p-care PRIVATE by Hirslanden

Supplementary insurance for outpatient treatment and inpatient treatment
in a single room, private ward

Supplementary terms
Sanitas Corporate Private Care

January 2005 edition (amended 2015)

sanitas

Purpose and basis

p-care PRIVATE by Hirslanden is a product offered by Sanitas in collaboration with the Hirslanden group of private hospitals and its partner hospitals. An additional range of services is available under Hirslanden Healthline. Insured persons should apply direct for detailed information.

p-care PRIVATE by Hirslanden will cover costs according to the following provisions. The insurance pays costs that exceed the benefits paid under mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal) and other social insurance pursuant to point 2 of the General Terms of Insurance.

The risk of accident cannot be excluded for the benefits specified in point 1 of these Supplementary Terms. For the benefits specified in point 2 of these Supplementary Terms, coverage for the risk of accident can be included.

The basis of these Supplementary Terms is the January 2005 edition of the General Terms of Insurance for supplementary insurance plans pursuant to the Swiss Federal Act on Insurance Contracts (VVG/LCA).

This translation is provided for the sake of convenience. The wording of the German original shall take precedence.

1 Benefits for outpatient care

1.1 Medical treatment throughout Switzerland

The insurance covers the costs of outpatient medical treatment outside the home or workplace in accordance with a recognised tariff, provided that the treatment is administered by doctors who are accredited in accordance with the Swiss Federal Health Insurance Act (KVG/LAMal) and who bill in accordance with KVG/LAMal (tariff protection as per Art. 44 KVG/LAMal).

1.2 Emergency outpatient treatment outside Switzerland

The insurance covers the full costs of treatment received while temporarily abroad, minus the chosen deductible for mandatory basic health insurance pursuant to the Swiss Federal Health Insurance Act (KVG/LAMal) and the statutory copayment/coinsurance.

1.3 Alternative medicine

The insurance covers 80% of the costs (of examinations, therapies and drugs/medication), up to a maximum of CHF 5,000 (a maximum of CHF 1,000 for inpatient treatment) per calendar year, of treatment administered in accordance with complementary medical methods by

- medical doctors
- pharmacists with the relevant additional training
- naturopathic doctors accredited by a canton
- NVS (full member) and FSPN naturopaths and natural health practitioners

Benefits will also be paid up to the stipulated amounts for treatment administered on medical prescription by other therapists with the relevant training.

1.4 Psychotherapy

The insurance covers 80% of the costs, up to a maximum of CHF 500 per calendar year, of medically prescribed psychotherapy conducted by independent psychotherapists.

1.5 Drugs/medication

The insurance provides worldwide coverage of 90% of the costs of medically prescribed, uninsured drugs, provided that the drug in question is registered with Swissmedic (the Swiss Agency for Therapeutic Products) for the indication in question.

Sanitas has a list of drugs that are not covered. This list is updated on an ongoing basis; it is available for inspection at Sanitas, and excerpts from the list can be furnished on request.

Alternative medical drugs that are insured as per 1.3 above are not covered under this provision.

1.6 Maternity

The mother's insurance covers 80% of the costs of the following maternity care, up to a maximum of CHF 1,000 per calendar year:

- Checkups during pregnancy (including 1 ultrasound scan)
- Pre- and postnatal exercise, and prenatal classes
- Milk substitute for a child under the age of two who can not tolerate mothers' milk, provided that this is medically prescribed and that the child also has this insurance.

1.7 Preventive/prophylactic treatment

The insurance covers 80% of the costs of the following preventive and prophylactic measures, up to a maximum of CHF 1,000 per calendar year:

- Vaccinations
- Checkups, 80% up to a maximum of CHF 500 per calendar year (including 1 HIV test per calendar year)
- Gynaecological checkups (including 1 mammogram per calendar year)
- Vasectomy or sterilisation
- Treatment for chronic back pain administered by certified physiotherapists on medical prescription
- Medically prescribed stop smoking treatment

1.8 Glasses or contact lenses

The insurance provides worldwide coverage for the following benefits for glasses (including frames) or contact lenses necessary for the correction of vision:

- Up to a maximum of CHF 300 every 3 calendar years for adults
- Up to a maximum of CHF 200 per calendar year for children under age 18

1.9 Dental treatment

The insurance pays the following benefits for dental treatment:

- 75% of the costs of orthodontic treatment for people under age 20
- Up to a maximum of CHF 100 per tooth for the removal of wisdom teeth
- The costs of drugs prescribed by a dentist

1.10 Medical aids

The insurance covers 80% of the costs of hiring or purchasing medically prescribed medical aids (except glasses and contact lenses), up to a maximum of CHF 500 per calendar year.

1.11 Cosmetic interventions

The insurance covers 80% of the costs of the following cosmetic interventions provided that they are medically prescribed:

- Breast operations
- Scar correction
- Operations to correct protruding ears (otoplasty)

Outpatient treatment will be covered in accordance with the KVG/LAMal tariff.

The costs of inpatient treatment will be covered up to a maximum of the tariff for the general ward of an acute hospital in the canton of residence with a cantonal mandate as per Art. 39 KVG/LAMal. In the case of cross-border commuters, the canton in which the employer is based applies.

