

General terms and conditions of insurance (CGA) Global School supplemental insurance

EG

EGGA01-E3 – Edition: 01 Jan 2017

Contents

Art. 1	Bases of the insurance contract	Art. 13	Healthcare provider rates
Art. 2	Purpose of the insurance	Art. 14	Advance premium and final premium statements
Art. 3	Definitions	Art. 15	Changes in premium rates
Art. 4	Policyholder and insured persons	Art. 16	Obligations of the policyholder
Art. 5	Start, duration and end of contract	Art. 17	Obligations of the insured person
Art. 6	Start and end of insurance coverage	Art. 18	Obligation to limit damages
Art. 7	Territorial validity	Art. 19	Adjustments to the insurance terms and conditions
Art. 8	Insured benefits	Art. 20	Notices
Art. 9	Entitlement to benefits and limitations	Art. 21	Prescription
Art. 10	Excluded benefits	Art. 22	Place of performance and applicable law
Art. 11	Several insurers and third-party benefits	Art. 23	Jurisdiction
Art. 12	Healthcare providers		

Art. 1 Bases of the insurance contract

1. The insurance proposal, these general terms and conditions (CGA), the insurance policy and the relevant annexes constitute the bases of the insurance contract.
2. The insurance contract is subject to the Federal Law of 2 April 1908 on Insurance Contracts (LCA/VVG) which regulates all aspects not covered by the aforesaid bases.
3. The contract is also governed by the Law on Data Protection (LPD/DSG), which the Insurer duly observes when processing data.

Art. 2 Purpose of the insurance

1. The purpose of this insurance is to cover insured persons for general supplemental benefits in case of illness and/or accident over and above:
 - compulsory health insurance (AOS/OKP) according to the Federal Law on Health Insurance (LAMal/KVG);
 - private insurance coverage equivalent to AOS/OKP for persons exempted from insurance under Article 2, paragraph 4 of OAMal/KVV (students, pupils or trainees from abroad who are staying in Switzerland within the scope of an education or professional development programme).
2. Global School insurance offers three levels of coverage:
 - Level 1
 - Level 2
 - Level 3
3. The insurance covers the economic consequences of illness and accident. Maternity benefits are excluded from the insurance.

Art. 3 Definitions

1. Illness means any impairment of the insured person's physical, psychological or mental health that was not caused by an accident and that requires that the insured person undergoes examinations or a medical treatment, or which causes incapacity for work.
2. Accident means any damaging, sudden and involuntary injury to the human body which is prejudicial to physical, mental or psychological health or leads to death and was occasioned by an extraordinary external cause. Where it is obvious they are not due to illness or to degenerative disorders, the following personal injuries, contained in the below comprehensive list, are assimilated to an accident, even if they are not caused by an extraordinary and external cause:
 - a. broken bones;
 - b. dislocation of articulations;
 - c. meniscus tear;
 - d. torn muscles;
 - e. pulled muscles;
 - f. torn tendons;
 - g. ligament injuries;
 - h. ear drum damage.
3. Maternity includes pregnancy and delivery, as well as recovery from the latter.

Art. 4 Policyholder and insured persons

1. The policyholder is the legal entity that concludes an insurance contract with the Insurer for the purpose of letting a third party benefit from insurance coverage.
2. The policyholder must be domiciled in Switzerland.
3. All persons belonging to the circle of insured persons defined in the insurance policy are insured.

Art. 5 Start, duration and end of contract

1. The insurance contract is concluded as soon as the Insurer has notified the Applicant that the proposal is accepted.
2. The contract begins at the date of entry into force stated in the insurance policy.
3. At the expiry date indicated on the policy, the contract will be automatically renewed from year to year unless it is terminated with three months' notice before expiry.
4. To be valid, the notice of termination must reach the Insurer or the policyholder at the latest the day before the start of the three-month notice period.
5. If the contract is concluded for a term of less than one year, it will in any event expire on the agreed expiry date.
6. After each claim in respect of which the Insurer is liable for benefits, the policyholder may withdraw from the contract within 14 days of hearing that the benefit was paid. If the policyholder withdraws from the contract, coverage ceases as soon as the Insurer receives the notice of termination.
7. Terminations must be notified by registered letter.
8. The Insurer may terminate the contract in case of non-payment of premiums, within the meaning of Article 14 of these general terms and conditions of insurance.

