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Special Terms and Conditions for H-Bonus supplemental hospitalisation insurance

HB

HBGA01-E5 – Edition: 01 Jan 2014 (with an addendum as of 01 Jan 2024)

Contents

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. H-Bonus insurance covers treatments, room and board and doctor's fees when the insured is hospitalised for inpatient treatment in a general, semi-private or private ward.
2. The insured person shall choose the hospital ward in which he wishes to be treated, at the latest upon admission to hospital.
3. Benefits are supplemental to those provided under the compulsory health insurance LAMal/KVG (hereafter, AOS/OKP).
4. The bonus system enables the insured to reduce his premium amount if he has not received any insurance benefits for hospitalisation in a semi-private or private ward.

Art. 2 Eligibility

H-Bonus supplemental insurance is open to all persons under the age of 60.

Art. 3 Risks covered

H-Bonus benefits provide illness, accident and maternity coverage.

Art. 4 Insured benefits

1. Choice of ward and co-insurance
   In case of hospitalisation for inpatient treatment (for more than 24 hours), and only in the following:
   – hospitals for treatment of acute conditions;
   – psychiatric facilities or
   – rehabilitation centres;

   the insured is free to choose the hospital ward, along with the following co-insurance amounts:

Ward	Insured's co-insurance
General ward	Fr. 0.–
Semi-private ward	CHF 100 per day, maximum 30 days per calendar year
Private ward	CHF 200 per day, maximum 20 days per calendar year

   In calculating the number of hospitalisation days subject to co-insurance, the days on which the insured enters and leaves the hospital are deemed as full days when invoiced by the hospital facility.
   If, during a calendar year, the insured chooses to be hospitalised in a semi-private or private ward, the maximum annual limit of the private ward is taken into account, i.e. CHF 4,000.
2. Coverage of maternity benefits
   a. In case of pregnancy and childbirth, H-Bonus insurance benefits will only be paid after the lapse of a non-availability period of 12 months.
   b. Interruptions of pregnancy within the meaning of the Swiss Federal Law on Health Insurance (LAMal/KVG), and any other maternity-related benefits are subject to the waiting period specified in letter (a) above.
   c. When childbirth is covered by the insurance, the Insurer will also cover the healthy newborn's hospital costs for the duration of the mother's stay in hospital, provided the child is also insured with the Insurer.

Art. 5 Scope of benefits

1. For H-Bonus benefits to be payable, hospitals shall be recognised within the meaning of LAMal/KVG (listed hospitals) or shall have concluded a tariff agreement with Groupe Mutuel Assurances GMA SA for the corresponding wards.
2. The Insurer will cover only treatment costs recognised under LAMal/KVG, room and board in hospital as well as doctors' fees, in accordance with the agreement concluded with the Insurer or the cantonal tariff regulations.
3. The present insurance does not include coverage for organ transplants covered by flat rates (since these costs are covered by the AOS/OKP) agreed by the SVK (Fédération suisse pour tâches communes des assureurs maladie, Solothurn). This rule also applies to hospital facilities which are not bound by flat-rate agreements.
4. In case of emergency and as long as the insured is unable to choose the ward, the Insurer will ensure the coverage of benefits in a general ward only.

Art. 6 Duration of benefits

1. Hospitalisation benefits are limited to the acute phase of the illness. The entitlement to benefits ceases once the condition is no longer considered acute, such as in the treatment of stabilised or chronic conditions in particular, or if hospitalisation does not serve to improve the insured's health.
2. In the event of hospitalisation in a psychiatric facility, the entitlement to benefits is limited to 90 days per calendar year.
3. In the event of a stay in a rehabilitation centre, the entitlement to benefits is limited to 90 days per calendar year.

Art. 7 Hospitalisation abroad

1. In case of emergency, if an insured falls ill or has an accident and is hospitalised, the Insurer will grant him a maximum daily allowance of CHF 500 per day for no more than 60 days per calendar year. The co-insurance amounts defined in Article 4.1 are not applicable.
2. Voluntary treatments abroad are covered subject to the Insurer's prior consent only.

