Mandatory basic health insurance

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

Terms of insurance

January 2009 edition (amended 2013)

Insurance carrier: Sanitas Grundversicherungen AG

sanitas

Contents

Basic

Mandatory basic health insurance (basic insurance)

General terms of insurance

January 2009 edition (amended 2013)

Insurance carrier: Sanitas Grundversicherungen AG

Insurance at a glance

Mandatory basic health insurance (the "Basic" plan) covers the costs of treatment in the event of illness, accident and maternity within the scope of the Swiss Federal Health Insurance Act (KVG/LAMal). 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 CallMed, CareMed and NetMed, 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/LAMal) and the Swiss Federal Act on the General Part of Social Insurance Law (ATSG/LPGA) 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 apply when taking out an alternative insurance model (a special form of mandatory basic health insurance).

4 This translation is provided for the sake of convenience. The wording of the German original shall take precedence.

5 In this document the masculine form refers to both genders.

2 Object of the insurance plans

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 the 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 for 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/LAMal).

Benefits

5 Scope of benefits

The benefits stipulated in the law will be paid.

6 Cost shares

The cost share paid by the insured person comprises the following:
- Annual deductible
- Coinsurance (percentage of claim)
- Hospital copayment

7 Lapse 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 of the Swiss Federal Act on the General Part of the Social Insurance Law (ATSG/LPGA) 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 care 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 care providers and 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 care providers.

Commencement and end of insurance coverage

14 Commencement of insurance

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

15 Amendments to the insurance

1 The annual deductible can be adjusted annually on January 1; the periods of notice stipulated in 17 below must be adhered to in the case of switches 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/LAMal) 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 December 31 or, provided that he has neither an elective deductible nor an alternative insurance model, with effect from June 30; 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/OAMal)
- 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/OAMal);
- 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, bi-monthly or monthly basis, with the insurance year beginning on January 1. 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 person 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 notify the suspension of benefits to the cantonal authority responsible for monitoring compulsory insurance.

2 If the insurance is terminated as per 17 above, 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 amounts outstanding 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 contents 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 shall be deemed to have been approved by him.

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/LPGA) and Art. 84 ff. of the Swiss Federal Health Insurance Act (KVG/LAMal).

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 transfers 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 care provider on the basis of contracts, Sanitas will pay benefits directly to the care provider and invoice the insured person for his share of 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 Changes in names or addresses, and contact addresses, must be notified to Sanitas in writing within 30 days. If changes and contact addresses are not notified, all deliveries 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

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 all changes related to compulsory insurance requirements within 30 days.

27 Legal recourse

1 If an insured person does not agree with a decision 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 the appeal decision issued by Sanitas may be lodged with the competent cantonal insurance court – the insurance court in either the canton of residence of the insured person or the canton of residence of the third party filing the appeal – within 30 days.

4 An appeal may also be lodged if Sanitas fails to issue a written decision or appeal decision in response to a request or demand 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 health insurance with initial consultation by phone

Supplementary terms

January 2009 edition (amended 2013)

Insurance at a glance

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/LAMal).

When taking out CallMed insurance, 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 care provider required within the scope of the KVG/LAMal.

Regulations for the insurance model

1 Basis of insurance

If any matter is not dealt with specifically in these Supplementary Terms, the General Terms of Insurance for the Basic plan 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, to 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 care provider of the insured person's choice is to take place. This also applies to any referrals to additional care 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 absolutely 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 insured person or others deem the condition of the insured person 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 Violations of obligation to compulsory consultation

1 If the insured person fails to seek an initial consultation with the medical advice centre before undergoing medical treatment, after one warning Sanitas will transfer him to the Basic plan, backdated to January 1 of the year in which the obligation to consult the medical advice centre was violated for the second time.

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 plan.

3 A transfer back to CallMed is prohibited for two years thereafter.

Amendments to the insurance

5 Amendments to the insurance initiated by the insured person

1 An insured person may transfer from the Basic plan to CallMed with effect from the beginning of any month.

2 A transfer from CallMed to the Basic plan or another alternative insurance model is possible only with effect from January 1. The periods of notice stipulated in point 17 of the General Terms of Insurance apply.

6 Amendments to insurance initiated by Sanitas

1 Sanitas shall transfer the insured person from CallMed to the Basic plan in the following cases:

- 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 4 above.

With the exception of the provision stipulated in 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 notice of two months. Thereupon, with effect from January 1 of the new year, insured persons will be transferred to the Basic plan or, if the insured person desires, to another alternative insurance model.

