The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd, Helsana Accidents Ltd, Avanex Insurance Ltd, Progrès Insurance Company Ltd, Sansan Insurance Ltd and Maxi.ch Insurance Ltd.

Helsana

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Supplementary Insurance Conditions (ZVB)
HOSPITAL BONUS Supplementary Hospital Insurance

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General

1 Purpose

HOSPITAL BONUS covers accommodation and treatment costs in a hospital and provides contributions towards subsistence costs for inpatient acute and transitional care, balneotherapy and convalescent therapy, home nursing and household help, as well as outpatient operations. The existence of medical necessity is the prerequisite for the payment of all benefits under this policy.

2 Insurance options

The following insurance plans are available for hospital stays:

a) HOSPITAL PLUS BONUS = semi-private ward
b) HOSPITAL COMFORT BONUS = private ward

Benefits

3 Insurance cover

3.1 HOSPITAL BONUS bears the costs for accommodation and treatment in the hospitals that fulfil the requirements according to Section 8.1 of the General Insurance Conditions (AVB). 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.

3.2 HOSPITAL PLUS BONUS covers, within the scope of the following conditions, the costs of an inpatient stay in a two-bed room in the semi-private ward of a hospital.

3.3 HOSPITAL COMFORT BONUS covers, within the scope of the following conditions, the costs of an inpatient stay in a single-bed room in the private ward of a hospital.

3.4 If a hospital does not have any ward classifications or has different ward classifications, or if the rates for a ward have not been recognised by the insurer, the conditions will be applied as if the insured person were to stay in the private ward of a hospital. In the event of underinsurance, the conditions set out in Section 7 of these Supplementary Insurance Conditions (ZVB) apply.

3.5 The insurer keeps a list of those hospitals which have no private, semi-private o general wards within the meaning of the conditions above. The insurer updates this list continuously. It can be inspected at the insurer's offices, or a copy can be requested.

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4 Need for hospital treatment

Benefits for scientifically recognised medical treatment during a hospital stay will be provided if the condition of the insured person requires inpatient treatment, and for the hospital or hospital ward in which the insured person belongs for medical reasons.

5 Hospital benefits

5.1 An acute care hospital or a psychiatric clinic is deemed to be a hospital if it fulfils the requirements according to Section 3.1 and if it appears appropriate to treat insured persons as described in Section 4 of these Supplementary Insurance Conditions.

5.2 In the event of hospital treatment, the following comprise the benefits within the limits of the rates recognised by the insurer for the relevant hospital:

a) the costs of accommodation and meals
b) doctors' fees
c) the costs of scientifically recognised diagnostic and therapeutic procedures
d) nursing care in the hospital
e) the costs of medicine, treatment materials, the operating room and anaesthesia
f) the costs of materials and supplies prescribed by the hospital

5.3 Benefits for dental treatment under Section 5.2 are paid by the supplementary hospital insurance, to the extent that a payment obligation exists under the KVG.

5.4 For benefits relating to inpatient acute and transitional care that are required following a hospital stay and are prescribed by the hospital, the insurer, in addition to its obligations to provide benefits under the KVG, shall reimburse the uncovered costs for accommodation and meals on a per diem basis for up to 14 days per calendar year:

a) HOSPITAL PLUS BONUS up to CHF 120
b) HOSPITAL COMFORT BONUS up to CHF 180

6 Outpatient operations

If a procedure can be performed at a more favourable cost on an outpatient basis and a hospital stay can be avoided, the insurer will pay the costs within the scope of the agreements made with the relevant hospital.

7 Benefits in the event of underinsurance

7.1 Persons who are insured with the insurer for a semi-private hospital ward will be provided 75% of the benefits of HOSPITAL COMFORT BONUS if they stay in a private ward, up to a maximum of 75% of the rates recognised by the insurer for the relevant hospital.

7.2 The insurer keeps a list of those hospitals whose rates have not been approved. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested.

8 Duration of benefits in acute care hospitals and psychiatric clinics

8.1 In the event of inpatient treatment in an acute care hospital, insured benefits will be paid without time limit so long as, in view of the diagnosis and the medical treatment as a whole, a stay in an acute care hospital is medically necessary.

