groupemutuel

Special Terms and Conditions for Global mi-privée Supplemental Insurance Coverage

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GMAM01-E7 – Edition: 01 Sep 2010 (with an addendum as of 01 January 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 Eligibility

1. Global mi-privée supplemental insurance is open to all persons up to their 55th birthday.
2. Insureds ages 0 to 18, i.e. until 31 December of the year coinciding with their 18th birthday, are granted the supplemental benefits described in Article 2, paragraph 2.2, under the heading Global Junior.
3. From 1 January of the year coinciding with their 55th birthday, insureds are granted the supplemental benefits described in Article 2, paragraph 2.3, under the heading Global Senior.
4. If a person has already contracted comparable coverage with another insurer and cannot for the time being terminate that insurance, he may join Global mi-privée insurance exclusively for the benefits designated in Article 2, paragraph 2.4, under the heading Global Temporis.

Art. 2 Insured benefits

1. General

The following benefits are covered supplementally to compulsory health insurance:

1. Hospitalisation

1. Insurance class
   Semi-private ward (room with two beds) of recognised hospital facility in Switzerland, in general or psychiatric wards, for treatment of acute conditions.
2. Deductibles on hospitalisation benefits
   The Insurer covers the cost of treatment, and room and board.
   a. no deductible;
   b. CHF 1,000 per calendar year;
   c. CHF 2,000 per calendar year;
   d. CHF 3,000 per calendar year;
   e. CHF 5,000 per calendar year.
   The selected deductible applies to hospitalisation-related benefits only.
3. Benefits
   a. General
      In case of hospitalisation, the Insurer covers the cost of treatment, and room and board
   b. Hospitalisation in semi-private ward
      If an insured is hospitalised in a ward which is higher than that covered by his insurance class, the following maximum benefits will be granted to him: 80% of room and board and treatment.
   c. Hospitalisation abroad
      If an insured falls sick or has an accident abroad and is hospitalised abroad, the Insurer grants him a maximum allowance of CHF 1,000 per day for no more than 60 days per calendar year.
      Voluntary treatment abroad is not covered unless the Insurer gives its prior consent.
4. Maternity benefits
   a. Entitlement to maternity and childbirth benefits commences upon completion of 12 months' insurance. The term of coverage under Global Temporis does not count for calculating that entitlement.
   b. Interruptions of pregnancy and any other maternity-related benefits are subject to the waiting period specified in sub-paragraph a.
   c. Where childbirth involves a hospital stay of less than 5 days in a semi-private ward, the Insurer will grant insureds a daily allowance of CHF 250 for each day of avoided hospitalisation. Hospital stays invoiced on a global lump-sum basis do not qualify for this allowance. Sub-paragraph a is reserved.
   d. In case of childbirth at home, the insured is entitled to an allowance of CHF 800 subject to sub-paragraph a.

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 for the duration of the mother's stay in hospital provided the baby is also insured with the Insurer. Personal expenses are not covered. Sub-paragraph a is reserved.

5. Scope and duration of benefits
   Payment of hospitalisation benefits is subject to the following terms and conditions:
   a. The Insurer covers the cost of recognised treatments, within the meaning of LAMal/KVG, of hospital boarding costs and of doctors' fees in accordance with tariff agreements or cantonal regulations.
   b. The Insurer reserves the right to restrict the entitlement to benefits if the fees charged for room and board or for medical services are overpriced.
   c. If there is no medical tariff agreement, the compulsory insurance tariff for hospital services will be applicable with a 50% increase for the semi-private ward.
   d. If a hospital does not apply the criteria for distinguishing between wards referred to in Article 2.1.1., or applies other criteria, or if no tariff agreement has been reached with the Insurer, the Insurer shall only recognise the private ward.
   e. The present insurance does not cover organ transplants for which the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie/Schweizerischer Verband für Gemeinschafts¬aufgaben der Krankenversicherer, Solothurn) has agreed specific lump-sum rates. This rule also applies to hospital facilities not bound by agreed lump-sum rates.
   f. The entitlement to benefits ceases as soon as the condition is no longer deemed acute.
   g. For psychiatric facilities, coverage for hospitalisation benefits is limited to 60 days' hospitalisation in any given calendar year.
   h. Coverage for hospitalisation benefits is limited to 90 days' hospitalisation in any given calendar year. The duration of treatment abroad or in psychiatric facilities (60 days) is imputed to the foregoing 90-day limit.
6. Obligations of the insured
   Prior to each hospitalisation, the insured shall check that the facility, hospital ward or clinic where he is to be treated is recognised by the Insurer.
7. Cost-saving measures
   – If, at the Insurer's proposal or by his own decision, an insured waives his entitlement to hospitalisation in a semi-private ward, the Insurer may grant him an indemnity of up to 50% of the savings estimated by the Insurer up to maximum CHF 1,500 per hospitalisation.
   – In case of childbirth at home, only Article 2.1.1(4)(d) applies.