Art. 6 Start and end of insurance coverage

1. The insurance coverage begins at the date of entry into force specified in the insurance certificate given to the insured person by the policyholder.
2. Coverage ends at the date specified in the insurance certificate which is given by the policyholder to the insured person or when the insured departs from the circle of insured persons as defined in the policy.
3. Coverage ceases at the end of the contract.

Art. 7 Territorial validity

1. Insurance is valid in Switzerland (cf. Article 8.1).
2. In case of journeys or temporary stays outside Switzerland not exceeding 90 consecutive days, the Insurer will cover the costs of emergency medical treatments defined in Article 8, paragraph 3 of these general terms and conditions of insurance. An emergency is when the insured person requires medical treatment and that a return to Switzerland is inappropriate.

Art. 8 Insured benefits

1. In Switzerland

	Level 1	Level 2	Level 3	Details
Hospitalisation	general ward	general ward	semi-private or private ward The insured option is mentioned in the insurance policy.	Description <ul style="list-style-type: none"> – In Switzerland, free choice of hospital facility depending on the applicable coverage level, in general or psychiatric wards, for the treatment of acute conditions and accidents. – Costs of treatments recognised under LAMa/KVG, of hospital boarding costs and of physician's fees in accordance with tariff agreements or cantonal regulations. Comments <ul style="list-style-type: none"> – Hospitals must be recognised facilities within the meaning of LAMa/KVG (listed hospitals), or they must have concluded a tariff agreement with the Insurer for the corresponding wards. – Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in psychiatric facilities in any given calendar year. – Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in a semi-private or private ward in any given calendar year. – Benefits granted for treatment in psychiatric facilities are deducted from the hospital benefits for a semi-private or private ward. Obligations of the insured person <ul style="list-style-type: none"> – The insured person shall check with the Insurer that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the Insurer.
Outpatient treatments	100%	100%	100%	Description <ul style="list-style-type: none"> – Free choice of treatment facility in Switzerland for outpatient treatments recognised under LAMa/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 healthcare provider.
Non-reimbursable drugs	90%	90%	90%	Description <ul style="list-style-type: none"> – Medication prescribed by a doctor or a healthcare provider recognised under LAMa/KVG, which is not reimbursed by compulsory health insurance (AOS/OKP). Exclusions <ul style="list-style-type: none"> – Products included on the list of pharmaceutical products for special application (LPPA/LPPV).

	Level 1	Level 2	Level 3	Details
Search, rescue and transport costs	90%	90%	90%	Description <ul style="list-style-type: none"> Transport to the nearest hospital facility or physician provided such transport is medically necessary. Comments <ul style="list-style-type: none"> This contribution is only granted for transport by ambulance or by helicopter. Public transport costs (bus or train) in connection with outpatient treatments designed to avoid hospitalisation are also refunded.
Alternative medicine treatments	30%, max. CHF 1,000 every three years	60%, max. CHF 1,000 every three years	90%, max. CHF 1,000 every three years	Description <ul style="list-style-type: none"> Therapies enumerated in the list below (see item 8.2 «List of alternative medicine therapies») carried out by a qualified physician or an alternative medicine practitioner recognised by the Insurer. Comments <ul style="list-style-type: none"> The Insurer keeps a list of the practitioners recognised for the envisaged therapy. This list is available on the website of the Insurer or can be sent to the policyholder or the insured person upon request. The list can be amended by the Insurer at all times. <p>Such amendments do not entitle the policyholder to terminate the contract.</p>
Glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	Description <ul style="list-style-type: none"> The specified amount for the purchase of medical glasses or contact lenses in Switzerland or abroad which are not covered by the compulsory health insurance.
Dental care	No benefits	80%, max. CHF 2,000 per calendar year	80%, max. CHF 2,000 per calendar year	Comments <ol style="list-style-type: none"> Dento-facial orthopaedic treatment (orthodontics) are not covered. For all other dental treatments, a financial contribution is granted depending on the coverage level: <ul style="list-style-type: none"> dental treatment by a qualified dentist; yearly prophylactic dental check-up; laboratory tests. Insured persons are immediately entitled to benefits for dental treatment following accidents that occur after the insurance comes into effect. Coverage for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following an accident is valid as soon as the insurance comes into effect; in other cases, not before a minimum insurance period of 12 months has lapsed. Benefits for other dental treatment are subject to a three-month waiting period and to items 2 and 3 above. The basis for the calculation of payable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%. 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 that would have been charged in Switzerland.
Thermal cures	No benefits	50%, max. 30 days per calendar year	90%, max. 30 days per calendar year	Description <ul style="list-style-type: none"> Treatment and board during thermal cures in marine cure facilities recognised under the Ordinance on Healthcare Insurance Benefits (OPAS/KLV). Benefits are payable provided the treatment is prescribed by an approved physician within the meaning of LAMal/KVG. Obligations of the insured person <ul style="list-style-type: none"> Subject to revocation of the entitlement to benefits, a coverage request and medical prescription must be submitted to the Insurer at least 20 days in advance.
Convalescence cures	No benefits	50%, max. 30 days per calendar year	90%, max. 30 days per calendar year	Description <ul style="list-style-type: none"> Treatment and board in case of convalescence cures in Switzerland in facilities recognised by the Insurer provided that the convalescence follows hospitalisation. Comments <ul style="list-style-type: none"> The Insurer keeps a list of the approved facilities. This list is available on the website of the Insurer or can be sent to the policyholder or the insured person upon request. The list can be amended by the Insurer at all times. <p>Such amendments do not entitle the policyholder to terminate the contract.</p> Obligations of the insured person <ul style="list-style-type: none"> Subject to revocation of the entitlement to benefits, a coverage request and medical prescription must be submitted to the Insurer at least 20 days in advance.

