
s-care BASIC

Supplementary insurance for outpatient treatment and inpatient treatment
in the general ward of any contractual hospital in Switzerland

Supplementary terms Sanitas Corporate Private Care

January 2005 edition (amended 2013)

sanitas

Purpose and basis

s-care BASIC will cover costs according to the following provisions. The insurance pays costs that exceed the benefits paid under mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal) and other social insurance pursuant to point 2 of the General Terms of Insurance.

The risk of accident cannot be excluded for the benefits specified in point 1 of these Supplementary Terms. For the benefits specified in point 2 of these Supplementary Terms, coverage for the risk of accident can be included.

The basis of these Supplementary Terms is the January 2005 edition of the General Terms of Insurance for supplementary insurance plans pursuant to the Swiss Federal Act on Insurance Contracts (VVG/LCA).

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

1 Benefits for outpatient care

1.1 Medical treatment throughout Switzerland

The insurance covers the costs of outpatient medical treatment outside the home or workplace in accordance with a recognised tariff, provided that the treatment is administered by doctors who are accredited in accordance with the Swiss Federal Health Insurance Act (KVG/LAMal) and who bill in accordance with KVG/LAMal (tariff protection as per Art. 44 KVG/LAMal).

1.2 Emergency outpatient treatment outside Switzerland

The insurance covers 90% of the costs of emergency treatment outside Switzerland. The insurance covers outpatient treatment conducted by medical doctors as well as medically prescribed outpatient treatment.

1.3 Alternative medicine

The insurance covers 80% of the costs (of examinations, therapies and drugs/medication), up to a maximum of CHF 5,000 (a maximum of CHF 1,000 for inpatient treatment) per calendar year, of treatment administered in accordance with complementary medical methods by

- medical doctors
- pharmacists with the relevant additional training
- naturopathic doctors accredited by a canton
- NVS (full member) and FSPN naturopaths and natural health practitioners

Benefits will also be paid up to the stipulated amounts for treatment administered on medical prescription by other therapists with the relevant training.

1.4 Psychotherapy

The insurance covers 80% of the costs, up to a maximum of CHF 500 per calendar year, of medically prescribed psychotherapy conducted by independent psychotherapists.

1.5 Drugs/medication

The insurance provides worldwide coverage of 90% of the costs of medically prescribed, uninsured drugs, provided that the drug in question is registered with Swissmedic (the Swiss Agency for Therapeutic Products) for the indication in question.

Sanitas has a list of drugs that are not covered. This list is updated on an ongoing basis; it is available for inspection at Sanitas, and excerpts from the list can be furnished on request.

Alternative medical drugs that are insured as per 1.3 above are not covered under this provision.

1.6 Maternity

The mother's insurance covers 80% of the costs of the following maternity care, up to a maximum of CHF 1,000 per calendar year:

- Checkups during pregnancy (including 1 ultrasound scan)
- Pre- and postnatal exercise, and prenatal classes
- Milk substitute for a child under the age of two who cannot tolerate mothers' milk, provided that this is medically prescribed and that the child also has this insurance.

1.7 Preventive/prophylactic treatment

The insurance covers 80% of the costs of the following preventive and prophylactic measures, up to a maximum of CHF 1,000 per calendar year:

- Vaccinations
- Checkups, 80% up to a maximum of CHF 500 per calendar year (including 1 HIV test per calendar year)
- Gynaecological checkups (including 1 mammogram per calendar year)
- Vasectomy or sterilisation
- Treatment for chronic back pain administered by certified physiotherapists on medical prescription
- Medically prescribed stop smoking treatment

1.8 Glasses or contact lenses

The insurance provides worldwide coverage for the following benefits for glasses (including frames) or contact lenses necessary for the correction of vision:

- Up to a maximum of CHF 300 every 3 calendar years for adults
- Up to a maximum of CHF 200 per calendar year for children under age 18

1.9 Dental treatment

The insurance pays the following benefits for dental treatment:

- 75% of the costs of orthodontic treatment for people under age 20
- Up to a maximum of CHF 100 per tooth for the removal of wisdom teeth
- The costs of drugs prescribed by a dentist

1.10 Medical aids

The insurance covers 80% of the costs of hiring or purchasing medically prescribed medical aids (except glasses and contact lenses), up to a maximum of CHF 500 per calendar year.

1.11 Cosmetic interventions

The insurance covers 80% of the costs of the following cosmetic interventions provided that they are medically prescribed:

- Breast operations
- Scar correction
- Operations to correct protruding ears (otoplasty)

Outpatient treatment will be covered in accordance with the KVG/LAMal tariff.

