groupemutuel

Special Terms and Conditions for Global GEM insurance

GGGA01-E3 – Edition: 01 Jun 2021 (with an addendum as of 01 Jan 2024)

Contents

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 the insurance

1. In relation to the framework agreement between the "Groupement des Entreprises Multinationales" (GEM) and the Insurer, the purpose of this insurance is to cover insured persons for specific supplemental benefits over and above the compulsory health insurance benefits (AOS/OKP) within the meaning of the Federal Law on Health Insurance (LAMal/KVG).
2. For persons who were subject to the compulsory health insurance (AOS/OKP) and who chose to maintain their insurance coverage in accordance with Article 7(a) of the Ordinance on Health Insurance (OAMal/KVV) by signing up to an optional health insurance pursuant to the Federal Law on Insurance Contracts (LCA/VVG), Global GEM benefits will be paid out in addition to the said insurance.
3. The insurance offers four levels of coverage:
   - Level 1 Light (outpatient treatments, hospitalisation in a general ward)
   - Level 1 (outpatient treatments, hospitalisation in a general ward, dental treatments)
   - Level 2 (outpatient treatments, hospitalisation in a semi-private ward, dental treatments)
   - Level 3 (outpatient treatments, hospitalisation in a private ward, dental treatments)

Art. 2 Risks covered

The benefits provide illness, accident and maternity coverage. The policyholder can exclude accident coverage.

Art. 3 Admission conditions

The framework agreement signed between GEM and the Insurer defines the circle of persons entitled to insurance and the admission conditions applicable to the different categories of applicants according to the level of coverage chosen by the insured person.

Art. 4 Special provisions

Derogating from Articles 7 and 8 of these special terms and conditions of insurance (CP), specific rules related to non-availability periods for maternity and dental treatments may apply to foreign or Swiss employees who are transferred or hired by their employer to work in Switzerland ("impatriates"), as well as to foreign or Swiss employees who are sent abroad by their employer ("expatriates"), including to their family members.

Art. 5 Continuation and termination of coverage in the event of a change of residence abroad

1. If the place of residence is transferred abroad during the term of the contract, Global GEM can be maintained without any increase in coverage, provided that the insured person remains subject to compulsory health insurance under LAMal/KVG, pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security agreements, or is covered pursuant to Art. 1, para. 2 of these special terms and conditions of insurance.
2. By way of derogation from Art. 14(d) CGC, no arrangement with the Insurer is required in this case.

3. The insured person residing abroad must notify the Insurer in writing within 30 days when he no longer complies with the criteria specified in Art. 5, para. 1 of these terms and conditions of insurance. In the event of a breach of this obligation, the insured person must reimburse to the Insurer any premiums paid as from the date on which the above criteria were no longer fulfilled.

Art. 6 Termination of the insurance contract

By way of derogation to Art. 13, para. (2) CGC, the insurance contract may be terminated by the insured person after three years of coverage and then on an annual basis, for the end of a calendar year with one month's advance notice, subject to the provisions set out in Article 11(8) of these special terms and conditions.

