HOSPITA

SUPPLEMENTARY CONDITIONS (SC) UNDER THE FEDERAL INSURANCE CONTRACT ACT (VVG).

Version of 2024, valid from 1 January 2024

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CUSTOMER INFORMATION

We wish to point out some contractual bases that are particularly important before you sign a contract.

The insurance contract is based on the documents according to the customer information in the General Insurance Conditions (separate document).

Look out for this symbol in the Supplementary Conditions below: !

Please ask someone to explain the marked text passages before you sign the contract. We use the symbol to emphasise the following:

- Who can take out insurance?
- What does the insurance cover and what does it exclude?
- What are the policyholder's obligations?
- When is an insured person entitled to benefits?

HOSPITA
HOSPITALISATION INSURANCE.

I. SCOPE OF APPLICATION

ART. 1 ❗ PURPOSE

SWICA Insurances Ltd, hereinafter referred to as "SWICA", covers supplementary benefits for inpatient hospital treatment as well as outpatient surgical procedures and interventions, in addition to benefits from the mandatory healthcare insurance (in accordance with the KVG, SR 832.10), under its HOSPITA hospitalisation insurance. SWICA maintains a hospital register that lists all the hospitals it recognises by insurance category (see Art. 3). For hospitals without a rate agreement with SWICA, the maximum rate[1] that SWICA specifies applies. The extent of participation is reviewed during the request for a cover note.
The hospital directory mentioned in these insurance conditions is available digitally, updated continuously and accessible at any time. Policyholders can ask SWICA Customer Services for extracts thereof at any time.
In addition, this supplementary insurance covers further benefits in accordance with the selected insurance category.

ART. 2 POLICYHOLDER

❗ Anyone who has a legal place of residence in Switzerland can apply for this supplementary insurance.

II. SCOPE OF INSURANCE

ART. 3 CHOICE OF INSURANCE CATEGORY

SWICA covers the costs of services if they are efficacious, purposeful and cost-effective.
The choice of insurance category includes:

Category 1 HOSPITA GENERAL: General ward in SWICA-recognised hospitals in Switzerland and the Principality of Liechtenstein. This category can be concluded with a guarantee that offers increased insurance in the semi-private or private hospital ward without a medical examination.

Category 2 HOSPITA SEMI-PRIVATE: Semi-private ward in SWICA-recognised hospitals in Switzerland and the Principality of Liechtenstein (list hospitals and contract hospitals) with a rate agreement. At hospitals without a rate agreement with SWICA, the maximum rate that SWICA specifies (recognised rate) applies.

Category 3 HOSPITA SEMI-PRIVATE LIST: Semi-private ward in hospitals in Switzerland and the Principality of Liechtenstein as indicated in SWICA's hospital directory.

Category 4 HOSPITA PRIVATE: Private ward in SWICA-recognised hospitals in Switzerland and the Principality of Liechtenstein (list hospitals and contract hospitals) with a rate agreement. At hospitals without a rate agreement with SWICA, the maximum rate that SWICA specifies (standard private rate) applies.

[1] The maximum rate is calculated based on the averages of the rate agreements between SWICA and comparable hospitals or the most recent rate with the hospital in question, whereby the lower of the two rates is used. The maximum rate is calculated separately for each hospital category.

Category 5 HOSPITA PRIVATE LIST: Private ward in hospitals in Switzerland and the Principality of Liechtenstein as indicated in SWICA's hospital directory.

Category 6 HOSPITA PRIVATE WORLDWIDE: Private ward in all public and private hospitals worldwide. In the absence of a contractual agreement, the maximum rate (standard rate for private patients) applies in Switzerland and the Principality of Liechtenstein.

Category 7 HOSPITA COMFORTA – two-bed room in all SWICA-recognised hospitals in Switzerland as indicated in SWICA's hospital directory.

Category 8 HOSPITA COMFORTA – one-bed room in all SWICA-recognised hospitals in Switzerland as indicated in SWICA's hospital directory.

ART. 4 GUARANTEE FOR CATEGORY CHANGE

1. Taking out a HOSPITA GENERAL plan, incl. guarantee for category change (= HOSPITA PLUS) makes it possible to change to a HOSPITA SEMI-PRIVATE or HOSPITA PRIVATE plan without a medical examination.
2. The guarantee for category change can be concluded as one of the two options below:
   a) Change from HOSPITA GENERAL to HOSPITA SEMI-PRIVATE (choice of category 2 or 3)
   b) Change from HOSPITA GENERAL to HOSPITA PRIVATE (choice of category 4 or 5)
3. A HOSPITA PLUS plan can be taken out until the end of the calendar year in which the person reaches the age of 18.
4. The HOSPITA PLUS category change guarantee can be included with HOSPITA GENERAL if the insured person passes a medical examination.
5. The change to the higher category is possible until the end of the calendar year in which the person reaches the age of 40. The change guarantee expires unless it is used by this date.
6. A change is possible on the following first calendar day of a month or by agreement.
7. ! A twelve-month qualifying period applies to all benefits after the change to the insured higher category. During this period, treatment in the general ward is covered.

