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2022 Edition

Hospital Insurance

Additional Insurance Terms and Conditions

I. General Information

1 Nature of Insurance

1.1 Hospital Insurance is classified as supplementary insurance to mandatory health insurance. It is governed by the General Insurance Terms and Conditions of Supplementary Care Insurances.

1.2 Hospital Insurance covers the costs of a stay in hospital. In addition, contributions are provided towards spa or convalescence cures, household help, rooming-in, and outpatient and home births.

1.3 Hospital Insurance is an indemnity policy, i.e. it provides cover for loss or damage.

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

2 Insurance Variants

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

2.2 These insurance variants may be taken out with the following options:
- 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 Prenatal application

If the application for insurance is made before 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 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. They must guarantee sufficient medical care, have the necessary skilled personnel and appropriate medical equipment at their disposal, guarantee appropriate pharmaceutical provision and be a member of a certified community under the Swiss federal law on electronic patient files (EPDG/LDEP/LCIP). In this sense, psychiatric clinics are also considered to be hospitals.

4.2 Sanatoriums, retirement and nursing homes and other institutions and medical facilities that are not intended for the treatment of patients in acute need of hospital treatment 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 mentioned above, or if the tariffs of a ward are not recognised by the insurance provider, it is considered to be a private ward.

4.7 If the insurance provider does not recognise the tariffs of a hospital, ward or department, it may decline to pay these tariffs or alternatively lay down maximum tariffs representing the highest level of benefits it is prepared to pay. The insurance provider may adjust the maximum tariffs at any time.

4.8 The insurance provider will publish a regularly updated list of the hospitals at which benefits will be paid in full, partly or not at all. The list or excerpts thereof may be obtained from the insurance provider.

5 Applicable Provisions

For all matters not specifically regulated in these Additional Insurance Terms and Conditions, the statutory provisions and the General Insurance Terms and Conditions of Supplementary Care Insurances apply.

II. Benefits

6 Need for Acute Hospital Care

Hospital benefits are paid:

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 the hospital or medical department that is most appropriate for the insured person on medical grounds.

7 Scope of Benefits

7.1 Provided that the conditions for providing benefits are fulfilled, the benefits cover the costs of stays and scientifically recognised treatment in the hospital as well as the treatment costs of doctors in accordance with the chosen insurance variant (general, semi-private or private ward) and in accordance with the tariff recognised by the insurance provider.

7.2 If an inpatient stay in an acute care hospital can be avoided by means of a lower-priced outpatient intervention, and 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 share is charged for the costs that exceed the statutory mandatory benefits.

8 Duration of Benefits

8.1 In the event of inpatient treatment in a hospital, the insured benefits are provided without time limit for as long as the need for acute hospital care exists. Treatments in accordance with Art. 8.2 remain reserved.

8.2 In the event of inpatient treatment in a psychiatric clinic or the psychiatric ward of another hospital, the insured benefits are provided as long as the stay in this institution is medically necessary and as long as there is no chronic clinical picture, 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 a private ward, 75% of the benefits in PRIVATE Hospital Insurance are reimbursed, but no more than 75% of the maximum tariff in accordance with Art. 4.7.

9.2 GENERAL Hospital Insurance: In the event of a stay in a private ward, 20% of the benefits in PRIVATE Hospital Insurance are reimbursed; in the event of a stay in a semi-private ward, 40% of the benefits in SEMI-PRIVATE Hospital Insurance are reimbursed. However, no more than 20% or 40% of the maximum tariff in accordance with Art. 4.7 will be reimbursed.

9.3 PRIVATE Hospital Insurance: In the event of a stay in a hospital that exceeds the tariff for private wards recognised by the insurance provider, no more than the maximum tariff in accordance with Art. 4.7 will be reimbursed.

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

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

10.2 The spa cure must be carried out in a health spa recognised by the insurance provider. The insurance provider maintains a regularly updated list of the health spas that it recognises. The list or excerpts thereof may be obtained from the insurance provider.

10.3 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 the cure plan must involve balneological/physical measures that are scientifically recognised in Switzerland.