CareMed

Basic health insurance with a chosen family doctor

Supplementary terms

January 2009 edition (amended 2013)

Insurance at a glance

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 a hospital for further treatment.

Regulations for the insurance model

1 Basis of insurance

If any matter is not dealt with specifically in these Supplementary Terms, the General Terms of Insurance for the Basic plan 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 family doctor conducts the necessary examination and treatment himself or, if required, refers the insured person to another care provider.

3 If the chosen family doctor is not available (for example is 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 absolutely necessary to seek treatment with the chosen family doctor. However, following initial treatment by another care provider, if possible any further treatment or follow-up checks should be conducted by the family doctor.

An emergency is defined as a situation where the insured person or others deem the condition of the insured person 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 checkups
- Dental treatment

4 Violations of obligation to consult family doctor

1 If the insured person receives medical care from care providers without first consulting his family doctor, after one warning Sanitas will transfer him to the Basic plan, backdated to January 1 of the year in which the obligation to consult the family doctor was violated for the second time.

2 A transfer back to CareMed is prohibited for two years thereafter.

Amendments to the insurance

5 Amendments to the insurance initiated by the insured person

1 An insured person may transfer from the Basic plan to CareMed with effect from the beginning of any month.

2 A transfer from CareMed to the Basic plan or another alternative insurance model is possible only with effect from January 1. The periods of notice stipulated in point 17 of the General Terms of Insurance apply.

6 Amendments to insurance initiated by Sanitas

1 Sanitas shall transfer the insured person from CareMed to the Basic plan in the following cases:
- 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 notice of two months. Thereupon, with effect from January 1 of the new year, insured persons will be transferred to the Basic 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 health insurance with a chosen coordinating doctor

Supplementary terms

January 2009 edition (amended 2013)

Insurance at a glance

NetMed is an alternative model of mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal). To offer this coverage, Sanitas enters into cooperation agreements with networks of physicians and HMO practices.

When taking out NetMed insurance, the insured person chooses a family doctor working in a network of physicians or HMO practice recognised by Sanitas (coordinating doctor), and declares that he is willing to consult this coordinating doctor for any medical treatment. The coordinating doctor is responsible for the integral 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.

Regulations for the insurance model

1 Basis of insurance

If any matter is not dealt with specifically in these Supplementary Terms, the General Terms of Insurance for the Basic plan 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 or HMO practice recognised by Sanitas (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 furnished on request.

2 If he requires medical treatment, the insured person consults his chosen coordinating doctor. The coordinating doctor conducts the necessary examination and treatment himself or, if required, refers the insured person to another care provider.

3 In justified cases, the insured person may change his chosen coordinating doctor. 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 insured person or others deem the condition of the insured person to be life-threatening or requiring immediate treatment.

2 As long as the coordinating doctor is informed in advance, the following examinations can be conducted directly by an accredited specialist:
- Gynaecological check-ups
- Maternity examinations, including childbirth
- Periodic eye checkups

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 receives medical care from care providers without being referred by his coordinating doctor, after one warning Sanitas will transfer him to the Basic plan, backdated to January 1 of the year in which the obligation to consult the coordinating doctor was violated for the second time.

2 A transfer back to NetMed is prohibited for two years thereafter.

Amendments to the insurance

5 Amendments to the insurance initiated by the insured person

1 An insured person may transfer from the Basic plan to NetMed with effect from the beginning of any month.

2 A transfer from NetMed to the Basic plan or another alternative insurance model is possible only with effect from January 1. The periods of notice stipulated in point 17 of the General Terms of Insurance apply.

3 If the insured person moves to another area, he chooses another coordinating doctor as per the list, notifying Sanitas accordingly before the first consultation at the latest. If no coordinating doctor is available at the new place or residence or work, the insured person must switch to the Basic plan or another alternative insurance model.

6 Amendments to insurance initiated by Sanitas

1 Sanitas shall transfer the insured person from NetMed to the Basic plan in the following cases:
- 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 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 NetMed with effect from the end of a calendar year, subject to notice of two months. Thereupon, with effect from January 1 of the new year, insured persons will be transferred to the Basic 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 to view treatment and billing information connected with his medical care.

2 Sanitas is entitled to pass on information necessary for the provision of NetMed coverage to the insured person's chosen coordinating doctor or a third party authorised by his chosen coordinating doctor in compliance with the relevant professional confidentiality and data protection requirements.

6009 10.13 en