8.2 In the event of inpatient treatment in a psychiatric clinic, insured benefits will be paid for a maximum of 90 days within a 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.

8.3 In the event of stays in psychiatric daytime and overnight clinics, no benefits will be paid.

9 Benefits abroad

9.1 In the event of an inpatient stay in an acute care hospital or psychiatric clinic abroad, the following benefits will be paid toward the costs of scientifically recognised and appropriate medical treatment and for accommodation and meals during a maximum of 60 days per calendar year:

a) HOSPITAL PLUS BONUS up to CHF 1,000 per day
b) HOSPITAL COMFORT BONUS up to CHF 1,500 per day

9.2 If an insured person with HOSPITAL COMFORT BONUS insurance cover becomes ill or has an accident during a temporary stay abroad of not more than 12 months, full cost cover exists for a maximum of 60 days per calendar year to the extent that return travel to Switzerland is not reasonable.

9.3 Claims for benefits according to Section 9.2 only exist for treatment in the country in which the insured person had to be brought for initial treatment in an acute care hospital or psychiatric clinic because of an illness or accident. No benefits are paid for relocation to, or treatment in, a third country.

10 Benefits for newborn children

The costs of a healthy newborn baby's stay in hospital will be paid from the mother's supplementary hospital insurance with the insurer during the period of the mother's stay in hospital, at most, however, for a period of 10 weeks.

11 Balneotherapy

11.1 If inpatient balneotherapy in a medically supervised spa in Switzerland has been medically prescribed before the treatment begins, the following benefits will be paid in respect of the proven costs for a maximum of 30 days per calendar year:
a) HOSPITAL PLUS BONUS up to CHF 60
b) HOSPITAL COMFORT BONUS up to CHF 90

11.2 Entitlement to the benefits under Section 11.1 only exists if the course of balneotherapy was preceded by intensive, scientifically recognised and appropriate treatment, or if scientifically recognised and appropriate therapy on an outpatient basis 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.

11.3 Section 11.1 notwithstanding, balneotherapy can also be performed in a therapeutic spa located elsewhere in Europe, if the requirements of Section 11.2 are fulfilled.

12 Convalescent therapy

12.1 In the event of convalescent therapy carried out in Switzerland, which is medically prescribed before the beginning of the convalescent therapy and which is necessary for recovery from a serious illness, the following benefits will be paid per day in respect of the proven costs for a maximum of 30 days per calendar year:
a) HOSPITAL PLUS BONUS up to CHF 60
b) HOSPITAL COMFORT BONUS up to CHF 90

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

13 Duration of benefits for balneotherapy and convalescent therapy

Benefits for balneotherapy and convalescent therapy will be paid for a combined maximum of 30 days per calendar year.

14 Treatment prescription

The insurer must receive the medical prescription for a balneotherapy or convalescent therapy reasonably in advance of the beginning of the treatment. The prescription must state the name of the relevant therapeutic spa or convalescent facility, and the date on which the treatment begins.

15 Home nursing

15.1 In the event of medically prescribed home nursing care that requires the paid services of a professional nursing care provider, and if such home nursing care can help avoid or shorten a hospital stay or stay in a convalescent facility, the following benefits will be paid per day in respect of the proven costs for a maximum of 30 days per calendar year:
a) HOSPITAL PLUS BONUS up to CHF 60
b) HOSPITAL COMFORT BONUS up to CHF 90

15.2 Any person who provides the required nursing services to the patient on a daily basis and thereby suffers demonstrable loss of income from their profession or employment, can be recognised as a nursing care provider for the purposes of these benefits.

15.3 If a person under the age of 15 insured under this insurance becomes ill or has an accident, and such child is under the care of a single working-parent, or a married couple or cohabiting partners who both go out to work the insurer will, instead of the benefits under Section 15.1 toward the costs of the child supervision and child care, that means the physical hygiene, giving of medication, as well as the preparation of meals, pay the following benefits:
a) HOSPITAL PLUS BONUS up to 60 hours per calendar year
b) HOSPITAL COMFORT BONUS up to 90 hours per calendar year

15.4 Payment of benefits in accordance with Section 15.3 is subject to the arrangements for such care being organised through the emergency and organisation centre appointed by the insurer. The benefits will not be provided if such care is not organised through this centre.

