CSS Insurance

Multimed

Alternative insurance model (AVM) in accordance with the Swiss Federal Health Insurance Act (KVG), involving a binding consultation with a coordination partner.

Multimed Regulations (KVG)
Version 01.2020 (valid as of 1 January 2020)

All terms referring to persons in these Regulations refer to persons of both genders.

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Multimed in brief

Multimed assumes the costs of treatment for illness, maternity or accident under the terms of the Swiss Federal Health Insurance Act (KVG). Multimed can be taken out with a regular or selectable deductible.

Multimed is an alternative insurance model (AVM), in other words a particular form of mandatory healthcare insurance which affords a restricted choice of service provider. Where so stated in the applicable individual regulations, the restrictions on choice of service provider that are determined for Multimed also apply by analogy to supplementary insurance products under the Federal Insurance Contract Act (VVG) taken out from CSS Versicherung AG and INTRAS Versicherung AG.

One of the features of Multimed is that the insured person has a choice of coordination partners for the provision of preventive health services and the treatment of health problems. The insured person is obliged to consult one of these coordination partners regarding preventive health services and the treatment of health problems. The coordination partner will advise the insured person and determine the further course of treatment in consultation with them. The instructions of the coordination partner are binding on the insured person. Further to the Multimed list of doctors, coordination partners are recognised coordinating doctors or group practices as well as the Centre for Telemedicine. The insured person can choose whether to go to one of these doctors or practices, or to contact the Centre for Telemedicine.

Arcosana Kranken-Versicherung AG («Arcosana») encourages and supports measures to achieve a long-term reduction in costs and a rational system of healthcare which is fit for purpose and demands that insured persons contribute actively to their own health and take independent responsibility.

Terms which appear in italics in the body of this document are explained in the glossary in the Annex to these Regulations. The glossary forms an integral part of these Regulations.

I Extent of cover

Art. 1 Basis of insurance cover

1.1 Multimed is an alternative insurance model (special form of insurance) that is offered within the mandatory health-care insurance framework. It affords a restricted choice of service provider as defined by Art. 41 para. 4 of the Federal Health Insurance Act (KVG) and Art. 99 of the Federal Health Insurance Ordinance (KVV).

1.2 The KVG and the Federal Act on General Aspects of Social Security Law (ATSG), with their associated ordinances in each case, as well as the Arcosana regulations governing insurance plans in accordance with the KVG apply to all matters that are not governed specifically by these Regulations.

1.3 Swiss federal and cantonal law take precedence over these Regulations and those governing insurance plans offered by Arcosana in accordance with the KVG, in the order stated.

Art. 2 Object and features of Multimed

2.1 Arcosana provides insurance against the financial consequences of illness, maternity or accident. Where a person is not or no longer covered by accident insurance under the Federal Accident Insurance Act (UVG), accident cover under the KVG is provided even if it is not stated on the policy (Art. 8 para. 2 KVG in conjunction with the sanctions set out under Art. 10 KVG).

2.2 When taking out insurance, the insured person must designate a recognised coordinating doctor or a group practice of their choice from the Multimed list of doctors as one of their coordination partners. The coordinating doctor or group practice designated by the insured person is stated on the insurance policy. The Centre for Telemedicine is available to the insured person as an additional coordination partner. It provides mandatory services as defined in the KVG.

2.3 To use preventive health services under Art. 26 KVG and in the event of health problems, the insured person must consult one of the coordination partners.

2.4 The circumstances described in Art. 9 of these Regulations are exempt from the prior consultation obligation.

2.5 The insured person must report a change of coordinating doctor or group practice to Arcosana prior to the first consultation. The newly designated coordinating doctor or group practice must be included in the applicable Multimed list of doctors.

Art. 3 Admission

3.1 Multimed is available to all natural persons who are resident for civil law purposes in the cantonal catchment area in which Multimed is offered and who are subject to the statutory obligation to be insured under the KVG.

3.2 Insured persons may be admitted at any time with effect from the first day of the month, unless they are subject to a statutory notice or waiting period owing to a change of insurance model.

II Benefits

Art. 4 Scope of benefits

Arcosana assumes the costs of the benefits described in Arts. 24 to 31 KVG under the conditions determined in Arts. 32 to 34 KVG, providing the insured person has complied with the course of treatment decided by the coordination partner in consultation with Arcosana, and with the former's instructions (obligations). The circumstances described in Art. 9 of these Regulations are exempt from this obligation. Failure to comply with these instructions (obligations) will result in the sanctions described in Art. 11 para. 1 of these Regulations.

