CONCORDIA
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2010 Edition

Hospital Insurance

Additional Insurance Terms and Conditions

I. General Information

1 Object of Insurance

1.1 Hospital Insurance is considered to be supplementary insurance to mandatory health care insurance, all within the framework of the General Insurance Terms and Conditions of the supplementary care insurances.

1.2 Hospital Insurance bears the costs of a stay in a hospital. In addition, contributions are provided towards spa cures or convalescence cures and towards household help.

1.3 For insured persons who have a special form of mandatory health care insurance (such as HMO or the family doctor model) in accordance with Art. 62 of the Swiss federal law on health insurance (KVG/LAMal), the Special Insurance Terms and Conditions regarding this also apply.

2 Insurance Options

2.1 The following insurance options may be chosen:
- PRIVATE Hospital Insurance: stay in the private ward
- SEMI-PRIVATE Hospital Insurance: stay in the semi-private ward
- GENERAL Hospital Insurance: stay in the general ward throughout Switzerland

2.2 revoked

2.3 These insurance options may be taken out in the following variants:
- without accident cover
- with accident cover
- without deductible
- with optional deductible (PRIVATE Hospital Insurance and SEMI-PRIVATE Hospital Insurance)
- with free choice of hospital in accordance with the KVG/LAMal
- with limited choice of hospital
- with extended choice of hospital

3 Taking Out Insurance Before a Birth

If the insurance proposal form is made before the birth, the child is admitted to GENERAL Hospital Insurance unconditionally. It is not possible to take out PRIVATE Hospital Insurance or SEMI-PRIVATE Hospital Insurance before a birth.

4 Definitions

4.1 Hospitals are considered to be medical institutions or the wards of medical institutions, managed and supervised by doctors, which are used to treat acute illnesses and consequences of accidents on an inpatient basis or to carry out medical rehabilitation on an inpatient basis, and which feature on the cantonal hospital list in accordance with Art. 39 para. 1 let. e of the KVG/LAMal. They must guarantee sufficient medical care, have the necessary skilled personnel and appropriate medical equipment at their disposal, and guarantee appropriate provision of pharmaceutical care. In this sense, psychiatric clinics are also considered to be hospitals.

4.2 Sanatoriums, retirement homes, nursing homes for the elderly and for the chronically ill, hospices and other medical institutions that are not intended for the treatment of acute illnesses are not considered to be hospitals.

4.3 A private ward is considered to be a one-bed room or, exceptionally, a two-bed room with a tariff that is recognised by the insurance provider.

4.4 A semi-private ward is considered to be a two-bed room or, exceptionally, a room with more than two beds with a tariff that is recognised by the insurance provider.

4.5 A general ward is considered to be a multi-bed room with a tariff that is recognised by the insurance provider.

4.6 If a hospital has no criteria or different criteria for classifying hospital wards from those aforementioned, or if the tariffs of a ward are not recognised by the insurance provider, it is considered to be a private ward. The insurance provider may set maximum tariffs, which are considered to be criteria for classifying the insured wards. The insurance provider maintains a list of hospitals that have no private, semi-private or general wards in the sense of the definitions in these provisions. This list is adjusted on an ongoing basis and may be seen at the office of the insurance provider or requested in excerpts there.

5 Applicable Provisions

For all matters not specifically regulated in these Additional Insurance Terms and Conditions, the legal provisions and the General Insurance Terms and Conditions of the supplementary care insurances apply.

II. Benefits

6 Need for Acute Hospital Care

Hospital benefits are granted:

6.1 if the need for acute hospital care exists in consideration of the diagnosis and the medical treatment as a whole;

6.2 for that acute hospital/hospital ward in which the insured person belongs for medical reasons.

7 Scope of Benefits

7.1 Provided that and as long as the conditions for receiving benefits are fulfilled, the benefits comprise all accommodation costs, the costs of scientifically recognised treatment in the acute hospital and the treatment costs of the doctors in accordance with to the stipulated insurance (general, semi-private or private ward) and in accordance with the tariff recognised by the insurance provider.