15.5 The costs of general housework such as shopping, washing and ironing, cleaning etc. are not insured.

15.6 In the event of a stay in a nursing home or similar institution, no benefits for home nursing will be paid.

16 Household help

16.1 If an insured person requires household help services, on the basis of a medical prescription in the event of 100% incapacity to work due to their health condition and personal family circumstances, and if a hospital stay or stay in a convalescent facility can thereby be avoided or shortened, the following benefits will be paid per day in respect of the proven costs for a maximum of 30 days per calendar year:

a) HOSPITAL PLUS BONUS up to CHF 60
b) HOSPITAL COMFORT BONUS up to CHF 90

16.2 A household help provider is anyone who looks after the household on behalf of the insured person, whether this is an independent professional help provider or one who works for an organisation.

16.3 Any person who acts on behalf of the ill insured person to maintain their household and thereby suffers demonstrable loss of income from their profession or employment can be recognised as a household help provider for the purposes of these benefits.

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

17 Duration of benefits for home nursing and household help

The insured daily benefits for home nursing care and household help are provided for a combined maximum of 30 days per calendar year.

Insurance Plan Options

18 Insurance plan with second opinion

18.1 For a reduced premium, the insurance plan with a second-opinion option can be concluded. Insured persons with this insurance plan are required to contact the insurer's confidential medical service before any of the operations listed in Section 18.4 in order that the medical necessity of an operation can be evaluated by another doctor. The costs of this examination are charged to the insurer.

18.2 The insured person is free to decide whether to follow the opinion of the second doctor.

18.3 If the insured person refuses to get the second opinion, they will bear 10% of the costs charged to their supplementary hospital insurance for this operation, up to a maximum of CHF 3,000.

18.4 Operations requiring second opinions are:

a) Curettage of the uterus
b) Hysterectomy (removal of the uterus)
c) Removal of bunions (hallux valgus operation)
d) Hip and knee replacement surgery (insertion of artificial joints)
e) Arthroscopy
f) Implantation of artificial ligaments on the knee or ankle joints
g) Removal of osteosynthesis material (removal of metal parts after bone operations)
h) Discus hernia operations (operations on intervertebral disks)
i) Coronarangiography (x-ray of coronary blood vessels)
k) Prostatectomy (removal of the prostate)
l) Tonsillectomy
m) Cholecystectomy (removal of the gallbladder)
n) Varicose vein operations
o) Spondylosyndesis (stiffening operation on the spinal column)

19 Insurance plan with limited choice of hospitals

19.1 For a reduced premium, the insurance plan with a limited choice of hospitals can be concluded. 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.

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

19.3 This insurance plan can be taken out with a compulsory health care insurance with limited choice of hospitals. If the health care insurance is cancelled or suspended, this insurance plan is discontinued. In this case, an automatic transfer to 'HOSPITAL BONUS without limited choice of hospitals' will take place.

20 Insurance plan with extended choice of hospitals

20.1 For an additional premium, the insurance plan with extended choice of hospitals can be concluded. In this insurance plan, the insurer also covers the costs for those hospitals which do not fulfil the requirements according to Section 3.1. In this case, the maximum rates recognised by the insurer for the relevant hospital are applied.

20.2 The insurer keeps a list of those hospitals whose rates have not been approved. This list is continuously updated and can be examined at the insurer's offices, or a copy can be requested.

21 Insurance plan with selectable annual deductible

21.1 For a reduced premium, the insurance plan with selectable annual deductible can be concluded. Insured persons with this insurance plan are required to pay in advance the chosen deductible per year in the event of a claim under the HOSPITAL BONUS. The selected annual deductible is charged only in the event of stays in acute care hospitals and psychiatric clinics.

21.2 If insured persons with HOSPITAL PLUS BONUS with a selectable annual deductible of CHF 1,000, 2,000 or 3,000 at the time of their hospitalisation admit themselves to a general hospital ward, then payment of the annual deductible will be waived. The same applies if insured persons with HOSPITAL COMFORT BONUS with one of these annual deductibles at the time of their hospitalisation admit themselves to a semi-private hospital ward or a general hospital ward.