The costs of inpatient treatment will be covered up to a maximum of the tariff for the general ward of an acute hospital in the canton of residence with a cantonal mandate as per Art. 39 KVG/LAMal. In the case of cross-border commuters, the canton in which the employer is based applies.

1.12 Rooming in

The insurance covers 80% of the following hospital accommodation costs, up to a maximum of CHF 2,000 per calendar year:

- The costs of hospital accommodation for a parent accompanying a child under the age of 5 undergoing inpatient treatment; paid via the child's insurance
- The costs of hospital accommodation for a nursing infant accompanying a mother undergoing inpatient treatment; paid via the mother's insurance

2 Benefits for inpatient care

2.1 Definitions

Acute hospitals are defined as treatment facilities and clinics that are directed and overseen by medical doctors and admit only persons suffering from acute illnesses or accidents. For the present purposes acute hospitals also include maternity, psychiatric and rehabilitation clinics.

Health spas, old-people's homes, nursing homes, chronic care facilities and other facilities not intended for acute care are not defined as acute hospitals for the present purposes.

Contractual hospitals are defined as acute hospitals with a cantonal mandate as per Art. 39 KVG/LAMal which have entered into a tariff agreement with Sanitas for the ward in question. The list of contractual hospitals is available for inspection at Sanitas, and excerpts from the list can be furnished on request.

Inpatient hospitalisation is defined as a stay of at least 24 hours.

Acute treatment or acute care is defined as treatment whereby an improvement in the person's state of health can be expected.

2.2 Hospitalisation in Switzerland

The insurance covers the accommodation, nursing care and treatment costs of inpatient acute care in a general ward of any contractual hospital in Switzerland.

In the event of hospitalisation in a semiprivate or private ward (or in a general ward without a binding tariff agreement), the insurance pays a maximum of CHF 50 per day towards the costs of accommodation and nursing care and CHF 2,000 per calendar year towards treatment costs, but only in hospitals that appear on the cantonal lists of hospitals divided into categories by mandate. This benefit will be paid even if the hospital in question runs a general ward with an agreement.

2.3 Emergency hospitalisation outside Switzerland

The insurance covers the costs of treatment and accommodation in a private ward (single room) during a temporary stay abroad of up to 12 months. Benefits are paid for a maximum of 60 days in hospital.

2.4 Psychiatric clinics

The costs of acute inpatient treatment in a psychiatric clinic or special psychiatric ward will be paid in accordance with 2.2 above for a period of 90 days.

From the 91st day the treatment costs and a maximum of CHF 20 per day towards the costs of accommodation and nursing care will be paid. At AHV/AVS retirement age these benefits will continue to be paid up to a maximum of 720 days within a period of 900 days.

Hospitalisation in psychiatric clinics abroad within the scope of 2.3 is included in the benefit period.

2.5 Nursing homes and chronic care facilities

The following benefits are paid in the event of hospitalisation in a nursing home or chronic care facility:

- Up to the 180th day: CHF 20 per day towards the costs of accommodation and nursing care, plus the costs of treatment
- 181st to 540th day: CHF 10 per day towards the costs of accommodation and nursing care, plus the costs of treatment.

Thereafter no further benefits will be paid.

2.6 Birth centres

The costs of accommodation, nursing care and treatment will be covered for confinement in an accredited birth centre. A corresponding list can be furnished by Sanitas on request.

2.7 Benefits for new-born infants

Provided it is hospitalised with its mother, the costs of hospitalisation for a healthy infant will be paid from the mother's insurance coverage.

2.8 Care at home

The following benefits will be paid up to the specified amounts for a maximum of 90 days per calendar year on the basis of detailed date-referenced invoices towards the costs of care at home if this care is necessary on medical grounds and prescribed by a doctor:

- CHF 20 per day towards the costs of care at home provided by qualified nurses or nursing auxiliaries. Other persons providing care at home are entitled to these benefits if they can prove loss of earnings to this extent due to providing care.
- In the event of childbirth, the abovementioned benefits will be paid for a maximum of 14 days within one month after the birth, and included in the maximum benefit period.

In total, a maximum of CHF 1,800 per calendar year will be paid towards the costs of care at home.

2.9 Domestic help

If necessary on medical grounds and prescribed by a doctor, the following benefits will be paid on the basis of detailed date-referenced invoices for domestic help:

CHF 25 per hour for domestic help provided by a person not living in the same household. The insured person running the household is entitled to this benefit immediately following hospitalisation.

In the event of childbirth, the abovementioned benefits will be paid for a maximum of 14 days within one month after the birth, and included in the maximum benefit period.