2. Supplemental treatment

The Insurer covers the following benefits within the limits stipulated in Article 3 (see table):

1. Restricted drugs
   The applicable percentage of the cost of drugs not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).
2. Non-reimbursable drugs
   The applicable percentage of the cost of drugs which are not on any official list (LS-LMT) and are not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).
3. Alternative medicine
   The Insurer will cover the cost of the following therapies provided they are administered by a doctor licensed to practice in Switzerland or by a natural therapy practitioner recognised by the Insurer and member of one of the following associations:
   – Association des praticiens en thérapeutique naturelle/Naturärzte-Vereinigung der Schweiz (APTN/NVS/ATN);
   – Association romande des thérapeutes (ART);
   – Société suisse des médecins naturalistes/Gesellschaft Schweizer Naturheilärzte (SSMN/GSN);
   – Fondation pour la reconnaissance et le développement des thérapies alternatives et complémentaires/Stiftung zur Anerkennung und Entwicklung der Alternativ- und Komplementärmedizin (ASCA);
   – Association suisse d'étiopathie/Vereinigung Schweizerischer Ätiopathen (ASE);
   – Fédération des praticiens de santé en naturopathie (FSPN);
   – Registre suisse des ostéopathes/Schweizerisches Register der Osteopathen (RSO/SRO);
   – Other associations may be accepted.

   The Insurer reserves the right to exclude certain natural therapy practitioners recognised by the above associations. A list of practitioners whose services are reimbursed is available to insureds.

   Naturopathy:
   Acupuncture, electroacupuncture, aromatherapy, biotherapy, chromotherapy, homeopathy, iridology, laser therapy, magnetotherapy, moratherapy, oxygenotherapy, sympathicotherapy, cupping, herbal medicine, phytotherapy, colonic hydrotherapy,

   Manipulation techniques:
   lymphasizing, etiopathy, postural integration, kinesiology, massage therapies, orthobionomy, osteopathy, reflexology, polarity, energy balancing, rolfing, shiatsu, acupressure, mesotherapy, anthroposophic medicine, autogenic training, reiki.

   Psychotherapy:
   Bio-energetics, sophrology, Tomatis method:
   – Voluntary changes in therapy or practitioner in the course of a treatment are subject to the

Insurer's prior consent;
- Sophrology treatments will be reimbursed provided they are administered by a doctor, a doctor-sophrologist with an ASS diploma, or a sophrologist who is not a doctor but holds an ASS diploma.

