groupemutuel

Special conditions for Global smart Supplemental Insurance Coverage

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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. The purpose of this insurance is to cover insured persons for specific supplemental benefits over and above compulsory health insurance (AOS/OKP) benefits 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 have chosen to retain their 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), the benefits under Global smart insurance will be paid out supplementally to the said insurance.
3. Global smart insurance offers three levels of coverage (basic module):
   - Level 1
   - Level 2
   - Level 3
4. This basic module may be supplemented by the option «Emergency hospitalisation abroad upgrade».

Art. 2 Risks covered

Global smart benefits provide sickness, accident and maternity coverage.

Art. 3 Acceptance conditions

1. Global smart coverage levels N1 and N2 are open to persons of all ages. The N3 coverage level is restricted to persons below age 65.
2. Global smart insurance can also be taken out by persons living abroad (including cross-border workers and employees on secondment as well as their family members) who remain subject to the compulsory health insurance (LAMal/KVG) pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions.
3. In the case of a group insurance plan, the group of persons entitled to insurance will be defined in the framework agreement signed between the insured company and the Insurer.
4. Special provisions for foreign or Swiss employees who are transferred or hired by their employer to work in Switzerland (hereafter referred to as «impatriates»), respectively foreign or Swiss employees who are sent abroad by their employer (hereafter referred to as «expatriates») as well as their family members.
   a. Partially derogating from Articles 6 and 9 CGC, the Insurer can facilitate acceptance conditions or increase the risks covered for applicants or impatriate or expatriate insureds, as well as for their family members.
   b. Derogating from Article 6.2 of the Special Conditions of insurance (CP), specific rules may apply to this category of insureds with regard to the 12-month non-availability period for maternity benefits.
   c. The framework agreement signed between the insured company and the Insurer defines these specific rules.

Art. 4 Termination of the insurance contract

Derogating from Article 13 CGC, the insurance contract may be terminated by the insured after three years of coverage and then on an annual basis, for the end of a calendar year subject to one month's advance notice.

Art. 5 Insured benefits

1. In Switzerland

	Level 1	Level 2	Level 3	Description
Hospitalisation	general ward	general ward	semi-private or private ward The insured option is mentioned in the insurance policy.	– In Switzerland, free choice of hospital facility depending on 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 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 treatment in psychiatric facilities is limited to 60 days. – Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in a semi-private or private ward in any given calendar year. The duration of treatment in psychiatric facilities (60 days) is imputed to the foregoing 180-day limit. – 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.
Outpatient treatment	100%	100%	100%	– Free choice of outpatient treatment in Switzerland within the meaning of LAMal/KVG. – Reimbursement of the difference between the rates applicable at the insured's place of work or residence, and those applicable at the place of residence of the provider of healthcare services.
Non-reimbursable drugs	90%	90%	90%	– Medication prescribed by a doctor or a recognised healthcare provider, within the meaning of LAMal/KVG, which is not reimbursed by compulsory health insurance (AOS/OKP). – Exclusions: products included on the list of pharmaceutical products for special application (LPPA/LPPV).
Transport costs	90%	90%	90%	– Transport to the nearest hospital facility or physician provided such transport is medically necessary. – This contribution is only granted for transport by ambulance or by helicopter. Public transport costs (bus or train) in connection with outpatient treatment designed to avoid hospitalisation are also reimbursed.
Alternative medicine treatment	30%	60%	90%	– Reimbursement of the therapies enumerated in the list below (point 5.2 list of 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 therapy concerned.
Glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	– Cost of frames, lenses or contact lenses.
Dental care	None	On or before 18th birthday 50%, max. CHF 2,000 per calendar year From 19th birthday 50%, max. CHF 500 per calendar year	On or before 18th birthday 50%, max. CHF 2,000 per calendar year From 19th birthday 50%, max. CHF 1,000 per calendar year	1. Depending on coverage level, reimbursement of the following costs: –dental treatment by a qualified dentist; – yearly prophylactic dental check-up; – dento-facial orthopaedic treatment; – laboratory. 2. Insureds are immediately entitled to benefits for dental treatment following accidents which occur after the insurance comes into effect. 3. Coverage for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following accidents is valid as soon as the insurance comes into effect; in other cases, not before a minimum insurance period of 12 months has lapsed. 4. Benefits for dental treatment are subject to a 3-month waiting period and to points 2 and 3 above. 5. The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%. 6. Treatments abroad are covered, provided that the foreign medical staff is trained to the equivalent of the Swiss training and that costs do not exceed those which would have been charged in Switzerland.

