctor conducts the necessary examination and treatment himself or, if required, refers the insured person to another health-care provider.
- 3 The insured person can switch his chosen variant or coordinating doctor in justified cases (e.g. no longer practising as a family doctor, closure of practice). If no doctor can be selected in the same network or in the same variant (no availability or the practice is not currently admitting new patients), the insured may select a doctor in another variant in the NetMed product. In this case he notifies Sanitas before the first consultation with the new coordinating doctor at the latest.

3 Exceptions to compulsory consultation with coordinating doctor

- 1 In emergencies the insured person is also expected to seek treatment with the coordinating doctor. If this is not possible, the insured person informs his coordinating doctor within ten days of the treatment conducted outside the coordinating doctor’s practice. If possible, any follow-up treatment or checks should be conducted by the coordinating doctor.

An emergency is defined as a situation where the condition of the insured is deemed by the insured himself or by a third party to be life-threatening or requiring immediate treatment.

- 2 The following examinations can be carried out directly by an accredited specialist:

- Gynaecological check-ups
- Maternity examinations, including childbirth
- Periodic eye check-ups

However, the insured person must be referred by the coordinating doctor for any other gynaecological or ophthalmological treatments administered by an accredited specialist.

- 3 Dental treatment can be administered directly by an accredited specialist without having to inform the coordinating doctor.

4 Violation of obligation to consult coordinating doctor

- 1 If the insured person claims medical benefits from healthcare providers without being referred by their coordinating doctor, Sanitas will transfer the insured person to the Basic standard plan for basic insurance after issuing a single reminder. The transfer will take effect from the first day of the month following written notification by Sanitas.
- 2 The insured person may not transfer back to NetMed for 2 years following the transfer.

Amendments to the insurance

5 Amendments to insurance initiated by the insured person

- 1 An insured person may transfer from standard Basic insurance to NetMed with effect from the beginning of any month.
- 2 A transfer from NetMed to standard Basic insurance or another alternative insurance model is possible only with effect from 1 January (with the exception of point 2, para 3). The periods of notice stipulated in point 17 of the general terms of insurance apply.
- 3 On moving to another region, the insured person selects a different coordinating doctor from the list. The insured must inform Sanitas of the change before the first consultation at the latest. If no coordinating doctor is available at the new place of residence or work, the insured person must switch to the Basic insurance model or another alternative insurance model.

6 Amendments to insurance initiated by Sanitas

- 1 Sanitas transfers the insured from NetMed to the standard Basic insurance plan:
 - if it is no longer possible for the coordinating doctor to administer medical treatment;
 - if the chosen doctor is no longer available as coordinating doctor and the insured person does not choose a new coordinating doctor;
 - if the insured person spends more than three months abroad;
 - if the insured person violates the obligation to consult the coordinating doctor as per point 4.

With the exception of the provision stipulated in point 4 above, the transfer shall be made on the first day of the month, subject to thirty days’ notice.

- 2 Sanitas may suspend NetMed with effect from the end of a calendar year, subject to notice of two months. Thereupon, with effect from 1 January of the new year, the insured person will be transferred to the standard Basic insurance plan.

Miscellaneous

7 Data capture and processing

- 1 In taking out NetMed insurance, the insured person authorises his chosen coordinating doctor or a third party authorised by his chosen coordinating doctor (e.g. specialists) to view treatment and billing information connected with his medical care. This is to ensure coordinated medical care.
- 2 Sanitas is entitled to pass on information necessary for the provision of NetMed to the coordinating doctor or a third party authorised by the coordinating doctor (e.g. IT system provider) in compliance with the relevant professional confidentiality and data protection requirements.

Medbase MultiAccess

Basic insurance with integrated care via Medbase

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Overview of insurance

Sanitas Grundversicherungen AG and Medbase AG (hereinafter "Medbase") are partners in the Medbase MultiAccess insurance model. Medbase is a company that operates independently of Sanitas Grundversicherungen AG in the area of basic care (family doctor medicine), offering outpatient medical, therapeutic and alternative medical services.