Art. 7 Insured benefits

1. In Switzerland

	Coverage	Description
Hospitalisation (including childbirth)	general ward (Level 1 Light and Level 1) semi-private ward (Level 2) private ward (Level 3)	– In Switzerland, free choice of hospital facility depending on the applicable coverage level, in general or psychiatric wards, for the treatment of acute conditions. – Reimbursement of treatments recognised under LAMal/KVG, of hospital boarding costs and of physician's fees in accordance with tariff agreements or cantonal regulations. – Hospitals must be recognised facilities within the meaning of LAMal/KVG (listed hospitals), or they must have concluded a tariff agreement with Groupe Mutuel Assurances GMA SA for the corresponding wards. – Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in any given calendar year. – The insured person shall check that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the Insurer.
Non-reimbursable drugs	90%	– Medication prescribed by a doctor or a healthcare provider recognised under LAMal/KVG, which is not reimbursed by compulsory health insurance (AOS/OKP). – Exclusions: drugs included on the list of pharmaceutical products for special application (LPPA/LPPV).
Alternative medicine	75%	– Reimbursement of the therapies listed below (item 7.3 - list of alternative medicine therapies) carried out by a qualified physician or a practitioner of natural therapies recognised by the Insurer. – Before each treatment, the insured person shall check that the attending practitioner is recognised by the Insurer for the relevant therapy.
Convalescence cures and thermal cures	90%, max. CHF 1,000/calendar year	– Treatment and board in case of convalescence cures and thermal cures in Switzerland in facilities recognised by the Insurer. – Subject to revocation of the entitlement to benefits, an application for authorisation along with the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
Medical glasses and contact lenses	– Children up to 18 years CHF 200 every year – Adults from 19 years of age, CHF 500 every five years	– Coverage of the costs of frames, lenses or contact lenses.
Surgical correction of vision	90%, max. CHF 800 every three years	– The contribution for surgical correction of vision is granted in addition to the costs of glasses or contact lenses.
Medical aids and appliances	90%, max. CHF 1,000/calendar year	– Coverage of the cost of purchasing and renting orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the Insurer's list.
Childbirth allowance	CHF 300	– Allowance paid irrespective of whether childbirth results in one or several births.
Childbirth preparation classes	CHF 150	– Painless childbirth preparation classes which are not covered by compulsory health insurance.
Vaccinations	90%, max. CHF 500/calendar year	– Reimbursement of medically prescribed vaccinations (not included in the Ordinance on Healthcare Insurance Benefits – OPAS/KLV) in Switzerland, and of any vaccinations recommended by the Federal Office of Public Health (FOPH) in the event of departure abroad.

	Coverage	Description
Transport and search and rescue costs	100%, unlimited (transport) 90%, max. CHF 75,000 /calendar year (search and rescue)	– Transport to the nearest hospital facility or physician provided such transport is medically necessary. – This contribution is only granted for transport by ambulance, by helicopter or for a search and rescue operation. Public transport costs (bus or train) in connection with outpatient treatment designed to avoid hospitalisation are also reimbursed.
Psychotherapy	90%, max. CHF 1,200/calendar year	– The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychologists.
Groupe Mutuel Assistance	As explained in the general terms and conditions of insurance of Groupe Mutuel Assistance.	– Coverage of benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured person's domicile). – By way of derogation from Article 21(c) of the general terms and conditions of Groupe Mutuel Assistance, coverage is not excluded for convalescence and ailments currently under treatment and not yet stabilised, relapses from illnesses identified previously and with a risk of serious deterioration.
Hospital accommodation for family member	90%, max. CHF 700/calendar year	– Coverage of the cost of hospital accommodation for one of the parents of the insured persons provided such cost is medically necessary.
Home help and placement costs	90%, max. CHF 3,000/calendar year	– The cost of home help hired from an official service to attend to the insured person's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning, etc.). – The cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Family members have to be placed with an official institution. – The insured person is required to obtain the Insurer's prior consent.
Voluntary sterilisation	90%, max. CHF 500	– Reimbursement of surgery costs.
Speech therapy	90%, max. CHF 500/calendar year	– Coverage of the cost of speech therapy treatments not recognised under LAMal/KVG but prescribed by a doctor and administered by a recognised speech therapist.
Dental care	75%, max. CHF 5,000/calendar year (No benefits for Level 1 Light)	1. Reimbursement of the cost of: – dental treatment by a qualified dentist; – yearly prophylactic dental check-up; – dento-facial orthopaedic treatment; – crowns, bridges and prostheses; – laboratory work. 2. Periods of non-availability: – three months for dental treatments due to an illness; – 12 months for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following illness. 3. The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%.