	Level 1	Level 2	Level 3	Details
Home help and placement costs	50%, max. CHF 1,500 per calendar year	50%, max. CHF 1,500 per calendar year	90%, max. CHF 2,500 per calendar year	Description <ul style="list-style-type: none"> 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.). Comments <ul style="list-style-type: none"> No benefits are payable if the insured person has been declared disabled by the Federal Disability Insurance (AI/IV), receives a disability allowance or is hospitalised or staying in a hospital, at a cure or convalescence facility.
Alcohol detoxification cures	CHF 50 /day, max. 30 days per calendar year	CHF 100 /day, max. 30 days per calendar year	CHF 100 /day, max. 30 days per calendar year	Description <ul style="list-style-type: none"> Contribution to the cost of treatment and board in case of residential cures in specialised rehabilitation facilities for alcoholics. Comments <ul style="list-style-type: none"> The Insurer keeps a list of the approved facilities. This list is available on the website of the Insurer or can be sent to the policyholder or the insured person upon request. The list can be amended by the Insurer at all times. Such amendments do not entitle the policyholder to terminate the contract.
Vaccinations	90%	90%	90%	Description <ul style="list-style-type: none"> Medically prescribed vaccinations in Switzerland (not included in the Ordinance on Healthcare Insurance Benefits – OPAS/KLV), and any vaccinations recommended by the Swiss Federal Office of Public Health for trips abroad.
Check-ups	90%, max. CHF 1,000 every three years	90%, max. CHF 1,000 every three years	90%, max. CHF 1,000 every three years	Comments <ul style="list-style-type: none"> Only check-ups carried out by recognised physicians within the meaning of LAMal/KVG will be reimbursed.
Second opinion	90%	90%	90%	Description <ul style="list-style-type: none"> The cost of a second opinion before hospitalisation provided that the doctor's bill indicates «second opinion».
Preventive healthcare services	50%, max. CHF 200/ calendar year	50%, max. CHF 200/ calendar year	50%, max. CHF 200/ calendar year	Description <ul style="list-style-type: none"> Costs as a result of benefits provided in a facility or by a healthcare provider recognised by the Insurer for back exercise schools, fitness centres or tobacco detoxification treatment. Comments <ul style="list-style-type: none"> The Insurer keeps a list of the facilities and healthcare providers approved for tobacco detoxification treatments. The Insurer keeps a list of the approval criteria for fitness centres and back exercise schools. These lists are available on the website of the Insurer or can be sent to the policyholder or the insured person upon request. The lists can be amended by the Insurer at all times. Such amendments do not entitle the policyholder to terminate the contract. If several preventive healthcare measures 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 Aromatherapy Auriculotherapy Bioresonance Biotherapy Chromotherapy Colon hydrotherapy Cupping Electroacupuncture Geobiology Herbal medicine Homeopathy Iridology Laser therapy Magnetic field therapy Magnetotherapy Morotherapy Naturopathy Nutritional counselling Oxygenotherapy Phytotherapy Sympathicotherapy	Acupressure Anthroposophic medicine Autogenic training Energy balancing Etiopathy Kinesiology Lymphasizing Myofascial release therapy Massage therapies Mesotherapy Metamorphosis Orthobionomy Osteopathy Polarity Postural integration Reflexology Reiki Rolfing Shiatsu Trager	Bio-energetics Eurythmy Rebirthing Sophrology Tomatis Method

