groupemutuel

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

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Contents

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.

Art. 2 Purpose of the insurance

1. The purpose of this insurance is to cover insured persons for general 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 Art. 2, para. 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. Bodily injuries within the meaning of Art. 6 para. 2 of the Federal Law on Accident Insurance (LAA/UVG) are considered as accidents.
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 group of insured persons defined in the insurance policy are insured.

Art. 4a Insurance proposal

1. Sending an insurance proposal does not constitute a request for an offer, but a formal declaration by the applicant to the insurer that he wishes to take out an insurance contract. The applicant remains bound to the insurer in accordance with the provisions of Art. 1 LCA/VVG, i.e. for 14 days, or four weeks if medical information is required.
2. The applicant may cancel the proposal within 14 days following the application to take out the contract. This deadline is met if the applicant submits the cancellation to the insurer in accordance with Art. 20 of the general terms and conditions of insurance (CGA), or if he submits the notice of cancellation by post no later than the last day of the deadline.
3. If the proposal is submitted by the insurer, the policyholder may cancel the contract at the latest within 14 days of its acceptance by the policyholder.
4. The insurer reserves the right to accept or reject the insurance proposal. It is not obliged to give reasons for its decision.

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. In accordance with Art. 35(a) para. 4 LCA/VVG, only the policyholder is allowed to exercise the right of termination.
4. To be valid, the notice of termination must reach the insurer 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. The contract shall expire when the insurer has withdrawn from the contract as a result of non-payment of premiums, in accordance with Art. 21, para. 1 LCA/VVG.
7. The insurer may terminate the contract in the event of culpable breach of the obligations set out in Art. 16, para. 1-4 of these general terms and conditions of insurance. In this case, the insurance contract shall end 14 days after the insurer has notified termination.
8. After each claim for which a benefit is payable by the insurer, the policyholder has the right to withdraw from the contract no later than 14 days after becoming aware that the benefit was paid. If the policyholder withdraws from the contract, the insurance ceases to have effect upon receipt of the notice of termination by the insurer. In accordance with Art. 35a, para. 4 LCA/VVG, only the policyholder may exercise this right of termination.
9. The right of termination for breach of the duty to inform by the insurer prior to the conclusion of the contract expires four weeks after the policyholder becomes aware of the breach and the information, but at the latest two years after the breach. Termination takes effect when it reaches the insurer. The premium is due only until the end of the contract if the latter is terminated or ends before expiry.
10. The contract may be terminated at any time by the policyholder or the insurer for good reasons within the meaning of Art. 35b LCA/VVG. In particular, the insurer is entitled to withdraw from the contract in the event of misrepresentation, fraud or attempted fraud.
11. Any termination must be made in accordance with Art. 20 of these general terms and conditions.

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 group of insured persons as defined in the policy.
3. Coverage ceases at the end of the contract.

Art. 6a Type of insurance

1. Global School insurance coverage falls within the scope of indemnity insurance.
2. Within the scope of indemnity insurance, coverage shall compensate for the actual loss suffered, up to the amount of the insured benefits.

Art. 7 Territorial validity

1. Insurance is valid in Switzerland (see Art. 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 Art. 8, para. 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** – In Switzerland, free choice of hospital facility depending on the applicable coverage level, in a general or psychiatric ward, for the treatment of acute conditions and accidents. **Comments** – 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, and depending on the type of treatment (acute, rehabilitation or psychiatric) and ward (semi-private or private), he will be entitled to the inpatient hospitalisation benefits actually invoiced, but not exceeding the amounts 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. – Coverage for hospitalisation in psychiatric facilities is limited to 180 days per calendar year. – Coverage for hospitalisation is limited to 180 days' hospitalisation in a semi-private or private ward, in any given calendar year. – The duration of hospitalisation in psychiatric facilities is imputed to hospitalisation in a semi-private or private ward. – 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. **Obligations of the insured person** – The insured person shall check with the insurer that the facility, hospital ward or clinic where he is to be treated is recognised by the insurer.
Outpatient treatments	100%	100%	100%	**Description** – Free choice of treatment facility in Switzerland for outpatient treatments recognised under 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 healthcare provider.
Restricted and non-reimbursable drugs	90%	90%	90%	**Description** – Medication prescribed by a doctor or a healthcare provider recognised under LAMal/KVG, which is not reimbursed by compulsory health insurance (AOS/OKP). **Exclusions** – Products on the list of pharmaceutical products for special application (LPPA/LPPV).
Search, rescue and transport costs	90%	90%	90%	**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. 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** – 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** – 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. Such amendments do not entitle the policyholder to terminate the contract.
Glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	**Description** – The specified amount for the purchase of medical glasses or contact lenses in Switzerland or abroad which is not covered by the compulsory health insurance.

