



Groupe Mutuel Assurances GMA SA

Terms and conditions of insurance

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General Terms and Conditions for Supplemental Health and accident insurance of Groupe Mutuel Assurances GMA SA

Note: in this document, any use of the masculine form applies to both males and females.

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The insurer is Groupe Mutuel Assurances GMA SA.

Art. 1 Individual insurance contract per product; bases of insurance contract

1. Unless otherwise stipulated in the terms and conditions of insurance, the insurance contract is subject to the Federal Law of 2 April 1908 on Insurance Contracts (LCA/VVG).
2. The insurance proposal, the insurance policy, these general terms and conditions (CGC) the special terms and conditions of insurance and any special agreements constitute the bases of the insurance contract.
3. A separate, individual contract will be concluded in respect of each insurance product regulated by the corresponding special terms and conditions.

Art. 2 Purpose of insurance

1. In principle, the insurance covers the economic consequences of illness, maternity and accident.
2. The special terms and conditions for each insurance product define the insured risks.

Art. 3 Definitions

1. Illness means any impairment of the insured person's physical, mental or psychological health which is not the result of an accident, requires medical examination or medical treatment, or 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 and was occasioned by an extraordinary external cause.
Bodily injury 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, childbirth and postnatal recovery.

Art. 3a Type of insurance

1. Unless otherwise provided in the special terms and conditions of insurance, the coverage of products governed by these general terms and conditions falls within the scope of indemnity insurance.
2. Insurance coverage within the scope of indemnity insurance shall compensate for the actual loss suffered up to the amount of the insured benefits.
3. In the event of a claim, insurance coverage that falls within the scope of fixed-sum insurance provides for the payment of the sum specified in the policy, regardless of the actual loss suffered.

Art. 4 Territorial validity

1. Coverage is valid worldwide.
2. If an insured person falls sick or has an accident in Switzerland and seeks medical treatment elsewhere, the cost of such treatment will only be reimbursed if the policyholder or the attending doctor submits an application to the insurer in advance and the insurer accepts it.

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

1. Unless otherwise stipulated in the special terms and conditions of insurance, insurance products may be retained if the insured person moves abroad during the term of the contract, without any increase in insurance coverage, provided that the insured person remains subject to compulsory health insurance under the LAMal/KVG in accordance with the Agreement on the Free Movement of Persons between the EU and EFTA or other international social security agreements, or is covered by equivalent insurance in accordance with Art. 7a of the Swiss Ordinance on Health Insurance (OAMal/KVV).
2. The insured person residing abroad must notify the insurer in writing within 30 days when he no longer complies with the criteria specified in Art. 4a, para. 1 of these terms and conditions of insurance. In the event of a breach of this obligation, the insured person must reimburse to the insurer any benefits paid from the date on which the above criteria were no longer fulfilled.

Art. 5 Applicant, policyholder and insured person

1. The applicant is the person who submits an application for an insurance contract to the insurer.
2. The policyholder is the person who has concluded a contract with the insurer.
3. The person who is mentioned as insured in the insurance policy is considered to be the insured person.

Art. 6 Insurance proposal

1. When an insurance proposal is sent, this is not a request for an offer; it constitutes a formal declaration of the applicant's intent to take out one or more insurance contracts. 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 application within 14 days of the application to take out the contract. This deadline is met if the applicant submits the cancellation to the insurer in accordance with Art. 37 of the general terms and conditions of insurance, or if he submits the notice of cancellation to the post office by the last day of the deadline.
3. If the proposal comes from the insurer, the policyholder may cancel the contract within 14 days of its acceptance by the policyholder.
4. The insurance proposal can be made using the form made available by the insurer. The applicant must answer all the questions on the insurance application, as well as in the health questionnaire, completely and truthfully. The applicant is responsible for ensuring that the answers given by a third party or by an intermediary are in accordance with his instructions. Insured persons must authorise third parties to provide the insurer with any documents and information it may require.

5. The insurer reserves the right to accept or refuse the insurance proposal, to issue medical exclusions or to apply higher premiums if the special terms and conditions of the product so require. The insurer is not obliged to give reasons for its decision.
6. The refusal of one or several products in the insurance application, or any medical exclusions issued for one or several products, does not justify the withdrawal from other products accepted by the insurer.
7. The refusal of products for other family members (spouse, children), or any other medical exclusions issued for other family members, does not justify withdrawal from the applicant's own application or contract(s).
8. The insurance application of a person who does not have the right to exercise civil rights must be ratified by his legal representative.

Art. 7 Medical information

1. The insurer may demand to have a medical report issued at its expense.
2. It can also require that the applicant undergoes a medical examination by a doctor designated by the insurer.

Art. 8 Restrictions

1. If a person is suffering from an illness or from the sequels of an accident when he files the insurance proposal, the insurer is entitled to restrict coverage for that illness or accident. Coverage may also be restricted for previous illnesses or accidents suffered by the insured person if experience shows that relapses are possible.
2. The ailment subject to the medical exclusion is communicated to the insured person by means of a declaration of consent. The insured person who agrees to conclude the contract that includes the medical exclusion is obliged to give his consent. If the insured person does not agree within the time limit set by the insurer, the insurer may consider that the insured person is waiving his the right to conclude the coverage subject to the medical exclusion.
3. Medical exclusions are valid for the entire duration of the contract. An insured person may have a certificate issued at his cost certifying that an exclusion is no longer justified. In that case, the insurer is entitled to maintain or cancel the exclusion.

Art. 9 Changes to the insurance coverage

1. A proposal to increase the insurance coverage (e.g. reduce the deductible amount, increase the level of coverage or the insured lump-sum) within the same product is regarded as a proposal for a new insurance contract within the meaning of Art. 6 to 13 of these general terms and conditions of insurance.
2. The insurer reserves the right to accept or refuse the proposal or to decide restrictions in compliance with the conditions and time limits set out in Art. 1 LCA/VVG and Art. 6 of these general terms and conditions. In particular, the terms and conditions of the contract, such as the termination notice period and a possible non-availability period (initial period of the contract during which insurance coverage is not acquired for all or certain benefits), shall apply again, and no acquired rights can be taken over from the old contract.
3. A reduction in coverage within the same product is only possible after the minimum contract term has expired, subject to one month's notice to the end of a calendar year. If the request for a reduction in coverage is made following a

premium increase, only one month's notice for the end of a calendar year is required.

Art. 10 Beginning of insurance contract and coverage

1. The insurance contract is concluded as soon as the insurer notifies the insured that it has accepted the proposal.
2. Coverage commences on the effective date indicated on the insurance policy.
3. The non-availability periods specified in the special terms and conditions of insurance are reserved.

Art. 11 Non-disclosure

1. If the policyholder, when responding to questions, concealed or stated incorrectly an important fact that he knew of or should have known (concealment), the insurer has the right to terminate the contract, within four weeks from the time of becoming aware of the concealment.
2. Termination shall take effect when it reaches the policyholder.

Art. 12 Term of insurance

1. The insurance term is one calendar year running from 1 January to 31 December.
2. If the contract is concluded during the course of a calendar year, the first insurance term runs from the effective date confirmed in the policy to the end of the calendar year.

Art. 13 Duration and termination of insurance contract

1. The contract is concluded without a time limitation, unless otherwise provided for in the special terms and conditions of insurance.
2. After three insurance terms, the policyholder may terminate the contract individually at the end of a calendar year by giving three months' notice. Exceptions to this are certain products, for which the term after which the policyholder may terminate the contract in accordance with the special terms and conditions is different.
In accordance with Art. 35a para. 4 LCA/VVG, only the policyholder is allowed to exercise this right of termination.
3. The insurer may terminate the contract in case of fraud or attempted fraud.
4. After each claim for which a benefit is paid by the insurer, the policyholder has the right to withdraw from the insurance product concerned within 10 days of becoming aware of the payment of the benefit. In accordance with Art. 35a para. 4 LCA/VVG, only the policyholder is allowed to exercise this right of termination. If the policyholder withdraws from the contract, the insurance ceases to be effective 14 days after the notice of termination has been sent to the insurer. The insurer remains entitled to the payment of the premium for the current insurance term if the policyholder terminates the contract within one year of the insurance coverage coming into force. In all other cases, the premium is due only until the end of the contract.
5. 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. The termination shall take 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 its expiry date.

6. 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.
7. The policyholder must give notice of termination in accordance with Art. 37 of these general terms and conditions of insurance.

Art. 14 End of insurance contract

The insurance contract and entitlements to benefits cease:

- a. at the death of the insured;
- b. on termination of the insurance contract;
- c. if the insurer rescinds the contract for non payment of premiums in accordance with Art. 21(1) LCA/VVG;
- d. in the event of a transfer of residence abroad, on the date of departure from Switzerland as notified to the competent municipal or cantonal authorities, provided that no other arrangements have been made within the meaning of Art. 4a of these terms and conditions of insurance;
- e. if the insured person residing abroad no longer fulfils the conditions for continued coverage as set out in Art. 4a of these terms and conditions of insurance.

Art. 15 Scope and duration of benefits

1. The benefits provided by the insurer for each insurance product are governed by the corresponding special terms and conditions of insurance.
2. Save any provision to the contrary in the special terms and conditions of insurance, accident benefits have the same scope as illness benefits.

Art. 16 Entitlement to benefits

1. Entitlement to benefits may only be claimed for illnesses or accidents occurring during the term of insurance.
2. The insured person must provide the insurer with detailed invoices.
3. At the insurer's request, the insured person must send the original invoice and other necessary supporting documents (medical reports, prescriptions, payment receipts, etc.).

Art. 17 Payment of benefits

1. As a rule, insured persons are liable for paying fees directly to healthcare providers. However, they shall agree to contracts concluded between the insurer and healthcare providers which, as an exception, provide for direct payment to healthcare providers.
2. Benefits are payable after the insurer has received all requisite information and documents enabling it to ascertain that the claims are well-founded and due.
3. The insurer can only settle accounts based on detailed invoices indicating the treatment dates, type of treatment, medical services provided, cost of each benefit and the names, addresses and telephone numbers of the Swiss and foreign healthcare providers. If necessary, the insurer may demand that documents in foreign languages be translated into one of Switzerland's official languages at the cost of the insured person.
4. Insured persons living abroad must communicate to the insurer a payment address in Switzerland.

Art. 18 Exclusions

1. Coverage is excluded:
 - a. for illnesses, accidents and their sequels which already existed when the contract was signed or which are subject to restrictions;

- b. for illness, accident and their sequels after the insurance contract has expired, as well as when benefits were paid out during the insurance term. This does not affect the obligation to grant periodic benefits in accordance with Art. 35c LCA/VVG;
 - c. for dental treatment, insofar as coverage is not expressly provided for in the various insurance products;
 - d. 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 to treatments that are unnecessary;
 - e. for infertility treatments;
 - f.
 - 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;
 - g. for treatment resulting from suicide, voluntary self-mutilation or attempts of one or the other;
 - h. for health damages caused by ionising rays and health damages caused by nuclear radiation;
 - i. for the consequences of events of war:
 - in Switzerland;
 - abroad, unless the insured was surprised by this event in the country where he is staying and the illness or accident occurs within 15 days of the start of these events;
 - j. for the consequences of disturbances of any kind and measures implemented to counteract them, unless the insured person can prove that he did not actively participate on the side of the perpetrators or incite them to further violence;
 - k. for illnesses caused by alcohol addiction;
 - l. for illnesses and accidents due to the overuse of medication or alcohol or the use of narcotics (drugs);
 - m. for sex change operations, including treatments and consequences;
 - n. for organ transplants for which the "Fédération suisse pour tâches communes des assureurs-maladie" (SVK) has provided for lump-sum payments per case. This rule also applies to hospital facilities which are not bound by agreed lump-sum rates (flat rates per case).
2. Moreover, are excluded illnesses or accidents which the insured suffers:
 - a. during military service abroad;
 - b. during earthquakes;
 - c. while deliberately committing or attempting to commit a crime or punishable offence, or while participating in acts of war or terrorism;
 - d. in the event of traffic accidents in which the insured person has a blood alcohol level that constitutes a serious offence under the Road Traffic Act;
 - e. while taking part in brawls and fights, unless he was injured as an innocent bystander or while attempting to assist a helpless person;
 - f. through exposing himself to danger by seriously provoking a third party;
 - g. during hazardous activities, i.e. activities where he exposes himself to extreme danger without being able to reduce risks to a reasonable level.

Art. 19 Gross negligence on the part of the insured

If the loss was caused by gross negligence on the part of the insured, the insurer's liability shall be reduced proportionately.

Art. 20 Multiple coverage 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, and to compulsory health insurance benefits in particular.
2. In the case of multiple insurance under the LCA/VVG, each insurer is liable for the loss in the proportion that the amount insured by it is equal to the total amount insured.
3. Upon occurrence of an insured event, the insurer is subrogated, within the limits of the benefits provided by it, to the rights of the insured against any third party liable for the event. The insurer is not bound by any agreements between the insured person and any third parties liable for benefits.
4. In absence of compulsory health insurance coverage, within the meaning of LAMal/KVG, benefits under this contract will be payable as if compulsory coverage existed.

Art. 21 Multiple insurance

1. If the same interest is insured for the same risk and the same duration by more than one insurer, and the aggregate insured sum exceeds the insurance value (multiple insurance), the policyholder shall notify the insurer without delay.
2. If the policyholder is not aware of multiple insurance when concluding a subsequent contract, he may terminate this contract within four weeks of becoming aware of multiple insurance.
3. If the policyholder deliberately fails to do so, or if he contracted multiple insurance with the intent of making an illegal profit, the insurer shall not be bound by the contract vis à vis the policyholder. The insurer shall be entitled to the full premium.

Art. 22 Excess benefits

1. The insurance benefits provided within the framework of the products governed by these general terms and conditions must not lead to excess benefits for the policyholder.
2. In the event of excess benefits, these shall be reduced accordingly.
3. This provision does not apply to products that fall within the scope of fixed-sum insurance.

Art. 23 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 recognised by the insurer.
3. **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.**
4. The insurer may keep a list of recognised or excluded healthcare providers.
5. The insurer may change the list of healthcare providers mentioned in paragraphs 1 and 2 above at any time.

6. Such modifications do not give policyholders the right to terminate their contract.

Art. 24 Tariffs of healthcare providers

1. The insurer recognises the tariffs applied by the Swiss social insurances and the private tariffs applied under tariff agreements to which it has adhered.
2. Entitlement to benefits is restricted to the tariff recognised by the insurer for the healthcare provider concerned.
3. The insurer is not bound by any rates' agreements concluded between issuers of invoices and insured persons.
4. In the event of dispute over medical rates, the insured person shall assign his rights to the insurer against the healthcare provider.

Art. 25 Assignment and pledging of benefits

Insured persons may not assign or pledge their claims against the insurer without the latter's consent.

Art. 26 Premium rates

1. Premiums are set based on a product-specific rate.
2. Rates may provide for differentiated premiums according to the gender, place of residence and age group of the insured person, as well as other criteria defined in the special terms and conditions of insurance.
3. The relevant age groups are in principle defined in the special terms and conditions of insurance.
4. A change in age group will in principle result in an automatic adjustment of the premium for the insured persons concerned.
5. The insurer may change the grading of the last age group if this is justified by demographic or actuarial reasons.
6. The insurer may change the premiums applicable to each region if justified by different cost trends within a premium region or between different premium regions.
7. In the event of a premium increase due to a change in age group, a change in the grading of the last age group, or a change in the premium regions, the policyholder is entitled to terminate the contract in accordance with Art. 29, para. 3 of these general terms and conditions.

Art. 26a Discounts and bonuses

1. The insurer may grant discounts or bonuses, the details of which are stated in the insurance policy and/or in the special terms and conditions of insurance.
2. The categories of discounts are as follows:
 - a. Discounts in connection with a framework agreement: these are defined in Art. 40 of these general terms and conditions.
 - b. Combination discounts: the special terms and conditions or contractual conditions define the combination of products that qualify for the discount. Discounts may be modified in accordance with Art. 29 of these general terms and conditions.
 - c. Discounts resulting from a time-limited campaign: the entitlement to a discount is valid for a period defined contractually.
 - d. Reductions for families, children and young adults: the entitlement to a discount is valid as long as the insured person meets the criteria for entitlement. The special terms and conditions define the criteria for granting the discount. The insurer may change or withdraw discounts or bonuses at any time, with effect from the end of the current calendar year at the latest.

3. In the event of a reduction/withdrawal of discounts or bonuses, the policyholder shall have the right to terminate the contract in accordance with Art. 29 para. 3 of these general terms and conditions.

There is no right of termination if the contractual terms and conditions for granting the insurance are no longer fulfilled by the policyholder, nor for discounts or bonuses granted as part of time-limited promotional campaigns.

Art. 27 Payment of premiums

1. Premiums are payable yearly in advance in Switzerland; subject to special agreement and to a surcharge for costs, premiums may also be paid in six-monthly, quarterly or monthly instalments.
2. The premium billing period is at least one month, except for the month during which the insurance begins or ends.

Art. 27a Formal reminder, notice of default and debt recovery proceedings

1. If the premium is not paid by the due date, the debtor is summoned, at his own expense, to make payment within 14 days of the date of the notice, with a reminder of the consequences of late payment. If the formal notice has no effect, the insurer's duty to pay benefits will end after the reminder period has lapsed.
2. The insured cannot claim benefits for illness, accidents or their sequels which existed or appeared during a suspension of the obligation to provide benefits, even if the premium was subsequently paid.
3. If the insurer initiates collection proceedings against a policyholder, it may claim administrative expenses.

Art. 28 Reimbursement of annual deductibles and co-insurance payments

1. If the insurer pays the healthcare provider directly, the policyholder shall transfer the agreed annual deductible and/or his co-insurance payment to the insurer within 30 days of the insurer's invoice date.
2. If the policyholder does not honour his payment obligation, Art. 27a shall apply mutatis mutandis.

Art. 29 Adjustment of premium rates

1. Each year, the insurer may adjust the premium rate and premium discounts (in accordance with Art. 26a), in particular due to:
 - changes in the frequency or expense of claims;
 - the adjustment of the scope of coverage in accordance with Art. 36 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 paragraph 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.
5. A change in premium rates due to a change of address is not considered to be an adjustment of the premium within the meaning of the above provisions. The right of termination does not apply in this case.