	Level 1	Level 2	Level 3	Details
Outpatient treatments	The insured amount cannot exceed CHF 100,000 per calendar year.			Description – Consultations, tests, X-rays and recognised drugs.
Hospitalisation				Description – Reimbursement of recognised treatments within the meaning of LAMal/KVG, of hospital boarding costs and of physicians' fees. Comments – Facilities must be recognised by the competent public health authorities of the country in which the treatment takes place.
Statutory co-insurance				Description – Full coverage of foreign statutory co-insurance amounts for outpatient or hospitalisation treatments pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions, subject to international legislation.
Search, rescue and transport costs				Description – Transport to the nearest hospital facility or physician provided such transport is medically necessary. Comments – This contribution is only granted for transport by ambulance or by helicopter.
Visit of a family member outside the home country of the insured person				Description – Visit of a family member if an insured person is hospitalised for seven days or longer, namely: <ul style="list-style-type: none"> – documented costs of a 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.

3. Emergencies outside Switzerland

- The benefits listed above are valid worldwide, Switzerland excluded, supplementally or in addition to Swiss or foreign social insurance plans or to other private insurance coverage.
- The insured benefits correspond to those covered in Switzerland when being treated for similar medical conditions.
- The benefits listed above are refunded when administered by persons or institutions with the suitable training, recognition and authorisation of the foreign social bodies.
- Payment of benefits
For foreign treatments, 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.

4. Groupe Mutuel Assistance

- Territorial validity
Groupe Mutuel Assistance benefits are valid in Switzerland as well as during journeys or temporary stays outside Switzerland that do not exceed 90 consecutive days.
- Insured benefits
 - Search, rescue and transport
 - Organisation of search and rescue operations when the insured person is in a situation of provable distress that justifies the costs.
 - Organisation of transport expenses as defined in Article 8, paragraphs 1 and 3 of these general terms and conditions of insurance, to the nearest hospital or doctor according to the care required by the insured person.

b. Repatriation on health grounds

- Organisation and coverage of the costs of repatriation under medical surveillance in a hospital near the insured's place of residence in Switzerland.
- Organisation and coverage of the costs of repatriation without medical surveillance to the insured's place of residence in Switzerland following hospitalisation.

c. Return of the mortal remains

In the event of the death of the insured person, organisation and coverage of the costs of transport of the coffin, on a regular passenger plane or in a van provided for the purpose, complying with national legislation or international agreements applicable to the transport of bodies, to the insured person's home abroad or in Switzerland and provided the transfer can be achieved and that the appropriate measures are taken by the family or by a representative of the insured person to take delivery of the body.

- Benefits are covered up to CHF 10,000 for all insured costs.
- Burial costs and other funeral expenses are excluded.
- Repatriations to areas subject to a travel warning by the Federal Department of Foreign Affairs (FDFA) or to areas subject to war, revolutions, rebellion or other internal disturbances, are excluded.

d. Advance on treatment costs

If the insured person has to be admitted to hospital or undergo expensive treatment outside Switzerland, Groupe Mutuel Assistance emergency call centre will provide if necessary an advance on treatment costs.

