groupemutuel

Special Terms and Conditions for “Global smart” insurance

GO

GOGA03-E1 – Edition: 01 Dec 2025

Table of 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 provide insured persons with specific benefits to supplement those provided by social insurance, in particular compulsory health insurance (hereinafter AOS/OKP), in accordance with the Federal Law on Health Insurance (LAMal/KVG), for diagnostic and therapeutic measures, medicines and medical aids that are effective, appropriate and cost-effective.
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 Art. 7(a) of the Ordinance on Health Insurance (OAMal/KVV) by signing up to an optional health insurance in conformity with the Federal Law on Insurance Contracts (LCA/VVG), “Global smart” benefits will be paid out in addition to the said insurance.
3. “Global smart” consists of three levels of coverage:
   - Level 1
   - Level 2
   - Level 3

Art. 2 Insured risks

“Global smart” benefits provide illness, accident and maternity coverage.

Art. 3 Conditions of admission

1. All persons domiciled in Switzerland may apply for “Global smart” insurance, Level 1 and Level 2, regardless of age. For Level 3, admission to “Global smart” may be requested to take effect no later than the applicant's 70th birthday.
2. In the case of a framework agreement, the group of persons eligible for insurance and the conditions of admission applicable to the various categories of insured persons are defined by the framework agreement concluded between the co-contracting company and the insurer.

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

1. In the event of a transfer of residence abroad during the term of the contract, “Global smart” insurance may be maintained without any increase in coverage, provided that the insured person remains subject to the AOS/OKP pursuant to the agreement on the free movement of persons between the EU/EFTA and Switzerland or other international agreements, or benefits from coverage in accordance with Art. 4 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. Insured persons domiciled abroad must inform the insurer in writing within 30 days if they no longer comply with the criteria set out in Art. 4, para. 1 of these special terms and conditions. In the event of a breach of this obligation, the insured person shall reimburse the insurer for any benefits paid from the date on which the above criteria are no longer met.

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 coverage option is specified in the insurance policy.	General information – Free choice in Switzerland, depending on the level chosen, of an acute care, psychiatric or rehabilitation hospital for acute patients. – Hospitalisation benefits in a psychiatric hospital are no longer paid after 60 days. – Coverage of the difference in cost in the event of hospitalisation in a hospital listed under the LAMal/KVG outside the insured person's canton of residence that is not justified on medical grounds or is not an emergency, when the hospital's rates exceed the reference rates for the insured person's canton of residence. Level 3 (semi-private and private ward) – Coverage also includes hospital accommodation costs, doctors' fees and additional medical services, in accordance with the agreement entered into with the insurer for the corresponding wards. – If an insured person receives benefits from non-recognised facilities or doctors (i.e. one with whom the insurer has not reached a tariff agreement), they will be entitled to the following for the services provided by the hospital or doctor, depending on the type of care (acute, rehabilitation or psychiatric) and the type of ward (semi-private or private): the inpatient hospitalisation benefits actually invoiced, but not exceeding the amounts shown in Appendix A per night of hospitalisation. – The list of healthcare providers recognised by the insurer is available on the insurer's website or on request. The list in force at the time of treatment is decisive. – The list of healthcare providers can be amended at any time by the insurer. Such an amendment to the list does not give the policyholder the right to terminate the insurance. – Before each hospitalisation, the insured person is required to find out whether the hospital, hospital ward or clinic where they will be treated is one of the facilities recognised by the insurer. – After 180 days of hospitalisation in a semi-private or private ward during a calendar year, hospitalisation benefits are no longer paid. The duration of benefits in a psychiatric care facility (60 days) is deducted from the 180 days mentioned above.

Outpatient surgery	No benefits	CHF 300/calendar year	CHF 600/calendar year	– When the insured person undergoes outpatient surgery, the insurer will pay the following benefits:
				  – upgrades charged by the hospital where the outpatient surgery takes place (e.g. private waiting room or recovery room, snacks);
				  – accommodation for the insured person and accompanying persons in a hospital or hotel for the night before and/or after the surgery;
				  – transportation of the insured person between their home and the healthcare provider in question;
				  – parking fees.