1.12 Rooming in

The insurance covers 80% of the following hospital accommodation costs, up to a maximum of CHF 2,000 per calendar year:

- The costs of hospital accommodation for a parent accompanying a child under the age of 5 undergoing inpatient treatment; paid via the child's insurance
- The costs of hospital accommodation for a nursing infant accompanying a mother undergoing inpatient treatment; paid via the mother's insurance

2 Benefits for inpatient care

2.1 Definitions

Acute hospitals are defined as treatment facilities and clinics that are directed and overseen by medical doctors and admit only persons suffering from acute illnesses or accidents. For the present purposes acute hospitals also include maternity, psychiatric and rehabilitation clinics.

Health spas, old-people's homes, nursing homes, chronic care facilities and other facilities not intended for acute care are not defined as acute hospitals for the present purposes.

Inpatient hospitalisation is defined as a stay of at least 24 hours.

Acute treatment or acute care is defined as treatment whereby an improvement in the person's state of health can be expected.

2.2 Hospitalisation in Switzerland

The insurance covers the accommodation and nursing care costs of inpatient acute care in a single room at a Hirslanden private hospital or one of its partner hospitals. Medical treatment is to be conducted by a doctor accredited for the p-care by Hirslanden plan. A corresponding list of hospitals and doctors is available from Sanitas and from the Hirslanden private group of hospitals via the Healthline.

If an acute treatment (elective intervention) is not carried out by the care providers mentioned above, the annual deductible specified in the policy shall apply. The insurance covers a single room in a private ward. In hospitals that do not appear on the cantonal list, mandatory basic health insurance benefits will also be covered.

In an emergency, the costs of a private ward at the nearest suitable hospital will be covered. The annual deductible will not be applied.

2.3 Emergency hospitalisation outside Switzerland

The insurance covers the costs of treatment and accommodation in a private ward (single room) during a temporary stay abroad of up to 12 months. Benefits are paid for a maximum of 180 days in hospital.

2.4 Hospitalisation abroad for planned treatments

In the event of planned acute inpatient treatments abroad, a maximum of CHF 1,500 per day will be paid towards accommodation, nursing care and treatment costs for a maximum of 180 days in hospital in any 360 consecutive days (subject to the agreement of Sanitas). The annual deductible stated in the policy will be applied.

2.5 Psychiatric clinics

The costs of acute inpatient treatment in a psychiatric clinic or special psychiatric ward will be paid in accordance with 2.2 above for a period of 180 days.

From the 181st day the treatment costs and a maximum of CHF 150 per day towards the costs of accommodation and nursing care will be paid. At AHV/AVS retirement age these benefits will continue to be paid up to a maximum of 720 days within a period of 900 days.

In psychiatric clinics or special psychiatric wards without a cantonal mandate, the costs that would have been paid by mandatory health insurance for a hospital with a cantonal mandate are paid from the 181st day for up to a total of 540 days, in addition to the benefits set out in paragraph 2.2 above.

Hospitalisation in psychiatric clinics abroad within the scope of 2.3 and 2.4 is included in the benefit period.

2.6 Nursing homes and chronic care facilities

The following benefits are paid in the event of hospitalisation in a nursing home or chronic care facility:

- Up to the 180th day: CHF 150 per day towards the costs of accommodation and nursing care, plus the costs of treatment
- 181st to 540th day: CHF 80 per day towards the costs of accommodation and nursing care, plus the costs of treatment

Thereafter no further benefits will be paid.

2.7 Benefits for new-born infants

Provided it is hospitalised with its mother, the costs of hospitalisation for a healthy infant will be paid from the mother's insurance coverage.

2.8 Exceptional out-of-pocket expenses

Sanitas will pay a maximum of CHF 200 per hospitalisation for exceptional out-of-pocket expenses incurred directly in connection with inpatient hospitalisation (taxi fares to and from hospital, telephone calls, etc.), provided that receipts are supplied.

2.9 Care at home

The following benefits will be paid on the basis of detailed date-referenced invoices towards the costs of care at home if this care is necessary on medical grounds and prescribed by a doctor:

- up to the following amounts for 90 days per calendar year:
  CHF 70 per day towards the costs of care at home provided by qualified nurses or nursing auxiliaries
- CHF 70 per day towards the costs of care at home provided by other persons who can prove loss of earnings to this extent due to providing care. This includes relatives and persons who live with insured persons in the same household who can prove loss of earnings to this extent due to providing care.

In the event of childbirth, the abovementioned benefits will be paid for a maximum of 14 days within one month after the birth, and included in the maximum benefit period.

In total, a maximum of CHF 7,000 per calendar year will be paid towards the costs of care at home.

2.10 Domestic help

If necessary on medical grounds and prescribed by a doctor, the following benefits will be paid on the basis of detailed date-referenced invoices for domestic help:

- CHF 25 per hour for domestic help provided by a person not living in the same household. The insured person running the household is entitled to this benefit immediately following hospitalisation or during outpatient treatment if hospitalisation can be avoided.
- In the event of childbirth, the abovementioned benefits will be paid for a maximum of 14 days within one month after the birth, and included in the maximum benefit period.