Art. 30 Set-off

1. The insurer may set off benefits payable against its receivables against the insured.
2. Insured persons have no right of set-off against the insurer.

Art. 31 Obligations in case of an insured loss

1. 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 timelimits specified in Art. 38 of these general terms and conditions.
2. If an insured person is admitted to a hospital or clinic, the insurer must be notified within five days of the admission date. If the insurer is required to guarantee coverage, it must be notified before admission.
3. The insured person or the beneficiary must report accidents to the insurer promptly, within 10 days of its occurrence at the latest. Information must be provided on the following:
 - a. the time, place, circumstances and sequels of the accident;
 - b. the doctor or hospital;
 - c. any persons whose liability is involved and the insurances concerned.
4. The death of an insured must be notified to the insurer by the beneficiary within 30 days at the latest, even if the accident was already declared.
5. In the event of a breach of obligations in the event of a claim, the insurer may reduce or refuse benefits. 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. 32 Obligation to notify

1. Any changes (name, first name, gender, marital status, place of residence, email address, telephone) as well as any deaths must be reported to the insurer as quickly as possible. In the event of a breach of his obligations, the insured person shall bear the consequences and the resulting costs.
2. When an insured person transfers his address and usual residence outside Switzerland, he must notify the insurer and provide a certificate of departure from his municipality or canton. On this basis, the insurer will terminate the insurance contract on the departure date indicated on the certificate.
3. If the insured person fails to notify the insurer of his departure, or fails to notify it within an appropriate period of time, the insurer may terminate the contract with retroactive effect to the actual date of departure. In this case, any undue benefits will be claimed from the insured person.
4. The insurer reserves the right to maintain contracts due to the continuation of compulsory health insurance in Switzerland in accordance with Art. 4a.

Art. 33 Information and verification

1. The insured person expressly authorises healthcare providers who provided treatment for the illness or accident, or on other occasions, to communicate all relevant information to the insurer's medical advisor for the purpose of appraising the case. To that effect, the insured shall release them from their professional secrecy obligation.
2. If the insurance coverage is supplemental to other private or social health insurance, the insured person must provide the insurer with the statement of benefits paid by the other insurers.
3. The insurer is entitled to request expert opinions, at its expense, from any doctors or specialists of its choice in order to establish the condition of the insured and his capacity for work. The insured person undertakes to submit to such examinations which are designed to establish the diagnosis and the entitlement to benefits.
4. The insured person must submit at any time to the supervision of the insurer's inspectors and medical advisors. He shall follow their instructions with a view to accelerating his recovery. Insured persons who refuse to undergo examination by the insurer's designated medical advisor risk having benefits refused.

Art. 34 Obligation to reduce damages

1. In the event of illness or accident, the insured person shall consult a qualified licensed healthcare provider from the outset and duly follow his instructions. He shall avoid impeding his own recovery or prolonging his sickness and shall comply with the practitioner's instructions for going out. The insurer is not liable for any worsening in the sequels of a illness or accident due to belated consultation of a healthcare provider or failure to comply with the healthcare provider's orders.
2. The insured person cannot induce a healthcare provider to carry out useless or uneconomical checks and treatment (e.g. unnecessary house calls, inpatient treatment instead of outpatient treatment, medical tourism, etc.).

Art. 35 Fraudulent invoices and insurance fraud

1. Benefits are not due for fake or forged invoices or in case of insurance fraud or attempted insurance fraud.
2. In such cases, the insured shall cover the cost of the insurer's verifications and handling of the case.

Art. 36 Adjustment of insurance terms and conditions

1. The insurer has right to adjust the terms and conditions of insurance, in particular in case of changes in any of the following areas:
 - a. progress of modern medicine;
 - b. establishment of new or onerous forms of therapies such as operating techniques, medication and the like;
 - c. increase in the number of health service providers, or establishment of new types of health service providers;
 - d. changes in compulsory health insurance benefits.
2. The new terms and conditions are valid for the policyholder and the insurer provided the adjustment is made in accordance with paragraph 1 during the term of insurance.
3. The insurer shall notify the policyholders 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 be accepted.

Art. 37 Notices

1. Notices between the policyholder 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 must be sent to the postal or email addresses indicated on the insurer's official documents.
3. Notices from the insurer are valid if they are sent to the last postal or email address communicated to the insurer by the policyholder or the insured person.
4. The insurer may also send general communications to the policyholders via the magazine for its insured persons. The insured person who no longer wishes to receive the magazine may so request from the insurer, in which case the insurer is released from any liability for the communications published.
These communications may also be made on the insurer's website and in a document enclosed when sending out the insurance policies each year.

Art. 38 Statute of limitations

Claims under the insurance contract become statutebarred within five years of the event giving rise to the obligation.

Art. 39 Special terms and conditions of insurance

1. For each of its insurance products, the insurer shall issue special terms and conditions supplementing the present general terms and conditions.
2. In case of discrepancy between the special terms and conditions of insurance and these general terms and conditions, the special terms and conditions shall prevail.

Art. 40 Framework agreement

1. For all insurance products, the insurer may conclude framework agreements with contractual partners (co-contractors) for the affiliation of persons with a specific legal relationship to this co-contractor.
2. The insurer may grant discounts in connection with a framework agreement.
3. The conditions for granting and withdrawing the discounts are communicated to the policyholder before the contract is concluded.
4. Discounts may be modified in accordance with Art. 29 of these general terms and conditions of insurance, depending on changes in the frequency or expense of claims.
5. An adjustment to the framework agreement may also result in the adjustment or cancellation of the discount, with effect from the end of the current insurance period.
6. Entitlement to discounts shall lapse if the insured person leaves the circle of persons entitled to insurance or if the framework agreement is terminated.
7. In the event of an adjustment or cancellation of the discount, the policyholder is entitled to terminate the insurance contract, with effect for the end of the ongoing insurance term, within 30 days of receiving the policy or being notified of the adjustment.

Art. 41 Place of performance and jurisdiction

1. Save special provisions to the contrary, the obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. In case of dispute, the policyholder or the beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the registered office of the insurer subject to international treaties.

Art. 42 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 the insurer 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 claims in respect of the rights of persons, 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 communicated, 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 mea-

sures 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 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

Art. 43 Protection of data relating to personal advice and guidance

1. The insurer may collect and use, from the beginning of the insurance contract, the demographic, contractual and medical information of the insured person for the following purposes:
 - to issue recommendations on prevention and health promotion;
 - to provide advice on all health-related matters;
 - to recommend suitable healthcare providers to attend to the insured person's health problem;
 - to suggest targeted offers for products or services that meet the criteria of cost-effectiveness.
2. The data used to provide the services described in paragraph 1 may be taken from all records concerning the insured person compiled within any of the companies of Groupe Mutuel Holding SA (including compulsory health insurance).
3. In order for data from the compulsory health insurance records to be communicated for one of the above-mentioned purposes, the insurer will require the additional express consent of the insured person in each specific case.
4. The insured may withdraw his consent at any time in accordance with Art. 42 of these terms and conditions of insurance.

Special Terms and Conditions for “Global” Supplemental Insurance Coverage

GLGA01-E7 – Edition: 01 Jul 2000

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 Eligibility

1. Global supplemental insurance is open to persons of all ages.
2. Insureds aged 0 to 18, i.e. until 31 December of the year coinciding with their 18th birthday, are granted the supplemental benefits described in Article 2, paragraph 2.2, under the heading Global Junior.
3. From 1 January of the year coinciding with their 55th birthday, insureds are granted the supplemental benefits described in Article 2, paragraph 2.3, under the heading Global Senior.
4. If a person has already contracted comparable coverage with another insurer and cannot for the time being terminate that insurance, he may join Global insurance exclusively for the benefits designated in Article 2, paragraph 2.4, under the heading Global Temporis.

Art. 2 Insured benefits

1. Global

The following benefits are covered supplementally to compulsory health insurance:

1. Hospitalisation

1. Insurance class
Free choice of recognised hospital facility in Switzerland, in general or psychiatric wards, for treatment of acute conditions.
2. Benefits
 - a. General principles
In case of hospitalisation, the Insurer covers the cost of treatment, and room and board.
 - b. Hospitalisation abroad
If an insured falls ill or has an accident and is hospitalised abroad, the Insurer will grant him a maximum daily allowance of CHF 500 for no more than 60 days per calendar year.
Voluntary treatment abroad cannot be covered without the Insurer's prior consent.

3. Scope and duration of benefits

Payment of hospitalisation benefits is subject to the following terms and conditions:

- a. The Insurer covers the cost of recognised treatments, within the meaning of LAMa/KVG, of hospital boarding costs and of physicians' fees in accordance with tariff agreements or cantonal regulations or any other agreement concluded with the Insurer.
- b. If an insured is hospitalised in a facility with which the Insurer has not concluded a tariff agreement for boarding and treatment costs (including medical fees), he will be allocated an allowance of CHF 200 per day within the limits of the general ward.
- c. The present insurance does not cover organ transplants for which the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn) has agreed specific lump-sum rates. This rule also applies to hospital facilities not bound by agreed lump-sum rates.

- d. The entitlement to benefits ceases as soon as the condition is no longer deemed acute.
- e. For psychiatric facilities, coverage for hospitalisation benefits is limited to 60 days' hospitalisation in any given calendar year.

4. Obligations of the insured

Prior to each hospitalisation, the insured shall check that the facility, hospital ward or clinic where he is to be treated is recognised by the Insurer.

2. Supplemental treatment

The Insurer covers the following benefits within the limits stipulated in Article 3 (see table).

1. Restricted drugs

The applicable percentage of the cost of drugs not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

2. Non-reimbursable drugs

The applicable percentage of the cost of drugs which are not on any official list (LS-LMT) and are not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

3. Alternative medicine

The Insurer will cover the cost of the following therapies provided they are administered by a physician holding a Swiss degree or a natural therapy practitioner recognised by the Insurer.

The Insurer reserves the right to exclude certain natural therapy practitioners; a list of practitioners whose services are reimbursed is available to insureds.

Before each treatment, the insured person shall check that the practitioner of his choice is recognised by the Insurer

List of “alternative medicine” therapies

Naturopathy:

Acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, nutritional counselling, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, moratherapy, oxygenotherapy, phytotherapy, sympathicotherapy, cupping.

Manipulation techniques:

Acupressure, lymphatising, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, orthobionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, autogenic training.

Psychotherapy:

Bio-energetics, rebirthing, sophrology, Tomatis method.

- Voluntary changes in therapy or practitioner in the course of a treatment are subject to the Insurer's prior consent.

- Sophrology treatments will be reimbursed provided they are administered by a doctor, a doctor-sophrologist with an ASS diploma, or a sophrologist who is not a doctor but holds an ASS diploma.
4. Thermal cures in Switzerland
The Insurer will pay a contribution to the cost of medical spa treatment and to convalescence cures in recognised facilities for maximum 30 days per calendar year. An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
 5. Thermal cures abroad
Subject to the Insurer's prior authorisation, contribution to the cost of medically necessary thermal cure treatment abroad.
An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.
 6. Tariff supplements
For outpatient treatment in Switzerland, the difference between the rates at the insured's place of work or residence, and those at the place of residence of the provider of health care services.
 7. Personal expenses indemnity during hospitalisation
Against presentation of supporting invoices, a single indemnity payment will be allocated for each hospital stay lasting longer than eight days.
 8. Hospital accomodation for family member
If the insured is hospitalised, the Insurer will cover the cost of hospital accommodation for one family member provided such cost is medically necessary.
 9. Home help and placement cost
The following will be reimbursed subject to prior application:
 - the percentage share of the cost of home help hired from an official service to attend to the insured's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning etc.);
 - the cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Family members have to be placed with an official institution.
 10. Glasses and contact lenses
The specified amount for the purchase of prescription glasses or contact lenses in Switzerland or abroad which is not covered by compulsory health insurance.
 11. Auxiliary appliances
The cost of purchasing and renting medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the Insurer's list.
 12. Childbirth preparation classes
The specified amount for painless childbirth preparation classes or childbirth preparation which is not covered by compulsory health insurance.
 13. One-time breast-feeding indemnity
Breast-feeding indemnity provided the mother breast-feeds her baby for at least 30 days and that that duration is certified by the doctor or midwife. In cases of multiple births, an indemnity is paid for each child.
 14. Ultrasound scans and mammographies
The specified amount for ultrasound scans and mammographies not covered by compulsory health insurance.
 15. Vaccinations
Vaccination costs for vaccinations that are not included in the ordinance on compulsory health insurance benefits and which are necessary in Switzerland or are prescribed for trips abroad.
 16. Elisa or HIV tests
The Insurer pays an annual contribution towards the cost of preventive tests prescribed and carried out by recognised health care providers.
 17. Voluntary sterilisation
The specified percentage of the cost of the operation.
 18. Dental treatment in case of accident
The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician with a federal diploma. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and point value).
 19. Dental treatment in case of illness
The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician with a federal diploma. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and point value).
 20. Transport costs
The Insurer will pay a contribution towards the cost of transport to the nearest hospital facility or doctor following an insured illness or accident provided such transport is medically necessary and is not covered by compulsory health insurance.
This contribution is only granted for transport by ambulance, helicopter or by a search and rescue action.
Public transport costs (bus or train) for outpatient treatment will also be reimbursed if such treatment serves to avoid hospitalisation.
 21. Independent psychologists and non-doctor psychotherapists
The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychotherapists.
3. **Groupe Mutuel Assistance**
The benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).
 4. **Allowance in the event of death**
A lump-sum benefit of CHF 2,000 will be paid to the insured's beneficiaries in the event of death following an illness or accident provided that, when he died, the insured was no younger than 3 and no older than 55 years' old.
A death certificate or another requisite document must be presented to the Insurer.
The Insurer may deduct any amounts owed to it by the deceased (premiums, co-insurance amounts, etc.) from the death benefit due to the beneficiaries.
The entitlement to death benefits expires, without further notice, two years after the insured's death unless a death certificate is presented beforehand.
2. **Global junior Supplemental benefits**
 - a. Home care for sick children
Deviating from Article 1(2), this benefit is granted for

children up to the age of 12. Benefits are payable if home care is provided by a person from an institution recognised by the Insurer and the parents are gainfully employed outside the home.

b. Contribution for sports

Against presentation of a supporting invoice, reimbursement of a share of the active member's fee in a sports club or association recognised by the Insurer.

3. Global senior

Supplemental benefits

a. Palliative care

The Insurer will pay a contribution to the cost of palliative treatment, i.e. medical and nursing care for persons at the end of life, administered at home by duly qualified persons under the supervision of an institution recognised by the Insurer.

A prior application must be submitted to the Insurer who will determine the amount of the contribution on a case-by-case basis. The contribution is set taking into account the overall cost of the treatment enabling the insured to stay at home.

b. Health and fitness cures

The Insurer pays an annual contribution for a health and fitness cure at recognised facilities offering a specific programme in the field.

c. Nutrition counselling and classes

The Insurer will pay an annual contribution to the cost of a nutrition counsellor and nutrition classes recognised by the Insurer.

4. Global temporis

a. Global Temporis provides temporary Global coverage to persons who have comparable coverage with another insurer.

b. Global Temporis covers the supplemental benefits described in sections 2.1.2, 2.1.3, 2.2 and 2.3; it does not cover the benefits contemplated in sections 2.1.1. (hospitalisation) and 2.1.4 (death benefit).

c. For the supplemental treatment covered by Global Temporis, benefits are equal to 30% of the benefits offered by Global.

d. Global Temporis benefits are payable in addition to those paid by the other insurer.

e. By granting an insured Global Temporis coverage, the Insurer simultaneously undertakes to extend to him full Global coverage, without a new medical examination, from the date indicated on the Global Temporis certificate. The transfer to full Global coverage must take place within three years at the latest.

f. Any participation by the Insurer in deductibles and co-insurance amounts of other insurers is excluded.

g. For the life of Global Temporis coverage, the premium is reduced compared with the Global premium.

h. Article 29(1) of the General Terms and Conditions of Supplemental Health and Accident Insurance granting the insured the right to terminate the policy is not applicable to the transfer from Global Temporis to Global coverage or the corresponding premium adjustment.

i. Any time limits applying to benefits paid under Global Temporis coverage will also count for the calculation of benefit entitlements after the transfer to Global coverage.

Art. 3 Scope of benefits

The benefits contemplated in Article 2 are payable within the limits and amounts indicated in the "Table of Global Benefits".

Art. 4 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect.

2. Entitlement to maternity and childbirth benefits commences upon completion of 12 months' insurance.

The term of coverage under Global Temporis does not count for calculating that entitlement.

3. Benefits are imputed to the annual insured sum chronologically, by order of treatment date. Costs incurred after entitlements are exhausted cannot be carried forward to the next year.

4. As provided in the present terms and conditions of insurance, the Insurer will reimburse any costs not covered by compulsory health insurance provided the treatment is carried out by a practitioner or a person who is duly authorised and recognised by the Insurer. Under no circumstances may the insurance benefits regulated by these terms and conditions be used for co-payments and deductibles under compulsory insurance or other supplementary insurance coverage.

Art. 5 Deductibles

Insureds have the following options:

– No deductible

– A deductible of CHF 150 per calendar year.

Global Temporis is concluded without deductible for its entire duration.

Art. 6 Advantages of "Le Club"

When he contracts Global insurance, the insured is entitled to all the advantages of "Le Club" membership including in particular:

1. Reduced rates in hotels

The Insurer keeps a list of the hotels offering reduced rates.

2. Rebates in drugstores, pharmacies and other shops

The Insurer keeps a list of the drugstores, pharmacies and other shops offering rebates.

Art. 7 Premium

When an insured person reaches the last year of his age group, he will be automatically transferred into the next age group at the beginning of the next calendar year. The applicable age groups are:

– from 0 to 18;

– from 19 to 25;

– from age 26, age groups are graduated in five-year brackets.