Medbase MultiAccess is an alternative model (special form) of mandatory basic health insurance with restrictions on the choice of healthcare provider as per Art. 41 para 4 of the Swiss Federal Health Insurance Act (KVG/HIA) and Art. 99 of the Health Insurance Ordinance (KVV/HIO).

When the insured person takes out the Medbase MultiAccess plan, he must choose a Medbase medical centre. The insured person declares that he is prepared to initially consult the approved Medbase healthcare provider each time he seeks medical treatment. Medbase is responsible for providing end-to-end treatment and care for all health matters and stipulates a binding further course of treatment for the insured person.

Insurance model regulations

1 Basis of insurance

1 If any matter is not dealt with specifically in these supplementary terms, the general terms of insurance for the Basic standard plan for basic insurance apply.

2 Sanitas pays the benefits for outpatient and inpatient treatment stipulated by law, provided that this treatment is delivered as part of the course of treatment laid down by Medbase.

3

2 Duties under the insurance model

1 On taking out Medbase MultiAccess, the insured person chooses a Medbase location (medical centre) from the Sanitas list (hereinafter "coordinating medical centre") and notifies Sanitas of his choice.

2 For all treatments, the insured person must first contact a Medbase healthcare provider approved for initial consultations. Sanitas maintains a list of these healthcare providers. In addition to the medical centre, this could also be a telemedicine service or pharmacy, for example. The initial healthcare provider either conducts the necessary examination and provides treatment himself or, if required, refers the insured person to another healthcare provider.

3 The insured person is obliged to follow the treatment plan set out in the initial consultation. The treatment plan may specify certain healthcare providers and treatment periods. It may also stipulate that medicines, medical aids or laboratory services must be procured from a specific Medbase or Sanitas provider. Any treatment plans in place when the insured takes out insurance (e.g. referral to a specialist) must be confirmed in advance by a Medbase healthcare provider.

4 The insured person agrees that original drugs may be replaced by generics if they are less expensive and the original preparation does not have to be taken for medical reasons.

5 The insured person is obliged to have vaccinations carried out by specific Medbase healthcare providers. A list of possible healthcare providers will be made available by Medbase.

6 If interdisciplinary treatment concepts or programmes that may improve the quality of care are indicated on the basis of Medbase's assessment, the insured person may be obliged to participate in such a programme.

7 If the assessment of Medbase or Sanitas indicates that Sanitas case management is appropriate, the insured person will be supported by the Sanitas case management team parallel to treatment once consent has been given.

8 If the assessment of Medbase indicates that an outpatient benefit (outpatient surgery, outpatient rehabilitation, etc.) can be provided in place of an inpatient benefit and this can be reasonably expected of the insured, the insured person may be obliged to undergo outpatient treatment.

3 Exceptions to compulsory consultation with Medbase

1 Treatment by Medbase is not compulsory in an emergency. Emergency treatment that is not provided by Medbase must be reported to the coordinating medical centre as soon as possible, but within ten days of the commencement of treatment at the latest. Any follow-up treatment or checks must be reported to Medbase and, whenever possible, provided by Medbase.

An emergency is defined as a situation where the condition of the insured is deemed by the insured himself or by a third party to be life-threatening or requiring immediate treatment.

2 An initial consultation with Medbase is not required in the following cases:

- Gynaecological check-ups
- Maternity examinations, including childbirth
- Dental treatment

3 Ophthalmic treatment does not have to be provided by a Medbase healthcare provider. However, Medbase may provide a binding list of healthcare providers for the initial consultation.

4 Paediatric treatments, including vaccinations, do not have to be provided by a Medbase healthcare provider. For children age 6 and above, Medbase may provide a binding list of healthcare providers for the initial consultation.

4 Violation of obligations under the insurance model

1 If the insured violates the obligations of this insurance model as per point 2 for a second time, Sanitas will transfer the insured to the Basic insurance plan. The transfer will take effect from the first day of the month following written notification by Sanitas.

2 Transfer back to Medbase MultiAccess is possible at the earliest two years after the transfer, effective as of the following calendar year.