In total, a maximum of CHF 500 per calendar year will be paid towards the costs of domestic help.

2.10 Spa therapies

Benefits of up to the following amounts will be paid towards the cost of spa therapies:

- CHF 50 (for spa therapies where the mandatory KVG/LAMal insurance pays a contribution) per day for a maximum of 21 days per calendar year for inpatient spa therapies in spas in Switzerland accredited as per Art. 40 KVG/LAMal or in spas in Abano and Montegrotto (Italy), and for spa therapies in health resorts in Switzerland that are directed and overseen by medical doctors (following serious illness or immediately after major operations). In addition, for spa therapies in Switzerland, 90% of the costs of medical doctors and drugs and medically necessary, medically prescribed treatments will be paid.
- CHF 100 per day for a maximum of 28 days per calendar year for spa therapies at the Dead Sea in Israel or Jordan to treat psoriasis or vitiligo (loss of skin pigmentation)

Sanitas has the right to request an examination by a company-appointed medical doctor before the spa therapy may be undertaken.

The abovementioned benefits will be paid for a maximum of one spa therapy per calendar year.

2.11 Transport, rescue and search costs

In total, a maximum of CHF 10,000 will be paid per calendar year for:

- The costs of travel in connection with radiotherapy, chemotherapy or haemodialysis conducted outside the home. The costs paid will not exceed the costs of public transport (travelling second class)
- Emergency transport to the nearest doctor or to the nearest hospital able to deliver appropriate treatment, and ambulances required for transport on medical grounds
- Rescue and search operations for persons who have had an accident or contracted an acute illness

2.12 Waiver of premium in the event of death or disability

The following insurance benefits apply only for insurance commencing before 1 January 2005 and insured events occurring before 1 January 2005.

Death or disablement of a parent

Premiums for all existing supplementary insurance plans will be waived for all children already insured with Sanitas up to and including the calendar year in which they reach age 18:

- In the event of the death of a parent who had basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal) with Sanitas
- In the event of the long-term disability of a parent who has basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal) with Sanitas, provided that a full disability pension is paid under the terms of the IV/AS

A waiver of the premium must be applied for in writing enclosing the relevant official documents (death certificate, IV/AS confirmation of pension entitlement).

If Sanitas receives the application later than one year after the death or IV/AS confirmation of pension entitlement, premiums will be waived as of the month in which the application was received by Sanitas.

If the disabled parent remarries or their degree of disablement is reduced, Sanitas must be notified immediately in writing, and the entitlement to a waiver of premium expires as of the month following the change. In the case of late notification, premiums will be backdated.

Disablement of an employee

If an employee is likely to be permanently unable to work as the result of a disability that commenced during the term of insurance, the supplementary insurance will be continued free of premiums until they reach AHV/AVS retirement age. For degrees of disablement of 25% or more, the premium will be reduced in proportion to the degree of disablement. The degree of disablement is determined in accordance with the decision of the pension fund. Only events that occur after the commencement of insurance are covered.

3 Miscellaneous

3.1 Obligations and qualifications for benefits

The benefits insured in the event of hospitalisation will be paid provided that acute hospital care is medically indicated.

Sanitas must be notified of admission to hospital immediately, but within four days at the latest. If a commitment to provide cover is required, Sanitas must be notified two weeks before admission.

If the insured person opts to exercise their right to choose a semiprivate or private ward, Sanitas must be notified two weeks before admission to hospital, except in the case of emergencies.

Benefits will be paid for spa therapies only if:

- The spa therapies are medically necessary and have been prescribed as part of medical treatment by a doctor accredited in Switzerland
- Sanitas receives the prescription for the spa therapy two weeks before commencement

Moreover, benefits for spa therapies will be paid only provided that outpatient treatment is inappropriate and unlikely to be effective and that the spa therapy involves therapeutic measures.

3.2 Benefit exclusions

In addition to the benefit exclusions specified in point 7 of the General Terms of Insurance, no benefits will be paid for treatments (e.g. organ transplants) for which the SVK (Schweizerischer Verband für Gemeinschaftsausgaben der Krankenversicherer) has agreed per case, all-inclusive payment arrangements for coverage by mandatory KVG/LAMal insurance.

3.3 Recognition of care providers

For treatments in Switzerland, only invoices issued by persons with a federal or cantonal diploma or the corresponding cantonal professional licence will be accepted.

3.4 Transfer to h-care

Subject to the following conditions, the insured person can transfer to the h-care product line with effect from the end of the year:

- transfer to the h-care COMFORT, h-care PRIVATE and h-care ROYAL categories is possible before the insured person has reached age 60, subject to a medical examination.