Table of benefits under Global

Type of benefits	Global 1
Restricted drugs	70% max. CHF 800/calendar year
Non-reimbursable drugs	70% max. CHF 800/calendar year
Alternative medicine	max. CHF 70/session, up to CHF 2,000/calendar year
Thermal cures in Switzerland	60% max. CHF 300
Convalescence cures	CHF 20/day max. 30 days/calendar year
Convalescence cures following hospitalisation	CHF 40/day max. 30 days/calendar year
Thermal cures abroad	no benefits
Tariff supplements	no benefits
Personal expenses indemnity in case of hospitalisation	CHF 100/case
Hospital accommodation for family member	CHF 500/calendar year
Home help and placement cost	70% max. CHF 1,500/calendar year
Glasses and contact lenses	CHF 100/3-year period
Auxiliary appliances	70% max. CHF 300/calendar year
Childbirth preparation classes	CHF 150/pregnancy
One-time breast-feeding indemnity	CHF 100/child
Ultrasound scans and mammographies	90%, unrestricted number of tests
Vaccinations	70% max. CHF 150/calendar year
Elisa or HIV tests	CHF 50/calendar year
Voluntary sterilisation	60% max. CHF 300
Dental treatment: in case of accidents	60% max. CHF 4,000/case
Dental treatment: in case of illness.	60% max. CHF 100/3-year period
Transport costs	60% max. CHF 1,000/calendar year
Indep. psychologists and non-doctor psychotherapists	60% max. CHF 600/calendar year
Hospitalisation in Switzerland	public ward throughout Switzerland
Hospitalisation abroad	CHF 500/day
Lump-sum death benefit	CHF 2,000 death by illness or accident
Groupe Mutuel Assistance	
Global Junior (ages 0 to18)	
Home care for sick children	CHF 200/calendar year
Contribution for sports	CHF 30/calendar year
Global Senior (from age 56)	
Palliative care	90% max. CHF 2,000/calendar year
Health and fitness cures	CHF 300/calendar year
Nutrition counselling and classes	50% max. CHF 150/calendar year

Global 2	Global 3	Global 4
90% max. CHF 800/calendar year	90%, unlimited prescriptions	90%, unlimited prescriptions
90% max. CHF 800/calendar year	90%, unlimited prescriptions	90%, unlimited prescriptions
max. CHF 70/session, up to CHF 2,000/calendar year	max. CHF 70/session, up to CHF 3,000/calendar year	max. CHF 70/session, up to CHF 6,000/calendar year
60% max. CHF 300	80% max. CHF 500/calendar year	80% max. CHF 750/calendar year
CHF 20/day max. 30 days/ calendar year	CHF 25/day max. 30 days/ calendar year	CHF 25 day max. 30 days/ calendar year
CHF 40/day max. 30 days/ calendar year	CHF 50/day max. 30 days/ calendar year	CHF 50/day max. 30 days/ calendar year
no benefits	50% max. CHF 500/calender year	80% max. CHF 1,000/calender year
CHF 600/calender year	CHF 800/calendar year	CHF 1,000/calendar year
CHF 100/case	CHF 200/case	CHF 200/case
CHF 500/calendar year	CHF 600/calendar year	CHF 700/calendar year
90% max. CHF 1,500/calendar year	90% max. CHF 2,500/calendar year	90% max. CHF 3,000/calendar year
CHF 100/3-year period	CHF 150/3-year period	CHF 200/3-year period
90% max. CHF 300/calender year	90% max. CHF 1,000/calender year	90% max. CHF 1,000/calender year
CHF 150/pregnancy	CHF 150/pregnancy	CHF 150/pregnancy
CHF 100/child	CHF 100/child	CHF 100/child
90%, unrestricted number of tests	90%, unrestricted number of tests	90%, unrestricted number of tests
90% max. CHF 150/calendar year	90% max. CHF 200/calendar year	90% max. CHF 250/calendar year
CHF 50/calendar year	CHF 50/calendar year	CHF 50/calendar year
80% max. CHF 300	80% max. CHF 400	80% max. CHF 500
80% max. CHF 4,000/case	80% max. CHF 6,000/case	80% max. CHF 8,000/case
80% max. CHF 100/3-year period	80% max. CHF 150/3-year period	80% max. CHF 200/3-year period
80% max. CHF 1,000/calendar year	80% max. CHF 2,500/calendar year	80% max. CHF 5,000/calendar year
70% max. CHF 600/ calendar year	80% max. CHF 700/calendar year	80% max. CHF 800/calendar year
public ward throughout Switzerland	public ward throughout Switzerland	public ward throughout Switzerland
CHF 500/day	CHF 500/day	CHF 500/day
CHF 2,000 death by illness or accident	CHF 2,000 death by illness or accident	CHF 2,000 death by illness or accident
Emergency medical assistance, support and repatriation for trips and stays abroad		
CHF 250/calendar year	CHF 300/calendar year	CHF 300/calendar year
CHF 30/calendar year	CHF 30/calendar year	CHF 30/calendar year
90% max. CHF 2,500/calendar year	90% max. CHF 3,000/calendar year	90% max. CHF 3,000/calendar year
CHF 300/calendar year	CHF 300/calendar year	CHF 300/calendar year
50% max. CHF 200/calendar year	50% max. CHF 250/calendar year	50% max. CHF 250/calendar year

Special Terms and Conditions for “Global Classic” Supplemental Insurance

GIGA02-E8 – Edition: 01 Nov 2008

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

The purpose of this insurance is to cover the insured for specific supplemental benefits over and above compulsory health insurance benefits within the meaning of the Federal law on Health Insurance (LAMal/KVG).

Art. 2 Acceptance conditions

“Global Classic” coverage is open to persons of all ages.

Art. 3 Risks covered

“Global Classic” insurance provides illness, accident and maternity benefits.

Art. 4 Insured benefits – basic module

1. Hospitalisation in Switzerland

1. Insurance class

For inpatient treatment (hospital stay exceeding 24 hours), the insured is free to choose the general ward of any

- hospital;
- psychiatric facility; or
- rehabilitation centre in Switzerland.

2. Hospitals

To qualify for the benefits referred to in point 1.1 of this Article, hospitals must be recognised establishments within the meaning of LAMal/KVG (hospitals with a cantonal mandate for the provision of services), or they must have concluded a tariff agreement with Groupe Mutuel Assurances GMA SA.

3. Scope and duration of hospitalisation benefits

Benefits shall be reimbursed subject to the following provisions:

- the Insurer shall reimburse recognised treatments under LAMal/KVG, hospital room and board costs and doctors’ fees in accordance with cantonal tariff regulations or the tariff agreement concluded with the Insurer;
- hospitalisation benefits are limited to the acute stage of the illness. The entitlement to benefits ceases as soon as the insured’s condition is no longer deemed acute; this applies, in particular, to the treatment of stabilised or chronic conditions or where hospitalisation does not serve to improve the insured’s health.

4. For inpatient psychiatric treatment

Entitlement to benefits is limited to 90 days per calendar year.

5. Organ transplants

The present insurance does not include coverage for organ transplants covered by flat rates agreed by the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn); such costs are covered by compulsory health insurance. This rule also applies to hospitals which are not bound by flat-rate agreements.

6. Rights and obligations of the insured in case of hospitalisation

The insured person shall ascertain that the hospital or clinic where he is to be treated is an establishment recognised by the Insurer.

2. Additional services

1. Restricted and non-reimbursable drugs

Reimbursement of 90% of the cost of restricted and non-reimbursable drugs (i.e. drugs which are not on any official list) which are not covered by compulsory insurance, excluding pharmaceutical products for special application (LPPA/LPPV, list available online at www.lppa.ch).

2. Thermal cures in Switzerland

Reimbursement of CHF 80 per day, up to max. CHF 800 per year for treatment and room and board in thermal cure facilities approved by the Insurer according to the list of recognised medical spa establishments of the Federal Ordinance on compulsory health insurance benefits (OPAS/KLV).

Benefits will be reimbursed if they are medically necessary and prescribed by a doctor. An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.

3. Post-hospitalisation convalescence cures

Reimbursement of CHF 50 per day for treatment and room and board during convalescence cures in facilities recognised by the Insurer, provided that the convalescence was prescribed following hospitalisation.

Benefits will be reimbursed if they are medically necessary and prescribed by a doctor. An application accompanied by a medical prescription must be filed with the Insurer at least 20 days before the start of the cure. The indemnity is limited to 30 days per calendar year.

4. Hospital room expenses for close relative

The Insurer will cover the cost of a hospital bed for a family member during the insured’s stay in hospital if the family member’s presence is medically justified.

This indemnity is limited to CHF 600 per calendar year. This guarantee also covers the medical expenses of a healthy newborn if the mother has to return to hospital within 10 weeks of giving birth.

5. Home help and cost of a home

Reimbursement of CHF 80 per day for 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.).

Reimbursement of CHF 80 per day for the cost of a temporary home for family members cohabiting with the insured in the event the insured has to be hospitalised. The family members will be temporarily placed with an official institution.

The total indemnity for both aforesaid benefits together is limited to CHF 800 per calendar year.

6. Glasses and contact lenses

Reimbursement of the purchase price, in Switzerland or abroad, of prescription glasses or contact lenses not covered by compulsory health insurance. This indemnity is limited to CHF 150. Insureds are entitled to claim

this indemnity once every calendar year up to their 18th birthday, and once every three years thereafter.

7. Auxiliary appliances

Reimbursement of 90% of the rental or purchase cost for medically prescribed orthopaedic equipment and auxiliary appliances (excluding dentures) required by the insured for his daily activities, in accordance with the Insurer's list.

The indemnity is limited to CHF 1,000 per calendar year.

8. Voluntary sterilisation

Reimbursement of 90% of the cost of the operation carried out by recognised health care providers.

9. Ear correction surgery (cosmetic surgery)

Reimbursement of 90% of the cost of ear pinning operations for children born with protruding ears. This benefit is granted if it is medically recommended for the insured with a view to avoiding or remedying psychological disorders.

10. Psychotherapists (non-doctor) and independent psychologists

Reimbursement of CHF 40 per session for the cost of medically prescribed treatment by non-doctor psychotherapists and independent psychologists.

The indemnity is limited to CHF 800 per calendar year.

11. Transport expenses

The cost of transport to the nearest hospital or doctor following an insured illness or accident provided such transport is medically required and is not covered by compulsory health insurance.

This contribution is only granted for transport by ambulance or by helicopter. Public transport costs (bus or train) in connection with outpatient treatment designed to avoid hospitalisation are also reimbursed.

The indemnity is limited to CHF 5,000 per calendar year.

12. Search and rescue costs

A contribution to the cost of unplanned search and rescue operations designed to save the insured's life in case of provable distress or to avoid a fast and significant deterioration in his condition.

The indemnity is limited to CHF 50,000 per calendar year.

13. Vaccinations

Reimbursement of 90% of the cost of vaccinations which are not included in the Federal Ordinance on compulsory health insurance benefits (OPAS/KLV) but are required in Switzerland, as well as any vaccinations recommended by the Federal Office of Public Health for trips to abroad.

The indemnity is limited to CHF 150 per calendar year.

14. Preventive tests (HIV or Elisa)

Reimbursement up to CHF 50 per year of tests prescribed and conducted by recognised health care providers.

15. Check-up

Reimbursement of 90% of the cost of a check up conducted by a doctor recognised by the Insurer, but no more than one check-up every three years.

16. Preventive gynaecological tests

Reimbursement of 90% of the cost of preventive gynaecological tests not covered by compulsory health insurance

17. Ultrasound exams and mammographies

Reimbursement of 90% of the cost of the ultrasound exams and mammographies not covered by compulsory health insurance or cantonal prevention plans.

18. One-time breast-feeding allowance

One-time breast-feeding allowance provided that the baby is breastfed for at least 30 days and that the dura-

tion of breast-feeding is confirmed by the doctor or the midwife. In case of multiple births, the allowance is paid for each child.

19. Groupe Mutuel Assistance

The benefits specified in the general terms and conditions of Group Mutuel Assistance, category ASS (repatriation and transport), will be reimbursed if the insured event occurs more than 20 km from the insured's domicile, in Switzerland or abroad.

Art. 5 Insured benefits – “Plus” option

In addition to the benefits referred to in Article 4 of these Special Terms and Conditions, the Insured may apply for the “Plus” option which entitles him to the following benefits at an additional premium:

1. Alternative medicine

The Insurer will pay a contribution of 80% towards the cost of the below therapies provided they are carried out by a qualified Swiss doctor or a natural therapy practitioner recognised by the Insurer (including a participation in the cost of alternative medicine drugs prescribed by such health care providers recognised by Swissmedic in accordance with the federal law on therapeutic products (LPT/HMG)). The Insurer reserves the right to exclude certain natural therapy practitioners. Before each treatment, the insured shall verify that the practitioner who is to attend him is recognised by the Insurer.

List of “alternative medicine” therapies:

Naturopathy

Acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, moratherapy, oxygenotherapy, phytotherapy, sympathetic therapy and cupping.

Manipulation techniques

Acupressure, lymphasizing, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, ortho-bionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, and autogenic training.

Psychotherapy

Bio-energetics, rebirthing, sophrology, Tomatis method. Voluntary changes in therapy or practitioner in the course of a treatment are subject to the Insurer's prior consent. The indemnity is limited to CHF 10,000 per calendar year. A yearly deductible of CHF 300 will be applied to the above-mentioned benefits (point 5.1 of this Article) from the 1 January following the insured's 18th birthday.

2. Health promotion

50% of the cost of health promotion measures in the following areas will be reimbursed:

- health centre;
- back school;
- tobacco and alcohol detoxification cures.

The relevant provider must be recognised by the Insurer.

The contribution towards the cost of a health centre subscription is limited to CHF 200. If several measures promoting good health are taken in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 500.

3. Nutritional counselling

Reimbursement of CHF 50 per session for nutritional counselling by a consultant recognised by the Insurer; maximum three counselling sessions per three-year period.

4. Medical visit for a second opinion

Reimbursement of 90% of the cost of a second opinion before hospitalisation from a doctor recognised by the Insurer. The doctor's bill must indicate "second opinion".

Art. 6 Scope of benefits

The benefits referred to in Articles 4 and 5 are subject to the limits and amounts specified in the annex to the regulations which is an integral part of these Special Terms and Conditions.

Art. 7 Entitlement to benefits

1. The insured is entitled to benefits from the effective date of the insurance policy.
2. The entitlement to pregnancy- and childbirth-related benefits starts after a waiting period of 12 months.
3. The benefits contemplated in Article 5 of these Special Terms and Conditions (benefits covered under the "Plus" option) will be granted if such coverage is specifically indicated in the insurance policy.
4. Benefits are imputed to the insured amounts per calendar year in chronological order by treatment date. Costs incurred after entitlements are exhausted (benefits subject to duration limits or reimbursement ceilings) cannot be carried forward to the next year.
5. The Insurer shall reimburse any costs not covered by compulsory health insurance within the limits of the present Special Terms and Conditions provided the treatment is carried out by a doctor 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 compulsory insurance or other supplementary insurance.

Art. 8 Premiums

An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year.

The applicable age groups are:

- from 0 to 18;
- from 19 to 25;
- from the 26th year to the 71st, age groups are graduated in five-year brackets.

Art. 9 Family bonus – basic module

A family bonus is granted on children's premiums up to their 18th birthday (basic module) if at least one parent and the child have contracted:

- "Global Classic" supplemental insurance, and
- compulsory health insurance

with a Groupe Mutuel health insurance company. The amount of the family bonus is indicated on the insurance policy.

Art. 10 Obligations of the insured

- Before he is hospitalised, the insured shall always check that the hospital, ward or clinic where he is to be treated is an establishment recognised by the Insurer.
- Before each treatment, the insured shall verify that the practitioner who will be attending him is recognised by the Insurer.

Annex

Insured benefits – basic module

Hospitalisation in Switzerland	Hospitalisation in general ward anywhere in Switzerland
Restricted and non-reimbursable drugs	90%, unlimited prescriptions
Thermal cures in Switzerland	Max. CHF 80 per day, max. CHF 800 per calendar year
Post-hospitalisation convalescence cures	Max. CHF 50 per day, max. 30 days per year
Hospital accommodation expenses for close relative	Max. CHF 600 per calendar year
Home help and cost of a home	Max. CHF 80 per day, max. CHF 800 per year
Glasses and contact lenses	CHF 150 per 3-year period (per calendar year for children up to age 18)
Auxiliary appliances	90%, max. CHF 1,000 per calendar year
Voluntary sterilisation	90% unlimited
Ear correction surgery	90% unlimited
Psychotherapists (non-doctor) and independent psychologists	CHF 40 per session, max. CHF 800 per calendar year
Transport expenses	Max. CHF 5,000 per calendar year
Search and rescue costs	Max. CHF 50,000 per calendar year
Vaccinations	90%, max. CHF 150 per calendar year
Preventive tests	CHF 50 per calendar year
Check-up	90%, every 3 years
Preventive gynaecological tests	90%, unlimited number of tests
Ultrasound exams and mammographies	90%, unlimited number of tests
One-time breast-feeding allowance	CHF 100 per child
For emergencies in Switzerland and abroad	Groupe Mutuel Assistance

Insured benefits – “Plus” option

Alternative medicine*	80%, max. CHF 10,000 per calendar year
Health promotion: Health centre, back school, tobacco and alcohol detoxification cures	50%, max. CHF 500 per calendar year (Health centre 50%, max. CHF 200 per calendar year)
Nutritional counselling	CHF 50 max. per session (max. 3 sessions per 3-year period)
Second medical opinion	90% unlimited

* subject to an annual deductible of CHF 300, from the insured's 18th birthday

Special Terms and Conditions for Global mi-privée Supplemental Insurance Coverage

GMGA01-E8 – Edition: 01 Jul 2000

The following provisions are subject to the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC) under the Federal Law on Insurance Contracts (LCA/VVG), whose edition is mentioned in the insurance policy.

Art. 1 Eligibility

1. Global mi-privée supplemental insurance is open to all individuals up to their 55th birthday.
2. Insureds aged 0 to 18, i.e. until 31 December of the year coinciding with their 18th birthday, are granted the supplemental benefits described in Article 2, paragraph 2.2, under the heading Global Junior.
3. From 1 January of the year coinciding with their 55th birthday, insureds are granted the supplemental benefits described in Article 2, paragraph 2.3, under the heading Global Senior.
4. If a person has already contracted comparable coverage with another insurer and cannot for the time being terminate that insurance, he may join Global mi-privée insurance exclusively for the benefits designated in Article 2, paragraph 2.4, under the heading Global Temporis.

Art. 2 Insured benefits

1. Global mi-privée

The following benefits are covered in addition to the compulsory health insurance:

1. Hospitalisation

1. Insurance class

Semi-private ward (room with two beds) of a recognised hospital facility in Switzerland, in general or psychiatric wards, for treatment of acute conditions.