2. Abroad
   1. The benefits listed below are valid worldwide, Switzerland excluded, for emergency medical care not covered by Swiss or foreign social insurances or by other private insurance coverage.
   2. The insured benefits correspond to those covered in Switzerland when being treated for similar medical conditions.
   3. Voluntary hospitalisation planned outside the EU/EFTA and the UK will be reimbursed only upon written request of the insured, subject to the Insurer's prior consent. The Insurer may require a detailed quote.
   4. The benefits listed below are reimbursed when administered by persons or institutions with the necessary training, recognition and authorisation of the foreign social bodies.
   5. Subject to revocation of the entitlement to benefits, expensive hospital stays and other treatments which are subject to a financial guarantee request from the healthcare provider shall be notified beforehand to Groupe Mutuel Assistance using the form "Notification of a financial guarantee request". Emergency cases shall be notified to Groupe Mutuel Assistance immediately.
   6. Payment of benefits
      If several family members simultaneously fall sick or are injured at the same time, a separate invoice must be requested for each insured person: from the physician, hospital, pharmacist, etc.
      To obtain reimbursement, the insured shall provide all requisite documents (original or scanned invoices, medical certificates, prescriptions, etc.). The Insurer reserves the right to request original documents and payment confirmations. For foreign invoices, the applicable exchange rate is the official Swiss Franc rate for that currency on the last day of treatment.
      The Insurer recognises the customary tariffs applied in the country or region where the treatment takes place. The Insurer reserves the right to reduce its benefits if invoices are exaggeratedly high.
   7. Special provisions regarding persons residing abroad and who remain subject to the compulsory health insurance (LAMal/KVG) or persons who have chosen to

retain insurance coverage in accordance with Article 7(a) of the Ordinance on Health Insurance (OAMal/KVV) by signing up to an optional healthcare insurance in conformity with the Federal Law on Insurance Contracts (LCA/VVG).
Derogating from Article 7, item 2.3 of these special terms and conditions, voluntary hospitalisation planned outside the EU/EFTA or the UK does not have to be subject to prior agreement of the Insurer.

	Coverage	**Description**
Hospitalisation (including childbirth)	room with more than two beds (Level 1 Light and Level 1) room with two beds (Level 2) room with one bed (Level 3)	– Free choice of hospital facility depending on the applicable coverage level, in general or psychiatric wards, for treatment of acute conditions. – Reimbursement of recognised treatments within the meaning of LAMal/KVG, of hospital boarding costs and of physician's fees. – Facilities must be recognised by the competent public health authorities of the country in which the treatment takes place. – Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in any given calendar year. – The insured person shall check with the Insurer that the medical facility, ward or clinic where he is to be treated is a facility recognised by the relevant health authorities of the country in which the treatment takes place.
Outpatient treatments	90%	– Consultations, tests, X-rays and recognised drugs.
Statutory co-insurance	100%	– Coverage of foreign statutory co-insurance amounts for outpatient or hospitalisation treatments pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions.
Alternative medicine	75%	– Reimbursement of the therapies in the list below (item 7.3 – list of alternative medicine therapies) carried out by a qualified physician or a practitioner of natural therapies recognised by the Insurer. – Before each treatment, the insured person is required to obtain the Insurer's prior consent. The Insurer will base its decision on the criteria applicable by analogy in Switzerland.
Convalescence cures and thermal cures	90%, max. CHF 1,000/calendar year	– Treatment and board in case of convalescence cures and thermal cures in Switzerland in facilities recognised by the Insurer according to the criteria applicable by analogy in Switzerland. – Subject to revocation of the entitlement to benefits, an application for authorisation along with the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
Medical glasses and contact lenses	– Children up to 18 years CHF 200 every year – Adults from 19 years of age, CHF 500 every five years	– Coverage of the costs of frames, lenses or contact lenses.
Surgical correction of vision	90%, max. CHF 800 every three years	– The contribution for surgical correction of vision is granted in addition to the costs of medical glasses or contact lenses.
Medical aids and appliances	90%, max. CHF 1,000/calendar year	– Coverage of the cost of purchasing and renting orthopaedic equipment and auxiliary appliances (excluding dental prostheses). – For the recognition of healthcare providers, the Insurer will consider the criteria applicable by analogy in Switzerland.
Childbirth allowance	CHF 300	– Allowance paid irrespective of whether childbirth results in one or several births.
Childbirth preparation classes	CHF 150	– Painless childbirth preparation classes which are not covered by compulsory health insurance.
Transport and search and rescue costs	100%, unlimited (transport) 90%, max. CHF 75,000/calendar year (search and rescue)	– Transport to the nearest hospital facility or physician provided such transport is medically necessary. – This contribution is only granted for transport by ambulance, by helicopter or for a search and rescue operation. Public transport costs (bus or train) in connection with outpatient treatment designed to avoid hospitalisation are also reimbursed.
Vaccinations	90%, max. CHF 500/calendar year	– Reimbursement of medically prescribed vaccinations (not included in the Ordinance on Healthcare Insurance Benefits – OPAS/KLV) in Switzerland, and of any vaccinations recommended by the relevant health authorities.
Psychotherapy	90%, max. CHF 1,200/calendar year	– The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychologists.

