groupemutuel

Special Terms and Conditions for supplemental hospitalisation insurance

HC

HCAM01-E7 – Edition: 01 Jan 2014 (with an addendum as of 01 January 2024)

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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 insurance

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

Art. 2 Insurance classes

Supplemental hospitalisation insurance offers four classes of coverage:
Class 1: Public general or psychiatric ward, in a Swiss hospital, for treatment of acute conditions.
Class 2: Semi-private general or psychiatric ward (room with two beds), in a Swiss hospital, for treatment of acute conditions.
Class 3: Private general or psychiatric ward (room with one bed), in a Swiss hospital, for treatment of acute conditions.
Class 4: Private general or psychiatric ward (room with one bed), in a hospital anywhere in the world, for treatment of acute conditions.

Art. 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 2,000 per calendar year
c. CHF 3,000 per calendar year
d. CHF 5,000 per calendar year

Art. 4 Acceptance conditions

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

Art. 5 Beginning of entitlement to benefits

1. Insureds are entitled to benefits as soon their supplemental hospitalisation insurance becomes effective, on the date specified in the insurance policy.
2. Maternity benefits are subject to a waiting period in accordance with Article 7 of these Special Terms and Conditions.

Art. 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 to him:
   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.
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 the lapse of a 12-month waiting period.
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

6 days in private or semi-private ward, the Insurer will grant insureds with class 2, 3 or 4 coverage an allocation 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 allocation. Paragraph 1 is reserved.
4. In case of childbirth at home, insureds with class 2 coverage will be granted an allocation of CHF 800 and insureds in classes 3 and 4 an allocation 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.

Art. 8 Scope and duration of benefits

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

a. The Insurer will reimburse treatments recognised by the LAMal/KVG, hospital room and board and doctors' fees in accordance with tariff agreements or cantonal regulations.
b. The Insurer reserves the right to restrict the entitlement to benefits if the fees charged for room and board or for medical services are overpriced. Room and board rates and medical fees which are more than twice the rates set in the relevant cantonal tariffs for compulsory insurance are deemed overpriced.
c. If there is no medical tariff agreement, the compulsory insurance tariff for hospital services will be applicable with a 50% increase for the semi-private word and a 100% increase for the private ward.
d. If a hospital does not apply the criteria for distinguishing between wards referred to in Article 2 (1), or applies other criteria, or if no tariff agreement has been reached with the Insurer, the Insurer shall only recognise the private ward. Only insureds in classes 3 and 4 are entitled to benefits.
e. The Insurer can limit or exclude the payment of supplemental hospitalisation insurance benefits in respect of hospitals, wards or clinics which do not meet the requirements of paragraph (a) and (b) of this Article. A list is kept at the disposal of the insureds.
f. 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.
g. In all four classes, the entitlement to benefits ceases as soon as the insured's condition is no longer acute.
h. After 60 days of hospitalisation in a psychiatric facility in a single calendar year, benefits under the supplemental hospitalisation insurance are no longer payable. After that time limit, if the compulsory health insurance does not pay benefits, the insured will be granted the equivalent of the compulsory health benefits.
i. In classes 2, 3 and 4, benefits under the supplemental hospitalisation insurance are no longer payable after 90 days' hospitalisation in a single calendar year. After that time limit, if the compulsory health insurance does not pay benefits, the insured will be granted the equivalent of the compulsory health benefits. 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.

Art. 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.

Art. 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 an establishment recognised by the Insurer.

Art. 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, age groups are graduated in 5-year brackets.
2. Premiums are set taking into account the insured's age when he joined the insurance.

Art. 12 Coinsurance amounts

1. For each hospitalisation in private or semi-private ward not covered by compulsory health insurance, the following co-insurance amounts will be deducted from the benefits paid under the insurance policy:
   – CHF 20 per day for class 2;
   – CHF 30 per day for classes 3 and 4.
2. Insureds who have not opted for a deductible are not subject to the rule in clause 1 of this article.

Art. 13 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 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 childbirth at home, only Article 7(4) applies.

Groupe Mutuel Assurances GMA SA (GMA SA)

Addendum to the special terms and conditions of insurance - Edition: 01 January 2024
Supplemental hospitalisation insurance - HCAM01

The provisions of the addendum will apply as of 01 January 2024 to persons who have taken out the supplemental hospitalisation insurance – HCAM01.

Scope and duration of benefits
Replaces Art. 8.
The benefits under the supplemental hospitalisation insurance are covered subject to the following provisions:

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 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.

c. This 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 facilities which are not bound by flat-rate agreements.
d. In all four classes, entitlement to benefits ceases as soon as the insured person's condition is no longer acute.
e. After 60 days of hospitalisation in a psychiatric facility in a single calendar year, benefits under the supplemental hospitalisation insurance are no longer payable. After that time limit, if the compulsory health insurance does not pay benefits, the insured person will be granted the equivalent of the compulsory health benefits.
f. In classes 2, 3 and 4, benefits under the supplemental hospitalisation insurance are no longer payable after 90 days' hospitalisation in a single calendar year. After that time limit, if the compulsory health insurance does not pay benefits, the insured will be granted the equivalent of the compulsory health benefits. 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.