groupemutuel

Special Terms and Conditions for supplemental hospitalisation insurance

HC

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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.

1. Purpose of the insurance

The insurance covers the economic consequences of illness, maternity and accidents.

2. Insurance classes

Supplemental hospitalisation insurance includes four classes of coverage:

Class 1

Public general or psychiatric ward, in a Swiss hospital, for the treatment of acute conditions.

Class 2

Semi-private general or psychiatric ward (room with two beds), in a Swiss hospital, for the treatment of acute conditions.

Class 3

Private general or psychiatric ward (room with one bed), in a Swiss hospital, for the treatment of acute conditions.

Class 4

Private general or psychiatric ward (room with one bed), in a hospital anywhere in the world, for the treatment of acute conditions.

3. Deductibles

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

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

4. Acceptance conditions

Supplemental hospitalisation insurance coverage is open to all persons up to age 60.

5. Beginning of entitlement to benefits

1. Insureds are entitled to benefits as soon as their supplemental hospitalisation insurance becomes effective, on the date specified in the insurance policy.
2. Maternity benefits are subject to a period of non-availability in accor-dance with Art. 7 of these Special Terms and Conditions.

6. Insured benefits

1. General

In case of hospitalisation, the insurer will cover treatment and room and board in accordance with the selected coverage class. Benefits under this insurance are supplemental to compulsory insurance benefits.

2. Hospitalisation in another ward

If an insured with class 1 or class 2 coverage is hospitalised in a superior ward, the following maximum benefits will be granted:

Class 1: CHF 100 per day for room and board and CHF 5,000 per calendar year for treatment costs;
Class 2: 80% of room and board and treatment costs.

3. Hospitalisation abroad

If an insured falls ill or has an accident abroad and has to be hospitalised there, the insurer will grant him, for no more than 60 days per calendar year and within the limits of the selected coverage, the following benefits:

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

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

Art. 7 Maternity benefits

1. In the case of pregnancy and childbirth, supplemental hospitalisation insurance benefits will only be paid after an insurance period of 12 months.
2. Interruptions of pregnancy within the meaning of the law, and any other maternity-related benefits are subject to the waiting period specified in paragraph 1.
3. Where childbirth involves a hospital stay of less than six days in private or semi-private ward, the insurer will grant insureds with class 2, 3 or 4 coverage an allowance of CHF 200 per day for each day of avoided hospitalisation. Hospital stays which are invoiced on a global lump-sum basis do not qualify for this allowance. Paragraph 1 is reserved.
4. In case of outpatient childbirth or childbirth at home, insureds with class 2 coverage will be granted an allowance of CHF 800 and insureds in classes 3 and 4 an allowance of CHF 1,200 subject to paragraph 1.
5. If an insured person is hospitalised in a ward corresponding to her coverage level, the insurer will also cover the newborn's hospital costs for the duration of the mother's stay in hospital, provided the child is also insured with the insurer. Personal expenses are not covered. Paragraph 1 is reserved.

8. Scope and duration of benefits

Supplemental hospitalisation benefits will be reimbursed subject to the following conditions:

a. The insurer will pay the costs of recognised facilities or doctors, i.e. those with which the insurer has concluded a tariff agreement.
b. If an insured person receives benefits from a non-recognised facility or doctor, he will be entitled to the inpatient hospitalisation benefits actually invoiced per night of hospitalisation, depending on the type of treatment (acute, rehabilitation or sychiatric) and the ward (semi-private or private), but not exceeding the amounts in Annex A.
c. 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.
   Art. 6, para. 2 does not apply in the case of benefits provided by a non-recognised facility or doctor.
d. The present insurance does not include coverage for organ transplants covered by flat rates agreed by the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn). This rule also applies to hospital establishments which are not bound by flat-rate agreements.
e. In all four classes, the entitlement to benefits ceases as soon as the insured's condition is no longer considered as acute.
f. After 60 days of hospitalisation in a psychiatric facility in a single calendar year, benefits under the supplemental hospitalisation insurance are no longer payable.
g. In classes 2, 3 and 4, benefits under the supplemental hospitalisation insurance are no longer payable after 90 days' hospitalisation. The duration of any benefits paid abroad or of benefits paid for treatment in psychiatric facilities (60 days) is imputed to the aforesaid 90-day limit.

9. Payment of benefits

1. Supplemental hospitalisation insurance claims are payable against presentation of the hospital invoice and 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.

10. Obligations of the insured

Before he is hospitalised, the insured shall always check that the hospital, ward or clinic where he is to be treated is recognised by the insurer.

11. Premium

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:
   – Children: 0 to 18
   – Adults: 19 to 25
   – from the 26th year until the 71st year, age groups are graduated in five-year brackets.
2. Premium rates are set taking into account the insured's age upon joining the insurance.

12. Cost-saving measures

1. If, at the insurer's proposal or by his own decision, an insured waives his entitlement to hospitalisation in a semi-private or private ward and instead stays in a general or comfort ward, the insurer may grant him an indemnity of up to 50% of the savings estimated by the insurer but not more than CHF 5,000 per hospitalisation.
2. In case of outpatient childbirth or childbirth at home, only Art. 7(4) applies.

Annex A

Maximum amounts reimbursed for hospital benefits provided by medical facilities 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 costs	CHF 500	CHF 500	CHF 0	CHF 0
Non-recognised hospital: Reimbursement of hospital costs	CHF 300	CHF 500	CHF 100	CHF 150
Non-recognised Hospital and Doctor: Total reimbursement – Medical costs – Hospital 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