	Coverage	Description
Groupe Mutuel Assistance	As specified in the general terms and conditions of insurance of Groupe Mutuel Assistance.	– Coverage of benefits specified in the general terms and conditions of Groupe Mutuel Assistance. – By way of derogation from Article 4(2) of the general terms and conditions of Groupe Mutuel Assistance, there are no restrictions for journeys or stays abroad exceeding 60 consecutive days. – By way of derogation from Article 21(c) of the general terms and conditions of Groupe Mutuel Assistance, coverage is not excluded for convalescence and ailments currently under treatment and not yet stabilised, relapses from illnesses identified previously and with a risk of serious deterioration.
Hospital accommodation for family member	90%, max. CHF 700/calendar year	– Coverage of the cost of hospital accommodation for one of the parents of the insured provided such cost is medically necessary.
Home help and placement costs	90%, max. CHF 3,000/calendar year	– The cost of home help hired from an official service to attend to the insured person's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning, etc.). – The cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Family members have to be placed with an official institution. – The insured person is required to obtain the Insurer's prior consent.
Voluntary sterilisation	90%, max. CHF 500	– Reimbursement of surgery costs.
Speech therapy	90%, max. CHF 500/calendar year	– Coverage of the cost of speech therapy treatments not recognised under LAMal/KVG but prescribed by a doctor and administered by a recognised speech therapist.
Dental care	75%, max. CHF 5,000/calendar year (No benefits for Level 1 Light)	1. Reimbursement of the cost of: – dental treatment by a qualified dentist; – yearly prophylactic dental check-up; – dento-facial orthopaedic treatment; – crowns, bridges and prostheses; – laboratory work. 2. Periods of non-availability: – three months for dental treatments due to an illness; – 12 months for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following illness. 3. The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%.

3. List of "alternative medicine" therapies

Naturopathy	Manipulation techniques	Other
Acupuncture	Acupressure	Bio-energetics
Aromatherapy	Lymphasizing	Eurythmy
Auriculotherapy	Etiopathy	Rebirthing
Bioresonance	Myofascial release therapy	Sophrology
Biotherapy	Postural integration	Tomatis Method
Chromotherapy	Kinesiology	
Nutritional counseling	Massage therapies	
Electroacupuncture	Anthroposophic medicine	
Geobiology	Mesotherapy	
Herbal medicine	Metamorphosis	
Homeopathy	Orthobionomy	
Iridology	Osteopathy	
Colon hydrotherapy	Polarity	
Laser therapy	Energy balancing	
Magnetic field therapy	Reflexology	
Magnetotherapy	Reiki	
Moratherapy	Rolfing	
Naturopathy	Shiatsu	
Oxygenotherapy	Trager	
Herbal medicine	Autogenic training	
Sympathicotherapy		
Cupping		

