groupemutuel

Special conditions for Global smart supplemental insurance coverage

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GOGA02-E8 – Edition: 01 June 2023

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 in addition 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 illness, accident and maternity coverage.

Art. 3 Eligibility

1. Global smart coverage levels N1 and N2 are open to all persons residing in Switzerland, without any age limit. For the N3 coverage level, application for Global smart insurance can be made to take effect no later than the applicant's 70th birthday.
2. In the case of a framework agreement, the group of persons entitled to insurance and the terms and conditions of admission applicable to the various categories of applicants are defined in the framework agreement signed between the co-contracting company and the insurer.

Art. 4 Continuation of insurance coverage in the event of a transfer of residence abroad

1. If the place of residence is transferred abroad during the contract, Global smart can be maintained, provided the insured person remains subject to compulsory health insurance (LAMal/KVG), pursuant to the EU/EFTA Agreement on the Free Movement of Persons or to other international social security agreements, or is covered pursuant to Art. 1, para. 2 of these special terms and conditions of insurance.
2. The insured person domiciled abroad must notify the insurer in writing within 30 days when he no longer complies with the criteria specified in Art. 4, 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 from the date on which the prescribed criteria were no longer fulfilled.

Art. 5 Termination of the insurance contract

After three insurance terms (within the meaning of Art. 12 of the general terms and conditions of insurance), the policyholder may terminate the contract for the end of a calendar year by giving one month's notice.

Art. 6 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 the chosen coverage level, in general or psychiatric wards, for treatment of acute conditions. – Reimbursement of treatments recognised under LAMal/KVG, of hospital boarding costs and of physician's fees in accordance with the tariff agreement concluded with the insurer for the corresponding wards. – The insurer will pay the costs of recognised facilities or doctor, 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 amounts specified in Annex A, per night of hospitalisation. – 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 a change in the list does not give the policyholder the right to terminate the contract. – 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. – 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. – 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 maximum CHF 5,000 per hospital stay.
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 6.2 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.

	Level 1	Level 2	Level 3	Description
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.
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 illness (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. 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 using the form “Notification of a financial guarantee request”. Failing this, the insurer may reduce the insurance benefits by the amount that would have been paid if the prior notification had been made. The insurer waives the right to reduce its benefits if it is clear from the circumstances that the breach of the obligation to notify is not at fault.
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. By way of derogation to Art. 6.3.3., voluntary treatment abroad for persons
   - who are resident abroad and remain subject to compulsory health insurance (LAMal/KVG), or
   - 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, are not subject to prior consent of the insurer.

	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 6.3.

Art. 7 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. If, when signing up to the insurance, the insured person can prove that she was covered by Groupe Mutuel Assurances GMA SA or another insurer during the last 12 months prior to the entry into force of the insurance contract with the same coverage in the event of hospitalisation (general, semi-private or private ward) and including the maternity risk, the 12-month period of non-availability for maternity benefits (Art. 7, para. 2(a) of these special terms and conditions) is not applied.
   c. 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 period of non-availability specified in paragraph (a) above.
   d. 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 6.5 of these special terms and conditions of insurance (“Emergency hospitalisation abroad upgrade” option) will be granted only if such coverage is specifically indicated in the insurance policy.

Art. 8 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 five-year brackets.

Premiums are graduated in accordance with the foregoing age groups.

Art. 9 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. 10 Departure from the circle of persons qualifying for insurance under the framework agreement and termination of the framework agreement

1. When an insured leaves the circle of insureds under a framework agreement, premiums are adjusted based on existing individual tariffs.
2. The same rule applies to the family members of a deceased employee insured under a framework agreement.
3. Any exclusions specified before the insured leaves the circle of insureds under a framework agreement shall be maintained.
4. The entry into force of the contract concluded before the insured leaves the circle of insureds under a framework agreement is taken into account for calculating the periods of non-availability.
5. Any benefits received before an insured leaves the circle of insureds under a framework agreement 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 person or the policyholder shall notify the insurer in writing of his departure from the circle of insureds under a framework agreement within 30 days.
   In the event of a breach of the obligation to notify, the policyholder 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 a 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 policyholder, who is the debtor of their payment.
9. The policyholder can terminate the contract within 30 days after having received his new policy.

Annex A

Maximum amounts reimbursed for hospitalisation benefits provided by facilities or doctors not recognised by the insurer (Art. 6, para. 1 of these special terms and conditions, section - "Hospitalisation in Switzerland").

	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