KLuG

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Supplementary Insurance Conditions (ZVB) HOSPITAL FLEX

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General

1 Purpose

1.1 HOSPITAL FLEX Supplementary Hospital Insurance provides benefits beyond those covered by the compulsory health care insurance, as follows:
- free choice of hospital throughout Switzerland: the costs of superior accommodation and the costs of selecting doctors in the general, semi-private or private wards for acute damage to patients' health in a hospital as well as in convalescence or psychiatric clinics thereafter;
- a contribution towards the costs of hospital treatment;

abroad and also provision of supplementary payments, provided they are also insured, for
- accommodation and meals for inpatient acute and transitional care
- balneotherapy and convalescent therapy
- household help
- childcare service

1.2 Benefits will be paid for costs arising from illness, accident and maternity. Accident cover may be excluded.

Benefits

2 Eligibility for benefits

2.1 Payment of all benefits under this policy is subject to the existence of medical necessity and the effectiveness, appropriateness and cost-effectiveness of treatments.

2.2 To receive maternity benefits, insurance cover must have commenced at least 365 days earlier.

2.3 Benefits in the event of hospital stays are only paid out if there is a need for hospital treatment.

3 Hospital benefits

3.1 At the latest upon being brought into a hospital, the insured person will decide in which ward they wish to be treated. No costs are due for services provided in the general ward; in the semi-private or private ward, the insured person will owe the share of costs agreed in the policy.

3.2 For stays and treatment in a hospital, convalescence or psychiatric clinic that fulfil the requirements in accordance to Section 8.1 of the General Insurance Conditions (AVB), the benefits consist of the tariffs agreed by the insurer for the institution concerned. According to this principle, for hospitals not recorded in the cantonal planning and hospital lists pursuant to Article 39 of the Federal Health Insurance Act (KVG) benefits are granted from this insurance policy provided the insurer has concluded a KVG contract with the relevant hospital (Helsana KVG contract hospital).

The insurer keeps a list of the Helsana KVG contract hospitals, which informs on the recognised benefits spectrum. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested.

3.3 For benefits relating to inpatient acute and transitional care that are required following a hospital stay and are prescribed by the hospital, the insurer, if insured under Section 1.1 of the ZVB and in addition to its obligations to provide benefits under the KVG, shall reimburse the uncovered costs for accommodation and meals at a rate of up to CHF 100 per day for up to 14 days per calendar year:

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4 Duration of hospital benefits

4.1 With inpatient treatment in a hospital for acute illness or in a convalescence clinic, the covered benefits for acute care will be paid out without time limitation, provided that, taking the diagnosis and overall aspects of the medical treatment into account, a stay in hospital is medically necessary and an improvement in the patient's state of health can be expected.

4.2 In the event of inpatient treatment in a psychiatric clinic, insured benefits will be paid for a maximum of 60 days within one calendar year so long as, in view of the diagnosis and the medical treatment as a whole, a stay in a psychiatric clinic is medically necessary and chronic symptoms do not exist.

5 Benefits abroad

With a stay as an inpatient in a hospital for acute care or a psychiatric clinic abroad, the agreed daily amount will be paid towards the costs of treatment that is scientifically recognised and necessary, and for accommodation and food for a maximum period of 60 days per calendar year.

6 Benefits for newborn children

The insurer will take on the costs of the stay of a healthy newborn child under HOSPITAL FLEX taken out by the mother for the length of the baby's stay in hospital, but for no longer than 10 weeks.

7 Flat-rate maternity benefit

If the child is born in a maternity station for outpatients, at home or when the mother is visiting a hospital as an outpatient, the insurer will pay out the agreed flat-rate maternity benefit.

8 Benefits for the accommodation of companions (rooming-in)

In the event of inpatient hospital treatment, the insurer shall contribute to the costs for accommodation and meals for a closely related person who accompanies the insured person in the hospital. The benefit will not be paid out for more than a maximum period of 15 days per calendar year.

9 Balneotherapy

9.1 Benefits for balneotherapy shall be paid, provided they are also insured in accordance to Section 1.1 of the Supplementary Insurance Conditions (ZVB).

9.2 Prior to starting a balneotherapy, a doctor must have prescribed it and it must take place in a Swiss or European spa run by doctors and recognised by the insurer.