In total, a maximum of CHF 1,000 per calendar year will be paid towards the costs of domestic help.

2.11 Spa therapies

Benefits of up to the following amounts will be paid towards the cost of spa therapies:

- CHF 200 (for spa therapies where the mandatory KVG/LAMal insurance pays a contribution) per day for a maximum of 21 days per calendar year for inpatient spa therapies (following serious illness or immediately after major operations). In addition, for spa therapies in Switzerland, 90% of the costs of doctors and drugs and medically necessary, medically prescribed treatments will be paid.
- CHF 200 per day for a maximum of 28 days per calendar year for spa therapies at the Dead Sea in Israel or Jordan to treat psoriasis or vitiligo (loss of skin pigmentation)

Sanitas has the right to request an examination by a company-appointed medical doctor before the spa therapy may be undertaken.

The abovementioned benefits will be paid for a maximum of one spa therapy per calendar year.

2.12 Transport, rescue and search costs

In total, a maximum of CHF 20,000 will be paid per calendar year for:

- The costs of travel in connection with radiotherapy, chemotherapy or haemodialysis conducted outside the home; even if the insured person travels by car, the costs paid will not exceed the costs of public transport (travelling first class)
- Emergency transport to the nearest doctor or to the nearest hospital able to deliver appropriate treatment, and ambulances required for transport on medical grounds
- Rescue and search operations for persons who have had an accident or contracted an acute illness

3 Miscellaneous

3.1 Obligations and qualifications for benefits

The benefits insured in the event of hospitalisation will be paid provided that acute hospital care is medically indicated.

In the event of emergencies, Sanitas must be notified within three days.

If a commitment to provide cover is required by another care provider, Sanitas must be notified two weeks before admission.

Benefits will be paid for spa therapies only if:

- The spa therapies are medically necessary and have been prescribed as part of medical treatment by a doctor accredited in Switzerland
- Sanitas receives the prescription for the spa therapy two weeks before commencement

Moreover, benefits for spa therapies will be paid only provided that outpatient treatment is inappropriate and unlikely to be effective and that the spa therapy involves therapeutic measures.

3.2 Benefit exclusions

In addition to the benefit exclusions specified in point 7 of the General Terms of Insurance, no benefits will be paid for treatments (e.g. organ transplants) for which the SVK (Schweizerischer Verband für Gemeinschaftsausgaben der Krankenversicherer) has agreed per case, all-inclusive payment arrangements for coverage by mandatory KVG/LAMal insurance.

3.3 Recognition of care providers

For treatments in Switzerland, only invoices issued by persons with a federal or cantonal diploma or the corresponding cantonal professional licence will be accepted.

3.4 No-claims bonus

General

If an insured person has no benefits paid out during a specific twelve-month observation period, Sanitas grants them a percentage discount on their premium for the following calendar year.

The discount applies to the gross premium. If an elective deductible has been agreed, the discount applies to the net premium (i.e. the premium after deduction of the discount for the chosen annual deductible).

An observation period runs from September 1 to August 31 of the following year. Benefits paid out during this observation period (as per the date of the claim settlement advice from Sanitas) apply for the purposes of the no-claims bonus.

If insurance commences in the period from January 1 to August 1, the first observation period runs from the commencement of insurance until August 31 of the same year.

If insurance commences in the period from September 1 to December 1, the first observation period runs from the commencement of insurance until August 31 of the following year.

If an insured person transfers to the p-care COMFORT by Hirslanden or p-care ROYAL by Hirslanden category, their existing bonus bracket is also transferred.

Bonus brackets

Each bracket represents a 3% discount on the premium. An insured person starting in bracket 0 could potentially achieve the maximum percentage discount of 24% in the ninth calendar year.

Bonus	Calendar year	Discount (in %)	Premium as per centage of gross premium
0	1	0	100
1	2	3	97
2	3	6	94
3	4	9	91
4	5	12	88
5	6	15	85
6	7	18	82
7	8	21	79
8	9	24	76
9	10	24	76
10	11	24	76
11	12	24	76
11	13 & following	24	76

Loss of no-claims bonus

If a claim is paid out during a particular observation period, the no-claims bonus (discount) for the following calendar year will be reduced by 4 brackets (12%), but not below bracket 0.

If benefits totalling more than CHF 20,000 are paid out during the observation period, the discount for the following calendar year will be reduced to bracket 0 regardless of the bracket the insured person was in.

3.5 Elective deductible

If the insured person chooses an elective deductible, the amount of the chosen deductible will be applied to the total benefits for a given calendar year.

If the contract commences from January 1 up to and including June 1, the full annual deductible will be applied; if the contract commences from July 1 up to and including December 1, half the annual deductible will be applied.

If a treatment goes on for more than ten days beyond the end of the year, the annual deductible must be paid again for the new year.

3.6 Transfers to p-care

Subject to the following conditions, the insured person can transfer to the p-care product line with effect from the end of the year:

- to p-care BASIC, p-care COMFORT and p-care PRIVATE without a medical examination

Sanitas must receive written notification of a transfer to p-care by November 30 at the latest.

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