3. Obligations of the policyholder and the insured person
In addition to the provisions of Articles 16 and 17 of these general terms and conditions of insurance, the policyholder or insured person must immediately notify Groupe Mutuel Assistance emergency call centre (phone number 0848 808 111, or +41 848 808 111 from abroad) of the case requiring medical assistance when it occurs. Only the doctors of the emergency call centre may decide upon the services to be provided and the relevant coverage.
4. Excluded benefits
In addition to the provisions of Article 10 of these general terms and conditions of insurance, there will be no insurance coverage if Groupe Mutuel Assistance emergency call centre has not given prior consent to benefits provided for by this Article.

Art. 9 Entitlement to benefits and limitations

1. Benefits are payable according to treatment dates.
When applying for insurance benefits, the insured person must provide the Insurer with all medical certificates, documentation and invoices from the various healthcare providers. The Insurer reserves the right to reduce benefits if invoices are exaggeratedly high.
It is not possible to accumulate identical or similar insured benefits in Switzerland or abroad for the same illness or the same accident.
Costs incurred after the expiry of entitlements (benefits subject to duration or reimbursement ceilings) cannot be carried forward to the next year.
If a medical treatment or alternative medicine treatment is no longer medically justified and no longer brings any therapeutic improvement, the Insurer will inform the insured person of the reduction or the end of the payment of benefits. As provided in these 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 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 insurance plans.
However, insurance coverage is extended to cover foreign statutory co-insurance amounts for treatments outside Switzerland pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions and providing it is not prohibited by the law of the relevant country.
2. Hospitalisation benefits are limited to the acute phase of the illness and/or accident. The entitlement to benefits ceases once the condition is no longer considered acute, including in the treatment of stabilised or chronic conditions, or if hospitalisation does not serve to improve the insured's health.
Coverage for treatment in psychiatric facilities is limited to 180 days per calendar year.
Coverage for hospitalisation benefits is limited to 180

days' hospitalisation in a semi-private or private ward in any given calendar year.

Coverage for treatment in psychiatric facilities are deducted from the hospital benefits for a semi-private or private ward.

3. Dento-facial orthopaedic treatment (orthodontics) are excluded from the insurance.
Dental coverage for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following an accident is valid as soon as the insurance comes into effect; in other cases, benefits are granted at the earliest after a minimum insurance period of 12 months has lapsed.
All other dental treatments are subject to a three-month waiting period.
The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value). Surcharges may not exceed 50%.
4. If a claim is notified late, the Insurer is allowed to reduce or refuse benefits. This penalty shall not apply if the duty to inform, pursuant to Article 45 LCA/VVG, was breached unintentionally. If this is the case, the insured event must be notified as soon as the insured is in a position to do so.
5. The Insurer is not liable for aggravated consequences of an illness and/or an accident due to the late consultation of a therapist or to non-compliance with his instructions.

Art. 10 Excluded benefits

1. There is no insurance coverage:
 - a. for illness, accident and their consequences after the insurance contract has expired and after departure from the circle of insured persons, as well as when benefits were paid out during the insurance term;
 - b. for operations designed to correct flaws or eliminate cosmetic physical imperfections, unless they are required following an insured event, for rejuvenation cures and treatments using tissue or cell implants;
 - c. in case of suicide, voluntary self-mutilation or attempts of one or the other;
 - d. for health damages caused by ionising rays and health damages caused by nuclear radiation;
 - e. for the costs of an inefficient, inappropriate or uneconomical treatment. «Inefficient» refers to treatments that have not been scientifically proven. «Inappropriate» refers to treatments that are contraindicated or cannot be tolerated, or when the medical indication has not been clearly established. «Uneconomical» refers to treatments that could have been replaced by another more affordable treatments, or treatments that are unnecessary;
 - f. for the consequences of events of war:
 - in Switzerland;
 - in another country, unless the illness and/or accident occurred within a period of 15 days from the first outbreak of warlike activities in the country in which the insured was staying and that he was taken by surprise by the outbreak of warlike activities while staying there;

