Special Terms and Conditions for OPTIMED Healthcare Network – Canton Geneva

RS

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Art. 1 Purpose of the insurance

1. To offer insureds high quality medical, pharmaceutical and hospital benefits at an economical price, Groupe Mutuel has created a healthcare network, hereafter referred to as the «Network», which insureds may join in accordance with these Special Terms and Conditions of Insurance.
2. By joining the Network, insureds agree to comply with the rights and obligations deriving from the Network's operational requirements, particularly with regard to their choice of healthcare providers. In exchange, members have the full benefit of all network advantages, in particular reduced premiums.
3. The functioning of the Network and network membership rules rely on the special provisions of Article 41(2) and (4) and Article 62(1) and (3) of the Federal Health Insurance Law of 18 March 1995 (LAMal/KVG) and Articles 99 to 101 of the Federal Health Insurance Ordinance of 27 June 1995 (OAMal/KVV). The general principles of the Federal Health Insurance Law and the relevant ordinances serve as reference in all other respects.

Art. 2 Joining the Network

Insureds may apply to join the Network at any time. Membership commences on the first day of the month following the application date.

Art. 3 Insurance policy

Coverage under the Network health insurance scheme is certified on the insurance policy. The policy serves to evidence membership in the Network vis à vis healthcare providers and official entities.

Art. 4 Benefits

Network benefits are comparable to compulsory health insurance benefits (Articles 24 to 34 LAMal/KVG).

Art. 5 Deductibles and co-insurance

Insureds are required to pay a deductible and a co-insurance share towards their healthcare costs under the same terms and conditions applicable to all other forms of compulsory health insurance (Articles 93, 94(1) and (2), and 103 to 105 OAMal/KVV).

Art. 6 Choice of health care provider (general rule)

1. Save in case of a medical emergency or justified need (see paragraph 4 below), insureds must choose a Network-approved healthcare provider. For updating purposes, the Insurer may at any time draw up a list of providers who are not approved.
2. If an insured is being treated by a healthcare provider who is no longer approved, he may continue the treatment with that provider for maximum two months from the date the approval was lost.
3. The insured is authorised to undergo treatment, have tests and analyses carried out, purchase drugs or medical aids and appliances from a non approved healthcare provider if he does so based on a specific decision of his primary care doctor (see Article 7 below), or otherwise of the Insurer's medical advisor.
4. In case of a medical emergency or of justified need, within the meaning of LAMal/KVG, an insured may consult a non approved healthcare provider if his primary care doctor cannot be reached. In that case, he may only pursue treatment with a doctor other than his primary care doctor with the consent of his primary care doctor or otherwise of the Insurer's medical advisor. Treatment may not then last longer than two months.

Groupe Mutuel
Rue des Cèdres 5
P.O. Box - CH-1919 Martigny
Phone 0848 803 111 - www.groupemutuel.ch

Art. 7 Free choice of a primary care doctor (special rules)

1. The primary care doctor is a doctor who has signed an agreement with the OPTIMED Network authorising him to direct the treatment of Network members and supervise the medical and financial effects of such treatment.
2. To initiate treatment, an insured is free to contact any primary care doctor from the Insurer's list of authorised practitioners. Thereafter, he may not change primary care doctor without an authorisation to do so from the Insurer's medical advisor.
3. As a rule, save in special cases, medical emergencies or need (Article 6(2) to (4) above), only the primary care doctor may administer first treatment, prescribe further medical treatment and refer his patient to a specialist.
4. In the following special cases, the insured may consult a doctor who is not a primary care doctor:
   a. diagnostic or therapeutic eye examination;
   b. gynaecological and pregnancy check-ups;
   c. first call on a specialist.

   In the case referred to in subparagraph c, the insured shall inform the specialist that he is a member of the Network; he shall also inform his primary care doctor by phone of his visit to the specialist, if possible before his appointment with the specialist but in any event no later than the day after the visit.

Art. 8 Leaving the Network

1. Subject to paragraph 2 below, members may only withdraw from the Network insurance scheme at the end of a calendar year; a withdrawal implies that the insured simultaneously transfers to another form of compulsory health insurance. A withdrawal does not constitute a notice of termination to the Insurer.
2. If the insured transfers his domicile to a place outside the Network area, he shall be obliged, mutatis mutandis in accordance with Article 6(2) above, to transfer to another form of compulsory health insurance no later than two months after taking up his new domicile.

Art. 9 Loss of entitlement to benefits

If the insured fails to comply with his obligations under these Special Terms and Conditions, and particularly if he starts or continues treatment with a non approved healthcare provider or a health care provider who is not expressly authorised, he shall forfeit all and any entitlement to benefits. The exceptions contemplated in Article 6(2) to (4) and Article 7(4) above are reserved.

Art. 10 Effective date

These regulations and the supplemental executory provisions for compulsory health insurance in accordance with LaMal/ KVG (CGA) come into effect on 1 January 2011. These regulations may be amended at any time by the Insurer.