	Level 1	Level 2	Level 3	Details
Dental care	No benefits	80%, max. CHF 2,000 per calendar year	80%, max. CHF 2,000 per calendar year	**Comments** 1. Dento-facial orthopaedic treatment (orthodontics) is not covered. 2. For all other dental treatments, a financial contribution is granted depending on the coverage level: a. dental treatment by a qualified dentist; b. yearly prophylactic dental check-up; c. laboratory tests. 3. Insured persons are immediately entitled to benefits for dental treatment following accidents that occur after the insurance comes into effect. 4. 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. 5. Benefits for other dental treatments are subject to a three-month waiting period and to items 2 and 3 above. 6. The basis for the calculation of payable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%. 7. 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.
Convalescence cures	No benefits	50%, max. 30 days per calendar year	90%, max. 30 days per calendar year	**Description** – Treatment and board in case of convalescence cures in Switzerland in facilities recognised by the insurer provided that the convalescence follows hospitalisation. **Comments** – 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. **Obligations of the insured person** – 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.
Thermal cures	No benefits	50%, max. 30 days per calendar year	90%, max. 30 days per calendar year	**Description** – Treatment and board during thermal cures in marine cure facilities recognised under the Ordinance on Healthcare Insurance Benefits (OPAS/KLV). – Benefits are covered provided the treatment is prescribed by an approved physician within the meaning of LAMal/KVG. **Obligations of the insured person** – 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.
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	**Description** – 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** – 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 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** – Contribution to the cost of treatment and board in case of residential cures in specialised rehabilitation facilities for alcoholics. **Comments** – 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.
Vaccines	90%	90%	90%	**Description** – Medically prescribed vaccines in Switzerland (not included in the Ordinance on Healthcare Insurance Benefits – OPAS/KLV), and any vaccines 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** – Only check-ups carried out by recognised physicians within the meaning of LAMal/KVG will be reimbursed.

	Level 1	Level 2	Level 3	Details
Second opinion	90%	90%	90%	**Description** – 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** – 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** – 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	Acupressure	Bio-energetics
Aromatherapy	Anthroposophic medicine	Eurythmy
Auriculotherapy	Autogenic training	Rebirthing
Bioresonance	Energy balancing	Sophrology
Biotherapy	Etiopathy	Tomatis Method
Chromotherapy	Kinesiology	
Colon hydrotherapy	Lymphasizing	
Cupping	Myofascial release therapy	
Electroacupuncture	Massage therapies	
Geobiology	Mesotherapy	
Herbal medicine	Metamorphosis	
Homeopathy Iridology	Orthobionomy	
Laser therapy	Osteopathy	
Magnetic field therapy	Polarity	
Magnetotherapy	Postural integration	
Moratherapy	Reflexology	
Naturopathy	Reiki	
Nutritional counselling	Rolfing	
Oxygenotherapy	Shiatsu	
Phytotherapy	Trager	
Sympathicotherapy		

3. Emergencies outside Switzerland

	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 cost-sharing		**Description** – Full coverage of foreign statutory cost-sharing 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: – 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.

1. The benefits listed above are valid worldwide, Switzerland excluded, supplementally or in addition to Swiss or foreign social insurance plans. In the case of multiple insurance under the LCA/VVG, each insurer is liable for the loss in the proportion which the amount insured by it bears to the total amount insured.
2. The insured benefits correspond to those covered in Switzerland when being treated for similar medical conditions.
3. The benefits listed above are refunded when administered by persons or institutions with the suitable training, recognition and authorisation of the foreign social bodies.
4. 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