2. Deductibles on hospitalisation benefits

- a. no deductible;
- b. CHF 1,000 per calendar year;
- c. CHF 3,000 per calendar year.

The selected deductible applies to hospitalisation-related benefits only.

3. Benefits

a. General

In case of hospitalisation, the Insurer covers the cost of treatment and of room and board.

b. Hospitalisation in a private ward

If an insured is hospitalised in a ward which is higher than that covered by his insurance class, the following maximum benefits will be granted to him:

80% of room and board and treatment costs.

c. Hospitalisation abroad

If an insured falls ill or has an accident abroad and is hospitalised abroad, the Insurer grants him a maximum allowance of CHF 1,000 per day for no more than 60 days per calendar year.

Voluntary treatment abroad is not covered unless the Insurer gives its prior consent.

4. Maternity benefits

- a. Entitlement to maternity and childbirth benefits commences upon completion of 12 months' insurance. The term of coverage under Global Temporis does not count for calculating that entitlement.
- b. Interruptions of pregnancy and any other maternity-related benefits are subject to the waiting

period specified in sub-paragraph (a).

- c. Where childbirth involves a hospital stay of less than five days in a semi-private ward, the Insurer will grant insureds a daily allowance of CHF 250 for each day of avoided hospitalisation. Hospital stays invoiced on a global lump-sum basis do not qualify for this allowance. Sub-paragraph (a) is reserved.
 - d. In case of outpatient childbirth or childbirth at home, the insured is entitled to an allowance of CHF 800 subject to sub-paragraph (a).
 - e. If an insured person is hospitalised in a ward corresponding to her coverage level, the Insurer will also cover the newborn's hospital costs for the duration of the mother's stay in hospital provided the baby is also insured with the Insurer. Personal expenses are not covered. Sub-paragraph (a) is reserved.
- ### 5. Scope and duration of benefits
- Payment of hospitalisation benefits is subject to the following terms and conditions:
- a. The Insurer covers the cost of recognised treatments, within the meaning of LAMal/KVG, of hospital boarding costs and of doctors' fees in accordance with tariff agreements or cantonal regulations.
 - b. If an insured is hospitalised in a hospital with which the Insurer has not concluded a tariff agreement covering room and board and treatment costs (including medical fees), he will be paid CHF 400 per day, within the limits of semi-private ward coverage.
Article 2.1.1(3)(b) is not applicable.
 - c. The present insurance does not cover organ transplants for which the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn) has agreed specific lump-sum rates. This rule also applies to hospital facilities not bound by agreed lump-sum rates.
 - d. The entitlement to benefits ceases as soon as the condition is no longer deemed acute.
 - e. For psychiatric facilities, coverage for hospitalisation benefits is limited to 60 days' hospitalisation in any given calendar year.
 - f. Coverage for hospitalisation benefits is limited to 90 days' hospitalisation in any given calendar year. The duration of treatment abroad or in psychiatric facilities (60 days) is imputed to the foregoing 90-day limit.
- ### 6. Obligations of the insured
- Prior to each hospitalisation, the insured shall check that the facility, hospital ward or clinic where he is to be treated is recognised by the Insurer.
- ### 7. Cost-saving measures
- If, at the Insurer's proposal or by his own decision, an insured waives his entitlement to hospitalisation in a private ward and instead stays in a general or comfort ward, the Insurer may grant him an indemnity of up to 50% of the savings es-

timated by the Insurer up to maximum CHF 1,500 per hospitalisation.

- In case of outpatient childbirth or childbirth at home, only Article 2.1.1(4)(d) applies.

2. Supplemental treatment

The Insurer covers the following benefits within the limits stipulated in Article 3 (see Table):

1. Restricted drugs

The applicable percentage of the cost of drugs not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

2. Non-reimbursable drugs

The applicable percentage of the cost of drugs which are not on any official list (LS-LMT) and are not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

3. Alternative medicine

The Insurer will cover the cost of the following therapies provided they are administered by a doctor licensed to practice in Switzerland or by natural therapy practitioner recognised by the Insurer.

The Insurer reserves the right to exclude certain natural therapy practitioners and can provide to the insured a list of practitioners whose services are reimbursed.

Before each treatment, the insured shall verify that the practitioner who is to attend him is recognised by the Insurer.

List of alternative medicine therapies

Naturopathy

Acupuncture, aromatherapy, auriculotherapy, bio-resonance, biotherapy, chromotherapy, nutritional advice, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, morotherapy, oxygenotherapy, phytotherapy, sympathicotherapy and cupping.

Manipulation techniques

Acupressure, lymphasizing, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, orthobionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, and autogenic training.

Psychotherapy

Bio-energetics, rebirthing, sophrology, Tomatis method.

- Voluntary changes in therapy or practitioner in the course of a treatment are subject to the Insurer's prior consent.

- Sophrology treatments will be reimbursed provided they are administered by a doctor, a doctor-sophrologist with an ASS diploma, or a sophrologist who is not a doctor but holds an ASS diploma.

4. Thermal cures in Switzerland

The Insurer will pay a contribution to the cost of thermal cures and convalescence cures in recognised facilities for a maximum of 30 days per calendar year. An application accompanied by the medical prescription shall be submitted to the Insurer at least 20 days before the start of the cure.

5. Thermal cures abroad

Subject to the Insurer's prior authorisation, contribu-

tion to the cost of medically indicated thermal cure treatment abroad. An application accompanied by the medical prescription shall be submitted to the Insurer at least 20 days before the start of the cure.

6. Tariff supplements

For outpatient treatment in Switzerland, the difference between the rates at the insured's place of work or residence, and those at the place of residence of the health care provider.

7. Personal expenses indemnity during hospitalisation

Against presentation of supporting invoices, a single indemnity payment will be allocated for each hospital stay lasting more than eight days.

8. Hospital accommodation for a family member

If the insured is hospitalised, the Insurer will cover the cost of hospital accommodation for one family member provided such cost is medically necessary.

9. Home help and placement costs

The following will be reimbursed subject to prior application by the insured:

- the percentage share of the cost of home help hired from an official service to attend to the insured's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning, etc.);
- the cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Family members have to be placed with an official institution.

10. Glasses and contact lenses

The specified amount for the purchase of prescription glasses or contact lenses in Switzerland or abroad which is not covered by compulsory health insurance.

11. Orthopaedic and prosthetic appliances

The cost of purchasing and renting medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the Insurer's list of reimbursable costs.

12. Childbirth preparation classes

The specified amount for painless childbirth preparation classes or childbirth preparation which is not covered by compulsory health insurance.

13. One-time breastfeeding indemnity

Breastfeeding indemnity provided the mother breastfeeds her baby for at least 30 days and that that duration is certified by the doctor or midwife. In cases of multiple births, an indemnity is paid for each child.

14. Ultrasound scans and mammograms

The specified amount for ultrasound scans and mammograms not covered by compulsory health insurance.

15. Vaccinations

Vaccination costs for vaccinations that are not included in the ordinance on compulsory health insurance benefits and which are necessary in Switzerland or are prescribed for trips abroad.

16. Elisa or HIV tests

The Insurer pays an annual contribution towards the cost of preventive tests prescribed and carried out by recognised health care providers.

17. Voluntary sterilisation

The specified percentage of the cost of the operation.

18. Dental treatment in case of accident

The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice in Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and charge point value).

19. Dental treatment in case of illness

The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice in Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and charge point value).

20. Transport costs

The Insurer will pay a contribution towards the cost of transport to the nearest hospital facility or doctor following an insured illness or accident, provided such transport is medically necessary and is not covered by compulsory health insurance.

This contribution is only granted for transport by ambulance, helicopter or by a search and rescue action.

Public transport costs (bus or train) for outpatient treatment will also be reimbursed if such treatment serves to avoid hospitalisation.

21. Independent psychologists and non-doctor psychotherapists

The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychotherapists.

3. **Groupe Mutuel Assistance**

The benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).

2. **Global Junior**

Supplemental benefits

a. Home care for ill children

By way of derogation from Article 1, paragraph 2, this benefit is granted for children up to the age of twelve. Benefits are payable if home care is provided by a person from an institution recognised by the Insurer and the parents are gainfully employed outside the home.

b. Contribution for sports

Against presentation of a supporting invoice, reimbursement of a share of the active member's fee in a sports club or association recognised by the Insurer.

3. **Global Senior**

Supplemental benefits

a. Palliative care

The Insurer will pay a contribution to the cost of palliative treatment, i.e. medical and nursing care for persons whose life is coming to an end, administered at home by duly qualified persons under the supervision of an institution recognised by the Insurer.

A prior application shall be submitted to the Insurer who will determine the amount of the contribution on a case-by-case basis. The contribution is set taking into account the overall cost of the treatment enabling the insured to stay at home.

b. Health and fitness cures

The Insurer pays an annual contribution for a health and fitness cure at recognised facilities offering a specific programme in that field.

c. Nutrition advisor and classes

The Insurer will pay an annual contribution to the cost of a nutrition advisor and nutrition classes recognised by the Insurer.

4. **Global Temporis**

a. Global Temporis provides temporary Global mi-privée coverage to persons holding comparable coverage with another insurer.

b. Global Temporis covers the supplemental benefits described in sections 2.1.2, 2.1.3, 2.2 and 2.3; it does not cover the benefits contemplated in section 2.1.1. (hospitalisation).

c. For the supplemental treatment covered by Global Temporis, benefits are equal to 30% of the benefits offered by Global mi-privée.

d. Global Temporis benefits are payable in addition to those paid by the other insurer.

e. By granting Global Temporis coverage to an insured, the Insurer simultaneously undertakes to extend to him full Global mi-privée coverage, without a new medical examination, from the date indicated on the Global Temporis certificate. The transfer to full Global mi-privée coverage must take place within two years at the latest.

f. Any participation by the Insurer in deductibles and co-insurance amounts of other insurers is excluded.

g. For the life of Global Temporis coverage, the premium is reduced compared with the Global mi-privée premium.

h. Article 29(1) of the General Terms and Conditions of Supplemental Health and Accident Insurance granting the insured the right to terminate the policy is not applicable to the transfer from Global Temporis to Global mi-privée coverage or the corresponding premium adjustment.

i. Any time limits applying to benefits paid under Global Temporis coverage will also count for the calculation of benefit entitlements after the transfer to Global mi-privée coverage.

Art. 3 Scope of benefits

The benefits contemplated in Article 2 are payable within the limits and amounts indicated in the "Table of benefits under Global mi-privée".

Art. 4 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect.

2. Benefits are imputed to the annual insured sum chronologically, by order of treatment date. Costs incurred after entitlements are exhausted cannot be carried forward to the next year.

3. As provided in the present terms and conditions of insurance, the Insurer will reimburse any costs not covered by compulsory health insurance provided the treatment is carried out by a practitioner or a person who is duly authorised and recognised by the Insurer. Under no circumstances may the insurance benefits regulated by these terms and conditions be used for co-payments and deductibles under compulsory insurance or other supplemental insurance coverage.

Art. 5 Advantages of “LeClub”

When he contracts Global mi-privée insurance, the insured is entitled to all the advantages of “LeClub” membership including in particular:

1. Reduced rates in hotels

The Insurer keeps a list of the hotels offering reduced rates.

2. Rebates in drugstores, pharmacies and other shops

The Insurer keeps a list of the drugstores, pharmacies and other shops offering rebates.

Art. 6 Premiums

When an insured person reaches the last year of his age group, he is automatically transferred into the next age group at the beginning of the next calendar year. The applicable age groups are:

- from 0 to 18;
- from 19 to 25;
- from age 26, age groups are graduated in five-year brackets.

Table of benefits under Global mi-privée

Type of benefits	Global mi-privée
Restricted drugs	90%, unlimited prescriptions
Non-reimbursable drugs	90%, unlimited prescriptions
Alternative medicine	max. CHF 70 per session, up to CHF 6,000 per calendar year
Thermal cures in Switzerland	80%, max. CHF 750 per calendar year
Convalescence cures	CHF 25 per day, max. 30 days per calendar year
Convalescence cures following hospitalisation	CHF 50 per day, max. 30 days per calendar year
Thermal cures abroad	80%, max. CHF 1,000 per calendar year
Tariff supplements	CHF 1,000 per calendar year
Personal expenses indemnity in case of hospitalisation	CHF 200 per case
Hospital accommodation for family member	CHF 700 per calendar year
Home help and placement cost	90%, max. CHF 3,000 per calendar year
Glasses and contact lenses	CHF 200 per three-year period
Orthopaedic and prosthetic appliances	90%, max. CHF 1,000 per calendar year
Childbirth preparation classes	CHF 150 per pregnancy
One-time breastfeeding indemnity	CHF 100 per child
Ultrasound scans and mammograms	90%, restricted number of tests
Vaccinations	90%, max. CHF 250 per calendar year
Elisa or HIV tests	CHF 50 per calendar year
Voluntary sterilisation	80%, max. CHF 500
Dental treatment: in case of accidents	80%, max. CHF 8,000 per case
Dental treatment: in case of illness	80%, max. CHF 200 per three-year period
Transport costs	80%, max. CHF 5,000 per calendar year
Indep. psychologists and non-doctor psychotherapists	80%, max. CHF 800 per calendar year
Hospitalisation in Switzerland	Semi-private ward throughout Switzerland
Hospitalisation abroad	CHF 1,000 per day
Groupe Mutuel Assistance	Emergency medical assistance, support and repatriation for trips and stays abroad

Global Junior (ages 0 to 18)

Home care for ill children	CHF 300 per calendar year
Contribution for sports	CHF 30 per calendar year

Global Senior (from age 56)

Palliative care	90%, max. CHF 3,000 per calendar year
Health and fitness cures	CHF 300 per calendar year
Nutrition advisor and classes	50%, max. CHF 250 per calendar year

Special Terms and Conditions for Global privée Supplemental Insurance Coverage

GPGA01-E8 – Edition: 01 July 2000

The following provisions are subject to the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC) under the Federal Law on Insurance Contracts (LCA/VVG), whose edition is mentioned in the insurance policy.

Art. 1 Eligibility

1. Global privée supplemental insurance is open to all individuals up to their 55th birthday.
2. Insureds aged 0 to 18, i.e. until 31 December of the year coinciding with their 18th birthday, are granted the supplemental benefits described in Article 2, paragraph 2.2, under the heading Global Junior.
3. From 1 January of the year coinciding with their 55th birthday, insureds are granted the supplemental benefits described in Article 2, paragraph 2.3, under the heading Global Senior.
4. If a person has already contracted comparable coverage with another insurer and cannot for the time being terminate that insurance, he may join Global privée insurance exclusively for the benefits designated in Article 2, paragraph 2.4, under the heading Global Temporis.

Art. 2 Insured benefits

1. Global privée

The following benefits are covered in addition to the compulsory health insurance:

1. Hospitalisation

1. Insurance class

Private ward (one-bed room) of a recognised hospital facility in Switzerland, in general or psychiatric wards, for treatment of acute conditions.

2. Deductibles on hospitalisation benefits

- a. no deductible;
 - b. CHF 1,000 per calendar year;
 - c. CHF 3,000 per calendar year;
- The selected deductible applies to hospitalisation-related benefits only.

3. Benefits

a. General

In case of hospitalisation, the Insurer covers the cost of treatment and of room and board.

b. Hospitalisation abroad

If an insured falls ill or has an accident abroad and is hospitalised abroad, the Insurer grants him a maximum allowance of CHF 1,500 per day for no more than 60 days per calendar year. Insureds with private worldwide coverage (option “privée monde”) are covered up to maximum CHF 3,000 per day for 60 days per calendar year at the most.

Voluntary treatment abroad is not covered unless the Insurer gives its prior consent.

4. Maternity benefits

- a. Entitlement to maternity and childbirth benefits commences upon completion of 12 months' insurance. The term of coverage under Global Temporis does not count for calculating that entitlement.
- b. Interruptions of pregnancy and any other maternity-related benefits are subject to the waiting period specified in sub-paragraph (a).
- c. Where childbirth involves a hospital stay of less than five days in a private ward, the Insurer will grant insureds a daily allowance of CHF 250 for

each day of avoided hospitalisation. Hospital stays invoiced on a global lump-sum basis do not qualify for this allowance. Sub-paragraph (a) is reserved.

- d. In case of outpatient childbirth or childbirth at home, the insured is entitled to an allowance of CHF 1,200 subject to sub-paragraph (a).

- e. If an insured person is hospitalised in a ward corresponding to her coverage level, the Insurer will also cover the newborn's hospital costs for the duration of the mother's stay in hospital provided the baby is also insured with the Insurer. Personal expenses are not covered. Sub-paragraph (a) is reserved.

5. Scope and duration of benefits

Payment of hospitalisation benefits is subject to the following terms and conditions:

- a. The Insurer covers the cost of recognised treatments, within the meaning of LAMal/KVG, of hospital boarding costs and of doctors' fees in accordance with tariff agreements or cantonal regulations.
- b. If an insured is hospitalised in a hospital with which the Insurer has not concluded a tariff agreement covering room and board and treatment costs (including medical fees), he will be paid CHF 600 per day, within the limits of private ward coverage.
- c. The present insurance does not cover organ transplants for which the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn) has agreed specific lump-sum rates. This rule also applies to hospital facilities not bound by agreed lump-sum rates.
- d. The entitlement to benefits ceases as soon as the insured's condition is no longer deemed acute.
- e. For psychiatric facilities, coverage for hospitalisation benefits is limited to 60 days' hospitalisation in any given calendar year.
- f. Coverage for hospitalisation benefits is limited to 90 days' hospitalisation in any given calendar year. The duration of treatment abroad or in psychiatric facilities (60 days) is imputed to the aforesaid 90-day limit.

6. Obligations of the insured

Prior to each hospitalisation, the insured shall check that the facility, hospital ward or clinic where he is to be treated is recognised by the Insurer.

7. Cost-saving measures

- If, at the Insurer's proposal or by his own decision, an insured waives his entitlement to hospitalisation in a private ward and instead stays in a general or comfort ward, the Insurer may grant him an indemnity of up to 50% of the savings estimated by the Insurer up to maximum CHF 1,500 per hospitalisation.
- In case of outpatient childbirth or childbirth at home, only Article 2.1.1(4)(d) applies.