	Level 1	Level 2	Level 3	Description
Thermal cures	None	50%, max. 30 days per calendar year	90%, max. 30 days calendar year	– Treatment and board during thermal cures in marine cure facilities recognised by the Ordinance on compulsory health insurance benefits in case of sickness (OPAS/KLV). – Benefits are payable provided the treatment is prescribed by a recognised physician within the meaning of LAMal/KVG. Subject to revocation of the entitlement to benefits, an application for authorisation accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
Convalescence cures	None	50%, max. 30 days per calendar year	90%, max. 30 days per calendar year	– Treatment and board in case of convalescence cures in Switzerland in facilities recognised by the Insurer provided that the convalescence follows hospitalisation. – Subject to revocation of the entitlement to benefits, an application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
Home help	50%, max. CHF 1,500 per calendar year	50%, max. CHF 1,500 per calendar year	90%, max. CHF 2,500 per 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.). – No benefits are payable if the insured person is declared disabled by the Federal Disability Insurance (AI/IV), receives an invalidity allowance or is hospitalised or staying at a cure or convalescence facility.
Alcohol detoxification cures	CHF 50 per day, max. 30 days per calendar year	CHF 100 per day, max. 30 days per calendar year	CHF 100 per day, max. 30 days per calendar year	– Contribution to the cost of treatment and board in case of residential cures in specialised rehabilitation facilities for alcoholics. – Only treatments in facilities recognised by the «Centrale de coordination nationale de l'offre de thérapies résidentielles pour les problèmes de drogue» (the national coordination office for residential therapies in connection with substance abuse) will be reimbursed. The list of recognised facilities is available from the Insurer.
Vaccinations	90%	90%	90%	– Reimbursement of medically prescribed vaccinations (not included in the Ordinance on compulsory health insurance benefits – OPAS/KLV) in Switzerland, and of any vaccinations recommended by the Swiss Federal Office of Public Health for trips abroad.
Check-ups	90%, max. 1 every three years	90%, max. 1 every three years	90%, max. 1 every three years	– Only check-ups defined and carried out by recognised physicians within the meaning of LAMal/KVG will be reimbursed. Check-ups include: – for persons under 40: a consultation (extended examination), glucose and cholesterol tests – for persons over 40: a consultation (extended examination), an electrocardiogram at rest, hematochemical, glucose and cholesterol tests.
Second opinion	90%	90%	90%	– Reimbursement of the cost of a second opinion before hospitalisation provided that the doctor's bill indicates «second opinion».
Preventive healthcare services	50%, max. CHF 200 per calendar year	50%, max. CHF 200 per calendar year	50%, max. CHF 200 per calendar year	– Reimbursement of a cure in a facility or centre recognised by the Insurer for back school, fitness or tobacco detoxification treatment. – If several measures promoting good health are taken in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 200.

2. List of «alternative medicine» therapies

Naturopathy	Manipulation techniques	Other
Acupuncture	Acupressure	Auto phoni psychology
Aromatherapy	Alexander technique	Bio-energetics
Auriculotherapy	Cardio technique	Eurythmy
Bioresonance	Lymphasizing	Gestalt
Biotherapy	Etiopathy	Rebirthing
Chromotherapy	Myofascial release therapy	Relaxation
Nutritional counseling	Inochi therapy	Sophrology
Electroacupuncture	Postural integration	NST (Advanced Bowen
Eutony	Kinesiology	Therapy)
Geobiology	Massage therapies	Tomatis Method
Herbal medicine	Anthroposophic medicine	
Homeopathy	Mesotherapy	
Iridology	Metamorphosis	
Colon hydrotherapy	Orthobionomy	
Kneipp therapy	Osteopathy	
Laser therapy	Pedicure (functional treatment)	
Magnetic field therapy	Polarity	
Magnetotherapy	Energy balancing	
Moratherapy	Reflexology	
Naturopathy	Reiki	
Oxygenotherapy	Rolfing	
Therapeutic painting	Shiatsu	
Phytotherapy	Touch for Health	
Breathing therapy	Trager	
Sympathicotherapy	Autogenic training	
Laboratory tests	Vitalpraktik therapy	
Cupping		

3. Abroad

1. The benefits enumerated below are valid worldwide, Switzerland and Liechtenstein 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 treatment abroad will be reimbursed only upon written request of the insured, subject to the Insurer's prior consent.
4. The benefits enumerated 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 hospitalisation cases and other treatments which are subject to a financial guarantee request from the healthcare provider shall be notified beforehand to Groupe Mutuel Assistance with 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 accidentally injured, 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, detailed invoices, medical certificates, prescriptions, payment confirmations, etc.).
   - 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 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 their 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).
   a. By way of derogation from Article 5.3.3, voluntary treatment abroad for the above-mentioned insureds are not subject to prior consent of the Insurer.
   b. The maximum insurance coverage duration of 12 months from the date of crossing the Swiss border provided for in Article 4.1 CGC is not applicable to these insureds.