Art. 5 Co-payment

5.1 The insured person's co-payment is governed by Art. 64 KVG in conjunction with Art. 103 et seq. KVV. In application of Art. 64 para. 6 c KVG in conjunction with Art. 99 para. 2 KVV, the insured person can be granted a reduced retention fee.

5.2 Entitlement to insurance benefits is governed by Art. 12 para. 1 of these Regulations.

Art. 6 Benefits from third parties

6.1 Under the terms of Art. 28 ATSG, the insured person is obliged to notify Arcosana immediately about any and all benefits received from third parties (e.g. accident, liability, military or disability insurance), as well as about agreements concerning financial settlements, if Arcosana is liable to pay benefits for the same insured event.

6.2 If Arcosana provides benefits in lieu of third parties, the insured person must assign the corresponding entitlements to Arcosana to the extent of the benefits they have received.

6.3 Agreements between the insured person and third parties are not binding on Arcosana.

Art. 7 Liability

Liability in respect of therapeutic and diagnostic services lies exclusively with the coordination partners and/or the service providers treating the insured person.

III Obligations and entitlement to insurance benefits

Art. 8 Obligation to consult a coordination partner and to comply with their instructions

8.1 In the event of health problems as a result of illness, maternity or accident, providing this latter risk is insured, and in order to use preventive health services, the insured person undertakes to contact one of the coordination partners.

8.2 In consultation with the insured person, the coordination partner determines the appropriate course of treatment. The instructions of the coordination partner are binding on the insured person. The coordination partner determines the time frame and service provider for any further treatment. If the time frame is insufficient, or if there is a change to the treatment plan, the insured person must obtain the authorisation of the coordination partner before using any further medical services.

8.3 Failure to comply with these obligations will result in the sanctions described in Art. 11 para. 1 of these Regulations.

Art. 9 Exceptions to the obligation to consult the coordination partner in advance

9.1 Prior contact with the coordination partner is not necessary in emergencies. A situation is deemed to be an emergency if the condition of the insured person might objectively be assessed as life-threatening or in need of immediate treatment. The insured person is obliged to report emergency treatment at the earliest possible opportunity, but within ten days at the latest. If ongoing treatment or check-ups are required thereafter, this must be reported to the coordination partner before such treatment or check-ups begin. Failure to comply with these reporting obligations will result in the sanctions described in Art. 11 para. 1 of these Regulations.

9.2 The coordination partner does not necessarily have to be contacted in advance in connection with the following examinations and treatement:
- physiotherapy, occupational therapy and/or speech therapy, provided this is prescribed by a specialist as part of coordinated further treatment under Art. 8 para. 2 of these Regulations,
- ophthalmological examinations and treatment,
- preventive gynaecological examinations and treatments, as well as pre- and post-natal check-ups,
- midwifery services,
- dental treatment.

Art. 10 Management measures

10.1 **Obligation to follow the instructions laid down in the patient care programme**

10.1.1 To the extent medically indicated, the coordination partner will determine a patient care programme in consultation with the insured person.

10.1.2 The instructions issued as part of the patient care programme must be followed.

10.1.3 Failure to comply with these instructions will result in the sanctions described in Art. 11 para. 2 of these Regulations.

10.2 **Obligation to purchase value-for-money medicines and aids**

10.2.1 The insured person undertakes to request value-for-money medicines (generic/biosimilar medicines or a comparatively low-cost original preparation) from the group of active ingredients prescribed by the doctor. Generic/biosimilar medicines must be purchased instead of original preparations if the former cost less and the insured person is not dependent for medical reasons on the original preparation.

10.2.2 Generic medicines: these are based on the list maintained by the Federal Office of Public Health (FOPH), entitled «New list of generic medicine with differentiated retention fees for original preparations and generic medicines» *(Neue Generikaliste mit differenziertem Selbstbehalt bei Originalen und Generika)*. The applicable list can be accessed via the FOPH website or requested from the coordination partner. If the insured person chooses a medicine from the list of generic medicine maintained by the FOPH that is subject to a higher retention fee (20%) and for which a more economical alternative is available, they will be reimbursed only 50% of the costs of the original medicine. This rule does not apply if the insured person is dependent for medical reasons on the original preparation with the higher retention fee. In such cases, appropriate evidence must be supplied by the coordination partner or service provider when services are billed.