2. Supplemental treatment

The Insurer reimburses the following benefits within the limits stipulated in Article 3 (see Table):

1. Restricted drugs

The applicable percentage of the cost of drugs not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

2. Non-reimbursable drugs

The applicable percentage of the cost of drugs which are not on any official list (LS-LMT) and are not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

3. Alternative medicine

The Insurer will cover the cost of the following therapies provided they are administered by a doctor licensed to practice in Switzerland or by a natural therapy practitioner recognised by the Insurer.

The Insurer reserves the right to exclude certain natural therapy practitioners and can provide to the insured a list of practitioners whose services are reimbursed.

Before each treatment, the insured shall verify that the practitioner who is to attend him is recognised by the Insurer.

List of alternative medicine therapies

Naturopathy

Acupuncture, aromatherapy, auriculotherapy, bio-resonance, biotherapy, chromotherapy, nutritional advice, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, morotherapy, oxygenotherapy, phytotherapy, sympathetic therapy and cupping.

Manipulation techniques

Acupressure, lymphatising, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, orthobionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, and autogenic training.

Psychotherapy

Bio-energetics, rebirthing, sophrology, Tomatis method.

- Voluntary changes in therapy or practitioner in the course of a treatment are subject to the Insurer's prior consent.
- Sophrology treatments will be reimbursed provided they are administered by a doctor, a doctor-sophrologist with an ASS diploma, or a sophrologist who is not a doctor but holds an ASS diploma.

4. Thermal cures in Switzerland

The Insurer will pay a contribution to the cost of thermal cures and convalescence cures in recognised facilities for a maximum of 30 days per calendar year. An application accompanied by the medical prescription shall be submitted to the Insurer at least 20 days before the start of the cure.

5. Thermal cures abroad

Subject to the Insurer's prior authorisation, contribution to the cost of medically indicated thermal cure treatment abroad. An application accompanied by the medical prescription shall be submitted to the Insurer at least 20 days before the start of the cure.

6. Tariff supplements

For outpatient treatment in Switzerland, the difference between the rates at the insured's place of work or residence, and those at the place of residence of the health care provider.

7. Personal expenses indemnity during hospitalisation

Against presentation of supporting invoices, a single indemnity payment will be allocated for each hospital stay lasting more than eight days.

8. Hospital accommodation for a family member

If the insured is hospitalised, the Insurer will cover the cost of hospital accommodation for one family member provided such cost is medically necessary.

9. Home help and placement costs

The following will be reimbursed subject to prior application by the insured:

- the percentage share of the cost of home help hired from an official service to attend to the insured's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning, etc.);
- the cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Family members have to be placed with an official institution.

10. Glasses and contact lenses

The specified amount for the purchase of prescription glasses or contact lenses in Switzerland or abroad which is not covered by compulsory health insurance.

11. Orthopaedic and prosthetic appliances

The cost of purchasing and renting medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the Insurer's list of reimbursable costs.

12. Childbirth preparation classes

The specified amount for painless childbirth preparation classes or childbirth preparation which is not covered by compulsory health insurance.

13. One-time breastfeeding indemnity

Breastfeeding indemnity provided the mother breastfeeds her baby for at least 30 days and that that duration is certified by the doctor or midwife. In cases of multiple births, an indemnity is paid for each child.

14. Ultrasound scans and mammograms

The specified amount for ultrasound scans and mammograms not covered by compulsory health insurance.

15. Vaccinations

Vaccination costs for vaccinations that are not included in the ordinance on compulsory health insurance benefits and which are necessary in Switzerland or are prescribed for trips abroad.

16. Elisa or HIV tests

The Insurer pays an annual contribution towards the cost of preventive tests prescribed and carried out by recognised health care providers.

17. Voluntary sterilisation

The specified percentage of the cost of the operation.

18. Dental treatment in case of accident

The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice in Switzerland. Den-

tal costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and charge point value).

19. Dental treatment in case of illness

The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice in Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and charge point value).

20. Transport costs

The Insurer will pay a contribution towards the cost of transport to the nearest hospital facility or doctor following an insured illness or accident, provided such transport is medically necessary and is not covered by compulsory health insurance. This contribution is only granted for transport by ambulance, helicopter or by a search and rescue action.

Public transport costs (bus or train) for outpatient treatment will also be reimbursed if such treatment serves to avoid hospitalisation.

21. Independent psychologists and non-doctor psychotherapists

The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychotherapists.

3. Groupe Mutuel Assistance

The benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).

2. Global Junior

Supplemental benefits

a. Home care for ill children

By way of derogation from Article 1, paragraph 2, this benefit is granted for children up to the age of twelve. Benefits are payable if home care is provided by a person from an institution recognised by the Insurer and the parents are gainfully employed outside the home.

b. Contribution for sports

Against presentation of a supporting invoice, reimbursement of a share of the active member's fee in a sports club or association recognised by the Insurer.

3. Global Senior

Supplemental benefits

a. Palliative care

The Insurer will pay a contribution to the cost of palliative treatment, i.e. medical and nursing care for persons whose life is coming to an end, administered at home by duly qualified persons under the supervision of an institution recognised by the Insurer.

A prior application shall be submitted to the Insurer who will determine the amount of the contribution on a case-by-case basis. The contribution is set taking into account the overall cost of the treatment enabling the insured to stay at home.

b. Health and fitness cures

The Insurer pays an annual contribution for a health and fitness cure at recognised facilities offering a specific programme in that field.

c. Nutrition advisor and classes

The Insurer will pay an annual contribution to the cost of a nutrition advisor and nutrition classes recognised by the Insurer.

4. Global Temporis

- a. Global Temporis provides temporary Global privée coverage to persons holding comparable coverage with another insurer.
- b. Global Temporis covers the supplemental benefits described in sections 2.1.2, 2.1.3, 2.2 and 2.3; it does not cover the benefits contemplated in section 2.1.1. (hospitalisation).
- c. For the supplemental treatment covered by Global Temporis, benefits are equal to 30% of the benefits offered by Global privée.
- d. Global Temporis benefits are payable in addition to those paid by the other insurer.
- e. By granting Global Temporis coverage to an insured, the Insurer simultaneously undertakes to extend to him full Global privée coverage, without a new medical examination, from the date indicated on the Global Temporis certificate. The transfer to full Global privée coverage must take place within two years at the latest.
- f. Any participation by the Insurer in deductibles and co-insurance amounts of other insurers is excluded.
- g. For the life of Global Temporis coverage, the premium is reduced compared with the Global privée premium.
- h. Article 29(1) of the General Terms and Conditions of Supplemental Health and Accident Insurance granting the right to terminate the policy is not applicable to the transfer from Global Temporis to Global privée or the corresponding premium adjustment.
- i. Any time limits applying to benefits paid under Global Temporis coverage will also count for the calculation of benefit entitlements after the transfer to Global privée coverage.

Art. 3 Scope of benefits

The benefits contemplated in Article 2 are payable within the limits and amounts indicated in the "Table of benefits under Global privée".

Art. 4 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect.
2. Benefits are imputed to the annual insured sum chronologically, by order of treatment date. Costs incurred after entitlements are exhausted cannot be carried forward to the next year.
3. As provided in the present terms and conditions of insurance, the Insurer will reimburse any costs not covered by compulsory health insurance provided the treatment is carried out by a practitioner or a person who is duly authorised and recognised by the Insurer. Under no circumstances may the insurance benefits regulated by these terms and conditions be used for co-payments and deductibles under compulsory insurance or other supplemental insurance coverage.

Art. 5 Advantages of "LeClub"

When he contracts Global privée insurance, the insured is entitled to all the advantages of "LeClub" membership including in particular:

1. Reduced rates in hotels
The Insurer keeps a list of the hotels offering reduced rates.
2. Rebates in drugstores, pharmacies and other shops
The Insurer keeps a list of the drugstores, pharmacies and other shops offering rebates.

Art. 6 Premiums

When an insured person reaches the last year of his age group, he is automatically transferred into the next age group at the beginning of the next calendar year. The applicable age groups are:

- from 0 to 18;
- from 19 to 25;
- from age 26, age groups are graduated in five-year brackets.

Table of benefits under Global privée

Type of benefits	Global privée
Restricted drugs	90%, unlimited prescriptions
Non-reimbursable drugs	90%, unlimited prescriptions
Alternative medicine	max. CHF 70 per session, up to CHF 6,000 per calendar year
Thermal cures in Switzerland	80%, max. CHF 750 per calendar year
Convalescence cures	CHF 25 per day, max. 30 days per calendar year
Convalescence cures following hospitalisation	CHF 50 per day, max. 30 days per calendar year
Thermal cures abroad	80%, max. CHF 1,000 per calendar year
Tariff supplements	CHF 1,000 per calendar year
Personal expenses indemnity in case of hospitalisation	CHF 200 per case
Hospital accommodation for family member	CHF 700 per calendar year
Home help and placement cost	90%, max. CHF 3,000 per calendar year
Glasses and contact lenses	CHF 200 per three-year period
Orthopaedic and prosthetic appliances	90%, max. CHF 1,000 per calendar year
Childbirth preparation classes	CHF 150 per pregnancy
One-time breastfeeding indemnity	CHF 100 per child
Ultrasound scans and mammograms	90%, restricted number of tests
Vaccinations	90%, max. CHF 250 per calendar year
Elisa or HIV tests	CHF 50 per calendar year
Voluntary sterilisation	80%, max. CHF 500
Dental treatment: in case of accidents	80%, max. CHF 8,000 per case
Dental treatment: in case of illness	80%, max. CHF 200 per three-year period
Transport costs	80%, max. CHF 5,000 per calendar year
Indep. psychologists and non-doctor psychotherapists	80%, max. CHF 800 per calendar year
Hospitalisation in Switzerland	Private ward throughout Switzerland
Hospitalisation abroad	CHF 1,500 per day CHF 3,000 per day (option "privée monde")
Groupe Mutuel Assistance	Emergency medical assistance, support and repatriation for trips and stays abroad

Global Junior (ages 0 to 18)

Home care for ill children	CHF 300 per calendar year
Contribution for sports	CHF 30 per calendar year

Global Senior (from age 56)

Palliative care	90%, max. CHF 3,000 per calendar year
Health and fitness cures	CHF 300 per calendar year
Nutrition advisor and classes	50%, max. CHF 250 per calendar year

Special conditions for Global smart supplemental insurance coverage

GOGA02-E8 – Edition : 01 June 2023

The following provisions are subject to the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), whose edition is specified in the insurance policy.

Art. 1 Purpose of the insurance

1. The purpose of this insurance is to cover insured persons for specific supplemental benefits over and above compulsory health insurance (AOS/OKP) benefits within the meaning of the Federal Law on Health Insurance (LAMal/KVG).
2. For persons who were subject to the compulsory health insurance (AOS/OKP) and who have chosen to retain their insurance coverage in accordance with Article 7(a) of the Ordinance on Health Insurance (OAMal/KVV) by signing up to an optional healthcare insurance in conformity with the Federal Law on Insurance Contracts (LCA/VVG), the benefits under Global smart insurance will be paid out in addition to the said insurance.
3. Global smart insurance offers three levels of coverage (basic module):
 - Level 1
 - Level 2
 - Level 3
4. This basic module may be supplemented by the option “Emergency hospitalisation abroad upgrade”.

Art. 2 Risks covered

Global smart benefits provide illness, accident and maternity coverage.

Art. 3 Eligibility

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

plicants are defined in the framework agreement signed between the co-contracting company and the insurer.

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

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

Art. 5 Termination of the insurance contract

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

Art. 6 Insured benefits

1. In Switzerland

	Level 1	Level 2	Level 3	Description
Hospitalisation	general ward	general ward	semi-private or private ward The insured option is mentioned in the insurance policy.	<ul style="list-style-type: none"> – In Switzerland, free choice of hospital facility depending on the chosen coverage level, in general or psychiatric wards, for treatment of acute conditions. – Reimbursement of treatments recognised under LAMal/KVG, of hospital boarding costs and of physician's fees in accordance with the tariff agreement concluded with the insurer for the corresponding wards. – The insurer will pay the costs of recognised facilities or doctor, i.e. those with which the insurer has concluded a tariff agreement. – If an insured person receives benefits from a non-recognised facility or doctor, he will be entitled to the following amounts per night of hospitalisation, depending on the type of treatment (acute, rehabilitation or psychiatric) and the ward (semi-private or private), the inpatient hospitalisation benefits actually invoiced, but not exceeding the amounts specified in Annex A, per night of hospitalisation. – The list of healthcare providers and maximum amounts is available on the insurer's website or can be obtained on request. The list valid at the time of treatment is decisive. – The list of healthcare providers can be amended at any time by the insurer. Such a change in the list does not give the policyholder the right to terminate the contract. – The insured person shall check that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the insurer. – Coverage for treatment in psychiatric facilities is limited to 60 days. – Coverage for hospitalisation benefits is limited to 180 days' hospitalisation in a semi-private or private ward in any given calendar year. The duration of treatment in psychiatric facilities (60 days) is imputed to the foregoing 180-day limit. – If, at the insurer's proposal or by his own decision, an insured person waives his entitlement to hospitalisation in a semi-private or private ward for the general ward, the insurer may grant an allowance of up to 50% of the savings estimated by the insurer and up to maximum CHF 5,000 per hospital stay.
Outpatient treatment	100%	100%	100%	<ul style="list-style-type: none"> – Free choice of outpatient treatment in Switzerland within the meaning of LAMal/KVG. – Reimbursement of the difference between the rates applicable at the insured's place of work or residence, and those applicable at the place of residence of the provider of healthcare services.
Non-reimbursable drugs	90%	90%	90%	<ul style="list-style-type: none"> – Medication prescribed by a doctor or a recognised healthcare provider, within the meaning of LAMal/KVG, which is not reimbursed by compulsory health insurance (AOS/OKP). – Exclusions: products included on the list of pharmaceutical products for special application (LPPA/LPPV).
Transport costs	90%	90%	90%	<ul style="list-style-type: none"> – Transport to the nearest hospital facility or physician provided such transport is medically necessary. – This contribution is only granted for transport by ambulance or by helicopter. Public transport costs (bus or train) in connection with outpatient treatment designed to avoid hospitalisation are also reimbursed.
Alternative medicine treatment	30%	60%	90%	<ul style="list-style-type: none"> – Reimbursement of the therapies enumerated in the list below (point 6.2 list of therapies) carried out by a qualified physician or a practitioner of natural therapies recognised by the insurer. – Before each treatment, the insured person shall check that the attending practitioner is recognised by the insurer for the therapy concerned.
Glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	<ul style="list-style-type: none"> – Cost of frames, lenses or contact lenses.

	Level 1	Level 2	Level 3	Description
Dental care	None	On or before 18 th birthday 50%, max. CHF 2,000 per calendar year From 19 th birthday 50%, max. CHF 500 per calendar year	On or before 18 th birthday 50%, max. CHF 2,000 per calendar year From 19 th birthday 50%, max. CHF 1,000 per calendar year	<ol style="list-style-type: none"> Depending on coverage level, reimbursement of the following costs: <ul style="list-style-type: none"> - dental treatment by a qualified dentist; - yearly prophylactic dental check-up; - dento-facial orthopaedic treatment; - laboratory. Insureds are immediately entitled to benefits for dental treatment following accidents which occur after the insurance comes into effect. Coverage for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following accidents is valid as soon as the insurance comes into effect; in other cases, not before a minimum insurance period of 12 months has lapsed. Benefits for dental treatment are subject to a 3-month waiting period and to points 2 and 3 above. The basis for the calculation of reimbursable 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 which would have been charged in Switzerland.
Thermal cures	None	50%, max. 30 days per calendar year	90%, max. 30 days calendar year	<ul style="list-style-type: none"> - Treatment and board during thermal cures in marine cure facilities recognised by the Ordinance on compulsory health insurance benefits in case of illness (OPAS/KLV). - Benefits are payable provided the treatment is prescribed by a recognised physician within the meaning of LAMal/KVG. Subject to revocation of the entitlement to benefits, an application for authorisation accompanied by the medical prescription must be submitted to the insurer at least 20 days before the start of the cure.
Convalescence cures	None	50%, max. 30 days per calendar year	90%, max. 30 days per calendar year	<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. - Subject to revocation of the entitlement to benefits, an application accompanied by the medical prescription must be submitted to the insurer at least 20 days before the start of the cure.
Home help	50%, max. CHF 1,500 per calendar year	50%, max. CHF 1,500 per calendar year	90%, max. CHF 2,500 per calendar year	<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.). - No benefits are payable if the insured person is declared disabled by the Federal Disability Insurance (AI/IV), receives an invalidity allowance or is hospitalised or staying at a cure or convalescence facility.
Alcohol detoxification cures	CHF 50 per day, max. 30 days per calendar year	CHF 100 per day, max. 30 days per calendar year	CHF 100 per day, max. 30 days per calendar year	<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. - Only treatments in facilities recognised by the "Centrale de coordination nationale de l'offre de thérapies résidentielles pour les problèmes de drogue" (the national coordination office for residential therapies in connection with substance abuse) will be reimbursed. The list of recognised facilities is available from the insurer.
Vaccinations	90%	90%	90%	<ul style="list-style-type: none"> - Reimbursement of medically prescribed vaccinations (not included in the Ordinance on compulsory health insurance benefits – OPAS/KLV) in Switzerland, and of any vaccinations recommended by the Swiss Federal Office of Public Health for trips abroad.
Check-ups	90%, max. 1 every three years	90%, max. 1 every three years	90%, max. 1 every three years	<ul style="list-style-type: none"> - Only check-ups defined and carried out by recognised physicians within the meaning of LAMal/KVG will be reimbursed. Check-ups include: <ul style="list-style-type: none"> - for persons under 40: a consultation (extended examination), glucose and cholesterol tests - for persons over 40: a consultation (extended examination), an electrocardiogram at rest, hematocchemical, glucose and cholesterol tests.
Second opinion	90%	90%	90%	<ul style="list-style-type: none"> - Reimbursement of the cost of a second opinion before hospitalisation provided that the doctor's bill indicates "second opinion".
Preventive healthcare services	50%, max. CHF 200 per calendar year	50%, max. CHF 200 per calendar year	50%, max. CHF 200 per calendar year	<ul style="list-style-type: none"> - Reimbursement of a cure in a facility or centre recognised by the insurer for back school, fitness or tobacco detoxification treatment. - If several measures promoting good health are taken in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 200.