- g. for the consequences of all sorts of troubles and for measures implemented to counteract them, unless the insured can prove that he did not actively participate on the side of the perpetrators or incite them to further violence;
 - h. for illnesses due to alcohol abuse;
 - i. for illness and accidents due to abuse of medication, drugs and other drug addictions;
 - j. for sex change operations, including treatments and consequences;
 - k. in case of organ transplants;
 - l. benefits are not granted if invoices are forged or falsified, as well as in case of fraud or attempt of insurance fraud;
 - m. In case of culpable breach by the policyholder or the insured person of their obligations as stipulated in Articles 16 and 17 of these general terms and conditions of insurance. The provisions of Article 45 LCA/VVG will apply if the breach of obligations does not result from misconduct of the policyholder or the insured person due to circumstances. If this is the case, the delayed action must be carried out as soon as the insured person is in a position to do so.
2. Are also excluded any illnesses and accidents suffered by the insured:
- a. when carrying out military service abroad;
 - b. during earthquakes;
 - c. during crimes or offences carried out or attempted deliberately, as well as in case of participation in war-like or terrorist activities;
 - d. while the insured person was taking part in brawls and fights, unless he was injured by a bystander or in attempting to assist a helpless person;
 - e. when the insured person exposes himself to danger by seriously provoking a third party;
 - f. when taking part in hazardous activities, that is activities in which the insured person exposes himself to particularly great danger without being able to take the measures to reduce the risk to acceptable levels.

Art. 11 Several insurers and third-party benefits

1. The benefits governed by these general terms and conditions of insurance are supplemental to the benefits provided by foreign or Swiss social security and private insurers or any liable third parties.
In case of a dual private insurance, the benefits governed by these general terms and conditions of insurance will be granted on a subsidiary basis in relation to the benefits granted by the other insurer, unless the terms and conditions of the other insurer also contain a subsidiarity clause; in this case, the rules of dual insurance will apply, as follows:
 - when the same interest is insured against the same risk, for the same period, by more than one insurer, in such a way that the total insured amounts exceed the insurance value (dual insurance), the policyholder is required to notify all insurers immediately and in writing;

- if the policyholder deliberately omitted the notification, or if the policyholder concluded dual insurance with the intention of producing an illegal profit, the Insurer is not bound by the contract;
 - each insurer is entitled to the agreed premium.
2. Upon occurrence of the insured risk, the Insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured person and his survivors against any liable third party. The Insurer is not bound by the agreements between the insured and third parties liable to pay benefits.

Art. 12 Healthcare providers

The insurance covers only the treatments carried out by healthcare providers recognised under the health insurance law or by the Insurer.

Art. 13 Healthcare provider rates

1. The Insurer recognises the rates approved under Swiss social insurance as well as private rates according to the agreements to which he signed up or private rates within the usual standards.
2. Benefits can only be claimed within the rates recognised by the Insurer for the relevant healthcare provider.
3. Agreements on fees, signed between healthcare providers and insured persons, shall not be binding for the Insurer.

Art. 14 Advance premium and final premium statements

1. The policyholder shall pay a provisional premium set at the start of each insurance term (advance premium) and corresponding as closely as possible to the presumed effective premium. The insurance term is set out in the policy. If instalments were agreed, the instalments maturing in the course of the insurance year are due.
2. A final premium statement is drawn up at the end of each insurance term or when the contract is terminated. The policyholder shall complete the form providing the Insurer with the requisite data for the final premium statement.
If the requisite information is not supplied within 30 days of the Insurer's request, the latter shall send a formal notice to the policyholder, giving him an additional 14 days from the date of the notice to comply.
If the formal notice has no effect, the Insurer shall then assess the rate itself, increasing the premium charged the preceding year by a percentage set at its own discretion. Additional amounts and refunds are payable within 30 days of receipt of the final premium statement. The Insurer may terminate the contract immediately if the policyholder does not send in the form in good time.
The Insurer shall notify the policyholder if an additional premium payment is due; additional premiums shall be settled within one month.
Surplus payments will be credited as a down payment on the provisional premium for the following insurance term or returned to the policyholder at his request.
The parties waive their rights to claim additional premium payments or surplus payment refunds of less than CHF 20.

3. If the additional or excess premium payment is more than CHF 500, the Insurer may adapt the provisional premium for the following insurance term accordingly.

Art. 15 Changes in premium rates

1. The Insurer may adjust the premium rates depending on the evolution of costs, claims and legal framework.
2. The Insurer shall inform the policyholder of the new contractual terms at least 30 days before the expiry of the insurance term. In this case, the policyholder is entitled to terminate the insurance contract affected by the change, with effect for the end of the ongoing insurance term, within 30 days of receiving the policy or being notified of the increase. Termination must have been received by the Insurer within the 30-day deadline.
3. If the policyholder does not terminate the contract, any premium adjustments will be considered as accepted.