7.2 If a lower-priced outpatient intervention means that an inpatient stay in an acute hospital may be avoided and if a contract exists between the insurance provider and the institution where the outpatient intervention is carried out, the costs of the intervention are borne by Hospital Insurance according to the contract rates. No cost shares are charged for the costs that exceed the legal mandatory benefits.

8 Duration of Benefits

8.1 In the event of inpatient treatment in an acute hospital, the insured benefits are provided without time limit for as long as the need for acute hospital care exists.

8.2 In the event of inpatient treatment in a psychiatric clinic or in the psychiatric ward of another hospital, the insured benefits are provided as long as the stay in the psychiatric clinic or in the psychiatric ward of another hospital is medically necessary and as long as there is no chronic clinical picture, but for a maximum of 180 days within a period of 365 consecutive days.

9 Benefits in the Event of Underinsurance

9.1 SEMI-PRIVATE Hospital Insurance: In the event of a stay in the private ward, 75% of the benefits from PRIVATE Hospital Insurance is reimbursed, but no more than 75% of the maximum tariff in accordance with Art. 4.6.

9.2 GENERAL Hospital Insurance: In the event of a stay in the private ward, 20% of the benefits from PRIVATE Hospital Insurance is reimbursed; in the event of a stay in the semi-private ward, 40% of the benefits from SEMI-PRIVATE Hospital Insurance is reimbursed. However, no more than 20% or 40% of the maximum tariff in accordance with Art. 4.6 shall be reimbursed.

9.3 PRIVATE Hospital Insurance: in the event of a stay in a hospital that exceeds the tariff for the private ward recognised by the insurance provider, no more than the maximum tariff in accordance with Art. 4.6 is reimbursed.

9.4 In the event of giving birth in the private or semi-private ward of a medical institution or in the general ward of a hospital outside of the canton of residence, the non-covered costs for the healthy new-born child that is insured from birth with the insurance provider are borne by the Hospital Insurance of the mother.

10 Spa Cures

10.1 In the event of medically prescribed spa cures carried out on an inpatient basis in a doctor-run, domestic health spa in accordance with Art. 40 of the KVG/LAMal, the following benefits are provided per day:

- PRIVATE Hospital Insurance: up to CHF 70
- SEMI-PRIVATE Hospital Insurance: up to CHF 50
- GENERAL Hospital Insurance: up to CHF 30

These contributions are also granted when the medically prescribed spa cures are carried out on an inpatient basis in a doctor-run, European health spa which has the necessary skilled personnel at its disposal and an appropriate range of therapies for the treatment of health spa patients.

10.2 These benefits are only provided if an intensive, scientifically-recognised and appropriate treatment has preceded the spa cure or such a treatment is not possible on an outpatient basis. In addition, an initial medical examination must be performed upon beginning the spa cure, and balneological/physical measures that are scientifically recognised in Switzerland must be carried out in accordance with the treatment schedule.

10.3 The insured daily benefit is provided for a maximum period of 21 days per calendar year.

11 Convalescence Cures

11.1 If a stay at a sanatarium is medically necessary and prescribed by a doctor for the healing process or recovery after a serious illness or operation, the following benefits are provided per day:

- PRIVATE Hospital Insurance: up to CHF 70
- SEMI-PRIVATE Hospital Insurance: up to CHF 50
- GENERAL Hospital Insurance: up to CHF 30

11.2 The convalescence cure must take place in a domestic sanatarium that is recognised by the insurance provider. The insurance provider maintains a list of sanatariums that it recognises and adjusts it on an ongoing basis. The list may be seen at the office of the insurance provider or requested in excerpts.

11.3 The insured benefits are provided for a maximum of 21 days per calendar year.

12 Duty to Notify

The doctor's prescription for a cure at a spa/institution shall be submitted in a timely manner before the cure begins, indicating the name of the health spa/sanatarium and the date the cure begins.