2. List of “alternative medicine” therapies

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

3. Abroad

- The benefits enumerated below are valid worldwide, Switzerland and Liechtenstein excluded, for emergency medical care not covered by Swiss or foreign social insurances or by other private insurance coverage.
- The insured benefits correspond to those covered in Switzerland when being treated for similar medical conditions.
- Voluntary treatment abroad will be reimbursed only upon written request of the insured, subject to the insurer's prior consent.
- The benefits enumerated below are reimbursed when administered by persons or institutions with the necessary training, recognition and authorisation of the foreign social bodies.
- Expensive hospitalisation cases and other treatments which are subject to a financial guarantee request from the healthcare provider shall be notified beforehand to Groupe Mutuel Assistance using the form “Notification of a financial guarantee request”. Failing this, the insurer may reduce the insurance benefits by the amount that would have been paid if the prior notification had been made. The insurer waives the right to reduce its benefits if it is clear from the circumstances that the breach of the obligation to notify is not at fault.
- Payment of benefits
 - If several family members simultaneously fall sick or are accidentally injured, a separate invoice must be requested for each insured person: from the physician, hospital, pharmacist, etc.
 - To obtain reimbursement, the insured shall provide all requisite documents (original, detailed invoices, medical certificates, prescriptions, payment confirmations, etc.).
 - For foreign invoices, the applicable exchange rate is the official Swiss Franc rate for that currency on the last day of treatment.
 - The insurer recognises the customary tariffs applied in the country or region where the treatment takes place. The insurer reserves the right to reduce benefits if invoices are exaggeratedly high.
- By way of derogation to Art. 6.3.3., voluntary treatment abroad for persons
 - who are resident abroad and remain subject to compulsory health insurance (LAMal/KVG), or
 - who have chosen to retain their insurance coverage in accordance with Article 7(a) of the Ordinance on Health Insurance (OAMal/KVV) by signing up to an optional healthcare insurance in conformity with the Federal Law on Insurance, are not subject to prior consent of the insurer.

	Level 1	Level 2	Level 3	Description
Outpatient treatment	The insured sum amounts to a maximum of CHF 100,000 per calendar year			Consultations, tests, X-rays and recognised drugs.
Hospitalisation				Hospitalisation for recognised treatment.
Transport costs				Necessary transport to the nearest hospital facility for treatment.
Repatriation, search and rescue				Reimbursement of the following costs only: <ul style="list-style-type: none"> – repatriation transport costs, including for a dead person, subject to the insurer's prior agreement – search and rescue costs for an insured person who is sick or whose physical integrity is threatened
Visit of a family member				Visit of a family member if an insured person is hospitalised for 7 days or longer, namely: <ul style="list-style-type: none"> – documented costs of round trip in economy class plus public transport fares to the facility where the insured is hospitalised; – documented meal and accommodation costs up to CHF 250 per day with a maximum ceiling of CHF 2,000.

4. Groupe Mutuel Assistance

The benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile, in Switzerland or abroad).

5. "Emergency hospitalisation abroad upgrade" option

This option may be contracted for an additional premium by insureds with Global smart N3 coverage. It entitles the insured to reimbursement of treatment and room and board in case of hospitalisation abroad up to a maximum amount of CHF 3,000 per day for no more than 60 days per calendar year. These benefits are additional to the other benefits mentioned in Article 6.3.

Art. 7 Entitlement to benefits

Benefits are payable according to treatment dates. Costs incurred after entitlements are exhausted (benefits subject to duration or reimbursement ceilings) cannot be carried forward to the next year.

It is not possible to accrue benefits insured in Switzerland and abroad.

As provided in the present terms and conditions of insurance, the insurer will reimburse any costs not covered by compulsory health insurance provided the treatment is carried out by a practitioner or a person who is duly authorised and recognised by the insurer. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover co-insurance payments and deductibles under the AOS/OKP or other supplemental insurances.

However, insurance coverage is extended to cover foreign statutory co-insurance amounts for treatments outside Switzerland and Liechtenstein pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security conventions.

1. Scope and duration of hospitalisation benefits

Hospitalisation benefits are limited to the acute phase of the illness. The entitlement to benefits ceases once the condition is no longer considered acute, as in the treatment of stabilised or chronic conditions in particular, or if hospitalisation does not serve to improve the insured's health.

2. Maternity coverage

- Benefits for inpatient treatment during pregnancy and childbirth are first payable after a 12-month insurance period.
- If, when signing up to the insurance, the insured person can prove that she was covered by Groupe Mutuel Assurances GMA SA or another insurer during the last 12 months prior to the entry into force of the insurance contract with the same coverage in the event of hospitalisation (general, semi-private or private ward) and including the maternity risk, the 12-month period of non-availability for maternity benefits (Art. 7, para. 2(a) of these special terms and conditions) is not applied.
- Interruptions of pregnancy within the meaning of the Swiss Federal Law on Health Insurance (LAMa/KVG), and any other maternity-related benefits are subject to the period of non-availability specified in paragraph (a) above.
- If an insured person is hospitalised in a ward corresponding to her coverage level, the insurer will also cover the newborn's hospital costs during the mother's stay in hospital provided that, within 30 days of the child's birth, health care coverage is contracted for the child with the insurer. Personal expenses are not covered. Notwithstanding, point (a) remains applicable.

3. Organ transplants

The present insurance does not include coverage for organ transplants covered by lump-sum rates agreed by the SVK (Fédération suisse pour tâches communes des assureurs maladie, Solothurn); such costs are covered by compulsory insurance. This rule also applies to hospital facilities which are not bound by agreed lump-sum rates.

4. “Emergency hospitalisation abroad upgrade” option

The benefits contemplated in Article 6.5 of these special terms and conditions of insurance (“Emergency hospitalisation abroad upgrade” option) will be granted only if such coverage is specifically indicated in the insurance policy.

Art. 8 Premiums

An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:

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

Premiums are graduated in accordance with the foregoing age groups.

Art. 9 Deductibles

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

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

1. When an insured leaves the circle of insureds under a framework agreement, premiums are adjusted based on existing individual tariffs.
2. The same rule applies to the family members of a deceased employee insured under a framework agreement.
3. Any exclusions specified before the insured leaves the circle of insureds under a framework agreement shall be maintained.
4. The entry into force of the contract concluded before the insured leaves the circle of insureds under a framework agreement is taken into account for calculating the periods of non-availability.
5. Any benefits received before an insured leaves the circle of insureds under a framework agreement are taken into account to calculate the maximum benefits.
6. The same provisions apply in case of termination of the framework agreement between the insured company and the insurer.
7. The insured person or the policyholder shall notify the insurer in writing of his departure from the circle of insureds under a framework agreement within 30 days.
In the event of a breach of the obligation to notify, the policyholder shall reimburse to the insurer any premium difference arising from the adjustment provided for in the first paragraph.
8. In case of a termination of a framework agreement which provides for the payment of all or part of the premiums by the insured company, the premiums due for the insurance periods following the end of the framework agreement will be invoiced directly to the policyholder, who is the debtor of their payment.
9. The policyholder can terminate the contract within 30 days after having received his new policy.

Annex A

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

	Amounts per night of hospitalisation			
	Acute care		Rehabilitation and Psychiatry	
	Semi-private	Private	Semi-private	Private
Non-recognised doctor: Reimbursement of medical costs	CHF 500	CHF 500	CHF 0	CHF 0
Non-recognised hospital: Reimbursement of hospitalisation costs	CHF 300	CHF 500	CHF 100	CHF 150
Non-recognised Hospital and Doctor: Total reimbursement - Medical costs - Hospitalisation costs	CHF 800 - CHF 500 - CHF 300	CHF 1'000 - CHF 500 - CHF 500	CHF 100 - CHF 0 - CHF 100	CHF 150 - CHF 0 - CHF 150

Special Terms and Conditions for Global confort supplemental insurance

GCGA01-E7 – Edition: 1 July 2000

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 Eligibility

1. Global confort supplemental insurance is open to persons up to age 55.
2. Insured persons between the ages of 0 and 18 years, i.e. until 31 December of the year of their 18th birthday, are entitled to the additional benefits set out in Art. 2, section 2.2 under the heading “Global junior”.
3. From 1 January of the year following their 55th birthday, insured persons are entitled to the additional benefits set out in Art. 2, section 2.3, under the heading “Global senior”.
4. If a person is already insured with another insurer for coverage comparable to that of Global confort insurance and cannot terminate insurance with the other insurer for the time being, the person may join Global confort insurance and therefore benefit exclusively from the benefits set out in Art. 2, section 2.4 under the heading “Global temporis”.

Art. 2 Insured benefits

1. Global confort

The following benefits are provided in addition to compulsory health insurance:

1. Hospitalisation

1. Insurance classes

a. General ward

Free choice of a recognised Swiss hospital facility, in a general or psychiatric ward, for the treatment of acute conditions.

b. General ward, “comfort” level

Depending on the option chosen, the accommodation supplement for a two-bed or single room in a Swiss hospital approved by the insurer.

Medical care in a general ward without free choice of doctor. Hospital facilities availability remains reserved.

2. Benefits

a. General

In the event of hospitalisation, the insurer will pay the costs of treatment and accommodation expenses.

b. Hospitalisation abroad

If an insured person falls ill or has an accident and is hospitalised, the insurer will grant a maximum benefit of CHF 500 per day for a maximum of 60 days per calendar year.

Voluntary treatments abroad are not covered unless the insurer gives prior consent.

3. Scope and duration of benefits

The benefits of hospitalisation insurance are covered subject to the following provisions:

a. The insurer will pay the cost of treatment recognised under the LAMal/KVG, accommodation in a hospital facility as well as doctors’ fees, in accordance with the agreement concluded with the insurer or with the cantonal tariff regulations.

b. If an insured person stays in a hospital with which the insurer has not concluded a tariff agreement for accommodation and treatment costs (including medical fees), an amount of CHF 200 per day

will be paid within the limits of the chosen category.

c. The choice of hospital at the “comfort” level is limited to the medical facilities approved by the insurer.

d. This insurance does not cover organ transplants for which the SVK (Fédération suisse pour tâches communes des assureurs maladie, Solothurn) has agreed on flat rates per case. This rule also applies to hospital facilities which are not bound by agreed flat rates per case.

e. As soon as the patient is no longer considered as having an acute illness, the entitlement to benefits lapses.

f. Coverage for hospitalisation benefits is limited to 60 days’ hospitalisation in a psychiatric institution in any given calendar year.

g. After 90 days of hospitalisation in any given calendar year, insurance benefits are no longer paid. The duration of benefits paid abroad or in psychiatric facilities (60 days) is imputed to the above-mentioned 90-day limit.

4. Obligations of the insured person

The insured person shall check that the facilities, hospital ward or clinic where he/she is to be treated is a facility recognised by the insurer.

2. Supplemental healthcare

The insurer shall provide the following benefits, within the limits of Article 3 (see table):

1. Restricted drugs

The estimated percentage of the costs of drugs that are not covered by the compulsory health insurance, with the exception, however, of pharmaceutical products charged to insured persons (LPPA/LPPV).

2. Non-reimbursable drugs

The estimated percentage of the costs of drugs not included in any official list (LS/SL) that are not covered by the compulsory health insurance, excluding, however, the pharmaceutical products charged to insured persons (LPPA/LPPV).

3. Alternative medicine

The insurer will reimburse the cost of the following therapies providing they are carried out by a qualified Swiss doctor or alternative medicine practitioner recognised by the insurer. The insurer reserves the right to exclude certain natural treatment practitioners and shall make available to the insured person a list of practitioners whose benefits are reimbursed. Before each treatment, the insured person shall verify that the chosen practitioner is recognised by the insurer.

List of “alternative medicine” therapies

Naturopathy

acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colon hydrotherapy, laser therapy,

magnetic field therapy, magnetotherapy, moratherapy, nutritional counselling, oxygenotherapy, phytotherapy, sympathicotherapy, cupping.

Manipulation techniques

acupressure, lymphasizing, etiopathy, eurythmy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, myofascial release therapy, orthobionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, autogenic training, trager

Psychotherapy

bio-energetics, rebirthing, sophrology, Tomatis method.

- Voluntary changes in therapy or practitioner during the course of a treatment are subject to the insurer's prior consent.
- Benefits relating to sophrology are reimbursed when treatments are carried out by a doctor, a doctor-sophrologist with an ASS diploma or by a sophrologist who is not a doctor but has an ASS diploma.

4. Thermal cures in Switzerland

A contribution to the costs of treatment in the case of a thermal cure and a contribution to the costs of a convalescent cure are granted in recognised facilities, but for a maximum of 30 days per calendar year. A request for approval must be submitted to the insurer together with the medical prescription at least 20 days before the start of the cure.

5. Thermal cures abroad

Contribution to the costs of medically necessary thermal cures abroad, which have been authorised in advance by the insurer. A request for approval must be submitted to the insurer together with the medical prescription at least 20 days before the start of the cure.

6. Additional fees

For outpatient treatments in Switzerland, 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.

7. Personal expenses allowance in case of hospitalisation

Upon presentation of a supporting invoice, a unique allowance will be paid for each hospital stay lasting longer than eight days.

8. Hospital accommodation for family member

In the event of hospitalisation of the insured person, the insurer will cover the cost of hospital accommodation for one family member provided such costs are medically necessary.

9. Home help and placement costs

At the insured person's request, the following benefits are reimbursed:

- the percentage of the costs 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.);
- the costs of temporary placement for family members cohabiting with the insured person if the latter has to be hospitalised on medical grounds. Family members have to be placed temporarily with an official institution.

10. Glasses and contact lenses

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.

11. Medical aids and appliances

The cost of purchasing and renting medically prescribed orthopaedic equipment and medical aids and appliances (excluding dental prostheses) in accordance with the insurer's list of reimbursable devices.

12. Childbirth preparation classes

The specified amount for the cost of painless childbirth preparation classes that are not covered by compulsory health insurance.

13. One-time breastfeeding allowance

A breast-feeding allowance provided the mother breastfeeds her baby for at least 30 days and that the duration of the breast-feeding is certified by the doctor or midwife. In case of multiple births, the allowance will be paid for each child.

14. Ultrasound scans and mammographies

The estimated costs of ultrasound scans that are not covered by compulsory health insurance.

15. Vaccinations

The costs of medically prescribed vaccinations (not included in the Ordinance on Healthcare Insurance Benefits – OPAS/KLV) in Switzerland, and of any vaccinations prescribed when travelling abroad.

16. Elisa or HIV test

The insurer grants an annual contribution to the costs of preventive tests prescribed and carried out by recognised healthcare providers.

17. Voluntary sterilisation

The estimate percentage of reimbursement of surgery costs.

18. Dental treatment in case of accident

The estimated amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist or dental technician licensed to practice in Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and point value).

19. Dental treatment in case of illness

The estimated amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist licensed to practice in Switzerland. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and point value).

20. Transport costs

The insurer will pay a contribution towards the cost of transport to the nearest hospital or doctor as a result of an insured illness or accident, provided that the transport is medically necessary and is not covered by the compulsory health insurance.

This contribution is only granted for transport by ambulance, by helicopter or in the case of a search and rescue operation.

Public transport costs (bus or train) in connection with outpatient treatment designed to avoid hospitalisation are also covered.

21. Non-doctor psychotherapists and independent psychologists

The insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychologists.

3. **Groupe Mutuel Assistance**

The benefits specified in the general terms and conditions of Groupe Mutuel Assistance (repatriation and

transport if the insured event occurs more than 20 km from the insured person's home).

4. Death allowance

The insurance provides for an allowance of CHF 2,000 for death by illness or accident to be paid to the beneficiaries after the death of the insured person, if the latter is aged between 3 and 55 years old.

The death certificate or any other document deemed to be relevant must be submitted to the insurer.

The insurer has the right to deduct from the death allowance granted to the beneficiaries the amounts that may still be due by the deceased person (premiums, co-insurance amounts, etc.).

The entitlement to the death allowance will expire, without further notice, after two years from the date of death if the death certificate is not submitted to the insurer.

2. Global junior

Additional benefits

a. Home care for sick children

By way of derogation to Article 1.2, this benefit is granted up to the age of 12. Benefits are granted if the care is provided by a person from an organisation approved by the insurer and the parents work outside the home

b. Contribution to sports fees

Upon presentation of a supporting invoice, contribution to an active member's fee in a sports club or association recognised by the insurer.

3. Global senior

Additional benefits

a. Palliative care

The insurer will pay a contribution for palliative care, i.e. all medical and nursing techniques for people at the end of their lives, provided at home by duly qualified staff working under the authority of an institution recognised by the insurer.

A prior request must be submitted to the insurer, which will determine the amount of the contribution granted for each case. This contribution is calculated by taking into account all the costs relating to treatments that help people to remain at home.

b. Health and fitness cures

The insurer will pay an annual contribution for health and fitness cures at recognised facilities that offer a specific programme in this area.

c. Nutrition advice and classes

The insurer will pay an annual contribution to the costs of a nutrition advisor and nutrition classes recognised by the insurer.

4. Global temporis

a. Global temporis provides, on a temporary basis, benefits under Global confort to persons insured for comparable coverage with another insurer.

b. Global temporis benefits relate to the supplemental healthcare described in sections 2.1.2, 2.1.3, 2.2, 2.3; they do not relate to benefits in section 2.1.1. (hospitalisation) and 2.1.4 (allowance in the event of death).

c. For the supplemental care covered, Global temporis benefits shall correspond to 30% of the benefits provided under Global confort.

d. Global temporis benefits are paid in addition to the benefits granted by the other insurer.

e. Simultaneously to joining Global temporis, the insurer accepts that the insured person may join Global confort insurance in the future without having to complete a new health questionnaire, for the date set in the declaration of admission. The insured person must join Global confort within a maximum of three years.

f. The contribution of the insurer to the cost-sharing amounts (deductibles and co-payments) of other insurers is excluded.

g. For the duration of Global temporis, the premium is reduced compared to the premium for Global confort.

h. When switching from Global temporis to Global confort insurance and adjusting the premium accordingly, the provision of Art. 29 para. 1 of the general terms and conditions of insurance for supplemental health and accident insurance (CGC), which authorises the insured person the right to terminate the contract, does not apply.

i. Benefits paid under Global temporis, the limits of which relate to a specific period, also count towards the calculation of the entitlement to benefits after the switch to Global confort coverage.

