groupemutuel

Special Terms and Conditions for supplemental hospitalisation insurance

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The following provisions are subject to the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), whose edition is specified in the insurance policy.

Art. 1 Purpose of the insurance

1. The insurance provides insured persons with benefits for inpatient hospital treatment in addition to those benefits provided by statutory insurance, in particular compulsory health insurance (hereinafter referred to as AOS/OKP) in accordance with the Federal Law on Health Insurance (LAMal/KVG).
2. The insurance covers the economic consequences of illness, maternity and accidents.

Art. 2 Insurance classes

Supplemental hospitalisation insurance comprises four insurance classes:

Class 1
General ward of a Swiss hospital providing acute, psychiatric or rehabilitation care for acute patients.

Class 2
Semi-private ward of a Swiss hospital (two-bed room) for acute, psychiatric or rehabilitation care for acute patients.

Class 3
Private ward of a Swiss hospital (one-bed room) for acute, psychiatric or rehabilitation care for acute patients.

Class 4
Private ward of a Swiss hospital (one-bed room) for acute, psychiatric or rehabilitation care for acute patients.

Art. 3 Deductibles

Persons insured in insurance classes 2, 3 and 4 may choose one of the following deductibles:

a. CHF 1,000 per calendar year.
b. CHF 3,000 per calendar year.

Art. 4 Eligibility

Any person domiciled in Switzerland may apply for insurance cover, which will take effect no later than the applicant's 60th birthday.

Art. 5 Start of entitlement to benefits

1. Entitlement to benefits under the supplemental hospitalisation insurance takes effect upon confirmation of the insurance policy.
2. For maternity benefits, a waiting period applies in accordance with Article 7 of these terms and conditions of insurance.

Art. 6 Insured benefits

1. Background
In the event of hospitalisation, the insurer will cover the treatment and accommodation costs that are effective, appropriate and economical in accordance with the chosen insurance class.

2. Hospitalisation in another type of ward in Switzerland
If an insured person in class 1 or 2 is hospitalised in a ward above their insurance class, the following maximum benefits shall be paid:
Class 1: CHF 100 per day for accommodation costs and
CHF 5,000 per calendar year for treatment costs;
Class 2: 80% of accommodation and treatment costs.

3. Hospitalisation abroad
If an insured person falls ill or has an accident abroad and is hospitalised, the insurer will grant them the following benefits for a maximum of 60 days per calendar year, depending on the insurance class selected:

a. Class 1: CHF 500 per day maximum.
b. Class 2: CHF 1,000 per day maximum.
c. Class 3: CHF 1,500 per day maximum.
d. Class 4: CHF 3,000 per day maximum.

Voluntary treatment abroad is not covered unless the insurer has given its prior consent.

Art. 7 Coverage of benefits in the event of maternity

1. Under the supplemental hospitalisation insurance, benefits for pregnancy and childbirth are only paid after an insurance period of 12 months.
2. In the event of termination of pregnancy within the meaning of the law and for any other benefits related to maternity, the waiting period specified in paragraph 1 applies.
3. In the event of an outpatient or home birth, insured persons in class 2 receive an allowance of CHF 800 and those in classes 3 and 4 receive an allowance of CHF 1,200, subject to paragraph 1.
4. When an insured person stays in a hospital ward corresponding to their insurance cover, the insurer shall also cover the costs of the newborn's stay during the mother's hospitalisation, provided that the newborn is also insured with the insurer. Personal expenses are not covered. Paragraph 1 remains reserved.

Art. 8 Scope and duration of benefits

Benefits under supplemental hospitalisation insurance are covered subject to the following provisions:

a. The insurer shall cover the costs of recognised facilities or doctors, i.e. those with whom the insurer has concluded a tariff agreement.
b. If an insured person receives benefits from non-recognised facilities or doctors, they will be reimbursed for the costs of these benefits, depending on the type of care (acute, rehabilitation or psychiatric) and the type of ward (semi-private or private), the inpatient hospitalisation benefits actually invoiced, but not exceeding the amounts specified in Appendix A per night of hospitalisation.
c. The list of healthcare providers and maximum amounts is available on the insurer's website or on request. The list in force at the time of treatment is decisive. The list of healthcare providers can be amended at any time by the insurer. Such an amendment to the list does not give the policyholder the right to terminate the insurance.
d. Article 6 paragraph 2 does not apply in the case of benefits provided by a non-recognised facility or doctor.
e. This insurance does not cover organ transplants for which the Swiss Federation for common tasks of health insurers in Solothurn (SVK) has agreed flat-rate fees. This rule also applies to hospitals for which no flat-rate fees have been agreed.
f. In all four classes, entitlement to benefits ceases as soon as the patient is no longer considered to be in acute care.
g. After 60 days of hospitalisation in a psychiatric care facility during a calendar year, benefits under supplemental hospitalisation insurance are no longer paid.
h. In classes 2, 3 and 4, after 90 days of hospitalisation during a calendar year, benefits under supplemental insurance are no longer paid. The duration of benefits paid abroad or in a psychiatric care facility (60 days) is deducted from the 90 days mentioned above.

Art. 9 Entitlement to benefits and limitations

1. Benefits under supplemental hospitalisation insurance are paid upon presentation of the hospital bill and the doctor's fee note. The insured person authorises the insurer's medical adviser to request the doctor's diagnosis or any other information necessary to determine entitlement to benefits.
2. Payment is made to the insured person, unless the insurer pays the benefits directly to the hospital under an agreement.
3. The benefits insured abroad in accordance with Art. 6, para. 3 of these terms and conditions of insurance correspond to those covered in Switzerland for similar health issues. They are covered if they are provided by persons or institutions that have the necessary training, recognition and authorisation from the competent health authorities in the country where the hospitalisation takes place.
4. In order to obtain reimbursement for benefits abroad, the insured person is required to provide all necessary original or digitally scanned supporting documents (detailed invoices, medical certificates, prescriptions, etc.). The insurer reserves the right to request the original documents and proof of payment.
   The official exchange rate of the Swiss franc on the last day of processing shall be used for invoices from abroad.

Art. 10 Obligations of the insured person

1. Before each hospitalisation in Switzerland, the insured person is required to find out whether the hospital, hospital ward or clinic where they will be treated is one of the hospitals recognised by the insurer.
2. In the event of emergency hospitalisation abroad, the Groupe Mutuel Assistance emergency call centre (telephone number +41 848 808 111) must be notified immediately so that treatment can be organised and the necessary payment guarantees issued.

Art. 11 Premiums

1. The rate is determined according to the age group, age at entry into the insurance, gender and canton of residence of the insured person.
2. Insured persons who reach the maximum age for their age group during the year are automatically transferred to the next age group at the beginning of the following calendar year. The age groups are as follows:
   - 0- 18 years;
   - 19- 25 years;
   - from ages 26 to 85, age groups are divided into five-year brackets.
   - 86 years and over.
3. A change in age group generally results in an automatic adjustment of the premium.

Art. 12 Cost-saving measures

1. If an insured person voluntarily or at the insurer's suggestion waives their right to a stay in a semi-private or private ward in favour of a stay in a general ward, the insurer may grant compensation of up to 50% of the costs saved and estimated by the insurer, but not exceeding CHF 5,000 per hospitalisation.
2. In the event of an outpatient or home birth, only the rule in Article 7 paragraph 3 shall apply.

Appendix A

Maximum amounts reimbursed for hospitalisation benefits provided by institutions or doctors not recognised by the insurer (Art. 8 of these special terms and conditions of insurance).

	Amounts per night of hospitalisation			
	Acute care		Rehabilitation and psychiatry	
	Semi-private	Private	Semi-private	Private
Non-recognised doctor: Reimbursement of medical expenses	CHF 500	CHF 500	CHF 0	CHF 0
Non-recognised hospital: Reimbursement of hospital expenses	CHF 300	CHF 500	CHF 100	CHF 150
Non-recognised hospital and doctor:				
Total reimbursement	CHF 800	CHF 1,000	CHF 100	CHF 150
- Medical expenses	– CHF 500	– CHF 500	– CHF 0	– CHF 0
- Hospital expenses	– CHF 300	– CHF 500	– CHF 100	– CHF 150