Art. 8 Obligation of the insured in case of hospitalisation

At the risk of being denied his entitlement to benefits, the insured shall check that the facility, hospital ward or clinic of his choice is recognised by the Insurer.

Art. 9 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect. Article 4, paragraph 2, letters (a) and (b), are reserved.
2. Benefits are imputed by treatment date on the benefit reimbursement ceilings and duration limits allowed in each calendar year. Costs incurred after entitlements are exhausted cannot be carried forward to the following year.
3. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover co-insurance payments and deductibles under the AOS/OKP or other supplemental insurances.

Art. 10 Payment of benefits

1. H-Bonus benefits will be paid against presentation of the hospital invoice and the doctor's bill. The insured authorises the Insurer's medical advisor to ask the attending doctor for the diagnosis and for any other relevant information with a view to ascertaining the insured's entitlement to benefits.
2. Claims are payable to the insured unless the Insurer is contractually required to make direct payment to the hospital.

Art. 11 Premium scale (bonus system)

1. For the calendar year an insured joins, premium level 0 applies.
2. The following premium levels are applicable:

% of premium	Premium levels
100	1
80	0

Art. 12 Variation of premium scale

1. If, during a given reference period, the insured has been granted benefits for a hospital stay in a semi-private or private ward, as set out in Article 4.1, his premium will be calculated at the beginning of the calendar year following the reference period and for three years based on premium level 1 (100% of the premium). If the Insurer is late in receiving the invoice from the hospital, the Insurer will adjust the premium scale subsequently.
2. At the end of this three-year period, and provided that no other insurance benefits were paid for hospitalisation in a semi-private or private ward, the premium for the following calendar year will be calculated based on premium level 0 (80% of the premium).
3. Every time the insured receives benefits for a new hospitalisation in a semi-private or private ward, the three-year period starts again at the beginning of the calendar year following the reference period.
4. The initial reference period which is used to determine the variation of the premium scale begins on the day the insured joins the insurance, as stated in the insurance policy, and ends on the following 30 June.
5. Subsequent reference periods contain 12 months and range from 1 July to 30 June.
6. The first day of hospitalisation is the decisive date for the allocation of benefits to a reference period.
7. In case there are several invoices for one single hospitalisation, only the date of the first day of hospitalisation is taken into account.

Art. 13 Premiums

1. An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:
   - from 0 to 18;
   - from 19 to 25;
   - from ages 26 to 80, age groups are graduated in 5-year brackets.
2. Premiums take into account the above-mentioned age brackets and the premium scale.
3. Changes in the premium scale (according to Article 12) do not qualify as premium adjustments conferring the right to termination within the meaning of Article 29 of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC).

Groupe Mutuel Assurances GMA SA (GMA SA)

Addendum to the special terms and conditions of insurance - Edition: 01 Jan 2024
Supplemental hospitalisation insurance H-Bonus - HBGA01

The provisions of the addendum will apply as of 01 January 2024 to persons who have taken out the supplemental insurance H-Bonus – HBGA01 insurance.

Scope of benefits
Replaces Art. 5, paras. 1 and 2.

1. The insurer will pay the costs of recognised facilities or doctors, i.e. those with which the insurer has concluded a tariff agreement.
2. If an insured person receives benefits from a non-recognised facility or doctor, he will be entitled to the following amounts per night of hospitalisation, depending on the type of treatment (acute, rehabilitation or psychiatric) and the ward (semi-private or private), the inpatient hospitalisation benefits actually invoiced, but not exceeding the following amounts per night of hospitalisation:

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

The list of healthcare providers and maximum amounts is available on the insurer's website or can be obtained on request. The list valid at the time of treatment is decisive.
The list of healthcare providers can be amended at any time by the insurer. Such an amendment in the list does not give the policyholder the right to terminate the contract.