Art. 8 Entitlement to benefits

Benefits are payable according to treatment dates.
It is not possible to accrue benefits insured in Switzerland and abroad.
Derogating from Article 17(4) CGC, insureds who wish to provide the Insurer with a payment address abroad may exceptionally do so.
Costs incurred after the expiry of entitlements (benefits subject to duration or reimbursement ceilings) cannot be carried forward to the next year.
If a medical treatment or alternative medicine treatment is no longer medically justified and no longer brings any therapeutic improvement, the Insurer will inform the insured person of the reduction or the end of the payment of benefits. As provided for in the present terms and conditions of insurance, the Insurer will reimburse any costs not covered by compulsory health insurance provided the treatment is carried out by a practitioner or a person who is duly authorised and recognised by the Insurer. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover co-insurance payments and deductibles under the AOS/OKP or other supplemental insurances.
However, insurance coverage is extended to cover foreign statutory co-insurance amounts for treatments outside Switzerland pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions and providing it is not prohibited by the law of the relevant country.

1. Scope and duration of hospitalisation benefits

a. Hospitalisation benefits are limited to the acute phase of the illness. The entitlement to benefits ceases once the condition is no longer considered acute, including in the treatment of stabilised or chronic conditions, or if hospitalisation does not serve to improve the insured's health.
b. If, at the Insurer's proposal or by his own decision, a person insured under Global GEM and having opted for level 2 or 3 waives his entitlement to hospitalisation in a semi-private or private ward for a general ward, the Insurer may grant him an allowance of up to 50% of the savings estimated by the Insurer and up to maximum CHF 5,000 per hospital stay. In case of outpatient childbirth or home birth, only the rule in Article 8, item 2, letter (d) will apply.

2. Maternity coverage

a. Benefits for inpatient treatment during pregnancy and childbirth are first payable after a 12-month insurance period, except for cases of free transfer.
b. Interruptions of pregnancy within the meaning of the Swiss Federal Law on Health Insurance (LAMal/KVG), and any other maternity-related benefits are subject to the non-availability period specified in paragraph (a) above.
c. Where childbirth involves a hospital stay of less than six days in an individual room or room with two beds, the Insurer grants an allowance of CHF 200 for each day of hospitalisation avoided to insureds with Global GEM insurance, level 2 or 3. Hospital stays subject to overall flat-rate invoicing do not give entitlement to this allowance. The provisions of Article 8(2) remain reserved.
d. In case of outpatient childbirth or home birth, the person insured under Global GEM, level 2, will receive a single allowance of CHF 800 and the person insured under level 3 will receive a single allowance of CHF 1,200 subject to the non-availability period specified in paragraph (a) above.
e. If an insured person is hospitalised in a ward corresponding to her coverage level, the Insurer will also cover the newborn's hospital costs during the mother's stay in hospital provided that, within 30 days of the child's birth, healthcare coverage is contracted for the child with the Insurer. Personal expenses are not covered. Paragraph (a) above remains reserved.

3. Organ transplants

Organ transplants are not covered under this insurance.

Art. 9 Deductible

Benefits are subject to a CHF 300 deductible per calendar year, except for medical glasses, contact lenses or surgical correction of vision.

Art. 10 Premiums

1. Premiums are identical for men and women.
2. 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 the following:
   – from 0 to 18;
   – from 19 to 25;
   – from ages 26 to 71, age groups are graduated in five-year brackets.

Art. 11 Departure from the circle of insureds qualifying for insurance under the GEM group insurance plan and termination of the framework agreement

1. When an insured person leaves the circle of insureds under the GEM group insurance plan, he will be transferred automatically to the following similar insurance solutions of Groupe Mutuel Assurances GMA SA:
   – Global Solution, Level 2 (category GO) with the "Extended benefits" option but without the "Dentaire plus" option **for persons previously insured with Global GEM insurance, level 1 Light;**
   – Global Solution, Level 2 (category GO) with the "Extended benefits" option and "Dentaire plus" option, class 1 **for persons previously insured with Global GEM insurance, level 1;**
   – Global Solution, Level 3 – semi-private ward (category GO) with the "Extended benefits" option and the "Dentaire plus" option, class 1 **for persons previously insured with Global GEM insurance, level 2 (semi-private ward).**
   – Global Solution, Level 3 – private ward (category GO) with the "Extended benefits" option and the "Dentaire plus" option, class 1 **for persons previously insured with Global GEM insurance, level 3 (private ward).**

The rates of the above coverage plans will then be applied to the relevant insured persons.