1. 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.
2. Insured benefits
   a. 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 Art. 8, para. 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 vehicle 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 Art. 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 0848 808 111, or +41 848 808 111 from abroad) of the case requiring medical assistance when it occurs. In all cases, the doctors of the "Groupe Mutuel Assistance" emergency call centre decide, if necessary in agreement with the insured's attending physician, which benefits may be provided and how they will be paid. The benefits provided for in this Art. 8 para. 4 are not granted if the "Groupe Mutuel Assistance" emergency call centre has not approved them beforehand. However, the insurer will not refuse benefits if the insured can prove that they were medically justified.
On the other hand, in the event of a breach of the obligation to contact the Groupe Mutuel Assistance emergency call centre immediately, this is considered not to be a fault in view of the circumstances and is not subject to a reduction in cover if it is clear from the circumstances that the breach is not attributable to the policyholder or the beneficiary.
The insurer declines all liability in the event that, as a result of strikes or circumstances beyond its control, including any case of force majeure (war, invasion, enemy aggression, declared or undeclared hostilities, civil war, rebellion, revolution, insurrection, riot or civil unrest, flight bans or those imposed by local legislation), it is impossible for it to provide its services or to provide them in good time.

4. Excluded benefits
In addition to the provisions of Art. 10 of these general terms and conditions of insurance, the following benefits are also excluded:
– cases for which the "Groupe Mutuel Assistance" emergency call centre has not been contacted, in application of the provisions of Art. 8, para. 4. item 3;
– minor illnesses or injuries which can be treated locally and which do not prevent the insured person from continuing his trip;
– cases where the insured's state of health allows him to travel normally in a seated position and without a medical escort, unless the doctors at the "Groupe Mutuel Assistance" emergency call centre agree to this being covered;
– pregnancy, unless there are clear and unforeseeable unforeseeable complications;
– mental illness that has already been the subject of treated.

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, reports, documentation and invoices from the various healthcare providers within the time limits specified in Art. 21 of these general terms and conditions.
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. 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 Art. 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 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 treatment; or treatments that are unnecessary;
   c. for infertility treatments;
   d. – for operations designed to correct or eliminate physical defects or cosmetic imperfections of an aesthetic nature, unless they are required following an insured event;
      – for rejuvenation cures or interventions designed to improve physical performance;
   e. for treatment resulting from suicide, voluntary self-mutilation or attempts of one or the other;
   f. for health damages caused by ionising rays and health damages caused by nuclear radiation;
   g. for the consequences of events of war:
      – in Switzerland;
      – abroad, unless the insured person was taken by surprise in the country where he is staying and the illness and/or accident occurs within 15 days of the start of these events;
   h. 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;
   i. for illnesses due to addiction to alcohol;
   j. for illness and accidents caused by over-consumption of medication or alcohol or the use of narcotics (drugs);
   k. for sex change operations, including treatments and consequences;
   l. for organ transplants for which the “Fédération suisse pour tâches communes des assureurs-maladie” (SVK) has concluded lump sum payments per case. This rule also applies to hospital facilities which are not bound by lump sum payments per case;
   m. cases in which false or falsified invoices have been drawn up by the insured and/or the policyholder, as well as in the event of fraud or attempted fraud against the insurance by the insured and/or the policyholder;
   n. cases where the policyholder or the insured person has culpably breached the obligations stipulated in Art. 17 para. 5 of these general terms and conditions. The provisions of Art. 45 LCA/VVG apply if, in view of the circumstances, the breach of obligations is not due to the fault of the policyholder or the insured, or if the policyholder or the insured can prove that the breach had no impact on the claim or the scope of benefits. 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 by the insured person, as well as in case of participation by the insured person in warlike or terrorist activities;
   d. in the event of traffic accidents in which the insured has a blood alcohol level that constitutes a serious offence under the Road Traffic Act;
   e. when taking part in brawls and fights, unless the insured person was injured by a bystander or in attempting to assist a helpless person;
   f. when the insured person exposes himself to danger by seriously provoking a third party;
   g. 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.
2. In the case of multiple insurance under the LCA/VVG, each insurer is liable for the loss in the proportion which the amount insured by it bears to the total amount insured.
3. 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 and his survivors against any liable third party of the event. The insurer is not bound by the agreements between the insured and third parties liable to pay benefits.

Art. 12 Healthcare providers recognised by the insurer

1. Treatments administered by healthcare providers recognised both by the compulsory health insurance (LAMal/KVG) and the insurance company are covered by the insurer.
2. Other healthcare providers not recognised under the compulsory health insurance (LAMal/KVG) may be approved by the insurer.
3. The insurer may keep a list of recognised or excluded healthcare providers. These lists are available on the insurer’s website or can be provided on request of the insured person.