Art. 16 Obligations of the policyholder

1. The policyholder must inform the insured persons of the main contents of this contract and of its amendments and termination. For this purpose, the Insurer will give the policyholder the document «Practical and legal information in accordance with the Federal Law on Insurance Contracts (LCA/VVG)».
2. The policyholder must inform the Insurer within five days at the most of the admission of an insured person to a hospital or clinic. If a guarantee of coverage is requested, the announcement must take place before admission.
3. The policyholder must notify the Insurer of any accident as soon as possible but at the latest 10 days after the accident. The policyholder must give all information regarding:
 - a. the time, the place, the circumstances and the consequences of the accident;
 - b. the doctor or hospital;
 - c. any liable persons and involved insurers.

Art. 17 Obligations of the insured person

1. The insured person shall provide all requisite documents (original or scanned invoices, medical certificates, prescriptions, etc.). The Insurer reserves the right to request original documents and payment confirmations.
2. The insured person shall check with the Insurer that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the Insurer.
3. Before each alternative medicine treatment, the insured person shall check that the attending practitioner is recognised by the Insurer for the relevant therapy.
4. Before every thermal or convalescence cure, a coverage request and medical prescription must be submitted to the Insurer at least 20 days in advance.
5. The insured person is required to check with the Insurer in advance that the facilities related to health promotion measures (back exercise schools, fitness centres and tobacco rehabilitation centres) are recognised by the Insurer.

6. The insured expressly authorises the practitioners who looked after him to disclose to the Insurer's medical advisor all of the information necessary for assessing the case. To this end, he shall release them from professional secrecy.
7. The Insurer has the right to request, at his expense, investigations carried out by doctors or designated experts in order to assess the insured person's state of health or his capacity for work. The insured must undergo these medical examinations that serve to determine the diagnosis and define the entitlement to benefits.
8. The insured person must notify Groupe Mutuel Assistance call centre immediately of any emergency medical cases abroad (phone number: +41 848 808 111).

Art. 18 Obligation to limit damages

1. From the beginning of the illness and/or the accident, the insured person must visit a qualified and licensed practitioner and fully comply with his instructions. The insured person must behave in a manner not to impede recovery or prolong the illness and must comply with the instructions given by the practitioner with regard to the hours allowed outside.
2. The insured person must not lead the practitioner to carry out unnecessary or uneconomical treatments or examinations (for example unnecessary home visits, inpatient instead of outpatient treatments, medical tourism).

Art. 19 Adjustments to the insurance terms and conditions

1. The Insurer has the right to adjust the insurance conditions in particular in case of important changes in the following areas:
 - a. modern medicine developments;
 - b. establishment of new or expensive forms of therapy, such as surgical techniques, medication and other similar techniques;
 - c. increase in the number or new types of healthcare providers;
 - d. in case of legal change or new trend.
2. The new conditions apply to the policyholder if they are adjusted in accordance with the first paragraph during the period of validity of the insurance. The Insurer notifies these changes in writing to the insured persons. **If the policyholder does not accept the changes, it may terminate the relevant contract effective the date of the adjustment.**
If termination is not notified to the Insurer in writing within 25 days (postal stamp) of the date of the notification, the new provisions will be considered as accepted.

Art. 20 Notices

1. Notices shall be addressed to the Insurer's general administration or to one of its official agencies at the addresses on the list provided by the Insurer.
2. Notices made by the Insurer are valid if they are sent to the last Swiss address communicated to the Insurer by the policyholder.

Art. 21 Prescription

Claims under the insurance contract become statute-barred within two years of the event giving rise to the obligation.

Art. 22 Place of performance and applicable law

1. Save any special provisions to the contrary, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. Swiss law is applicable.

Art. 23 Jurisdiction

1. In case of dispute, the policyholder or the beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland or his usual address in Switzerland, or of the registered office of the Insurer.
2. If the policyholder or the beneficiary is domiciled abroad, the courts of the registered office of the Insurer have exclusive jurisdiction.