10.2.3 Biosimilars are approved products which are very similar to the original biologic medicine. Should the insured person choose an original medicine for which a more economical alternative is available, they will be reimbursed only 50% of the costs of the original medicine. The insured person should ask the coordination partner about approved biosimilars, with their trade name, active ingredient and reference to the original preparation. This rule does not apply if the insured person is dependent for medical reasons on the original preparation with the higher retention fee. In such cases, appropriate evidence must be supplied by the coordination partner or service provider when services are billed.

10.2.4 Purchase of medicines from a Arcosana-designated mail-order pharmacy: as a general rule, the insured person is free to choose where in Switzerland they wish to purchase their medicine (i.e. a doctor›s surgery, pharmacy or mail-order pharmacy). Medicines which are subject to repeat prescriptions are the exception to this freedom of choice. In such cases, the prescription will state that it is a repeat prescription, may be marked «ad rep» or «rep» or «to be repeated until», may prescribe several packs of the medicine, or contain other remarks. These medicines must without exception be obtained from a Arcosana-designated mail-order pharmacy. Failure to comply with this obligation will result in the sanctions described in Art. 11 para. 1 of these Regulations.

10.2.5 Aids and appliances: the insured person undertakes to purchase value-for-money aids and appliances such as diabetes-related products, walking aids, inhalers and respiratory therapy devices, bandages, crutches or incontinence supplies, etc., from the health insurance provider partner companies (outlets). Should the insured person choose a more expensive aid or appliance that is not offered by a health insurance provider partner company, the reimbursement will be no more than the costs laid down in the supply agreement with the partner company (outlet). An overview of partner companies and the aids and appliances they offer can be found on the health insurer›s website, and/or may be requested from the coordination partner.

Art. 11 Sanctions in the event of failure to comply with Multimed obligations

11.1 The following sanctions are imposed in response to failure to comply with these Regulations as set out under Art. 4 (scope of benefits), Art. 8 (obligation to consult a coordination partner and to comply with their instructions), Art. 9 para. 1 (obligation to report an emergency after the fact) and Art. 10.2 para. 4 (purchase of medicines from a mail-order pharmacy not designated by Arcosana):

a) First breach of the Regulations: a written reminder setting out the sanctions that will apply if the breach is repeated.
b) Second breach of the Regulations onwards: the insured person must themselves pay a maximum amount of CHF 500 per bill. As it results from a failure to comply with the Regulations, this payment will not be counted towards the deductible and retention fee.
c) From the second breach of the Regulations onwards, Arcosana may also reassign the insured person to the Arcosana mandatory healthcare insurance scheme without further notice and with effect from the first of the following month.

The costs that the insured person must pay are calculated on the basis of all the benefits that they have claimed in connection with the breach of the Regulations.

The sanction applies irrespective of fault, point in time, or the age of the insured person.

11.2 In the event of failure to comply with Art. 10.1 of these Regulations (obligation to follow the instructions laid down in the patient care programme), after two written reminders Arcosana may reassign the insured person to the Arcosana mandatory healthcare insurance scheme without further notice and with effect from the first of the following month.

11.3 Generic/biosimilar medicine: should the insured person choose an original medicine for which a more economical alternative is available, they will be reimbursed only 50% of the costs of the original medicine. This rule does not apply if the insured person is dependent for medical reasons on the original preparation with the higher retention fee. In such cases, appropriate evidence must be supplied by the coordination partner or service provider when services are billed (Art. 10.2 paras. 2 and 3 of these Regulations).

11.4 Aids and appliances: should the insured person choose a more expensive aid or appliance that is not offered by a

health insurance provider partner company, the reimbursement will be no more than the costs laid down in the supply agreement with the partner company (outlet) (Art. 10.2 para. 5 of these Regulations).

Art. 12 Entitlement to insurance benefits

12.1 Entitlement to outstanding benefits or contributions expires five years after the end of the month in which the benefit was owed and five years after the end of the calendar year in which the contribution was owed (Art. 24 para. 1 ATSG).

12.2 The co-payment is governed by Art. 5 of these Regulations.

Art. 13 Assignment and pledge of benefits

The insured person is not permitted either to pledge or to assign claims against Arcosana without its consent. The assignment of claims to service providers remains reserved.