13 Household Help

13.1 If the insured person is completely incapable of working and requires household help because of his state of health and personal family circumstances, on the basis of a doctor's prescription, the following benefits, are provided per day for costs that are evidenced and are not covered by DIVERSA Insurance:

- PRIVATE Hospital Insurance: up to CHF 70
- SEMI-PRIVATE Hospital Insurance: up to CHF 50
- GENERAL Hospital Insurance: up to CHF 30

13.2 Household help is considered to be any person whose occupation, on his own account or for an organisation, consists in taking care of the household in place of the insured person. The same contribution may also be provided if another person takes care of the household in place of the ill insured person and the costs associated with this are evidenced.

13.3 The insured daily benefit is provided a maximum of 30 times per calendar year.

13.4 Benefits for household help are not granted at the same time as other benefits from Hospital Insurance.

14 Second Opinion

Prior to an operation, insured persons may visit the insurance provider's consulting doctor so that the medical necessity of the intervention may be assessed by the latter or by an additional doctor. The costs of this assessment are borne by the insurance provider.

15 PRIVATE Hospital Insurance Benefits Abroad

15.1 In the event of an acute or planned, medically necessary inpatient stay in an acute hospital or a psychiatric clinic abroad, the costs of treatment that is scientifically recognised in Switzerland and the costs for accommodation and food are borne by PRIVATE Hospital Insurance. No benefits from SEMI-PRIVATE Hospital Insurance and GENERAL Hospital Insurance are provided abroad.

15.2 In the event of a plannable inpatient treatment abroad, the request for guarantee of payment must be submitted to the insurance provider no later than seven days prior to hospital admission. The request must contain the date of admission, the planned medical treatment, the chosen service provider and the chosen ward. If the request has not been submitted to the insured provider by that point in time, no benefits from PRIVATE Hospital Insurance are provided. If no guarantee of payment has been given by the insurance provider at the time of hospital admission, no benefits are borne by PRIVATE Hospital Insurance.

15.3 For benefits to be provided, the insured person must submit the medical information required as well as the detailed original bill in one of the Swiss national languages or in English. If the insured person is unable to provide any detailed bills, the benefits are determined by taking into account the type, gravity and duration of the illness or the consequences of an accident.

15.4 For cross-border commuters, abroad is considered to be anywhere outside of Switzerland as well as outside the area stretching 20 km from the Swiss national border.

16 Provision of Benefits

Benefit provision is determined by Art. 33 of the General Insurance Terms and Conditions. If the canton of residence declines to bear the additional costs of a medically justified hospitalisation outside of the canton contrary to Art. 41 para. 3 of the KVG/LAMal, the insurance provider calculates the benefits as if the canton were bearing the additional costs incurred outside of the canton as part of a stay in the general ward.

17 Exclusion from Benefits

No benefits are provided from Hospital Insurance:

17.1 for outpatient treatments, with the exception of Art. 7.2;

17.2 for treatments and stays in acute hospitals and psychiatric clinics due to the abuse of drugs, narcotics, alcohol or pharmaceuticals as well as in the event of chronic illness;

17.3 for personal expenses incurred (telephone, postage costs, television, radio, etc.);

17.4 for dental treatments that are not part of the mandatory benefits of mandatory health care insurance;

17.5 for treatment, care, supervision and stays in a nursing home, a home for the chronically ill or a retirement home;

17.6 for treatment and stays in the event of an organ transplant for which the Swiss association for the common tasks of health insurance providers (SVK) has stipulated flat-fee payments per case. This also applies to clinics in which no flat-fee payments per case have been stipulated;

17.7 for treatments in hospitals that do not feature on the cantonal hospital list according to Art. 39 para. 1 let e of the KVG/LAMal. Insurance with extended choice of hospital remains reserved;

17.8 for treatments abroad, in the cases of SEMI-PRIVATE Hospital Insurance and GENERAL Hospital Insurance;

17.9 in the cases that are listed in Art. 31 of the General Insurance Terms and Conditions.