ART. 5 ! CO-PAYMENT OPTIONS

1. For categories 1–6, the policyholder can select special co-payment models with an excess amount per calendar year:
   - 1,000 francs
   - 2,000 francs
   - 5,000 francs
2. Persons covered under HOSPITA SEMI-PRIVATE (categories 2 and 3) can also choose co-payment models with a 300 francs deductible per hospital day, up to 6,000 francs per calendar year.
3. Insured persons with HOSPITA PRIVATE cover (categories 4 and 5) can also choose co-payment models with a 300 francs deductible per day in hospital up to 6,000 francs per calendar year for treatment in a semi-private ward and 400 francs per day in hospital up to 8,000 francs per calendar year for treatment in a private ward.
4. The premium is reduced in accordance with the selected co-payment model. Co-payments (excess and deductible) already paid for basic insurance or another SWICA supplementary insurance are factored into the calculation of the maximum annual co-payment of this supplementary insurance.
5. Requests to change to a lower co-payment are possible at the beginning of a calendar year, subject to a three-month adjustment period. For persons who undergo a medical examination, SWICA can agree to reduce the co-payment, exclude illnesses and the consequences of accidents that exist at the time of the co-payment reduction request, or reject the request.
6. In the case of maternity, a 360-day qualifying period applies when changing to a lower co-payment amount.
7. The medical examination for reducing the co-payment also applies simultaneously when reducing the insurance category. Exception: In the case of reduction to HOSPITA GENERAL (option without guarantee for category change), a medical examination is not required for reducing the co-payment.
8. The same terms apply to suspending co-payments as to reducing them.

ART. 6 SECOND MEDICAL OPINION

With insurance categories 3 and 5, the policyholder can ask SWICA for a second medical opinion before agreeing to a recommended surgical procedure.

III. BENEFITS

ART. 7 ENTITLEMENT TO BENEFITS IN CASE OF ILLNESS (INPATIENT HOSPITAL TREATMENT)

1. SWICA covers the stay and treatment costs during hospital stays in accordance with the selected insurance category.
2. SWICA covers the stay and treatment costs in the general ward (Category 1) of its recognised hospitals (as indicated in SWICA's hospital directory). Cover includes only benefits for inpatient treatment in other cantons, i.e. the portion exceeding the reference rate of the canton of residence for which mandatory cover applies, unless this portion is covered by mandatory insurance for medical reasons.
3. Benefit entitlement in categories 2 and 4 is contingent on a rate agreement being in effect between SWICA and the relevant service provider. These contractual rates cover the full cost of the services provided (as indicated in SWICA's directory of hospitals). In the absence of a contract with SWICA, cover is based on the maximum rate that SWICA defined or in accordance with Art. 9 for categories 2 and 3. If the service provider claims amounts that are higher than SWICA's recognised maximum rate, the policyholder must pay the difference between that rate and the amount on the service provider's invoice.
4. Categories 3 and 5 include benefits for the hospitals indicated in SWICA's hospital directory. Hospitals that do not have a contract with SWICA are not included in SWICA's hospital directory, and SWICA does not cover the costs of their services.
5. In category 6, the full hospital costs abroad are covered. In the absence of a contract with a hospital in Switzerland or the Principality of Liechtenstein, SWICA's maximum rate applies. If the service provider claims amounts that are higher than SWICA's recognised maximum rate (standard rate for private patients), the policyholder covers the difference between that rate and the amount on the service provider's invoice.
6. In the case of COMFORTA category 7 (two-bed room) and category 8 (one-bed room), the cost of accommodation and meals is covered based on SWICA's contract with these hospitals. The insurance does not cover doctor's fees and the cost of treatment and diagnoses. Hospitals that do not have a contract with SWICA are not included in SWICA's hospital directory, and SWICA does not cover the costs of their services.
7. Supplementary insurance does not cover additional costs incurred through treatment in other cantons for medical reasons.
8. For bone marrow and organ transplants, benefits are based on SWICA's recognised rate.

ART. 8 BENEFIT PERIOD

Unless stated otherwise in these insurance conditions, the HOSPITA plan provides benefits for an unlimited term.