IV Beginning and end of insurance

Art. 14 Beginning of insurance

Admission to Multimed is governed by the KVG and the associated ordinance provisions. The insured person receives an insurance policy as confirmation of insurance cover.

Art. 15 Amendments to the insurance on the part of the insured person

15.1 Subject to compliance with the statutory notice periods, insured persons may change to a lower selectable deductible, to a different form of insurance or to a different health insurer with effect from the end of the calendar year.

15.2 At the request of the insured person, accident cover may be excluded if they can provide proof of insurance for occupational and non-occupational accidents in accordance with the Federal Accident Insurance Act (UVG). The exclusion takes effect at the earliest on the first day of the month following the request.

15.3 Accident cover is included in health insurance immediately when accident insurance under the UVG ends. Arcosana must be notified within 30 days of the loss of accident insurance.

Art. 16 Amendments to the insurance on the part of Arcosana

If it is no longer possible for medical treatment to be provided by the coordination partner (owing to the insured person being abroad for more than three months, their stay in a nursing home, on the care ward of a retirement home, a chronic illnesses ward in an acute hospital, or a long-term stay of three months or more in an acute hospital, a psychiatric clinic or rehabilitation clinic or similar, or if the person is serving a prison sentence, has moved away from the catchment area, or if the coordinating doctor or group practice has left Multimed without a new doctor or group practice, etc. being appointed), the insured person will be reassigned to the Arcosana mandatory healthcare insurance scheme.

Art. 17 End of obligation to comply with Multimed Regulations

An insured person is no longer required to comply with Multimed Regulations in particular:

- if they cancel the insurance in accordance with Art. 15 para. 1 of these Regulations,
- if they are excluded from Multimed and reassigned to regular healthcare insurance in accordance with Art. 11 paras. 1 and 2 of these Regulations,
- under the circumstances described in Art. 16 and Art. 28 para. 2 of these Regulations,
- if the insured person is no longer subject to the obligation to be insured (Art. 5 para. 3 KVG),
- if they are classified as a cross-border commuter in accordance with Art. 7 para. 4 KVV,
- upon the death of the insured person

V Premiums

Art. 18 Premium payments and due dates

18.1 Premiums fall due for payment as at the end of the previous month (Art. 90 KVV). Payments may be made annually, semi-annually, quarterly, bi-monthly or monthly. The insurance year begins on 1 January.

18.2 If the insurance is cancelled before the end of the period for which premiums have been paid, the unused part of the premium will be refunded on a pro-rata basis.

18.3 The insured person may not offset premiums that are owed against outstanding benefits.

Art. 19 Reminders and consequences of default

Arcosana charges appropriate fees and interest on arrears for reminders and official debt collection proceedings.

VI Data protection

Art. 20 Data processing on the part of Arcosana

20.1 Arcosana processes data (data processing) to determine premiums, process claims, and for statistical analyses concerning Multimed. Data is stored either as hard copy or electronically. Arcosana employees are bound by the legal obligation to maintain confidentiality as well as by additional legal stipulations, and regulations governing data protection.

20.2 Where necessary and permitted by law, Arcosana may disclose data to authorised third parties (e.g. service providers, other insurers, and authorities) and/or obtain data from these third parties to the same extent.

Art. 21 Data processing on the part of the service provider or coordination partner

The information that is needed for treatment is available to all parties involved in the treatment in question (service providers or coordination partners) and may be exchanged between them or processed for the purposes of quality assurance and to ensure the best possible treatment. The data in question specifically concerns the diagnosis, treatment and billing of the insured person.

VII Procedure in case of disputes

Art. 22 Issue of an official decision

If an insured person does not agree with a decision made by Arcosana, they may request within a reasonable period that Arcosana issue an official written decision which states its reasons and the available avenues of appeal.

Art. 23 Objection procedure

An objection to an official decision may be lodged with Arcosana within 30 days. Arcosana will review this objection and issue a substantiated written objection decision, stating available avenues of appeal.

Art. 24 Appeal procedure

24.1 An appeal against the objection decision made by Arcosana may be lodged within 30 days with the cantonal insurance court. The insurance court in the canton of residence of the insured person or the third party lodging the appeal has jurisdiction. If the insured person or third

party lodging the appeal is resident abroad, the insurance court in the canton in which they were last resident in Switzerland or in which their last Swiss employer was domiciled has jurisdiction. If neither of these locations can be determined, authority lies with the insurance court in the canton in which the implementing body has its registered office (Art. 58 para. 2 ATSG).

