CONCORDIA
Bound by trust

2007 Edition

LIBERO Hospital Insurance

Additional Insurance Terms and Conditions

I. General Information

1 Object of Insurance

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

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

2 Applicable Provisions

2.1 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.

2.2 For insured persons who have a special form of mandatory health care insurance in accordance with Art. 62 of the Swiss federal law on health insurance (KVG/LAMal), any existing Special Insurance Terms and Conditions also apply.

3 Insurance Options

Insurance may be taken out in the following variants:
- without accident cover,
- with accident cover,
- with free choice of hospital in accordance with the KVG/LAMal,
- with limited choice of hospital,
- with extended choice of hospital.

4 Submitting the Proposal Form

4.1 In order to be admitted to LIBERO Hospital Insurance, the designated proposal form must be filled out truthfully and completely and sent to the insurance provider in accordance with Art. 3.1 of the General Insurance Terms and Conditions of supplementary care insurances.

4.2 It is not possible to take out LIBERO Hospital Insurance before a birth.

5 Definitions

5.1 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.

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

5.3 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.

5.4 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.

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

5.6 The concept of inpatient treatment is determined by the provisions of the KVG/LAMal.

5.7 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.

II. Contract Duration

6 Term and Cancellation

6.1 The contract is made for the fixed duration indicated in the policy and is subsequently extended tacitly for one year at a time unless the policy holder has cancelled the contract, subject to a three-month cancellation period, for the end of its duration.

6.2 If no contract duration is mentioned in the policy, the contract is made for one calendar year and is subsequently extended tacitly for one year at a time unless the policy holder has cancelled the contract, subject to a three-month cancellation period, for the end of its duration. In cases where the insurance contract begins during the course of the year, the first contract period ends on 31 December of that calendar year.

6.3 If the insurance provider replaces the existing insurance terms and conditions with new terms and conditions in order to adapt to new market conditions, it has the right, in contrast with Art. 16.3 of the General Insurance Terms and Conditions, to cancel the insurance effective at the end of the contract duration, subject to a three-month period of notice. In this case, the policy holder is entitled to transfer to the new insurance, regardless of state of health and age. Existing insurance reserves and, if it has been chosen, the variant of LIBERO Hospital Insurance with limited choice of hospital also apply to the new insurance.

III. Choice of Hospital Ward and Cost Sharing

7 Right to Choose

7.1 The insured persons may announce in writing, at the latest upon being admitted to hospital, that they wish to stay in the semi-private or private ward. If the insured persons do not choose a particular hospital ward in writing, they are considered to have chosen the general ward.

7.2 During inpatient treatment, insured persons may choose another hospital ward in writing and proceed to another hospital ward.

7.3 If the insured person is not in a position to make the choice of hospital ward due to the consequences of illness or an accident, the costs of the general ward are borne. The written choice of hospital ward by the spouse, by the legal representative or by a person the insured person has authorised specifically for this purpose remains reserved.

8 Cost Sharing for Hospital Benefits

8.1 If insured persons stay in the general ward, no cost sharing is charged.

8.2 If insured persons choose the semi-private ward, they must contribute to the incurred costs that are borne by LIBERO Hospital Insurance with a retention fee of 20%, but in total no more than CHF 2,000 per calendar year.

8.3 If insured persons choose the private ward, they must contribute to the incurred costs that are borne by LIBERO Hospital Insurance with a retention fee of 35%, but in total no more than CHF 4,000 per calendar year.

8.4 If another hospital ward is chosen during the course of a stay, insured persons must contribute to the incurred costs that are borne by LIBERO Hospital

Insurance on the basis of the entire duration of the stay, in the event of a partial stay in the private ward in accordance with Art. 8.3, otherwise in accordance with Art. 8.2. In the event of several hospital stays during one calendar year, Art. 8.5 applies.

8.5 If insured persons choose both the semi-private ward and the private ward of a hospital in the event of several hospital stays in the course of one calendar year, they must contribute to the incurred costs that are borne by LIBERO Hospital Insurance for the stay in the semi-private ward in accordance with Art. 8.2 and for the stay in the private ward in accordance with Art. 8.3, but in total no more than CHF 4,000 per calendar year.

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

8.7 If two or more persons covered by LIBERO Hospital Insurance are related to each other in a family-law relationship and live together in the same household, they must contribute in total no more than CHF 4,000 per calendar year towards the incurred costs borne by LIBERO Hospital Insurance in the event of hospital stays in the private or semi-private ward.

8.8 If insured persons choose a hospital ward which is not recognised by the insurance provider in accordance with Art. 5.7 or stay in a general ward which is not recognised by the insurance provider in accordance with Art. 5.7, the cost-sharing regulations apply according to the classification recognised by the insurance provider.

8.9 For benefits in accordance with Arts. 13, 14 and 16, no cost sharing is charged.

9 Adjustment of Cost Sharing

Taking into consideration the development of costs in public healthcare, the insurance provider may increase the maximum amounts of cost sharing in accordance with Art. 8 with effect on the first day of the next insurance period. This requires the insurance provider to notify the policy holder in writing of the new contract terms and conditions no later than 25 days before the new contract takes force. The policy holder then has the right to cancel the insurance for the end of the current insurance period. If the policy holder exercises this right, the insurance expires at the end of the current insurance period. The notice of cancellation must reach the insurance provider no later than the last day of the current insurance period. If the policy holder omits to cancel the insurance, he is considered to have agreed to its adjustment.