ART. 9 CHOICE OF ANOTHER HOSPITAL WARD/ TREATMENT ABROAD

1. Choice of another hospital ward
   If a higher hospital category is chosen that differs from the insurance that was purchased, costs are paid supplementary to benefits from mandatory healthcare insurance.
   The following maximum amounts apply:

Category 1	up to 50 francs per day towards room and board and up to 5,000 francs per calendar year towards the cost of treatment
Categories 2 + 3	up to 100 francs per day towards room and board and up to 10,000 francs per calendar year towards the cost of treatment
Category 7	up to 100 francs per day towards room and board

   Any co-payments by the policyholder are deducted from the amounts mentioned above.
2. Hospital treatment abroad
   In the case of hospital stays abroad, the insurance covers the following benefits for inpatient treatment and outpatient treatment in accordance with Art. 10 no. 2, supplementary to mandatory healthcare insurance:

Category 1	up to 50 francs per day towards room and board and up to 5,000 francs per calendar year towards the cost of treatment
Categories 2 + 3	up to 100 francs per day towards room and board and up to 10,000 francs per calendar year towards the cost of treatment
Categories 4 + 5	up to 150 francs per day towards room and board and up to 30,000 francs per calendar year towards the cost of treatment
Category 6	full cost cover
Category 7	up to 100 francs per day towards room and board
Category 8	up to 150 francs per day towards room and board

   Any co-payments by the policyholder are deducted from the amounts mentioned above.

3. Co-payment
   If a privately or semi-privately insured person with a co-payment option under Art. 5 no. 2 and no. 3 chooses treatment in a general ward, the supplementary insurance deductible for treatment in the general ward ceases to apply. If a privately insured person with a co-payment option under Art. 5 no. 3 chooses treatment in the semi-private ward, the deductible is reduced to 300 francs per day, max. 6,000 francs per year.
4. Maximum benefit
   The amounts under Art. 9 nos. 1 and 2 cannot be cumulated and are the maximum per category for all benefit payments.

ART. 10 OUTPATIENT MEDICAL CENTRES (HOSPITALS, DAY CLINICS OR OUTPATIENT CLINICS WITH CORRESPONDING FACILITIES)

1. Benefit entitlement is contingent on a rate contract being in effect between SWICA and the relevant service provider. SWICA keeps a directory of the service providers it recognises.
2. SWICA keeps a list of procedures for which it covers the additional accommodation, treatment and ancillary costs that exceed amounts covered by mandatory health insurance.
3. Insured persons are not subject to co-payments for the costs that exceed statutory mandatory benefits.

ART. 11 SPECIAL CLINICS AND PSYCHIATRIC CLINICS

1. SWICA contributes as follows towards stays in psychiatric clinics or special wards for mentally ill patients in its recognised hospitals and in special clinics, rehabilitation centres, multi-purpose sanatoria, climate control wards, sleep clinics and sleep wards from its cover in categories 2 to 5, in addition to the healthcare insurance:

Day 1–180	Cover based on the insured hospital ward	
from day 181	Category 2 + 3	80 francs per day
	Category 4 + 5	150 francs per day

   In HOSPITA Category 6, no cost limit applies.
   In HOSPITA Categories 1, 7 + 8, no benefits are paid.
2. These benefits are paid for max. 720 days within 900 consecutive days.

ART. 12 MATERNITY

1. SWICA pays the same benefits for maternity as for illness. In addition, SWICA reimburses from the mother's insurance also the costs of the healthy child's stay and treatment following confinement, provided that the child is insured with SWICA and was in hospital together with the mother.
2. SWICA pays a maximum of 50 francs per night for the child's additional bed (for a child up to the age of six) for a maximum of 30 days per calendar year in the child's categories 2 to 6, provided that the mother is receiving medically indicated inpatient treatment and the child is still actively breastfeeding.
3. SWICA pays a maximum of 50 francs per night for the mother's additional bed for a maximum of 30 days per calendar year in the mother's categories 2 to 6, provided that the child (up to the age of six) is receiving medically indicated inpatient treatment and the mother is still actively breastfeeding the child.
4. Entitlement to benefits for maternity starts 360 days after the insurance begins.

ART. 13 MEDICAL SPA TREATMENT

1. In the case of spa treatments that are medically necessary, prescribed by a doctor, SWICA-approved in advance, and administered in a SWICA-recognised health spa in Switzerland or in special cases – upon request and with SWICA's prior approval – abroad, SWICA contributes as follows to the cost of the stay and the treatment for up to 30 days per calendar year:

Category 1	30 francs per day
Categories 2 + 3	60 francs per day
Categories 4 + 5	80 francs per day
Category 6	100 francs per day

   No benefits are paid from Categories 7 + 8.
2. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 14 CONVALESCENCE STAYS

1. For medically prescribed and justified convalescent stays that SWICA has approved in advance and a spa on SWICA's list administers, SWICA contributes as follows towards the cost of the stay for max. 30 days per calendar year:
   Category 1 — 15 francs per day
   Categories 2 + 3 — 30 francs per day
   Categories 4 + 5 — 40 francs per day
   Category 6 — 50 francs per day
   No additional benefits are paid from Categories 7 + 8.
2. The spa prescription must be submitted to SWICA at least 14 days before the treatment begins.