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

11 Convalescence Cures

11.1 If a stay at a sanatorium 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 sanatorium recognised by the insurance provider. The insurance provider maintains a regularly updated list of sanatoriums that it recognises. The list or excerpts thereof may be obtained from the insurance provider.

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

12 Duty to Notify in Case of Cures

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

13 Household Help

13.1 If the insured person is completely incapable of working and, on the basis of a doctor's prescription, requires household help because of their state of health and personal family circumstances, 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 their own account or for an organisation, consists in taking care of the household in place of the insured person. The same contribution is provided if another person takes care of the household in place of the insured person and the associated costs are evidenced.

13.3 The insured daily benefits are provided a maximum of 30 times per calendar year.

13.4 Benefits for household help will not be paid at the same time as other benefits from Hospital Insurance.

14 Rooming-in

14.1 If a parent stays overnight in a chargeable hospital room of a hospital in which an insured child under the age of 10 is hospitalised, or if one or more children under the age of 10 stay overnight in a chargeable hospital room of a hospital in which an insured parent is hospitalised, up to CHF 60 of the costs per night will be reimbursed by the hospitalised person's Hospital Insurance.

14.2 This entitlement also exists for foster children and stepchildren.

14.3 The Hospital Insurance benefits will be paid for hospitalisations in Switzerland.

14.4 If benefits are also paid by a DIVERSA Insurance policy for the same overnight stays, these take precedence and the benefits under Hospital Insurance are supplementary.

15 Outpatient and Home Births

15.1 If the mother has held Hospital Insurance for at least 270 days at the time of an outpatient or home birth in Switzerland, the following amounts will be paid out by Hospital Insurance:

- PRIVATE Hospital Insurance: CHF 1,500
- SEMI-PRIVATE Hospital Insurance: CHF 1,000
- GENERAL Hospital Insurance: CHF 300

15.2 There is no entitlement when the mother's stay in hospital is extended or she enters the hospital within 24 hours of the birth.

15.3 The payment is only made once for multiple births.

16 Second Opinion

Prior to a planned operation or serious medical intervention, insured persons may contact the insurance provider who, for selected diagnoses, will enable the insured persons to obtain a second medical opinion by means of a review of the medical file. The costs of this assessment by an external partner are borne by the insurance provider.

17 Benefits Abroad of PRIVATE Hospital Insurance

17.1 In the event of an acute or planned, medically necessary inpatient stay in hospital abroad, the cost of treatment that is scientifically recognised in Switzerland and the cost of accommodation and meals are borne by PRIVATE Hospital Insurance. No benefits from SEMI-PRIVATE Hospital Insurance and GENERAL Hospital Insurance are provided abroad.

17.2 In the event of a plannable inpatient treatment abroad, the request for commitment to provide coverage 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 healthcare 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 commitment has been given by the insurance provider at the time of hospital admission, no benefits are paid by PRIVATE Hospital Insurance.

17.3 For benefits to be provided, the insured person must submit the medical information required as well as the detailed bill in one of the Swiss national languages or English. The insurance provider may request the original documents. If the insured person is unable to provide any detailed bills, the insurance provider will determine the benefits by taking into account the type and gravity of the illness or consequences of the accident.

18 Provision of Benefits

18.1 Benefit provision is determined by Art. 34 of the General Insurance Terms and Conditions.

18.2 If, contrary to Art. 41 para. 3 KVG/LAMal, the canton of residence declines to bear the additional costs of a medically justified hospitalisation, the insurance provider will nonetheless calculate the benefits as if the canton was reimbursing the additional costs as part of a stay on a general ward.

18.3 If, contrary to Art. 41 para. 1bis KVG/LAMal, the canton of residence declines to bear the costs of hospitalisation at the reference tariff, the insurance provider will nonetheless calculate the benefits as if the canton was reimbursing the reference tariff as part of a stay on a general ward.