21.3 If persons insured with HOSPITAL PLUS BONUS with a selected annual deductible of CHF 5,000 or 7,000 at the time of their hospitalisation admit themselves to a general hospital ward, then an annual deductible of CHF 2,000 or 4,000, respectively, will be charged. The same applies if insured persons with HOSPITAL COMFORT BONUS with one of these annual deductibles at the time of their hospitalisation admit themselves to a semi-private hospital ward or a general hospital ward.

22 Accident cover

Insurance cover for the consequences of accidents can be excluded. Insured persons who have excluded this insurance cover can make a request to have it included or reinstated up to completion of their 70th year of age.

23 Special condition for special types of insurance

For insured persons who have obtained other special forms of insurance under compulsory health care insurance pursuant to the KVG (e.g. HMOs, other general practitioner models or insurance models with limited choice of service providers), the limiting conditions for a benefits claim set forth in the relevant General Insurance Conditions apply to this insurance as well.

Miscellaneous

24 Bonus system

If, in accordance with Section 25 of these ZVB, no benefits are claimed for hospital or outpatient treatment within two observation periods, this results in a premium reduction.

25 Premiums

25.1 The initial premium in the bonus system is the current premium fixed on 1 January of an insurance year based on the age of the insured person and any selected insurance plan option with premium reductions or supplemental premiums.

25.2 If an insured person has not claimed any benefits during two observation periods, each lasting from 1 July through the following 30 June, with effect from 1 January of the third year they receive the benefit of a premium reduction (bonus), to the extent that the insured person is not already at the lowest bonus level as follows:

	Bonus as a percentage of the initial premium	Bonus level
Basic level	0%	4
after one observation period with no benefits claimed (second year)	0%	3
after two observation periods with no benefits claimed (third year)	10%	2
after three observation periods with no benefits claimed (fourth year)	15%	1
after four and more observation periods with no benefits claimed (from fifth year)	20%	0

25.3 If an insured person has claimed benefits during the course of an observation period, the premium increases with effect from 1 January of the following year to the level of the initial premium under Section 25.1. Each treatment date is considered a claim for benefits.

25.4 If benefits were claimed in the previous qualifying period, the insured person shall be informed in writing about it and has the possibility up to 30 September to reinstate the lost bonus through repayment of the benefits paid by the insurer.

25.5 To make a valid claim for benefits under the supplementary hospital insurance, the invoices for the expenses claimed must be delivered to the insurer within 30 days after they were received. If they are delivered late, this results in a retroactive correction of the bonus level. Any premium reduction improperly granted to the insured persons will be offset against any of the insurer's benefits or reclaimed.

26 Option on CURA Long-Term Care Insurance

26.1 On 1 January following the attainment of official AHV retirement age, and without the need for a health examination, the insured person with HOSPITAL BONUS has the right to be automatically provided with CURA Long-term Care Insurance variant 30, with a waiting period of 720 days, in the variant offered by the company at the time in which the option is exercised. This insurance will be provided as follows:

a) HOSPITAL PLUS BONUS variant 60
b) HOSPITAL COMFORT BONUS variant 90

26.2 For insured persons under Section 26.1, the obligation to pay benefits under CURA Long-term Care Insurance begins after 720 consecutive days on which the prerequisites for inpatient treatment for chronic illness, home nursing and household help have been met. For the calculation of the waiting period, the doctor's prescription is authoritative.

26.3 After the issuance of CURA Long-term Care Insurance, insured persons under Section 26.1 have the right until 31 January to withdraw from the CURA Long-term Care Insurance retroactively to the 1st of January of that year, by way of derogation from the general conditions for giving notice of termination according to Section 10 of the General Insurance Conditions (AVB).

27 Suspension of the insurance cover

27.1 In return for a reduction in premium the policyholder can suspend the claim for benefits arising from HOSPITAL Supplementary Hospital Insurance 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.

27.2 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.

28 Insurance card

Insured persons are provided with an insurance card in accordance with Section 28 AVB.