24.2 An appeal may also be lodged if Arcosana has not complied with the request of the person concerned to issue an official decision or if it has not issued any objection decision.

24.3 To the extent permitted by the Federal Supreme Court Act (BGG), an appeal against the ruling of a cantonal insurance court may be lodged with the Federal Supreme Court.

VIII Miscellaneous

Art. 25 Payment of benefits

25.1 Arcosana transfers its benefits to the post office or bank account specified by the insured person (or their statutory representative). Arcosana may charge an indemnity for the additional costs incurred if it is asked to make payments by other means. Payments are made exclusively to addresses in Switzerland.

25.2 Where Arcosana is contractually obliged to pay fees to the service provider, it will transfer its benefits to the latter and then bill the insured person for their co-payment (this is referred to as the tiers payant system).

25.3 Up to the point at which an official debt collection application is made, Arcosana may offset insurance benefits that are owed against both outstanding premium claims and outstanding co-payments.

Art. 26 Obligation to report

26.1 The insured person is obliged to notify Arcosana immediately of any and all changes concerning the insurance relationship (change of name, change of address, change of coordinating doctor or group practice, etc.). The insured person is liable for any and all loss or damage resulting from late notification.

26.2 The delivery address for communications to Arcosana or claims against Arcosana is the address stated on the insurance policy.

Art. 27 Amendments to the insurance conditions

Amendments to these Regulations will be published in the CSS Magazine and on the health insurer's website.

Art. 28 Multimed list of doctors

28.1 The Multimed list of doctors (service providers and group practices recognised by Arcosana) may be amended by Arcosana unilaterally at any time. An amendment to the Multimed list of doctors does not entitle the insured person to cancel their insurance.

28.2 The insured person will be informed in writing if their coordinating doctor or group practice is no longer featured on the Multimed list of doctors. In such cases, the insured person is obliged to select a new coordinating doctor or new group practice from the Multimed list of doctors within 30 days, otherwise they will be reassigned to Arcosana's mandatory healthcare insurance scheme.

28.3 The Multimed list of doctors is published on the health insurer's website.

Art. 29 Use of health insurance provider applications

The health insurance provider provides a range of applications which can be used to process claims and to support treatment.

Art. 30 Multimed customer information

Further information about the Multimed insurance product, how it is structured and the necessary contact addresses and sources (such as websites, links, etc.) can be found in the client information sheet. The client information sheet does not form an integral part of these Regulations and has no legal effect.

Art. 31 Call recording

Advisory calls with the Centre for Telemedicine are recorded and archived. In case of dispute, recordings may be used as evidence and submitted to the court as such if necessary. In the absence of express authorisation by the insured person, Arcosana has no direct access to this information.

Art. 32 Fees

The insured person pays the usual telephone and data charges.

Art. 33 Entry into force

These Regulations enter into force on 1 January 2020. They are published on the health insurer's website.

Glossary

Accident
An accident is defined as the sudden, unintentional, harmful effect of an unusual external factor on the human body that results in an impairment of physical, mental or psychological health, or that leads to death. Occupational accidents and physical injuries that are similar to accidents are also classified as such.

Aids and appliances /aids and appliances list (MiGeL)
Aids and appliances are used to help treat or monitor an illness or its consequences. They include walking aids, inhalers and respiratory therapy devices, bandages, crutches and incontinence supplies, etc. The MiGeL aids and appliances list sets out the aids and appliances that health insurers must cover by law under mandatory healthcare insurance.

Alternative insurance model (AVM)
An alternative insurance model (AVM) is a particular form of mandatory healthcare insurance which affords a restricted choice of service provider. Restricting the choice of service provider under Art. 41 para. 4 KVG allows the premium to be reduced.

Application (app for short):
Applications (apps) are computer programs which are used to offer or support a useful or desirable function that is not offered by the system itself. Arcosana provides a range of applications which can be used to process claims and to support treatment.

Biosimilars
Biologic medicines which display sufficient similarity with an approved reference preparation and also reference its documentation (Art. 4 para. 1 a novies Swiss Therapeutic Products Act [HMG]). In other words, biosimilars are approved products which are very similar to the original biologic medicine. Biosimilars are similar rather than identical to the original product.

