

Planning a Family

Supplementary insurance for
treatments to improve chances
of a successful pregnancy

December 2019 edition (amended 2023)

Insurance carrier: Sanitas Privatversicherungen AG

1 Purpose and basis

The Planning a Family plan covers the cost of fertility treatments and diagnostic procedures in accordance with 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/HIA), other social insurance pursuant to point 2 of the general terms of insurance, and other supplementary insurance with Sanitas.

The basis of these supplementary terms is the general terms of insurance for supplementary insurance plans pursuant to VVG/IPA.

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

2 Geographic coverage

The insurance covers benefits claimed in Switzerland. The insured person must be legally domiciled in Switzerland. Claims can be paid abroad if Sanitas recognises care providers in the country in question.

3 Insured events

The insurance covers the eventuality where it is medically ascertained during the term of the contract that the insured woman cannot become pregnant by natural means, as well as maternity commencing during the term of the contract.

4 Benefits

1 Treatments

The following benefits are covered:

- Artificial insemination in the womb (homologous insemination) with the sperm of the insured's partner; all methods (ICI, IUI and ITI), maximum two rounds. The insurance covers 75% of costs, up to a maximum of CHF 2,000.
- Artificial insemination outside the womb with the sperm of the insured's partner (in vitro fertilisation, intracytoplasmic sperm injection, blastocyst culture, including aneuploidy screening). The insurance covers 75% of costs, up to a maximum of CHF 12,000.
- The insurance covers genetic embryo screening before the egg is implanted in the uterus (preimplantation diagnostics) in accordance with the statutory provisions in Switzerland. The insurance covers 75% of costs, up to a maximum of CHF 5,000.
- Non-invasive prenatal testing (NIPT, a validated test of the mother's blood to identify potential trisomy 21, 13 and 18 chromosomal disorders in the child) with a proven combined trisomy risk of less than 1:1,000 in accordance with the diagnostic procedure specified by the Schweizerische Gesellschaft für Gynäkologie und Geburtshilfe (SGGG, Swiss Society for Gynaecology and Obstetrics). The insurance covers 75% of costs, up to a maximum of CHF 500.
- NIPT for natural pregnancies is insured to the same amount.
- After every birth, these benefits are replenished to the maximum amounts.
- Sanitas pays a share of additional services designed to support pregnancy and fertility treatment and keeps lists of recognised measures, providers and cost contributions (see 4.3).

2 Conditions for the payment of benefits

All treatment options covered by mandatory insurance pursuant to KVG/HIA, including drug and hormone treatment, must have been exhausted or declared in the individual case to be not effective, expedient or economical.

Benefits will only be paid if Sanitas has issued a commitment to cover costs before treatment commences and the treatment is provided by a recognised care provider. This does not apply to non-invasive prenatal testing.

3 Accredited healthcare providers, measures and cost contributions

Sanitas keeps lists of recognised healthcare providers, measures and cost contributions. The list valid at commencement of treatment applies. The list is available at sanitas.com or can be provided on request. The lists can be amended, in particular in line with the selection of healthcare providers, the availability of products and medical advances.

5 Waiting periods

The following waiting periods apply for treatments:

- 9 months after commencement of the Planning a Family plan for prenatal diagnostic testing (NIPT)
- 24 months after commencement of the Planning a Family plan for artificial insemination inside and outside the womb and preimplantation diagnostics
- There is no waiting period for any other benefits.

6 Age restriction

The cover expires on 31 December of the year in which the insured turns 44. For treatments that have already begun, the date of commencement of treatment applies.

7 Terms diverging from the general terms of insurance VVG/IPA

1 Change of age group and legal domicile (point 22) and change of term of contract

The premium tariff may specify different premium scales according to age, sex, legal domicile and term of contract (multi-year discount that ceases to apply once the term originally agreed expires); a change in any one of these factors results in a change in premium. With the exception of changes on the basis of age, this change in premium does not entitle the insured person to terminate the contract, as per point 18 of the general terms of insurance VVG/IPA.

Age groups

The insured person is assigned to the following age groups based on their current age:

18–25	26–30	31–35	36–40	41–44
-------	-------	-------	-------	-------

The insured person is assigned to an age group based on their age in the calendar year in which the contract starts.

They switch to the next age group at the start of the calendar year in which they reach the first birthday of the higher age group (age-dependent tariff).

Switching to a higher age group usually involves an increase in premium.