Restricted and non-reimbursable drugs	90%, max. CHF 100,000/calendar year	90%, max. CHF 125,000/calendar year	90%, max. CHF 150,000/calendar year	– Medication recognised by Swissmedic at current market prices prescribed by a doctor or a healthcare provider recognised under LAMal/KVG, not covered by the AOS/OKP. – Exclusions: products on the list of pharmaceutical products for special application (LPPA/LPPV).
Transport and search and rescue costs	90% (transport) 90%, max. CHF 50,000/calendar year (search and rescue)	90% (transport) 90%, max. CHF 75,000/calendar year (search and rescue)	90% (transport) 90%, max. CHF 100,000/calendar year (search and rescue)	– Transport to the nearest hospital facility or doctor provided such transport is medically necessary. – This contribution is only granted for transport by ambulance or by helicopter or for a search and rescue operation. – The cost of transport (public or private) required for outpatient treatment is reimbursed up to the cost of public transport if it is justified by the importance of the side-effects of the treatment or makes it possible to avoid hospitalisation.

	Level 1	Level 2	Level 3	Description
Alternative medicine	30%, max. CHF 1,000/calendar year, including max. CHF 200/calendar year for massages	60%, max. CHF 2,500/calendar year, including max. CHF 300/calendar year for massages	80%, max. CHF 3,000/calendar year, including max. CHF 500/calendar year for massages	– Medically necessary therapies that appear on the insurer's list and are performed by a qualified doctor or an alternative medicine therapist recognised by the insurer for the therapy in question. – The insurer keeps a list of the recognised therapies and therapists and reserves the right to exclude certain therapies and/or therapists at any time. – Before each treatment, the insured person shall check that the attending practitioner is recognised by the insurer for the relevant therapy. – There is no entitlement to benefits for sessions provided between family members.
Mammograms and ultrasounds	90%	90%	90%	– Mammograms and ultrasounds not covered by the AOS/OKP.
Preventive gynaecological examinations	90%	90%	90%	– Preventive gynaecological examinations not covered by the AOS/OKP.
HIV preventive tests	90%	90%	90%	– The cost of preventive HIV tests when prescribed and provided by recognised providers within the meaning of the LAMal/KVG.
Medical aids	No benefits	90%, max. CHF 1,000/calendar year	90%, max. CHF 2,000/calendar year	– Rental and purchase costs of orthopaedic appliances and medical aids (excluding dental prostheses) in accordance with the list drawn up by the insurer.
Medical glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	– The specified amount for the purchase of medical glasses or contact lenses which are not covered by the AOS/OKP.

Dental treatment	No benefits	Up to age 18
		50%, max. CHF 2,000/calendar year
		
		From age 19
		50%, max. CHF 500/calendar year
			Up to age 18
			50%, max. CHF 2,000/calendar year
			
			From age 19
			50%, max. CHF 1,000/calendar year
				– Coverage only for the following costs incurred by a healthcare provider recognised under the LAMal/KVG:
				  – dental treatment;
				  – dentofacial orthopaedic care;
				  – laboratory costs.
				– Depending on the level chosen, coverage of the costs of an annual prophylactic dental check-up (including scaling) carried out by a qualified dentist, hygienist or prophylaxis assistant.
				– For dental treatment following an accident that occurred after the insurance came into effect, entitlement to benefits is immediate.
				– In the event of an accident, benefits for prosthetic treatment (replacement of teeth, fitting of crowns, pivot teeth, bridges, partial or full dentures, etc.) are granted immediately after the insurance comes into force; in other cases, benefits are granted at the earliest after 12 months' affiliation to the insurance.
				– For dentofacial orthopaedic care (including dentofacial orthopaedic laboratory costs) and dental treatment, benefits are granted by the insurer after a waiting period of three months, except in the case of an accident.
				– The tariff applicable to social insurance (dental rates under health insurance, accident insurance, military insurance or disability insurance) (nomenclature and point value) is decisive for the calculation of the benefits covered. A possible increase in the dental rate under accident insurance may be accepted but may not exceed 50%.
				– No benefits are granted for dental hygiene products.

Convalescence cures and spa treatments	No benefits	50%, max. 30 days/calendar year	90%, max. 30 days/calendar year	– Treatment and boarding costs for convalescence cures in Switzerland following a stay in hospital, in facilities recognised by the insurer. – Treatment and accommodation costs for spa treatments in facilities recognised under the Ordinance on Healthcare Insurance Benefits (OPAS/KLV). – Benefits are payable provided the treatment is prescribed by a recognised physician within the meaning of LAMal/KVG. – The insurer keeps a list of the recognised pharmacists. – A request for authorisation and the medical prescription must be submitted to the insurer beforehand, otherwise the right to benefits will lapse.