19 Exclusion from Benefits

No benefits are provided from Hospital Insurance:

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

19.2 for treatments and stays in hospitals relating to the consumption of drugs, narcotics or addictive substances or the misuse of alcohol and medicines (including complications and long-term effects). Benefits are also excluded if the treatment is only partly due to the consumption or misuse of these substances, or the consumption or misuse has only had an impact on the duration of the treatment;

19.3 for personal expenses (e.g. telephone, postage costs, television, radio);

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

19.5 for treatment, care, supervision and stays in a nursing or retirement home;

19.6 for treatment and stays in the event of organ and stem cell transplants in accordance with the insurance provider's list. The list of excluded transplants, or excerpts of the list, may be obtained from the insurance provider;

19.7 when there is no longer a medical need for acute hospital treatment;

19.8 for treatments and stays in hospitals whose tariffs the insurance provider has not recognised in their entirety, or has not recognised for the relevant ward or department, and for which it has not laid down any maximum tariffs (Art. 4.7);

19.9 for treatments abroad, in the case of SEMI-PRIVATE Hospital Insurance and GENERAL Hospital Insurance;

19.10 for treatments for which there is no duty to provide benefits under the Swiss federal health insurance legislation and for the treatment of related complications and long-term effects;

19.11 in the cases listed in Art. 32 of the General Insurance Terms and Conditions.

III. Options of Hospital Insurance

20 Optional Deductible

20.1 In exchange for a corresponding reduction in premiums, persons with PRIVATE Hospital Insurance or SEMI-PRIVATE Hospital Insurance have the option to pay up to a fixed amount per calendar year of the costs incurred by Hospital Insurance (deductible). The following optional deductibles are available:

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

20.2 Choosing a deductible in an existing Hospital Insurance is possible with effect from the beginning of a month, regardless of the insured person's state of health and age.

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

20.4 In order to change to a lower deductible, the insured person must undergo a new admission procedure by submitting an application. This change is possible with effect from the end of a calendar year, no earlier than after a duration of insurance of three years, subject to a three-month notice period.

20.5 If the policy with an optional deductible is not in place for a full calendar year, the deductible is calculated pro rata temporis.

20.6 In the event of a claim on Hospital Insurance, insured persons with an optional deductible must first pay the chosen deductible themselves each calendar year.

20.7 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, for the calendar year during which the hospital stay began.

20.8 If insured persons with an optional deductible go into a general ward in accordance with Art. 4.5, the deductible is waived.

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

21 Limited Choice of Hospital

21.1 In exchange for a corresponding reduction in premiums, persons that are insured by Hospital Insurance have the possibility of taking out the limited choice of hospital option, provided that the insurance provider offers such an option nationally throughout Switzerland or regionally at the insured person's place of residence.

21.2 With the limited choice of hospital option, benefit cover is limited to the hospitals designated by the insurance provider.

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

21.4 Changing from the limited choice of hospital option to the non-limited choice of hospital option is possible, for the first time after an insurance duration of three years with effect from the end of a calendar year, and thereafter from the end of any calendar year. In each case, a 12-month notice period must be observed. It is not necessary to undergo a new admission procedure by means of an application.

22 Extended Choice of Hospital

22.1 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 option, provided that the insurance provider offers such an option nationally throughout Switzerland or regionally at the insured person's place of residence.

22.2 The benefits provided are limited to the tariff recognised by the insurance provider for this option and for the hospital, ward or department concerned, or to the maximum tariff. The insurance provider may decide not to set a maximum tariff and decline to provide benefits altogether.

IV. Transitional Regulations

23 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.

If there are differences in content between the English and the German, French or Italian Insurance Terms and Conditions, the Insurance Terms and Conditions in the language in which the policy is written apply.

The following abbreviations, with corresponding translations in German, French, Italian and English, are used in these Additional Insurance Terms and Conditions:

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

EPDG/LDEP/LCIP
EPDG: Bundesgesetz über das elektronische Patientendossier
LDEP: Loi fédérale sur le dossier électronique du patient
LCIP: Legge federale sulla cartella informatizzata del paziente
Swiss federal law on electronic patient file

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2.20.E.04 (09.23)