4. Cures in Switzerland
   The Insurer will pay a contribution to the cost of bath cure treatment and to convalescence cures in recognised facilities for maximum 30 days per calendar year. An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
5. Thermal cures abroad
   Subject to the Insurer's prior authorisation, contribution to the cost of medically necessary thermal cure treatment abroad. An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
6. Tariff supplements
   For outpatient treatment in Switzerland, the difference between the rates at the insured's place of work or residence, and those at the place of residence of the provider of health care services.
7. Personal expenses indemnity during hospitalisation
   Against presentation of supporting invoices, a single indemnity payment will be allocated for each hospital stay lasting longer than 8 days.
8. Hospital accommodation for family member
   If the insured is hospitalised, the Insurer will cover the cost of hospital accommodation for one family member provided such cost is medically necessary.
9. Home help and placement cost
   The following will be reimbursed subject to prior insured's application:
   - the percentage share of the cost of home help hired from an official service to attend to the insured'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.
10. Orthoptlcs
    The specified percentage of treatment cost in accordance with AI/IV tariff
11. Spectacles and contact lenses
    The specified amount for the purchase of prescription spectacles or contact lenses in Switzerland or abroad which is not covered by compulsory health insurance.
12. Orthopaedic and prosthetic appliances
    The cost of purchasing and renting medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the Insurer's list of reimbursable costs.
13. Childbirth preparation classes
    The specified amount for painless childbirth preparation classes or childbirth preparation which is not covered by compulsory health insurance.
14. One-time breast-feeding indemnity
    Breast-feeding indemnity provided the mother breast-feeds her baby for at least 30 days and that that duration is certified by the doctor or midwife. In cases of multiple births, an indemnity is paid for each child.
15. Ultrasound scans and mammographies
    The specified amount for ultrasound scans and mammographies not covered by compulsory health insurance.
16. Vaccinations
    Vaccination costs for vaccinations that are not included in the ordinance on compulsory health insurance benefits and which are necessary in Switzerland or are prescribed for trips abroad.
17. Elisa or HIV tests
    The Insurer pays an annual contribution towards the cost of preventive tests prescribed and carried out by recognised health care providers.
18. Voluntary sterilisation
    The specified percentage of the cost of the operation in accordance with the tariffs which would have applied under compulsory health insurance.
19. Dental treatment in case of accident
    The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice In Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff.
20. Dental treatment in case of illness
    The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice In Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff.
21. Transport costs
    The Insurer will pay a contribution towards the cost of transport to the nearest hospital facility or doctor following an insured illness or accident provided such transport is medically necessary and is not covered by compulsory health insurance. This contribution is only granted for transport by ambulance, helicopter or by a search and rescue action. Public transport costs (bus or train) for outpatient treatment will also be reimbursed if such treatment serves to avoid hospitalisation.
22. Independent psychologists and non-doctor psychotherapists
    The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychotherapists.

3. Groupe Mutuel Assistance

The benefits specified in the general terms and condi-

tions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).

2. Global junior

Supplemental benefits:

a. Home care for sick children

Benefits are payable if home care is provided by a person from an institution recognised by the Insurer.

b. Contribution for sports or nature

Against presentation of a supporting invoice, reimbursement of a share of the active member's fee in a sports club or association recognised by the Insurer.

3. Global senior

Supplemental benefits:

a. Palliative care

The Insurer will pay a contribution to the cost of palliative treatment, i.e. medical and nursing care for persons at the end of life, administered at home by duly qualified persons under the supervision of an institution recognised by the Insurer.

A prior application must be submitted to the Insurer who will determine the amount of the contribution on a case-by-case basis.

b. Health and fitness cures

The Insurer pays an annual contribution for a health and fitness cure at recognised facilities offering a specific programme in the field.

c. Nutrition advisor and classes

The Insurer will pay an annual contribution to the cost of a nutrition advisor and nutrition classes recognised by the Insurer.

4. Global temporis

a. Global Temporis provides temporary Global mi-privée coverage to persons having comparable coverage with another insurer.

b. Global Temporis covers the supplemental benefits described in sections 2.1.2, 2.1.3, 2.2 and 2.3; it does not cover the benefits contemplated in sections 2.1.1. (hospitalisation) and 2.1.4 (death benefit).

c. For the supplemental treatment covered by Global Temporis, benefits are equal to 30% of the benefits offered by Global mi-privée

d. Global Temporis benefits are payable in addition to those paid by the other insurer.

e. By granting an insured Global Temporis coverage, the Insurer simultaneously undertakes to extend to him full Global mi-privée coverage, without a new medical examination, from the date indicated on the Global Temporis certificate. The transfer to full Global mi-privée coverage must take place within 2 years at the latest.

f. Any participation by the Insurer in deductibles and coinsurance amounts of other insurers is excluded.

g. For the life of Global Temporis coverage, the premium is reduced compared with the Global mi-privée premium.

h. Article 29 of the General Terms and Conditions of Supplemental Health and Accident Insurance granting the insured the right to terminate the policy is not applicable to the transfer from Global Temporis to Global mi-privée coverage or the corresponding premium adjustment.

i. Any time limits applying to benefits paid under Global Temporis coverage will also count for the calculation of benefit entitlements after the transfer to Global mi-privée coverage.

Art. 3 Scope of benefits

The benefits contemplated in Article 2 are payable within the limits and amounts indicated in the «Table of Global Benefits».