	Level 1	Level 2	Level 3	Description
Home help	50%, max. CHF 1,500/calendar year	50%, max. CHF 1,500/calendar year	90%, max. CHF 2,500/calendar year	– Costs resulting from the medically justified hiring of a home help who carries out this activity on a professional basis for his/her own account or that of a company or organisation and who takes care of the daily domestic and household chores on behalf of the insured person. All other costs are excluded (spring cleaning, etc.). – The insured person is required to obtain the insurer's prior consent.
Care for sick children at home	No benefits	90%, max. CHF 250/calendar year	90%, max. CHF 300/calendar year	– For children up to the age of 12, coverage of child-minding costs by the Red Cross or an official institution with a similar purpose if the parents have a professional activity outside the home.
Vaccines	90%	90%	90%	– Costs for vaccines recognised by the AOS/OKP when the conditions for coverage defined in Art. 12(a) of the OPAS/KLV are not met. – Costs for vaccines recommended by the Federal Office of Public Health (FOPH) in the event of travel abroad. – Vaccines must be recognised by Swissmedic. – The insurer covers vaccinations carried out by a doctor or pharmacist recognised by the AOS/OKP.
Voluntary sterilisation	No benefits	90%, max. CHF 300	90%, max. CHF 500	– Coverage of the cost of sterilisation.
Check-ups	one check-up every three years, 90%, max. CHF 1,000	one check-up every three years, 90%, max. CHF 1,000	one check-up every three years, 90%, max. CHF 1,500	– Only check-ups defined and carried out by recognised physicians within the meaning of LAMal/KVG will be reimbursed. – The insurer keeps a list of insured check-ups.
Second opinion	90%	90%	90%	– The cost of a second opinion before hospitalisation provided that the doctor‘s bill indicates “second opinion”.
Health Promotion	50%, max. CHF 200/calendar year	50%, max. CHF 200/calendar year	50%, max. CHF 200/calendar year	– Coverage of costs for the following measures: – exercise training, – fitness membership and classes, – other preventive measures. – The insurer keeps a list of recognised fitness courses and other preventive measures. – For fitness subscriptions, the insurer keeps a list of recognised fitness centres. – If several health promotion measures are carried out during the same calendar year, the maximum total benefit covered is CHF 200. – For fitness memberships and courses that are not valid for a full calendar year, the insurer's benefit for each calendar year is calculated on a pro rata basis according to the membership period that has elapsed by the end of the calendar year.

2. Outside Switzerland

1. The benefits in the table below are valid worldwide, excluding Switzerland, as a supplement to Swiss or foreign social insurance.
2. The benefits insured by “Global smart” insurance correspond to those covered in Switzerland by analogy with the criteria applicable in Switzerland. They are covered if they are provided by persons or institutions that have the necessary training, recognition and authorisation foreign social security organisations.
3. For emergency treatment within the meaning of Art. 36, para. 2 OAMal/KVV, coverage supplements the AOS/OKP benefits for costs exceeding the AOS/OKP maximum coverage. In accordance with the OAMal/KVV, an emergency exists when the insured person requires medical treatment and a return to Switzerland is not appropriate.
4. For benefits that are not included in the AOS/OKP catalogue (e.g. search, rescue and repatriation costs) or where there is no AOS/OKP benefit obligation, the benefits listed in the table below are covered exclusively by this insurance. There is no obligation for the AOS/OKP compulsory health insurance to provide benefits in the following situations:
   - voluntary treatment abroad,
   - continuation of treatment abroad following an emergency when a return to Switzerland would be appropriate.

   The provisions of Art. 7, para. 5 of these special terms and conditions remain reserved.
5. Voluntary treatment abroad is covered in accordance with section 4, provided that the cost of such treatment abroad (including dental treatment) is lower than the corresponding cost in the canton of residence of the insured person. To avoid any risk of refusal of reimbursement, it is recommended that a prior request be made to the insurer to check whether the proposed treatment is appropriate, economical and effective. This coverage, which is limited to voluntary treatment abroad at a lower cost than the corresponding costs in Switzerland, does not apply to voluntary treatment abroad for persons:
   - residing abroad and remaining subject to the AOS/OKP or
   - who have chosen to maintain their insurance coverage in accordance with Article 7(a) of the

OAMal/KVV by signing up to an optional health insurance under the LCA/VVG.