9.3 A claim is only valid when there has either first been an intensive, scientifically recognised treatment designed for the purpose, or therapy as an outpatient that is scientifically recognised and designed for the purpose is not possible. A medical entry examination must be carried out at the beginning of the balneotherapy, and the balneotherapy and related physical treatment must be carried out in accordance with a treatment plan. The minimum duration for balneotherapy is 14 days.

10 Convalescent therapy

10.1 Benefits for convalescent therapy shall be paid, provided they are also insured in accordance to Section 1.1 of the Supplementary Insurance Conditions (ZVB).

10.2 The convalescent therapy must be carried out in a convalescent facility recognised by the insurer.

10.3 The convalescent therapy must be prescribed by a doctor and must be medically necessary for recovery from a serious illness. The insurer must receive the medical prescription 10 days before the beginning of the convalescent therapy. The prescription must state the name of the relevant therapeutic spa or convalescent facility, and the date on which the treatment begins.

11 Household help

11.1 Benefits for household help will be paid out provided they are also insured in accordance to Section 1.1 of the ZVB and if the insured person needs household help as a result of an acute illness or owing to his family situation.

11.2 A medical certificate is required to prove the necessity of such services.

11.3 In the event of a stay in a nursing home or similar institution, no benefits for household help will be provided.

12 Duration of benefits for balneotherapy/convalescent therapy and household help

The insurer will pay the documented costs, but not more than CHF 100 per day, for the cost of balneotherapy and convalescent therapy for a maximum period of 21 days per calendar year. It will also pay CHF 50 per day towards the documented costs for household help for a maximum period of 30 days per calendar year.

13 Childcare service

13.1 If an insured person stays in hospital for inpatient treatment, the insurer, if insured under Section 1.1 of the ZVB, shall cover third-party childcare costs for one or more children under the age of 15 who are under the parental guardianship of the insured person, during standard weekly working hours, and up to a maximum of 30 hours per calendar year.

13.2 Benefits will only be paid if the insured person contacts the organisation centre designated by the insurer in advance, which will then arrange the childcare.

14 Benefit exclusions

14.1 Besides the reasons stated in Section 21 AVB, no benefits are provided for:

- treatment and care of chronically mentally ill people;
- stays in nursing homes;
- stays in psychiatric daytime or overnight clinics;
- stays in a hospital not on the insurer's list if the insurance option with a restriction on the choice of hospital has been agreed.

14.2 Section 21.1 lit. l AVB does not apply.

Insurance Plan Options

15 Insurance plan with limited choice of hospitals

15.1 The insurer may offer a reduction in premium in return for an insurance plan placing a restriction on the choice of hospital. For this option, the insurer maintains a list of hospitals that may be selected. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested.

15.2 In the event of a hospital stay in a hospital which is not on the insurer's list, no costs will be paid.

15.3 This insurance plan can be taken out with a compulsory health care insurance with limited choice of hospitals. In the case of the insured persons who have chosen this special form of the compulsory health care insurance, the restrictive terms defining the drawing of benefits stated in the respective General Insurance Conditions also apply to this insurance plan. If this special form of the compulsory health care insurance is cancelled or suspended, this insurance plan is discontinued. In this case, an automatic transfer to HOSPITAL FLEX without limited choice of hospital will take place.

Premiums

16 Premium adjustments

16.1 Premiums are calculated based on the age and gender of the insured person. Insured persons are assigned to the age group that corresponds to their current age.

16.2 Section 12.2 of the General Insurance Conditions (AVB) for Supplementary Health Insurances does not apply to the HOSPITAL FLEX product.

Miscellaneous

17 Bonus system

The insurer reserves the right to introduce a bonus system into this supplementary hospital insurance. The insured persons will be automatically reallocated in the insurance product adjusted by this change to the system. In derogation of the normal terms of notice of the General Insurance Conditions, these persons will be entitled to withdraw with retroactive effect from HOSPITAL FLEX within a period of three months.

18 Suspension of the insurance cover

18.1 In return for a reduction in premium the policyholder can suspend the claim for benefits arising from HOSPITAL FLEX, subject to their providing evidence that they have alternative insurance cover (group contract, company health care insurance, foreign insurance, etc.) for the insurance to be suspended.

18.2 The policyholder must reactivate the insurance cover with the insurer within 30 days of the expiry of the alternative insurance cover, with the premium being adjusted in accordance with Section 12 AVB. If the policyholder fails to adhere to this grace period, the conditions for new inclusion shall apply to the continuation of the insurance policies.