Amendments to the insurance

5 Amendments to insurance initiated by the insured person

- 1 An insured person may transfer from standard Basic insurance to Medbase MultiAccess with effect from the beginning of any month.
- 2 Transfer from Medbase MultiAccess to standard Basic insurance or another alternative insurance model is only possible with effect 1 January. The periods of notice stipulated in point 17 of the general terms of insurance apply.
- 3 The insured person may change coordinating medical centre at any time. Sanitas must be notified of the change within 30 days, but before the next consultation at the latest.
- 4 If the insured person moves house and Medbase MultiAccess is not available at the new place of residence, the insured may transfer to the standard Basic insurance model or another alternative insurance model effective as of the 1st day of the month of the move. If Sanitas receives no notification of transfer to another alternative insurance model within 30 days, the insured will automatically be transferred to standard Basic insurance.

6 Amendments to insurance initiated by Sanitas

Sanitas will transfer insured persons from Medbase MultiAccess to standard Basic insurance:

- if the insured person is no longer in a position to undertake the initial consultation with an approved Medbase healthcare provider. This could be due, for example, to a stay in a nursing home, a stay of more than three months in a rehabilitation clinic or a stay abroad of more than three months. The insured person may transfer back to Medbase MultiAccess effective as of the first day of the month in which the insured is able to undertake the initial consultation with an approved Medbase healthcare provider;
- if the chosen coordinating medical centre is no longer available and the insured person does not choose a new coordinating medical centre within 30 days.

The transfer shall be made on the first day of the following month, subject to thirty days' notice from expiry of the deadline.

Sanitas may suspend Medbase MultiAccess with effect from the end of a calendar year, subject to two months' notice. Thereupon, with effect from 1 January of the following year, the insured person will be transferred to the standard Basic insurance plan or, if the insured person desires, to another alternative insurance model. If no notification is received of transfer to another alternative insurance model, the insured will automatically be transferred to standard Basic insurance effective as of 1 January of the following year.

Miscellaneous

7 Data capture and processing

- 1 In taking out Medbase MultiAccess, the insured person authorises Medbase or a third party authorised by Medbase (e.g. specialists) to view treatment and billing information connected with his medical care. This is to ensure coordinated medical care.
- 2 Sanitas is entitled to pass on information necessary for the provision of Medbase MultiAccess to Medbase or a third party authorised by Medbase (e.g. IT system provider) in compliance with the relevant professional confidentiality and data protection requirements.

Compact One

Basic insurance with initial consultation by phone

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Amended 2022

Overview of insurance

Compact One is an alternative insurance model (a special form of insurance with restrictions on the choice of healthcare provider) of mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/HIA).

When taking out Compact One, the insured person declares that he is prepared to consult the telemedicine centre before medical treatment. This centre is available to insured persons around the clock, 365 days a year. It advises the insured person in case of health problems and defines the further course of treatment, which is binding.

Sanitas promotes and supports measures to cut healthcare costs in the long term. This also includes sensible and appropriate healthcare, which requires that the insured person makes an active contribution and takes personal responsibility. In some cases, Sanitas may introduce specific measures to reduce or waive the insured person's regular cost share.

Insurance model regulations

1 Basis of insurance

If any matter is not dealt with specifically in these supplementary terms, the general terms of insurance for the Basic standard plan for basic insurance apply.

2 Duties under the insurance model

- 1 The insured person is obliged to contact the telemedicine centre by phone before undergoing medical treatment. The centre provides the initial medical consultation and defines the best course of treatment depending on the insured's specific situation. The treatment plan is binding for the insured. Specifically, the insured person must
 - restrict his use of services to the extent necessary from a medical point of view;
 - adhere to the defined treatment plans;
 - make reasonable efforts of his own to ensure his recovery.
- 2 If medical treatment is required as a result of the telemedical consultation, the telemedicine centre will determine the healthcare provider and treatment plan as set out in paragraph 1. Based on Art. 99 of the Health Insurance Ordinance (KVV/HIO), Sanitas can limit the choice of healthcare providers.
- 3 The medical treatment plan covers the probable duration of the treatment and the probable number of consultations required. If this treatment plan is not sufficient for successful treatment, the insured person is obliged to contact the telemedicine centre again before the treatment plan expires.
- 4 If inpatient hospitalisation is indicated as part of the treatment plan described in paragraph 1, the insured person is obliged to contact the telemedicine centre before registering with a hospital. This does not apply to emergencies in accordance with point 3, paragraph 1.