6. Cases of hospitalisation and other costly treatments for which the healthcare provider has requested a financial guarantee must be reported in advance to the “Groupe Mutuel Assistance” assistance platform using the “notification of request for financial guarantee” form. Failing this, the insurer may reduce the insurance benefits by the amount that would have been paid if prior notification had been given. The insurer will not reduce its benefits if it is clear from the circumstances that the breach of the notification obligation was not the fault of the insured person.
7. Payment of benefits
   - If several insured members from the same family fall ill or are accidentally injured at the same time, a separate invoice for each insured person must be requested from the doctor, hospital or pharmacy, etc.
   - In order to obtain reimbursement of expenses, the insured person is required to provide all necessary original or digitally scanned supporting documents (detailed invoices, medical certificates, prescriptions, etc.). The insurer reserves the right to request the original documents and proof of payment.
   - The official exchange rate of the Swiss franc on the last day of processing shall be used for invoices from abroad.
   - The insurer recognises the standard rates applicable in the country or region where treatment was provided. It reserves the right to reduce invoices that are excessively high.

	Level 1	Level 2	Level 3	Description
Outpatient treatment	The amount insured is a maximum of CHF 200,000 per calendar year for all benefits outside Switzerland.			– Coverage of outpatient care (e.g. medical consultations, tests, medication) corresponding to the benefits recognised by the AOS/OKP.
Hospitalisation				– Coverage of treatment and accommodation costs according to the level chosen: – room with several beds for insured persons with level 1 or 2 coverage – room with two beds for insured persons with level 3 coverage, semi-private – room with one bed for insured persons with level 3 coverage, private.
Dental treatment				– Treatment abroad is covered provided that the foreign medical staff have training equivalent to Swiss training. – The benefits and coverage criteria applicable to benefits in Switzerland as defined in Art. 5, para. 1 (Dental treatment) apply by analogy.
Medical glasses and contact lenses				– The specified amount for the purchase of medical glasses or contact lenses which are not covered by the AOS/OKP. – The maximum benefits defined for medical glasses and contact lenses in Switzerland according to the chosen level apply by analogy.
Transport costs				– Transportation required for treatment in the nearest hospital.
Repatriation, search and rescue				– Coverage of repatriation, search and rescue costs in accordance with the Groupe Mutuel Assistance general terms and conditions of insurance applicable at the time the contract was taken out for costs exceeding the amounts insured by Groupe Mutuel Assistance coverage.
Visit by a family member				– Visit by a family member of the insured person who has been hospitalised for more than seven days, namely: – documented costs of round trip in economy class plus public transport fares to the facility where the insured person is hospitalised; – documented costs for room and board not exceeding CHF 250 per day up to maximum CHF 2,000;
Statutory cost-sharing amounts				– Coverage of foreign statutory cost-sharing amounts for outpatient or inpatient treatment under the EU/EFTA Agreement on the Free Movement of Persons or other international social security agreements, subject to foreign law.

3. Groupe Mutuel Assistance

The benefits provided for in the general terms and conditions of Groupe Mutuel Assistance insurance applicable at the time the contract is concluded (repatriation and transport when the incident occurs beyond a radius of 20 kilometres from the insured person's place of residence, in Switzerland and abroad).

Art. 6 Lists of benefits and providers

1. The lists mentioned in these special terms and conditions of insurance are available on the insurer's website or on request from the insured person.
2. The lists valid at the time of treatment or use of a benefit are decisive.
3. These lists may be modified at any time by the insurer. Such an amendment to the list does not give the policyholder the right to terminate the insurance.