Art. 3 Scope of benefits

The benefits set out in Article 2 are provided within the limits and up to the amounts shown in the "Table of benefits under Global confort".

Art. 4 Entitlement to benefits

1. The insured person is entitled to benefits as soon as the insurance policy comes into effect.

2. For benefits related to pregnancy and childbirth, entitlement to benefits begins after 12 months of insurance. The period of time spent in Global temporis is not counted towards the insurance period.

3. Benefits are charged according to the dates of treatment towards the insured amounts per calendar year. Costs incurred after entitlements are exhausted cannot be carried forward to the following year.

4. To the extent provided for in these terms and conditions, the insurer will reimburse the costs not covered by the compulsory health insurance (AOS/OKP) if the benefits are provided by a doctor or a person duly authorised and recognised by the insurer. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover co-insurance payments and deductibles under the AOS/OKP or other supplemental insurances.

Art. 5 Deductible amounts

Insured persons can choose between the following:

- no deductible,
- a deductible of CHF 150 per calendar year

For the duration of Global temporis, the insurance is concluded a without deductible amount.

Art. 6 "LeClub" advantages

By taking out Global confort insurance, the insured person shall benefit from the "LeClub" advantages, which are, in particular:

1. Hotel discounts

Discounts are granted in hotels on a list maintained by the insurer.

2. Discounts in drugstores, pharmacies or other shops

Discounts are granted in drugstores, pharmacies and other shops on a list maintained by the insurer.

Art. 7 Premium

Insured persons who reach the maximum level of their age group during the year are automatically transferred to the next higher age group at the beginning of the next calendar year. The relevant age groups are as follows:

- from 0 to 18;
- from 19 to 25;
- from age 26, age groups are graduated in five-year brackets.

Table of benefits under Global confort

Type of benefits	Global 1
Restricted drugs	70%, max. CHF 800/calendar year
Non-reimbursable drugs	70%, max. CHF 800/calendar year
Alternative medicine	Max. CHF 70/session, up to CHF 2,000/calendar year
Thermal cures in Switzerland	60%, max. CHF 300/calendar year
Convalescence cures	CHF 20/day, max. 30 days/calendar year
Convalescence cures following hospitalisation	CHF 40/day, max. 30 days/calendar year
Thermal cures abroad	No benefits
Additional fees	No benefits
Personal expenses allowance in case of hospitalisation	CHF 100/case
Hospital accommodation for family member	CHF 500/calendar year
Home help and placement costs	70%, max. CHF 1,500/calendar year
Glasses and contact lenses	CHF 100 every three years
Medical aids and appliances	70%, max. CHF 300/calendar year
Childbirth preparation classes	CHF 150 per pregnancy
One-time breastfeeding allowance	CHF 100 per child
Ultrasound scans and mammographies	90%, unlimited number of examinations
Vaccinations	70%, max. CHF 150/calendar year
Elisa or HIV test	CHF 50/calendar year
Voluntary sterilisation	60%, max. CHF 300
Dental treatment in case of accident	60%, max. CHF 4,000 per case
Dental treatment in case of illness	60%, max. CHF 100/every three years
Transport costs	60%, max. CHF 1,000/calendar year
Non-doctor psychotherapists and independent psychologists	60%, max. CHF 600/calendar year
Hospitalisation in Switzerland	General ward throughout Switzerland
Hospitalisation abroad	CHF 500/day
Death allowance	CHF 2,000 death/illness or accident
Groupe Mutuel Assistance	
Global junior (0-18 years)	
Home care for sick children	CHF 200/calendar year
Contribution to sports fees	CHF 30/calendar year
Global senior (from 56 years onwards)	
Palliative care	90%, max. CHF 2,000/calendar year
Health and fitness cures	CHF 300/calendar year
Nutrition advice and classes	50%, max. CHF 150/calendar year

Global 2	Global 3	Global 4
90%, max. CHF 800/calendar year	90%, unlimited benefits	90%, unlimited benefits
90%, max. CHF 800/calendar year	90%, unlimited benefits	90%, unlimited benefits
Max. CHF 70/session, up to CHF 2,000/calendar year	Max. CHF 70/session/session, up to CHF 3,000/calendar year	Max. CHF 70/session/session, up to CHF 6,000/calendar year
60%, max. CHF 300/calendar year	80%, max. CHF 500/calendar year	80%, max. CHF 750/calendar year
CHF 20/day, max. 30 days/calendar year	CHF 25/day, max. 30 days/calendar year	CHF 25/day, max. 30 days/calendar year
CHF 50/day, max. 30 days/calendar year	CHF 40/day, max. 30 days/calendar year	CHF 50/day, max. 30 days/calendar year
No benefits	50%, max. CHF 500/calendar year	80%, max. CHF 1,000/calendar year
CHF 600/calendar year	CHF 800/calendar year	CHF 1,000 per calendar year
CHF 100/case	CHF 200/case	CHF 200/case
CHF 500/calendar year	CHF 600/calendar year	CHF 700/calendar year
90%, max. CHF 1,500/calendar year	90%, max. CHF 2,500/calendar year	90%, max. CHF 3,000/calendar year
CHF 100 every three years	CHF 150 every three years	CHF 200 every three years
90%, max. CHF 300/calendar year	90%, max. CHF 1,000/calendar year	90%, max. CHF 1,000/calendar year
CHF 150 per pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy
CHF 100 per child	CHF 100 per child	CHF 100 per child
90%, unlimited number of examinations	90%, unlimited number of examinations	90%, unlimited number of examinations
90%, max. CHF 150/calendar year	90%, max. CHF 200/calendar year	90%, max. CHF 250/calendar year
CHF 50/calendar year	CHF 50/calendar year	CHF 50/calendar year
80%, max. CHF 300	80%, max. CHF 400	80%, max. CHF 500
80%, max. CHF 4,000 per case	80%, max. CHF 6,000 per case	80%, max. CHF 8,000 per case
80%, max. CHF 100/every three years	80%, max. CHF 150/every three years	80%, max. CHF 200/every three years
80%, max. CHF 1,000/calendar year	80%, max. CHF 2,500/calendar year	80%, max. CHF 5,000/calendar year
70%, max. CHF 600/calendar year	80%, max. CHF 700/calendar year	80%, max. CHF 800/calendar year
General ward throughout Switzerland	General ward throughout Switzerland	General ward throughout Switzerland
CHF 500/day	CHF 500/day	CHF 500/day
CHF 2,000 death/illness or accident	CHF 2,000 death/illness or accident	CHF 2,000 death/illness or accident
assistance, supervision and repatriation in the event of a medical emergency while travelling abroad		
CHF 250/calendar year	CHF 300/calendar year	CHF 300/calendar year
CHF 30/calendar year	CHF 30/calendar year	CHF 30/calendar year
90%, max. CHF 2,500/calendar year	90%, max. CHF 3,000/calendar year	90%, max. CHF 3,000/calendar year
CHF 300/calendar year	CHF 300/calendar year	CHF 300/calendar year
50%, max. CHF 200/calendar year	50%, max. CHF 250/calendar year	50%, max. CHF 250/calendar year

Special Terms and Conditions for Global flex Supplemental Insurance

GXGA01-E7 – Edition: 01 April 2005

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

Global flex insurance combines the basic module “Hospiflex”, which allows the insured to choose freely between a general, semi-private or private ward when being admitted to hospital, with “Careflex”, an optional supplemental healthcare module. Benefits are supplemental to those provided under the compulsory insurance LAMa/KVG (hereafter, AOS/OKP).

Art. 2 Eligibility

Global flex supplemental insurance is open to all persons under the age of 55.

Art. 3 Risks covered

Global flex benefits provide illness and accident coverage (maternity excluded).

Art. 4 “Hospiflex” – basic module

1. Choice of ward and co-insurance

For inpatient treatment (hospital stay exceeding 24 hours) in:

- a hospital;
- a psychiatric care facility; or
- a rehabilitation facility;

the insured is free to choose the hospital ward, along with the following co-insurance amounts:

Ward	Insured's co-insurance
General ward	CHF 0
Semi-private ward	CHF 400 per day, maximum CHF 4,000 per calendar year
Private ward	CHF 600 per day, maximum CHF 5,000 per calendar year

In calculating the number of hospitalisation days subject to co-insurance, the days on which the insured enters and leaves the hospital are deemed as full days when invoiced by the hospital facility.

If, during a calendar year, the insured chooses to be hospitalised in semi-private and private wards, the maximum annual limit of the private ward is taken into account.

2. Hospitals

So that Global flex benefits may be provided, hospitals must be recognised within the meaning of the Federal Law on Health Insurance – LAMa/KVG – (hospitals with a cantonal mandate) or have concluded a rate agreement with Groupe Mutuel Assurance GMA SA for the corresponding wards.

3. Scope and duration of hospitalisation benefits

Benefits are reimbursed subject to the following provisions:

- The Insurer reimburses the costs of treatments recognised by the LAMa/KVG, accommodation in hospital and medical expenses, in accordance with the agreement concluded with the Insurer or with the cantonal rate agreement.

- Hospital benefits are limited to the acute stage of the illness. The entitlement to benefits ceases once the condition is no longer considered acute, as in the treatment of stabilised or chronic conditions in particular, or if hospitalisation does not serve to improve the insured's health.

4. Psychiatric facilities

The entitlement to benefits is limited to 90 days per calendar year.

5. Stay in a rehabilitation centre

The entitlement to benefits is limited to 90 days per calendar year.

6. Hospitalisation abroad

a. In case of emergency or medical necessity:

If an insured falls ill or has an accident and is hospitalised abroad, the Insurer will grant him a maximum daily allowance of CHF 500 for no more than 60 days per calendar year. Co-insurance amounts defined in Article 4.1 are not applicable.

b. Voluntary treatments abroad:

Coverage only with the Insurer's prior consent.

7. Organ transplants

This insurance does not cover organ transplantation for which the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn) has agreed specific lump-sum rates (these costs are covered by the AOS/OKP). This rule also applies for hospitals with which no lump-sum rates have been agreed.

8. Rights and obligations of the insured in the event of hospitalisation

- The insured shall check that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the Insurer.
- The insured shall notify the Insurer of the choice of the ward (general, semi-private or private) before being admitted.
- In emergency cases, when the insured is unable to choose the ward upon admittance, the Insurer guarantees benefits in a general ward.

Art. 5 “Careflex” – optional module

In addition to the basic module “Hospiflex” outlined in Article 4 of these Special Terms and Conditions, the insured may, at an additional premium, extend his insurance coverage to include the following benefits:

1. Benefits subject to an annual deductible of CHF 150

	Benefits	Description
Alternative medicine	90% unlimited	<ul style="list-style-type: none"> – Coverage of therapies according to the list below*. – The Insurer reserves the right to exclude some natural therapeutic practitioners. – The insured shall check that the therapist is a practitioner recognised by the Insurer.
Limited and unlisted drugs	90% unlimited	<ul style="list-style-type: none"> – Drugs not reimbursed under the AOS/OKP. – Exclusions: pharmaceutical products for special application (LPPA/LPPV) – www.lppa.ch.
Placement costs	90% unlimited	<ul style="list-style-type: none"> – Upon prior request to the Insurer, the cost of temporary placement and support for family members cohabiting with the insured if the latter has to be hospitalised – Family members have to be placed with an official institution. – During the insured's stay in hospital, the cost of a hospital bed for a family member if the family member's presence is medically justified.
Auxiliary appliances	90% unlimited	<ul style="list-style-type: none"> – Rental and purchase of medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) required by the insured for his daily activities, in accordance with the Insurer's list of auxiliary appliances.
Transport costs	90% unlimited	<ul style="list-style-type: none"> – To the nearest hospital or doctor provided such transport is medically required. – Type of transport reimbursed: ambulance, helicopter or search operation. – Public transport costs (train or bus) in connection with outpatient treatment designed to avoid hospitalisation are also reimbursed.
Free choice of doctor in Switzerland	90% unlimited	<ul style="list-style-type: none"> – Free choice of place of treatment in Switzerland for outpatient treatments within the meaning of the LAMa/KVG. – Reimbursement of the difference between the rate applicable at the insured's place of work or residence, and the rate applicable at the place of residence of the healthcare provider.
Thermal cures in Switzerland	90% unlimited (max. 30 days per year)	<ul style="list-style-type: none"> – Treatment and room and board costs in thermal cure facilities approved by the Federal Ordinance on Healthcare Insurance benefits (OPAS/KLV). – Benefits are granted if they are prescribed by a doctor. An application accompanied by the medical prescription shall be submitted to the Insurer at least 20 days before the start of the cure.
Convalescence cures in Switzerland	90% unlimited (max. 30 days per year)	<ul style="list-style-type: none"> – Treatment and room and board costs during convalescence cures in Switzerland in facilities recognised by the Insurer, provided that the convalescence was prescribed following a hospital stay. – An application accompanied by the medical prescription shall be submitted to the Insurer at least 20 days before the start of the cure.
Home help	90% (max. CHF 2,500 per year)	<ul style="list-style-type: none"> – Costs 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.). – Benefits are granted following hospitalisation and upon prior request to the Insurer. – No benefits are payable if the insured is recognised as disabled under the Federal Disability Insurance (AI/IV), receives a disability allowance or is staying in a hospital or at a cure or convalescence facility.
Medical glasses and contact lenses	CHF 150 per 3-year period	<ul style="list-style-type: none"> – Purchase price in Switzerland or abroad.
Meals-on-wheels	CHF 20 per day (30 days per year)	<ul style="list-style-type: none"> – Cost of meals-on-wheels delivered by an institution recognised by the Insurer to the insured's home upon medical prescription following a hospital stay.
Drugs for home delivery	Shipping costs	<ul style="list-style-type: none"> – Prescribed drugs delivered by a partner recognised by the Insurer.

2. Benefits not subject to a deductible

	Benefits	Description
Second opinion	90% unlimited	– Cost of a second medical opinion before hospitalisation . The doctor's bill must indicate "second opinion".
Mammographies	90% unlimited	
Vaccinations	90% unlimited	– Vaccinations required in Switzerland and recommended by the Federal Office of Public Health for trips abroad.
Preventive tests (HIV, Elisa)	90% unlimited	– Carried out by recognised healthcare providers .
Check-ups	90% unlimited max. 1 every 3 years	– Conducted by a doctor recognised by the Insurer, but no more than one check-up every three years .
Psychotherapy	2 sessions per year, max. CHF 140	– Treatments medically prescribed and dispensed by non-doctor psychotherapists and independent psychologists.
Dental check-up	max. CHF 75 per year	– Preventive annual check-up conducted by a dentist with federal qualifications.
Nutritional counselling	CHF 50 per session, max. 3 sessions every 3 years	– Carried out by consultants recognised by the Insurer, but no more than three nutritional counselling sessions every three years.
Health promotion	50% (max. CHF 200 per year)	– Back school, fitness and tobacco and alcohol detoxification cures in a facility or with a healthcare provider recognised by the Insurer . – If several measures promoting good health are taken in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 200.
Groupe Mutuel Assistance	In case of emergency, in Switzerland or abroad	– Benefits specified in the general terms and conditions of Groupe Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile, in Switzerland or abroad).

*List of "alternative medicine" therapies

Naturopathy

Acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, morotherapy, oxygenotherapy, phytotherapy, sympathetic therapy, cupping.

Manipulation techniques

Acupressure, lymphasizing, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, orthobionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, autogenic training.

Other

Bio-energetics, rebirthing, sophrology, Tomatis method.

Art. 6 Entitlement to benefits

1. The benefits contemplated in Article 5 of these Special Terms and Conditions ("Careflex" module) will be granted if such coverage is specifically indicated in the insurance policy.
2. Benefits are imputed by treatment date. Costs incurred after entitlements are exhausted (benefits subject to duration limits or reimbursement ceilings) cannot be carried forward to the following year.
3. The Insurer shall reimburse any costs not covered by the AOS/OKP within the limits of these Special Terms and Conditions provided the treatment is carried out by a doctor whose qualifications are recognised by Swiss law or by a person who is duly authorised and recognised by the Insurer. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover co-insurance payments and deductibles under the AOS/OKP or other supplemental insurances.

Art. 7 Premiums

An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:

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

Premiums take into account the above age groups.

Special Terms and Conditions for Supplemental Health Insurance Coverage

SC

SCGA01-E7 – Edition: 01 July 2000

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 Eligibility

Supplemental health insurance is open to persons of all ages.

Art. 2 Annual insured sums

The Insurer guarantees the benefits contemplated in these General Terms and Conditions up to the following annual amounts:

- a. coverage per calendar year: CHF 8,000 SC1
- b. coverage per calendar year: CHF 10,000 SC2
- c. coverage per calendar year: CHF 15,000 SC3
- d. coverage per calendar year: CHF 20,000 SC4

Art. 3 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect.
2. Benefits payable under this insurance are supplemental to compulsory insurance benefits.
3. Benefits are imputed to the annual insured sum. If an insured exhausts his insured sum, his entitlement will be renewed from 1 January of the next year. Costs incurred after entitlements are exhausted cannot be carried forward to the next year.
4. If any benefits offered under the Vitalis insurance (SP), dental care insurance (DP) and dental cost insurance (TD) overlap with SC or SB supplemental health insurance benefits, the benefits payable under the latter shall be paid after SP, DP and TD supplemental benefits.

Art. 4 Excessive fees and invoices

The Insurer reserves the right to contest fees and other invoices which it regards as being clearly excessive, and to limit its benefits. Are considered excessive, charges for ineffectual, inadequate or uneconomical treatment.

Art. 5 Health care benefits

1. As provided in these terms and conditions of insurance, the Insurer shall reimburse any costs not covered by compulsory health insurance provided the treatment is carried out by a practitioner or a person who is duly authorised and recognised by the Insurer. Under no circumstances may the insurance benefits governed by these terms and conditions be used for co-payments and deductibles under compulsory health insurance or other supplementary insurance coverage.
2. The Insurer covers the following benefits within the limits stipulated in Article 6 (see table).
 1. Restricted drugs (SC1, SC2, SC3 and SC4)
The specified percentage of the cost of drugs not covered by compulsory health insurance with the exclusion of pharmaceutical products for special application (LPPA/LPPV).
 2. Restricted drugs (SC1, SC2, SC3 and SC4)
The specified percentage of the cost of drugs which are not on any official list (LS-LMT) and are not covered by compulsory health insurance, excluding pharmaceutical products for special application (LPPA/LPPV).