4. The insurer may change the group of recognised or excluded healthcare providers at any time.
5. Such a modification does not entitle the policyholder to a right of termination.

Art. 13 Healthcare provider rates

1. The insurer will pay the rates valid for Swiss social insurance, as well as the private rates applied according to agreements to which it has signed up and private rates within the normal standards.
2. Fee agreements, signed between healthcare providers and insured persons, shall not be binding for the insurer.
3. In the event of a dispute over the cost of medical benefits, the insured person shall assign his rights to the insurer against the healthcare provider.

Art. 14 Premiums

1. Insurance premiums are calculated based on the age and gender of the insured persons.
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 applicable age groups are:
   - from 0 to 18;
   - from 19 to 25;
   - from 26 to 30;
   - from 31 to 35;
   - from 36 to 40 years.
3. A change in age group will in principle result in an automatic adjustment of the premium.
4. 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.
5. 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.
6. 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. Each year, the insurer may adjust the premium rates depending on:
   – changes in the frequency or expense of claims;
   – the adjustment of the scope of coverage in accordance with Art. 19 of these general terms and conditions.
2. The insurer shall inform the policyholder of the new contractual terms at least 30 days before the expiry of the insurance term.
3. In the event of a premium increase (see para. 1 above), the policyholder shall be entitled to terminate the insurance contract affected by the increase, within 30 days of receiving the policy or being notified of the increase, with effect for the end of the ongoing insurance term. Notice of termination must have been received by the insurer within 30 days. If the policyholder does not terminate the contract, the adjustments made to the premiums shall be deemed to have been accepted.
4. In the event of a reduction in the premium rate (see para. 1 above), the policyholder has no right of termination.

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)" as well as the general terms and conditions of insurance (CGA).
2. The insurer must be informed within 30 days of all new persons joining the group of insured persons.
3. The policyholder must inform the insurer in writing within 30 days of a person's departure from the group of insured persons.
4. The policyholder undertakes to check that the insured persons belong to the insurable persons within a period of 30 days from the date on which the insurer submits the list of insured persons to the policyholder.
5. 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.
6. Exchanges between the insurer and the policyholder (the school) are limited to administrative information. No sensitive personal data can be exchanged between the school and the insurer without the explicit consent of the insured person (student).

Art. 17 Obligations in the event of a claim

1. The insured person shall check with the insurer that the medical facilities, cure facilities, hospital ward or clinic where he is to be treated is a facility recognised by the insurer.
2. Before each treatment, the insured person must find out whether the healthcare provider who is to attend him is one of the healthcare providers recognised by the insurer.
3. Subject to revocation of the entitlement to benefits, the insured person or the policyholder must:
   a. 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.
   b. notify the insurer of any accident of the insured person as soon as possible but at the latest 10 days after the accident. The policyholder must give all information regarding:
      – the time, the place, the circumstances and the consequences of the accident;
      – the doctor or hospital;
      – any liable persons and involved insurers.
   c. provide the insurance company with any information about the facts known to him that may be of use in determining the circumstances in which the loss or damage occurred or in determining the consequences of the loss or damage, at the latest within the time limits set out in Art. 21 of these terms and conditions of insurance. Therefore, the insured person shall provide all requisite original or scanned documents (detailed invoices, medical certificates, prescriptions, etc.), provided that they can be obtained without great expense. The insurer reserves the right to request original documents and payment confirmations.
   d. submit, before every thermal or convalescence cure, a request for reimbursement together with the medical prescription to the insurer at least 20 days in advance;
   e. expressly authorise the practitioners who looked after the insured person to disclose to the insurer's medical advisor all of the information necessary for assessing the case. To this end, he shall release the healthcare providers from professional secrecy;
   f. undergo, as the insured person, the medical examinations that serve to determine the diagnosis and define the entitlement to benefits. These expert examinations are requested by the insurer – at its expense – and are carried out by doctors or designated specialists in order to assess the insured person's state of health;
   g. request the prior consent of the insurer in advance for planned voluntary hospitalisation outside the EU and EFTA and their country of residence.
4. notify beforehand to Groupe Mutuel Assistance, using the form "Notification of a financial guarantee request" any expensive hospitalisation cases and other treatments outside Switzerland. Any emergency cases outside Switzerland must be announced immediately to Groupe Mutuel Assistance call centre (telephone number indicated on the insurance policy and certificate).
5. In the event of a breach of the obligations set out in Art. 17, para. 3, letter c of these general terms and conditions, the insurer may refuse to pay benefits until it has received the information and supporting documents that enable it to determine the validity of the policyholder's or insured person's claim.
6. In the event of a breach of the obligations set out in Art. 17, para. 3 letters e, f, g and h of these general terms and conditions of insurance, the insurer may reduce or refuse benefits. In accordance with Art. 10, para. 1, letter n of these general terms and conditions of insurance, these penalties shall not apply if the breach of duty is not the fault of the insured person or if the insured person can prove that the breach of duty had no influence on the occurrence of the anticipated event and on the extent of the benefits payable by the insurer.