Art. 7 Entitlement to benefits

1. Benefits are payable according to treatment dates. Costs incurred after entitlement has been exhausted (benefits subject to a time or reimbursement limit) cannot be carried over to the following year.
2. It is not possible to combine insured benefits in Switzerland and abroad.
3. As provided for in these special terms and conditions of insurance, the insurer will reimburse any costs not covered by compulsory health insurance (AOS/OKP) 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 governed by these provisions be used to cover statutory co-insurance payments and deductibles under the AOS/OKP.
4. 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.
5. In the event of multiple insurance coverage within the meaning of the LCA/VVG, the insurer will pay benefits in proportion to the insurance coverage taken out.
6. If insurance coverage begins during the course of the year, the insurer may reduce the maximum amount covered by calendar year proportionally.
7. Scope and duration of benefits in the event of hospitalisation
   Hospitalisation benefits are limited to the acute phase of the illness. As soon as the patient is no longer considered to be in an acute phase, in particular during treatment for stabilised or chronic conditions, or when the hospital stay does not serve to improve the insured person's state of health, the entitlement to benefits ceases.
8. Coverage of benefits in the event of maternity
   a. Benefits for inpatient treatment in the event of pregnancy and childbirth are only paid after a 12-month insurance period.
   b. If, when signing up to the insurance, the insured person proves 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. 8(a) of these special terms and conditions) is not applied.
   c. Interruptions of pregnancy within the meaning of the LAMal/KVG, and any other maternity-related benefits are subject to the waiting period specified in item (a) above.
   d. When an insured person stays in a hospital ward corresponding to her insurance cover, the insurer will also cover the costs of the newborn's stay during the mother's hospitalisation, provided that the child is covered by health insurance with the insurer within 30 days of birth. Personal expenses are not covered. Item (a) of this section remains reserved.
9. Organ transplants
   Under this insurance, there is no coverage for organ transplants for which the SVK (Fédération suisse pour tâches communes des assureurs maladie, Solothurn) has agreed flat rates per case (these costs are covered by the AOS/OKP). This rule also applies to hospitals for which no flat-rate fees have been agreed.

Art. 8 Saving measures

If a person insured under Level 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 calendar year.

Art. 9 Premiums

1. The rate is determined according to the age group, gender and canton of residence of the insured person.
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 relevant age groups are as follows:
   - from age 0 to 18;
   - from age 19 to 25;
   - from ages 26 to 85, age groups are graduated in five-year brackets;
   - 86 years and over.
3. A change in age group generally results in an automatic adjustment of the premium.

Art. 10 Family discount

1. A family discount may be granted on the premium for children up to the age of 18 if at least one of their parents and the child are affiliated to “Global smart” insurance and the level of coverage taken out by the parent is equivalent to or higher than that taken out by the child.
2. The family discount shall be withdrawn as soon as the conditions for granting it as set out in para. 1 are no longer met.
3. Pursuant to Art. 26a, para. 2(d), letter d of the general terms and conditions of insurance, the insurer may change or withdraw the family discount at any time, with effect at the end of the current calendar year at the earliest.

Art. 11 Departure from the group of insured persons under a framework agreement and termination of the framework agreement

1. In the event of departure from the group of insured persons under a framework agreement, premiums shall be adjusted on the basis of the individual rates in force.
2. The same rule applies to family members of the deceased employee who are insured under a framework agreement.
3. Any medical exclusions already in place prior to departure from the group of insured persons under a framework agreement shall be maintained.
4. The effective date of the contract concluded before leaving the group of insured persons under a framework agreement is taken into account when calculating waiting periods.
5. Benefits received before leaving the group of insured persons under a framework agreement are taken into

account when calculating maximum benefits.

6. The same provisions apply in the event of termination of the framework agreement between the insured company and the insurer.
7. The insured person or policyholder must inform the insurer in writing of their withdrawal from the group of insured persons under a framework agreement within 30 days.
8. In the event of a breach of this notification obligation, the policyholder shall reimburse the insurer for any difference in premiums resulting from the adjustment provided for in section 1.
9. In the event of termination of a framework agreement providing 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 shall be invoiced directly to the policyholder, who shall be liable for their payment.
10. The policyholder may terminate the contract within 30 days of receiving the new policy.

Appendix A

Maximum amounts reimbursed for hospitalisation benefits provided by institutions or doctors not recognised by the insurer (Art. 5, para. 1 of these special terms and conditions of insurance, 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 expenses	**CHF 500**	**CHF 500**	**CHF 0**	**CHF 0**
Non-recognised hospital:				
– Reimbursement of hospital expenses	**CHF 300**	**CHF 500**	**CHF 100**	**CHF 150**
Non-recognised hospital and doctor:				
Total reimbursement	**CHF 800**	**CHF 1,000**	**CHF 100**	**CHF 150**
- Medical expenses	**– CHF 500**	**– CHF 500**	**– CHF 0**	**– CHF 0**
- Hospital expenses	**– CHF 300**	**– CHF 500**	**– CHF 100**	**– CHF 150**