III. Variants of Hospital Insurance

18 Optional Deductible

18.1 In exchange for a corresponding reduction of premiums, persons with PRIVATE Hospital Insurance or SEMI-PRIVATE Hospital Insurance have the possibility of bearing the costs incurred within the framework of Hospital Insurance up to a fixed amount per calendar year (deductible). The following optional deductibles are possible:
CHF 1,000 per calendar year
CHF 2,000 per calendar year
CHF 3,000 per calendar year
CHF 5,000 per calendar year
CHF 10,000 per calendar year

18.2 Choosing a deductible in the already existing Hospital Insurance is possible with effect at the beginning of a month, regardless of one's state of health and age.

18.3 Changing from a lower to a higher deductible is possible with effect at the end of a calendar year, regardless of one's state of health and age.

18.4 In order to change to a lower deductible, it is necessary to undergo a new admission procedure by means of an insurance proposal form. This change is possible with effect at the end of a calendar year, no earlier than after a duration of insurance of three years, subject to a three-month cancellation period.

18.5 If insurance with optional deductible does not exist for the entire duration of a calendar year, the deductible is calculated pro rata temporis.

18.6 In the event of a claim on Hospital Insurance, insured persons with an optional deductible must first bear the chosen deductible themselves per calendar year.

18.7 In the event of a hospital stay of a maximum of 30 days over the end of the year, the optional deductible is charged only once during the calendar year at the beginning of this hospital stay.

18.8 If insured persons with an optional deductible proceed to a general ward in accordance with Art. 4.5, the charging of the deductible is waived.

18.9 If persons with PRIVATE Hospital Insurance with an optional deductible proceed to a semi-private ward in accordance with Art. 4.4, only half of the deductible is charged.

19 Limited Choice of Hospital

19.1 In exchange for a corresponding reduction of premiums, persons that are insured by Hospital Insurance have the possibility of taking out the limited choice of hospital variant.

19.2 With the limited choice of hospital variant, benefit cover is limited to the acute hospitals designated by the insurance provider. The insurance provider maintains a list of those acute hospitals that may be chosen with this variant and adjusts it on an ongoing basis. This list may be seen at the office of the insurance provider or requested in excerpts there.

19.3 In case of emergency or if the required benefits are not offered in the designated acute hospitals, full cover exists. Art. 9 remains reserved.

19.4 Changing from the limited choice of hospital variant to the cover variant without limited choice of hospital is possible with effect at the first time after a duration of insurance of three years for the end of a calendar year, and afterwards for the end of any calendar year. In each case, a 12-month cancellation period must be observed. It is not necessary to undergo a new admission procedure by means of an insurance proposal form.

20 Extended Choice of Hospital

20.1 In exchange for a corresponding premium surcharge, persons that are insured by Hospital Insurance have the possibility to take out the extended choice of hospital variant.

20.2 With the extended choice of hospital variant, the insurance provider also grants benefits for stays in hospitals that do not feature on the cantonal hospital list (Art. 39 para. 1 let. e of the KVG/LAMal).

20.3 The benefits provided are determined by, at the most, the maximum tariff recognised by the insurance provider for the hospital concerned.

IV. Transitional Regulations

21 Premium Discount

Insured persons who took out Hospital Insurance before 1997 enjoy a premium discount. The amount of the discount is determined by the duration of the insurance that existed on 31 December 1996.

The following abbreviations, with corresponding translations in German, French, Italian and English, are used in these Regulations:

KVG/LAMal
KVG: Bundesgesetz über die Krankenversicherung; Krankenversicherungsgesetz
LAMal: Loi fédérale sur l'assurance-maladie
LAMal: Legge federale sull'assicurazione malattie
Swiss federal law on health insurance

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2.20.E.03 (07.16)