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 is entitled to adjust the general terms and conditions of insurance, in particular if there are changes in the following areas:
   a. modern medicine developments;
   b. the introduction of new or expensive forms of therapy, such as surgical techniques, medication and other similar techniques;
   c. an increase in the number or introduction of new types of healthcare providers;
   d. changes in benefits under compulsory health insurance.
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.
3. The insurer shall notify the policyholder of these adjustments. If the policyholder does not accept the changes, he may terminate the relevant contract effective the date on which the adjustments take effect. If termination is not notified to the insurer within 30 days, the new provisions are deemed to have been accepted.

Art. 20 Notices

1. Notices between the policyholder, the insured person and the insurer are valid if they are sent in writing or by any other means that can be proved by written text (email or another mean of communication made available by the insurer), with the exception of social networks.
2. Notices from the policyholder or the insured person must be sent to the postal or email addresses indicated on the insurer's official documents.
3. Notices made by the insurer are valid if they are sent to the last Swiss address communicated to the insurer by the policyholder or the insured person.

Art. 21 Prescription

Claims under the insurance contract become statute-barred within five 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. The Swiss Law, in particular the Law on Insurance Contracts (LCA/VVG), 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.

Art. 24 Departure from the group of persons qualifying for insurance

In the event of departure from the group of persons qualifying for insurance, insured persons may continue to be covered on an individual basis, without having to undergo a health examination, by the following similar product of Groupe Mutuel Assurances GMA SA, provided that they are covered by compulsory health insurance (AOS/OKP) in accordance with the Swiss Federal Law on Health Insurance (LAMal/KVG) or by an optional health insurance in accordance with the Law on Insurance Contracts (LCA/VVG) in accordance with Art. 7a of the Ordinance on Health Insurance (OAMal/KVV):

– Global smart, level 1 (category GO) for insured persons who were previously covered under Global School, level 1 (general ward);
– Global smart, level 2 (category GO) for insured persons who were previously covered under Global School, level 2 (general ward);
– Global smart, level 3 – semi-private ward (category GO) for insured persons who were previously covered under Global School, level 3 (semi-private ward);
– Global smart, level 3 – private ward (category GO) for insured persons who were previously covered under Global School, level 3 (private ward).

  Insured persons must claim this right within 90 days of leaving the group of persons qualifying for insurance. They can also opt for a lower level of the relevant product.

  The applicable insurance rates and conditions for this product are then applied to the relevant insured persons.

  The duration of insurance and the benefits received before leaving the group of persons qualifying for insurance are taken into consideration when calculating maximum benefits.

Art. 25 Data protection

Personal and sensitive data

Groupe Mutuel Services SA processes the personal and sensitive data of the policyholder, the insured person, and where applicable their beneficiaries or related persons (hereinafter: persons concerned) on behalf of Groupe Mutuel Assurances GMA SA, your insurer. Data processing is entrusted to Groupe Mutuel Services SA (hereafter: Groupe Mutuel), a company under Groupe Mutuel Holding SA. Both companies are subject to the Federal Law on Data Protection (LPD/DSG).

Personal data refers to information relating to the persons concerned, including the administrative management of the insurance contract. Sensitive data refers to information relating to the state of health of insured persons and claims. In general, the following categories of personal and sensitive data are processed: the declaratory personal data of the persons concerned, i.e. the data that Groupe Mutuel may collect from the persons concerned when they express interest and/or subscribe to products and services that it offers or distributes; personal data relating to the benefits provided or the functioning of products and services or their use, in particular when using online services; personal data from third parties, other services or public information where authorised.