ART. 15 HOME NURSING CARE

1. SWICA contributes as follows towards the verified cost of care at the policyholder's own home:
   Category 1 — 30 francs per day
   Categories 2 + 3 — 60 francs per day
   Categories 4 + 5 — 80 francs per day
   Category 6 — 100 francs per day
   No benefits are paid from categories 7 + 8.
2. The policyholder's need for care must be verified in a medical certificate.
3. The contributions are also paid to family members or relatives if the help they provide results in a verifiable loss of earnings.
4. These benefits are paid for max. 720 days within 900 consecutive days.

ART. 16 HOME HELP

1. SWICA pays the following contributions towards the verified cost of necessary home help in the policyholder's own household for max. 60 days per calendar year:
   Category 1 — 15 francs per day
   Categories 2 + 3 — 30 francs per day
   Categories 4 + 5 — 40 francs per day
   Category 6 — 50 francs per day
   No benefits are paid from categories 7 + 8.
2. The need for home help must be verified in a medical certificate.
3. The contributions are also paid to family members or relatives if the help they provide results in a verifiable loss of earnings.

ART. 17 ORTHODONTIC SURGERY

1. For orthodontic surgery, SWICA assumes the costs that are not covered, up to 10,000 francs, based on the reference rate of the policyholder's canton of residence per calendar year.
2. For outpatient treatment, SWICA pays 50% of the costs that are not covered, up to 10,000 francs, based on the rate that applies under the KVG per calendar year.
3. No benefits are paid from Categories 7 + 8.

ART. 18 EMERGENCY TRANSPORTS AND TRANSFERS

SWICA covers up to 90% of the effective total cost (other benefit contributions are offset) of emergency transport or medically necessary transfers to the nearest doctor or hospital in Switzerland and abroad as follows:
Category 1 — 5,000 francs per calendar year
Categories 2–6 — unlimited
No benefits are paid from categories 7 + 8.

ART. 19 COST OF REPATRIATION AND OF SEARCH/RESCUE OPERATIONS

1. SWICA covers 90% of the repatriation cost from abroad to Switzerland and of the search/rescue cost for an insured person, subject to the following maximum contributions per event:
   Category 1 — 5,000 francs
   Categories 2–6 — 20,000 francs
   No additional benefits are paid from Categories 7 + 8.
2. Benefits are paid only if SWICA's emergency call centre was involved in the arrangements.
3. SWICA can reduce or refuse benefits if such operations are conducted without its authorisation.

IV. LISTS AND DIRECTORIES

ART. 20 LISTS AND DIRECTORIES

Art. 7 of the GIC applies in respect of the lists and directories referred to in these provisions.

V. PREMIUMS

ART. 21 CHOICE OF PREMIUM MODEL

SWICA sets premiums annually as a rate. The rate for the selected premium model is definitive. Policyholders of HOSPITA supplementary insurance can choose between the following models:

1. Premium rate model based on age at the time of enrolment
   If the policyholder chooses the rate model based on age at the time of enrolment, his age at that time serves as basis for calculating the premium.
2. Age-based premium model
   If the policyholder chooses the age-based premium model, the premium is adjusted regularly at the beginning of each calendar year whenever the age group changes. Notwithstanding the age-group distribution specified in Art. 17 GIC, the age groups are as follows: 0–18, 19–25, 26–30 and then in five-year increments up to the 71+ age group.
3. For policyholders included in the insurance at a special rate for children or young people, the next higher premium rate is calculated from the beginning of the insurance year following the year in which this person reaches the age of 18 or 25. Policyholders are assigned automatically to the age-based rate unless they expressly request the rate based on age at enrolment.
4. Policyholders can change from the age-based rate to the rate based on age at enrolment at the beginning of the next calendar year until they reach the age of 50, irrespective of their state of health, while keeping their current insurance cover. In this case, the time during which they have been insured so far is taken into account. Policyholders are automatically reassigned according to these rules when they reach the age of 50.
5. Policyholders can, in writing, waive the automatic reallocation from the age-based rate to the rate based on age at enrolment until they reach the age of 50 and request to continue the age-based rate. Policyholders who forgo this change cannot have the time they have been insured so far taken into account.

VI. GENERAL PROVISIONS

ART. 22 COORDINATION WITH OTHER INSURANCE PLANS

1. The benefits provided under these insurance conditions are paid only in addition to those from mandatory healthcare insurance and from COMPLETA TOP and COMPLETA FORTE with SWICA.
2. The percentage of the co-payment is applied in addition to other supplementary insurance cover and calculated separately for each SWICA insurance product.

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