3 Exceptions to compulsory consultation

- 1 In emergencies it is not necessary to contact the telemedicine centre before treatment. The telemedicine centre must be notified of any emergency treatment as soon as possible, at the latest within 10 days or before any follow-up treatment. An emergency is defined as a situation where the condition of the insured person is deemed to be life-threatening or requiring immediate treatment. A health problem outside surgery hours is not necessarily deemed to be an emergency.
- 2 In the following cases it is not necessary to contact the telemedicine centre:
 - Gynaecological check-ups
 - Maternity examinations, including childbirth
 - Vaccinations
 - Dental treatment

4 Management measures

- 1 If a Sanitas disease management programme is indicated as a result of the telemedical consultation within the meaning of point 2, the insured person is obliged to participate in such a programme. Disease management refers to structured and systematic treatment programmes for certain, predominantly chronic diseases (e.g. high blood pressure, heart failure, diabetes, asthma). The aim is to provide meaningful, appropriate and coordinated care on the basis of the latest medical knowledge. The idea is to avoid unnecessary and ineffectual diagnosis and therapy.
- 2 If coordination by case management is indicated on the basis of the teleconsultation as per point 2, the insured person undertakes to be guided through the treatment by the Sanitas case manager. Case management provides in-depth support for cases that are usually medically complex and expensive. Case managers assume three main functions: Ensure that the patient's interests are respected (advocate function), negotiate and facilitate optimum care solutions (facilitator function), and select and manage access to care (gatekeeper function).
- 3 If the insured person requires drugs, medical aids or laboratory services in connection with a course of treatment as per point 2 above, Sanitas can require the insured person to obtain them from a healthcare provider stipulated by Sanitas.
- 4 If a drug or medication has to be prescribed or supplied as part of a course of treatment as per point 2 above, the insured person must in all cases request a generic product. When reimbursing the costs of generic drugs, Sanitas may reduce or waive the insured person's copayment in accordance with section 6 of the general terms of insurance for the Basic insurance plan.

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5 Violation of the compulsory consultation

- 1 If the insured person breaches the obligations of the teleconsultation by the telemedicine centre as per point 2, para 1, Sanitas shall transfer the insured person to the standard Basic plan after issuing a single reminder. The transfer will take effect from the first day of the month following written notification by Sanitas.
- 2 If the insured person refuses a management measure as per point 4 paras 1 to 3, he will be given time to reconsider. If the insured person still refuses to comply, Sanitas shall transfer the insured person to the Basic insurance plan. The transfer will take effect from the first day of the month following written notification by Sanitas.
- 3 Following a transfer from Compact One to Basic, a transfer back to Compact One is prohibited for two years thereafter.

Amendments to the insurance

6 Amendments to insurance initiated by the insured person

- 1 An insured person may transfer from standard Basic insurance to Compact One with effect from the beginning of any month.
- 2 A transfer from Compact One to the standard Basic insurance plan or another alternative insurance model is possible only with effect from 1 January. The periods of notice stipulated in point 17 of the general terms of insurance for Basic insurance apply.

7 Amendments to insurance initiated by Sanitas

- 1 Sanitas transfers the insured person to the Basic insurance plan
 - if the insured person can no longer meet the telephone consultation requirement before seeking medical treatment;
 - if the insured person spends more than three months abroad;
 - if the insured person violates the compulsory teleconsultation requirement as per point 2;
 - if the insured person refuses to participate in management measures as per point 4.

The transfer shall be made on the first day of the following month, subject to thirty days' notice from expiry of the deadline.
- 2 Sanitas may suspend Compact One with effect from the end of a calendar year, subject to two months' notice. Thereupon, with effect from 1 January of the new year, insured persons will be transferred to Basic.

Miscellaneous

8 Data capture and processing

- 1 In taking out Compact One, the insured person authorises the telemedicine centre to view treatment and billing information connected with his medical care.
- 2 Sanitas is entitled to pass on information necessary for the provision of Compact One coverage to the telemedicine centre in compliance with the relevant professional confidentiality and data protection requirements.