Centre for Telemedicine
The Centre for Telemedicine offers remote medical consultations. Tele-consultations offer patients with acute and general health issues advice, care and treatment from medical professionals, around the clock and 365 days a year. The Centre for Telemedicine offers its services in French, German, Italian and English.

Coordinating doctor
The coordinating doctor is a doctor or group practice from the Multimed list of doctors.

Coordination partner(s)
The coordinating doctor or group practice according to the Multimed list of doctors, and the Centre for Telemedicine, are referred to both individually and collectively as the coordination partner(s).

Co-payment (retention fee and deductible)
When an insured person uses medical services, such as a doctor's appointment, medicine or therapy, they pay part of the associated costs themselves. This is referred to as the co-payment. It consists of the deductible, which is a fixed amount per year, and a retention fee, which is a percentage of those costs which exceed the deductible.

Deductible
cf. co-payment

Emergency
A situation is deemed to be an emergency if the condition of the insured person might objectively be assessed as life-threatening or in need of immediate treatment.

Generic medicine
Generic medicines are approved drugs which are essentially the same as an original preparation. Since they contain identical active ingredients and are administered in exactly the same way and same dosage, they can be used as substitutes for the original drug (Art. 4 para. 1a septies Swiss Therapeutic Products Act [HMG]). They cost much less than the original preparation because there are few, if any associated development costs.

Group practice
This is a collective term for all forms of collaboration between independent doctors in the outpatient healthcare segment.

Illness
Illness means any impairment of physical, mental or psychological health which is not caused by an accident and which requires medical examination or treatment, or which leads to work incapacity.

Inpatient treatment
Inpatient treatment describes treatment involving a hospital stay of at least 24 hours or one night.

Maternity
Maternity includes pregnancy, childbirth and the mother's postnatal recovery period.

Multimed list of doctors
The list of coordinating doctors and group practices recognised by the health insurance provider.

Outlet
Approved service provider for aids and appliances for examinations or treatment, the costs of which are covered by mandatory healthcare insurance (Art. 35 para. 2 g KVG).

Outpatient treatment
A procedure or treatment which does not require an overnight stay in hospital, or for which the stay is less than 24 hours.

Partner company (outlet)
A cooperation agreement between the company supplying the aids and appliances (known as an outlet), and the health insurance provider (cf. Art. 35 para. 2 g KVG).

Patient care programme
The patient care programme is designed to help chronically ill patients to improve their quality of life and to minimise the effects of their illness. The coordination partner is aware of the patient care programmes currently offered by Arcosana. Specific participation criteria apply to each individual patient care programme. Where medically indicated, participation in such a programme will be agreed together with the insured person.

Preventive health services
Insurance covers the cost of the following preventive health services (Art. 26 KVG):
a) vaccinations (Art. 12a KLV);
b) measures to prevent disease (Art. 12b KLV);
c) general health check-ups (Art. 12c KLV);
d) measures to detect illness at an early stage among certain risk groups (Art. 12d KLV);
e) measures to detect illness at an early stage among the general population, including those aimed at all individuals in a certain age group, or at all men, or at all women (Art. 12e KLV).

Retention fee
cf. co-payment

Form. 816e-10.19-eff

Service provider(s)
A service provider is a person or body which is authorised to charge their services to mandatory healthcare insurance. Service providers include doctors, pharmacists, chiropractors, midwives, individuals providing services on the instructions or on behalf of a doctor, and organisations which employ such individuals (such as the Centre for Telemedicine), as well as laboratories, outlets for aids and appliances which assist in examinations or treatment, hospitals, birth centres, nursing homes, spas, transport and rescue companies, and facilities which support outpatient healthcare from doctors.

Tiers garant
The insured person is responsible for paying the bill issued by the service provider (Art. 42 para. 1 KVG). The health insurer then refunds the costs that the insured person is entitled to claim, less the co-payment. The tiers garant system applies where no other method of payment has been agreed between the service provider and the health insurer, i.e. they have not concluded any contract.

Tiers payant
The health insurer is liable for paying the bill issued by the service provider (Art. 42 para. 2 KVG). For information purposes and so that they can check the bill, the service provider is obliged to provide the insured person with a copy (Art. 42 para. 3 KVG and Art. 59 para. 4 KVV). The health insurer pays the service provider the full sum of the bill (100%). It then bills the insured person for the co-payment that is due from them (generally the deductible, retention fee and any contribution to hospital costs). The tiers payant system applies where there is a contract between the health insurer and the service provider.

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