	Level 1	Level 2	Level 3	Description
Outpatient treatment	The insured sum amounts to a maximum of CHF 100,000 per calendar year			Consultations, tests, X-rays and recognised drugs.
Hospitalisation				Hospitalisation for recognised treatment.
Transport costs				Necessary transport to the nearest hospital facility for treatment.
Repatriation, search and rescue				Reimbursement of the following costs only: – repatriation transport costs, including for a dead person, subject to the Insurer's prior agreement – search and rescue costs for an insured person who is sick or whose physical integrity is threatened
Visit of a family member				Visit of a family member if an insured person is hospitalised for 7 days or longer, namely: – documented costs of round trip in economy class plus public transport fares to the facility where the insured is hospitalised; – documented meal and accommodation costs up to CHF 250 per day with a maximum ceiling of CHF 2,000.

4. **Groupe Mutuel Assistance**
   The 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's domicile, in Switzerland or abroad).
5. **«Emergency hospitalisation abroad upgrade» option**
   This option may be contracted for an additional premium by insureds with Global smart N3 coverage. It entitles the insured to reimbursement of treatment and room and board in case of hospitalisation abroad up to a maximum amount of CHF 3,000 per day for no more than 60 days per calendar year. These benefits are additional to the other benefits mentioned in Article 5.3.

Art. 6 Entitlement to benefits

Benefits are payable according to treatment dates. Costs incurred after entitlements are exhausted (benefits subject to duration or reimbursement ceilings) cannot be carried forward to the next year.
It is not possible to accrue benefits insured in Switzerland and abroad.
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 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 and Liechtenstein pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions.

1. **Scope and duration of hospitalisation benefits**
   Hospitalisation benefits are limited to the acute phase of the illness. The entitlement to benefits ceases once the condition is no longer considered acute, as in the treatment of stabilised or chronic conditions in particular, or if hospitalisation does not serve to improve the insured's health.
2. **Maternity coverage**
   a. Benefits for inpatient treatment during pregnancy and childbirth are first payable after a 12-month insurance period.
   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 waiting period specified in paragraph (a) above.
   c. 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, health care coverage is contracted for the child with the Insurer. Personal expenses are not covered. Notwithstanding, point (a) remains applicable.
3. **Organ transplants**
   The present insurance does not include coverage for organ transplants covered by lump-sum rates agreed by the SVK (Fédération suisse pour tâches communes des assureurs maladie, Solothurn); such costs are covered by compulsory insurance. This rule also applies to hospital facilities which are not bound by agreed lump-sum rates.
4. **«Emergency hospitalisation abroad upgrade» option**
   The benefits contemplated in Article 5.5 of these Special Terms and Conditions («Emergency hospitalisation abroad upgrade» option) will be granted only if such coverage is specifically indicated in the insurance policy.

Art. 7 Premiums

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:

– from 0 to 18;
– from 19 to 25;
– from ages 26 to 71, age groups are graduated in 5-year brackets.

Premiums are graduated in accordance with the foregoing age groups.

Art. 8 Deductibles

1. Insureds can choose one of the following options:
   – no annual deductible;
   – a deductible of CHF 500 per calendar year.
2. Insureds having chosen level 3 can also opt for an annual deductible of CHF 1,000.
3. The benefits under Groupe Mutuel Assistance are not subject to a deductible.

Art. 9 Departure from the circle of insureds qualifying for insurance under the group insurance plan and termination of the framework agreement

1. When an insured leaves the circle of insureds under a group insurance plan, premiums are adjusted based on existing individual tariffs.
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 group insurance plan shall be maintained.
4. The entry into force of the contract concluded before the insured leaves the circle of insureds under a 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 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 the insured company 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.
   In the event of a breach of the obligation to notify, the insured shall reimburse to the Insurer any premium difference arising from the adjustment provided for in the first paragraph.
8. In case of a termination of the framework agreement which provides for the payment of all or part of the premiums by the insured company, the premiums due for the insurance periods following the end of the framework agreement will be invoiced directly to the insured person, who is the debtor of their payment.
9. The insured person can terminate the contract within 30 days after having received his new policy.