2. The same rule applies to the family members of a deceased employee insured under the group insurance plan.
3. Any exclusions specified before the insured leaves the circle of insureds under the GEM group insurance plan shall be maintained.
4. The entry into force of the contract concluded before the insured leaves the circle of insureds under the GEM group insurance plan is taken into account for calculating the periods of non-availability.
5. Any benefits received before an insured leaves the circle of insureds under the GEM group insurance plan are taken into account to calculate the maximum benefits.
6. The same provisions apply in case of termination of the framework agreement between GEM and the Insurer or case of termination of the framework agreement between the member company of GEM and the Insurer.
7. The insured shall notify the Insurer in writing of his departure from the circle of insureds under the group insurance plan within 30 days.
8. The insured person can terminate the contract within 30 days after having received his new policy.
9. Insured persons residing in Switzerland who have made use of their right of termination according to item 8 above can choose the following similar insurance solutions of Groupe Mutuel Assurances GMA SA:
   - Supplemental hospitalisation insurance, class 1 - general ward (HC category) and/or supplemental health insurance, class 4 (SC category) and/or Mundo insurance (MU category), **for persons previously insured with Global GEM insurance, level 1, Light;**
   - Supplemental hospitalisation insurance, class 1 - general ward (category HC) and/or Supplemental health insurance, class 4 (category SC) and/or “Dentaire plus” dental care insurance, class 3 (category DP) and/or Mundo insurance (category MU) **for persons previously insured with Global GEM insurance, level 1;**
   - Supplemental hospitalisation insurance, class 2 - semi-private ward (category HC) and/or Supplemental health insurance, class 4 (category SC) and/or “Dentaire plus” dental care insurance, class 3 (category DP) and/or Mundo insurance (category MU) **for persons previously insured with Global GEM insurance, level 2;**
   - Supplemental hospitalisation insurance, classes 3 or 4 - private ward (category HC) and/or Supplemental health insurance, class 4 (category SC) and/or “Dentaire plus” dental care insurance, class 3 (category DP) and/or Mundo insurance (category MU) **for persons previously insured with Global GEM insurance, level 3.**

   The rates of the above coverage plans will then be applied to the relevant insured persons.

   The provisions set out in items 2 to 5 above will apply by analogy.

Art. 12 Data protection

Personal and sensitive data

Groupe Mutuel Services SA processes the personal and sensitive data of the policyholder, the insured person, and where applicable their beneficiaries or related persons (hereinafter: persons concerned) on behalf of Groupe Mutuel Assurances GMA SA, your insurer. Data processing is entrusted to Groupe Mutuel Services SA (hereafter: Groupe Mutuel), a company under Groupe Mutuel Holding SA. Both companies are subject to the Federal Law on Data Protection (LPD/DSG).

Personal data refers to information relating to the persons concerned, including the administrative management of the insurance contract. Sensitive data refers in particular to information relating to the state of health of insured persons and claims. In general, the following categories of personal and sensitive data are processed: the declaratory personal data of the persons concerned, i.e. the data that Groupe Mutuel may collect from the persons concerned when they express interest and/or subscribe to products and services that it offers or distributes; personal data relating to the benefits provided or the functioning of products and services or their use, in particular when using online services; personal data from third parties, other services or public information where authorised.

Legal basis

Groupe Mutuel shall process the personal and sensitive data of the persons concerned and implement the processing operations according to the following legal grounds: the consent of the persons concerned, respectively the express consent for sensitive data; the legal provisions applicable to the activities of Groupe Mutuel (including the LPD/DSG); the contract concluded between Groupe Mutuel and the persons concerned; the overriding public interest or the overriding private interest of Groupe Mutuel or the persons concerned, within the meaning of the LPD/DSG.