Art. 4 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect.
2. Benefits are imputed to the annual insured sum chronologically, by order of treatment date. Costs incurred after entitlements are exhausted cannot be carried forward to the next year.
3. As provided 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 may the insurance benefits regulated by these terms and conditions be used for co-payments and deductibles under compulsory insurance or other supplemental insurance coverage.

Art. 5 Advantages of «LeClub»

When he contracts Global mi-privée insurance, the insured is entitled to all the advantages of «Le Club» membership including in particular:

1. Reduced rates in hotels
   The Insurer keeps a list of the hotels offering reduced rates.
2. Credit card reductions
   Insureds may apply for or renew their credit card at the reduced rates indicated on the list kept by the Insurer.
3. Rebates in drugstores, pharmacies and other shops
   The Insurer keeps a list of the drugstores, pharmacies and other shops offering rebates.

Art. 6 Premiums

When an insured person reaches the last year of his age group, he will be automatically transferred into the next age group at the beginning of the next calendar year. The applicable age groups are:

– from 0 to 18;
– from 19 to 25;
– from age 26, age groups are graduated in 5-year brackets.

Type of benefits	Global mi-privée
Restricted drugs	90% max. CHF 1,000 per calendar year
Non-reimbursable drugs	90% max. CHF 1,000 per calendar year
Alternative medicine	80% max. CHF 3,000 per calendar year
Thermal cures in Switzerland	80% max. CHF 500 max. 30 days per calendar year
Convalescence cures	CHF 25 per day max. 30 days per calendar year
Convalescence cures following hospitalisation	CHF 50 per day, max. 30 days per calendar year
Thermal cures abroad	50% max. CHF 500 per calendar year
Tariff supplements	CHF 800 per calendar year
Personal expenses indemnity in case of hospitalisation	CHF 200 per case
Hospital accommodation for family member	CHF 600 per calendar year
Home help and placement cost	90% max. CHF 2,500 per calendar year
Orthoptics	80% max. CHF 3,000 per calendar year
Spectacles and contact lenses	CHF 150 per 3-year period
Orthopaedic and prosthetic appliances	CHF 400 per calendar year
Childbirth preparation classes	CHF 150 per pregnancy
One-time breast-feeding indemnity	CHF 100 per child
Ultrasound scans and mammographies	CHF 200 per calendar year
Vaccinations	90% max. CHF 200 per calendar year
Elisa or HIV tests	CHF 50 per calendar year
Voluntary sterilisation	80% max. CHF 400
Dental treatment: in case of accidents	80% max. CHF 6,000 per case
Dental treatment: in case of illness	80% max. CHF 150 per 3-year period
Transport costs	80% max. CHF 2,000 per calendar year
Indep. psychologists and non-doctor psychotherapists	80% max. CHF 700 per calendar year
Hospitalisation	semiprivate ward throughout Switzerland
Groupe Mutuel Assistance	Emergency medical assistance, support and repatriation for trips and stays abroad
«LeClub» Advantages Global junior (ages 0 to 18)	Reductions in some hotels and shops
Home care for sick children	CHF 300 per calendar year
Contribution for sports or nature	CHF 30 per calendar year
Global senior (from age 56)	
Palliative care	90% max. CHF 3,000 per calendar year
Health and fitness cures	CHF 300 per calendar year
Nutrition advisor and classes	50% max. CHF 250 per calendar year

Groupe Mutuel Assurances GMA SA (GMA SA)

Addendum to the special terms and conditions of insurance - Edition: 01 January 2024 Global mi-privée - GMAM01

The provisions of the addendum will apply as of 01 January 2024 to persons who have taken out Global mi-privée – GMAM01.

Insured benefits
Replaces the Article 2.1.1.5 let. a, b and c.

a. The insurer will pay the costs of recognised facilities or doctors, i.e. those with which the insurer has concluded a tariff agreement.
b. 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.

Article 2.1.1.3. letter b does not apply in the case of benefits provided by a non-recognised facility or doctor.

Cost-saving measures
Replaces Art. 2.1.1.7 first indent
If, at the insurer's proposal or by his own decision, an insured person waives his entitlement to hospitalisation in a semi-private or private ward for the general ward, the insurer may grant an allowance of up to 50% of the savings estimated by the insurer and up to a maximum CHF 5,000 per hospital stay.