Legal basis

Groupe Mutuel shall process the personal and sensitive data of the persons concerned and implement the processing operations according to the following legal grounds: the consent of the persons concerned, respectively the express consent for sensitive data; the legal provisions applicable to the activities of Groupe Mutuel (including the Federal Law on Data Protection); the contract concluded between Groupe Mutuel and the persons concerned.

Purposes

Personal data is used in particular to assess the risks to be insured, process claims, ensure the administrative, statistical and financial follow-up of the contract, allow the management of Groupe Mutuel's activities (statistics, internal and external audit, etc.) and compliance with its legal obligations, the improvement and development of services provided, the optimisation and cost-effectiveness of insurance costs, prospecting and marketing operations, the management of unpaid debts and disputes, the fight against fraud, money laundering, terrorist financing and tax fraud. To this end, this data may be com-

municated, shared and exchanged between Groupe Mutuel and third parties (see below). These exchanges are the subject of contracts specifying the obligations and responsibilities of each of the parties, or are based on a legal provision.

Security
When personal data is processed, and with regard to the risks presented by data processing operations, Groupe Mutuel, its insurance intermediaries and other agents (for example a reinsurance company), undertake to take all necessary measures to comply with data protection law. These provisions include, in particular, the technical, physical and organisational measures required to safeguard the security of personal data and prevent its modification, damage or access by unauthorised third parties.

Data transfer
The data is treated confidentially and may be disclosed to third parties (e.g. insurance intermediaries, reinsurance companies, doctors, beneficiaries, disability insurance office (AI/IV), social security of the insured person's country of residence), including abroad. Disclosure of data takes place on the basis of legal obligations, court decisions, general insurance terms and conditions or the consent of the persons concerned. Consent must be express in the case of sensitive data. If the data processing operations are subject to a subcontracting, outsourcing or partnership contract with third parties, the latter shall undertake, as part of their contractual relationship with Groupe Mutuel, to comply with data protection law. Groupe Mutuel selects subcontractors who provide the necessary guarantees. The data entrusted to insurance intermediaries will be recorded and sent to Groupe Mutuel for the handling of insurance applications and for the administrative and financial follow-up between the insurance intermediary and the insurer. The latter is not responsible for the processing of personal data that the person concerned may have authorised from third parties or those that are carried out independently of Groupe Mutuel. It is up to the persons concerned to refer to the data protection policies of these third parties in order to check the terms and conditions of the processing operations carried out, or to exercise their rights with regard to these operations.

Profiling
During its relationship with Groupe Mutuel, the person concerned may be subject to marketing profiling, so that the insurer can offer services and products that meet the person's expectations, profile and needs. The modalities of this profiling are specified in the appropriate data protection policy. Other types of profiling may take place for the purposes outlined above.

Storage period
Personal data is stored for as long as required by law, the management of the insurance contract, claims, recourse rights, debt recovery and/or any disputes between Groupe Mutuel, the insured, the insurance intermediary or third parties.

Rights of access and correction
The persons concerned have the right to access their personal data, to have their data corrected, to have their data deleted within the limits of the applicable legal provisions, to limit the processing of their data, to request that their data is transferred, to withdraw their consent to the processing of personal data, subject to the processing required for the performance of the contract, and to appeal to the competent supervisory authority.

Data Protection Officer
Groupe Mutuel has appointed a Data Protection Officer who can be contacted at the following address: dataprotection@groupemutuel.ch.
Further information on data protection is available on the Groupe Mutuel website: www.groupemutuel.ch.

Annex A

Maximum amounts reimbursed for hospitalisation benefits provided by facilities or doctors not recognised by the insurer (Art. 8, para. 1 of these Special Terms and Conditions of Insurance, section Hospitalisation).

	Amounts per night of hospitalisation			
	Acute care		Rehabilitation and Psychiatry	
	Semi-private	Private	Semi-private	Private
Non-recognised doctor: Reimbursement of medical costs	CHF 500	CHF 500	CHF 0	CHF 0
Non-recognised hospital: Reimbursement of hospital costs	CHF 300	CHF 500	CHF 100	CHF 150
Non-recognised Hospital and Doctor: Total reimbursement – Medical costs – Hospital 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