IV. Benefits

10 Hospital Benefits

Hospital benefits are granted:

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

10.2 for the acute hospital or the specialist medical ward of a hospital in which the insured person belongs for medical reasons.

11 Scope of Benefits

11.1 Provided that and as long as the conditions for receiving benefits are fulfilled, the hospital benefits comprise the costs of stays and scientifically recognised treatment in the acute hospital as well as the treatment costs of doctors in the general ward or the chosen semi-private or private ward, according to the tariff recognised by the insurance provider. In the event of a stay in a hospital ward which is not recognised by the insurance provider or in a hospital that exceeds the tariff recognised by the insurance provider for the chosen hospital ward, no more than the maximum tariffs are reimbursed in accordance with Art. 5.7. Cost sharing by insured persons remains reserved in accordance with Art. 8.

11.2 If the mother chooses a private or semi-private ward for childbirth or stays 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 LIBERO Hospital Insurance of the mother.

12 Duration of Benefits

12.1 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 hospital care exists.

12.2 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.

13 Spa Cures

13.1 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, up to CHF 30 is provided per day. This contribution is also granted when the medically prescribed spa cures are carried out on an inpatient basis in a doctor-run, European health spa which is recognised by the insurance provider and which has the necessary skilled personnel at its disposal and an appropriate range of therapies for the treatment of health spa patients.

13.2 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.

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

14 Convalescence Cures

14.1 If a stay at a sanatarium is medically necessary and prescribed by a doctor for the healing process or for recovery after a serious illness or operation, up to CHF 30 is provided per day.

14.2 The 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 there.

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

15 Duty to Notify in the Case of Cures at a Spa/Institution

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.

16 Household Help

16.1 In the event of a medically-certified, complete incapacity to run the household, if the insured person requires household help because of his state of health and personal family circumstances, on the basis of a doctor's prescription, up to CHF 30 is provided per day for costs that are evidenced and are not covered by DIVERSA Insurance. If household help is required due to a chronic illness, no benefits are provided.

16.2 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 is provided if another person takes care of the household in place of the ill insured person and the costs incurred for the person taking care of the household (loss of earnings, expenses, etc.) are evidenced.

16.3 The insured daily benefit is provided a maximum of 30 times within a period of 365 consecutive days.

16.4 Benefits for household help are only provided up to the insured person's 65th year of age.

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

17 Benefits Abroad

No benefits from LIBERO Hospital Insurance are provided abroad. Benefits for spa cures remain reserved.

18 Provision of Benefits

18.1 Benefit provision is determined by Art. 33 of the General Insurance Terms and Conditions.

18.2 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.

19 Exclusion from Benefits

No benefits are provided from LIBERO Hospital Insurance for:

19.1 outpatient treatments;

19.2 the additional costs of a stay incurred by general ward patients who stay in a one-bed or two-bed room or for the additional costs that are incurred due to general ward patients exercising free choice of doctor;

19.3 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;

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

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

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

19.7 treatment and stays in the event of an organ transplant for which the Swiss association for shared 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;

19.8 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;

19.9 treatments for which no duty to provide benefits exists in accordance with the Swiss federal legislation regarding health, accident, military and disability insurance as well as for the treatment of the complications and after-effects thereof;

19.10 treatments of which the effectiveness, appropriateness and cost effectiveness are not proven by scientific methods as well as for treatment of the complications and after-effects of these;

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

V. Variants of LIBERO Hospital Insurance

20 Limited Choice of Hospital

20.1 In exchange for a corresponding reduction of premiums, persons that are insured by LIBERO Hospital Insurance have the possibility of taking out the limited choice of hospital variant provided that the insurance provider offers such a variant.

20.2 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. This list is adjusted on an ongoing basis and may be seen at the office of the insurance provider or requested in excerpts there.

20.3 In case of emergency or if the required benefits are not offered in the designated acute hospitals, full cover exists.

20.4 Changing from the limited choice of hospital variant to the cover variant with non-limited choice of hospital is possible for the first time after a duration of insurance of three years with effect at the end of a calendar year, and afterwards with effect at the end of any calendar year. In each case, a 12-month cancellation period must be observed. It is necessary to undergo a new admission procedure by means of an insurance proposal form.

21 Extended Choice of Hospital

21.1 In exchange for a corresponding premium surcharge, persons that are insured by LIBERO Hospital Insurance have the possibility of taking out the extended choice of hospital variant provided that the insurance provider offers such a variant.

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

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

21.4 Changing from the extended choice of hospital variant to the cover variant with non-limited choice of hospital is possible for the first time after a duration of insurance of three years with effect at the end of a calendar year, and afterwards with effect at the end of any calendar year. In each case, a three-month cancellation period must be observed. It is not necessary to undergo a new admission procedure by means of an insurance proposal form.

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

CONCORDIA
Bound by trust

CONCORDIA
Bundesplatz 15
6002 Lucerne
Phone +41 (0)41 228 01 11
www.concordia.ch
info@concordia.ch

2.23.E.02 (07.17)