Purposes

Personal and sensitive data are used in particular to assess the risks to be insured, process claims, ensure the administrative, statistical and financial follow-up of the contract, allow the management of Groupe Mutuel’s activities (statistics, internal and external audit, etc.) and compliance with its legal obligations, the improvement and development of services provided, the optimisation and cost-effectiveness of insurance costs, prospecting and marketing operations, the management of unpaid debts and disputes, the fight against fraud, money laundering, terrorist financing and tax fraud. To this end, this data may be communicated, shared and exchanged between Groupe Mutuel and third parties (see below). The data used for statistical purposes is made anonymous.

Security

When personal data is processed, and with regard to the risks presented by data processing operations, Groupe Mutuel, its insurance intermediaries and other agents (for example a reinsurance company), undertake to take all necessary measures to comply with data protection law. These provisions include, in particular, the technical, physical and organisational measures required to safeguard the security of personal data and prevent its modification, damage or access by unauthorised third parties.

Data transfer
The data is treated confidentially and may be disclosed to third parties (e.g. insurance intermediaries, reinsurance companies, doctors, beneficiaries, disability insurance office (AI/IV), social security of the insured person's country of residence), including abroad. Disclosure of data takes place on the basis of legal obligations, court decisions, general insurance terms and conditions or the consent of the persons concerned. Consent must be express in the case of sensitive data. If the data processing operations are subject to a subcontracting, outsourcing or partnership contract with third parties, the latter undertake, as part of their contractual relationship with Groupe Mutuel, to comply with data protection law. Groupe Mutuel selects subcontractors who provide the necessary guarantees. The data entrusted to insurance intermediaries will be recorded and sent to Groupe Mutuel for the handling of insurance applications and for the administrative and financial follow-up between the insurance intermediary and the Insurer. The latter is not responsible for the processing of personal data that the person concerned may have authorised from third parties or those that are carried out independently of Groupe Mutuel. It is up to the persons concerned to refer to the data protection policies of these third parties in order to check the terms and conditions of the processing operations carried out, or to exercise their rights with regard to these operations.

Profiling
During its relationship with Groupe Mutuel, the person concerned may be subject to marketing profiling, so that the Insurer can offer services and products that meet the person's expectations, profile and needs.

Storage period
Personal data is stored for as long as required by law, the management of the insurance contract, claims, recourse rights, debt recovery and/or any disputes between Groupe Mutuel, the insured, the insurance intermediary or third parties.

Rights of access and correction
The persons concerned have the right to access their personal data, to have their data corrected, to have their data deleted within the limits of the applicable legal provisions, to limit the processing of their data, to request that their data is transferred, to withdraw their consent to the processing of personal data, subject to the processing required for the performance of the contract, and to appeal to the competent supervisory authority.

Data Protection Officer
Groupe Mutuel has appointed a Data Protection Officer who can be contacted at the following address:
dataprotection@groupemutuel.ch.
Further information on data protection is available on the Groupe Mutuel website: www.groupemutuel.ch

Groupe Mutuel Assurances GMA SA (GMA SA)

Addendum to special terms and conditions of insurance - Edition: 01 Jan 2024 Global GEM - GGGA01

The provisions of the addendum will apply as of 01 January 2024 to persons who have taken out Global GEM – GGGA01 insurance.

Insured benefits
Replaces the section «Hospitalisation (including childbirth)» in Art. 7 para. 1, column «Description».

- The insured has, in Switzerland, a free choice of hospital facility depending on the applicable coverage level, in general or psychiatric wards, for the treatment of acute conditions.
- The insurer will pay the costs of recognised facilities or doctors, i.e. those with which the insurer has concluded a tariff agreement.
- 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.
- Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in any given calendar year.
- The insured person shall check that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the insurer.