3. Alternative medicine (SC2, SC3 and SC4)

The Insurer will reimburse the cost of the following therapies provided they are administered by a physician holding a Swiss degree or a natural therapy practitioner recognised by the Insurer.

The Insurer reserves the right to exclude certain natural therapy practitioners; a list of practitioners whose services are reimbursed is available to insureds. Before each treatment, the insured person shall check that the practitioner of his choice is recognised by the Insurer.

List of "alternative medicine" therapies

Naturopathy:

Acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, nutritional counselling, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, morotherapy, oxygenotherapy, phytotherapy, sympatheticotherapy, cupping.

Manipulation techniques:

Acupressure, lymphasizing, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, ortho bionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, autogenic training.

Psychotherapy:

Bio-energetics, rebirthing, sophrology, Tomatis method.

- Voluntary changes in therapy or practitioner in the course of a treatment are subject to the Insurer's prior consent.
- Sophrology treatments are reimbursed provided they are administered by a doctor, a doctor-sophrologist with an ASS diploma, or a sophrologist who is not a doctor but holds an ASS diploma.

4. Osteopathy (SC1, SC2, SC3 and SC4)

The specified percentage of the cost of treatment administered by a therapist recognised by the Insurer.

5. Acupuncture, homeopathy, electro-acupuncture, sophrology (SC1, SC2, SC3 and SC4)

The specified percentage of the cost of treatment not covered by compulsory health insurance, provided it is administered by a therapist recognised by the Insurer.

6. Thermal cures in Switzerland (SC1, SC2, SC3 and SC4)
Contribution to the cost of bath cure treatment and to convalescence cures in recognised facilities for maximum 30 days per calendar year.

An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.

7. Thermal cures abroad (SC3 and SC4)

Subject to the Insurer's prior authorisation, contribution to the cost of medically necessary thermal cure treatment abroad. An application accompanied by the medical prescription must be submitted to the Insurer at least 20 days before the start of the cure.

8. Tariff supplement (SC1, SC2, SC3 and SC4)

For outpatient treatment in Switzerland, the difference between the rates at the insured's place of work or res-

idence, and those at the place of residence of the provider of health care services.

9. Personal expenses allowance during hospitalisation (SC1, SC2, SC3 and SC4)

Against presentation of the supporting invoices, a single indemnity payment will be allocated for each hospital stay lasting longer than eight days.

10. Hospital accommodation for family member (SC1, SC2, SC3 and SC4)

If the insured is hospitalised, the Insurer will cover the cost of hospital accommodation for one family member provided such cost is medically necessary.

11. Home help and placement cost (SC1, SC2, SC3 and SC4)

The following will be reimbursed on prior application:

- 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.).
- The cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Family members have to be placed with an official institution.

12. Glasses and contact lenses (SC2, SC3 and SC4)

The specified amount for the purchase of prescribed glasses or contact lenses in Switzerland or abroad which is not covered by compulsory health insurance.

13. Auxiliary appliances (SC1, SC2, SC3 and SC4)

The cost of purchasing or renting medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the Insurer's list.

14. Childbirth preparation classes (SC1, SC2, SC3 and SC4)

The specified amount for painless childbirth preparation classes or childbirth preparation which is not covered by compulsory health insurance.

15. One-time breast-feeding indemnity (SC1, SC2, SC3 and SC4)

Breast-feeding indemnity provided the mother breast-feeds her baby for at least 30 days and that that duration is certified by the doctor or midwife. In case of multiple births, an indemnity is paid for each child.

16. Ultrasound scans and mammographies (SC1, SC2, SC3 and SC4)

The specified amount for ultrasound scans and mammographies not covered by compulsory health insurance.

17. Vaccinations (SC1, SC2, SC3 and SC4)

Vaccination costs for vaccinations that are not included in the ordinance on compulsory health insurance benefits and which are necessary in Switzerland or are prescribed for trips abroad.

18. Elisa or HIV test (SC1, SC2, SC3 and SC4)

The Insurer will pay an annual contribution towards the cost of preventive tests prescribed and carried out by recognised health care providers.

19. Voluntary sterilisation (SC1, SC2, SC3 and SC4)

The specified percentage of operation costs.

20. Dental treatment following an accident (SC1, SC2, SC3 and SC4)

The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist with a federal diploma. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and point value).

21. Dental treatment in case of illness (SC2, SC3 and SC4)

The specified amount for dental treatment not covered by compulsory health insurance provided such treatment is administered by a dentist with a federal diploma. Dental costs are reimbursed in accordance with the official LAA/UVG tariff (nomenclature and point value).

22. Transport costs (SC1, SC2, SC3 and SC4)

The Insurer pays a contribution towards transport costs to the nearest hospital facility or doctor following an insured illness or accident provided such transport is medically necessary and is not covered by compulsory health insurance. This contribution is only granted for transport by ambulance, helicopter or by a search and rescue action. Public transport costs (bus or train) for outpatient treatment are also reimbursed if such treatment is designed to avoid hospitalisation.

23. Independent psychologists and non-doctor psychotherapists (SC1, SC2, SC3 and SC4)

The Insurer covers the cost of medically prescribed treatment administered by independent psychologists and non-doctor psychotherapists. The entitlement to such benefits is cancelled once they are covered by compulsory health insurance.

24. Groupe Mutuel Assistance (SC1, SC2, SC3 and SC4)

The benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).

Art. 6 Scope of benefits

The benefits contemplated in Article 5 are payable within the limits and amounts indicated in the table in annex.

Art. 7 Premium

1. An insured person who reaches the last year of his age group during the year will be automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:

- children: 0 to 18
- adults: 19 to 25
- from age 26, age groups are graduated in 5-year brackets.

2. The premium rate also takes into account the insured's age when he entered the insurance.

Art. 8 Deductibles

1. Insureds may choose between the following options:

- no annual deductible
- annual deductible of CHF 50.

2. No deductible is charged on Groupe Mutuel Assistance benefits.

Scope of benefits

Type of benefits	1
Restricted drugs	90%, max. CHF 600 per calendar year
Non-reimbursable drugs	90%, max. CHF 600 per calendar year
Alternative medicine	no benefits
Osteopathy, sophrology, acupuncture, homeopathy, electroacupuncture	max. CHF 70 per session, CHF 500 per calendar year
Thermal cures in Switzerland	50%, max. CHF 250 per calendar year
Convalescence cures	CHF 15 per day max. 30 days per calendar year
Convalescence cures following hospitalisation	CHF 30 per day max. 30 days per calendar year
Thermal cures abroad	no benefits
Tariff supplements	CHF 500 per calendar year
Personal expenses indemnity in case of hospitalisation	CHF 100 per case
Hospital accommodation for family member	CHF 400 per calendar year
Home help and placement cost	CHF 1,000 per calendar year
Glasses and contact lenses	no benefits
Auxiliary appliances	90%, max. CHF 200 per calendar year
Childbirth preparation classes	CHF 150 per pregnancy
One-time breast-feeding indemnity	CHF 100 per child
Ultrasound scans and mammographies	90% of cost
Vaccinations	90%, max. CHF 100 per calendar year
Elisa or HIV tests	CHF 50 per calendar year
Voluntary sterilisation	80%, max. CHF 200 per calendar year
Dental treatment: in case of accidents	80%, max. CHF 3,000 per case
Dental treatment: in case of illness	no benefits
Transport costs	50%, max. CHF 500 per calendar year
Indep. psychologists and non-doctor psychotherapists	CHF 500 per calendar year
Insured amount per calendar year	CHF 8,000
Groupe Mutuel Assistance	Emergency medical assistance, support and repatriation for trips and stays abroad

2	3	4
90%, max. CHF 800 per calendar year	90% of costs	90% of costs
90%, max. CHF 800 per calendar year	90% of costs	90% of costs
max. CHF 70 per session, CHF 2,000 per calendar year	max. CHF 70 per session, CHF 3,000 per calendar year	max. CHF 70 per session, CHF 4,000 per calendar year
60%, max. CHF 300 per calendar year	80%, max. CHF 500 per calendar year	80%, max. CHF 750 per calendar year
CHF 20 per day max. 30 days per calendar year	CHF 25 per day max. 30 days per calendar year	CHF 25 per day max. 30 days per calendar year
CHF 40 per day max. 30 days per calendar year	CHF 50 per day max. 30 days per calendar year	CHF 50 per day max. 30 days per calendar year
no benefits	50%, max. CHF 500 per calendar year	80%, max. CHF 1,000 per calendar year
CHF 600 per calendar year	CHF 800 per calendar year	CHF 1,000 per calendar year
CHF 100 per case	CHF 200 per case	CHF 200 per case
CHF 500 per calendar year	CHF 600 per calendar year	CHF 700 per calendar year
CHF 1,500 per calendar year	CHF 2,500 per calendar year	CHF 3,000 per calendar year
CHF 100 per 3 year period	CHF 150 per 3 year period	CHF 200 per 3 year period
90%, max. CHF 300 per calendar year	90%, max. CHF 1,000 per calendar year	90%, max. CHF 1,500 per calendar year
CHF 150 per pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy
CHF 100 per child	CHF 100 per child	CHF 100 per child
90% of cost	90% of cost	90% of cost
90%, max. CHF 150 per calendar year	90%, max. CHF 200 per calendar year	90%, max. CHF 250 per calendar year
CHF 50 per calendar year	CHF 50 per calendar year	CHF 50 per calendar year
80%, max. CHF 300 per calendar year	80%, max. CHF 400 per calendar year	80%, max. CHF 500 per calendar year
80%, max. CHF 4,000 per case	80%, max. CHF 6,000 per case	80%, max. CHF 8,000 per case
80%, max. CHF 100 per 3-year period	80%, max. CHF 150 per 3-year period	80%, max. CHF 200 per 3-year period
80%, max. CHF 1,000 per calendar year	80%, max. CHF 2,500 per calendar year	80%, max. CHF 5,000 per calendar year
CHF 600 per calendar year	CHF 700 per calendar year	CHF 800 per calendar year
CHF 10,000	CHF 15,000	CHF 20,000
Emergency medical assistance, support and repatriation for trips and stays abroad	Emergency medical assistance, support and repatriation for trips and stays abroad	Emergency medical assistance, support and repatriation for trips and stays abroad

Special Terms and Conditions for Bonus Supplemental Health Insurance Plan

SBGA01-E10 – Edition: 01 Apr 2003

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 insurance

The purpose of this insurance plan is to provide the insureds with specific supplemental benefits over and above their compulsory health insurance plan. By granting a no-claims bonus, it gives insureds greater responsibility and enables them to reduce their premiums (Article 8).

Art. 2 Acceptance conditions

The Bonus Supplemental Health Insurance Plan is open to all persons under the age of 60.

Art. 3 Insured benefits

Benefits under this insurance plan are supplemental to compulsory insurance benefits: (see Annex A which forms an integral part of these Special Terms and Conditions).

1. Benefits entering into account in calculating the bonus and deductible

1. Alternative medicine

The Insurer will cover the cost of the following therapies provided they are administered by doctors whose degrees are recognised under Swiss law or by natural therapy practitioners recognised by the Insurer. The Insurer reserves the right to exclude any natural therapy practitioners. Before each treatment, the insured shall verify that the practitioner who is to attend him is recognised by the Insurer.

List of alternative medicine therapies

Naturopathy

Acupuncture, aromatherapy, auriculotherapy, bioresonance, biotherapy, chromotherapy, electroacupuncture, geobiology, herbal medicine, homeopathy, iridology, colonic hydrotherapy, laser therapy, magnetic field therapy, magnetotherapy, morotherapy, oxygenotherapy, phytotherapy, sympathetic therapy and cupping.

Manipulation techniques

Acupressure, lymphatising, etiopathy, eurythmy, myofascial release therapy, postural integration, kinesiology, massage therapies, anthroposophic medicine, mesotherapy, metamorphosis, ortho bionomy, osteopathy, polarity, energy balancing, reflexology, reiki, rolfing, shiatsu, trager, and autogenic training.

Other

Bio-energetics, rebirthing, sophrology, Tomatis method. Voluntary changes in therapy or practitioner during treatment are subject to the Insurer's prior consent.

2. Restricted drugs

The allotted percentage of the cost of drugs which are not covered by compulsory health insurance except for the drugs on the list of pharmaceutical products for special application (LPPA/LPPV).

3. Non reimbursable drugs

The specified percentage of the cost of drugs which are not on the official lists of reimbursable drugs (LS-LMT) and are not covered by compulsory health insurance; excepted are the drugs on the list of pharmaceutical products for special application (LPPA/LPPV).

4. Accommodation for accompanying person; home for

dependents

Subject to advance request to the Insurer, reimbursement of a percentage of the cost of a temporary home for family members cohabiting with the insured in the event the insured has to be hospitalised on medical grounds. The persons concerned must be placed with an official institution.

The Insurer will cover the cost of a hospital bed for a family member during the insured's stay in hospital provided the family member's presence is medically justified.

5. Disability medical equipment

The Insurer will cover the specified percentage of the rental or purchase cost for medically prescribed orthopaedic equipment and disability medical aids (excluding dentures) in accordance with the Insurer's list.

6. Transport expenses

The specified percentage of the cost of transport to the nearest hospital or doctor following an insured sickness or accident provided such transport is medically required and is not covered by basic health insurance.

This contribution is only granted for transport by ambulance or by helicopter or for emergency rescue.

Public transport costs (bus or train) for outpatient treatment designed to avoid hospitalisation are also reimbursed.

7. Outpatient treatment

Free choice of outpatient treatment in Switzerland within the confines of the LAMa/KVG and provided the health care provider is recognised by the Insurer.

Reimbursement of the specified percentage 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 health care provider.

8. Thermal cures in Switzerland

Reimbursement of the specified percentage of the cost of treatment and room and board in thermal cure facilities approved by the Insurer according to the list of recognised marine cure establishments of the Federal Ordinance on compulsory health insurance benefits (OPAS/KLV). Benefits will be reimbursed if they are medically necessary and prescribed by a doctor.

An application accompanied by a medical prescription must be filed with the Insurer at least 20 days before the start of the cure.

9. Convalescence cures in Switzerland

Reimbursement of the specified percentage of the cost of treatment and room and board in case of convalescence cures in Switzerland in facilities recognised by the Insurer and provided that the convalescence is prescribed following hospitalisation. An application accompanied by a medical prescription must be filed with the Insurer at least 20 days before the start of the cure.

10. Home help

A lump-sum contribution to 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 in the aftermath of a hospital stay relating to an illness or accident. All other costs are excluded (general cleaning etc.)

No benefits are payable if the insured person is declared disabled by the Federal Disability Insurance (AI/IV), receives an invalidity allowance or is staying in a hospital or at a cure or convalescence facility.

11. Glasses and contact lenses

The specified contribution to the cost of prescribed glasses or contact lenses in Switzerland or abroad which are not covered by compulsory health insurance.

12. Meals on wheels

The specified contribution to the cost of meals on wheels delivered by an institution recognised by the Insurer to the insured's home on medical prescription following a hospital stay.

13. Drugs for home delivery

Reimbursement of shipping costs for prescribed drugs delivered by a partner recognised by the Insurer.

2. The following benefits do not affect the bonus calculation and are not subject to a deductible:

1. Groupe Mutuel Assistance

The benefits specified in the General Terms and Conditions of Group Mutuel Assistance, category ASS (repatriation and transport), will be reimbursed if the insured event occurs more than 20 km from the insured's domicile, in Switzerland or abroad.

2. Prevention

1. Second opinion

Reimbursement of the specified percentage of the cost of a second opinion before hospitalisation from a doctor recognised by the Insurer. The doctor's bill must indicate "second opinion".

2. Mammographies

The specified percentage of the cost of mammographies not covered by an insured's compulsory health insurance.

3. Vaccinations

The cost of vaccinations which are not included in the Federal Ordinance on compulsory health insurance benefits (OPAS/KLV) but are required in Switzerland, as well as any vaccinations recommended by the Federal Office of Public Health for trips abroad.

4. Preventive tests (HIV or Elisa)

Reimbursement of the specified percentage of preventive tests prescribed and carried out by recognised health care providers.

5. Check-ups

Reimbursement of the specified percentage of the cost of no more than one check-up every three years conducted by a doctor recognised by the Insurer.

6. Psychotherapy

Payment of the specified contribution to the cost of medically prescribed treatment dispensed by non-doctor psychotherapists and independent psychologists, up to no more than two sessions per year. These benefits are supplemental to compulsory health insurance.

7. Annual dental check-up

The specified contribution to the cost of an annual preventive check-up conducted by a dentist with federal qualifications and not covered by compulsory health insurance.

8. Nutritional counselling

The specified contribution to the cost of no more than three nutritional counselling sessions every three years with a consultant recognised by the Insurer.

9. Health promotion

The Insurer covers the specified percentage, up to the maximum amount indicated in Annex A, of the fees invoiced by health care providers recognised by the Insurer for services designed to foster good health such as fitness, back school and tobacco and alcohol detoxification cures in a recognised facility. If several measures promoting good health are taken in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 200.

Art. 4 Entitlement to benefits

1. The insured is entitled to benefits from the effective date of the insurance policy.
2. Benefits are imputed chronologically following treatment dates. Costs incurred after entitlements are exhausted (benefits subject to time limits or reimbursement ceilings) cannot be carried forward to the next year.
3. The Insurer shall reimburse any costs not covered by compulsory health insurance, within the limits of the present Special Terms and Conditions, provided the treatment is carried out by a doctor or a person who is duly authorised and recognised by the Insurer. Under no circumstances may the insurance benefits governed by these Special Terms and Conditions be used to cover co-insurance payments and deductibles under compulsory insurance or other supplemental insurance.

Art. 5 Deductible

1. The benefits under Article 3.1 are subject to an annual deductible of CHF 150.
2. The benefits under Article 3.2 are not subject to a deductible.

Art. 6 Premiums

1. An insured who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:
 - from 0 to 18;
 - from 19 to 25;
 - from ages 25 to 71, age groups are graduated in five-year brackets.
2. Premiums take into account the above-mentioned age brackets and the premium scale. Changes in the premium scale (according to Article 8) do not qualify as premium adjustments within the meaning of Article 29 of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC). Accordingly, insureds are not entitled to terminate their policy in that case.

Art. 7 Premium scale

1. For the year an insured joins and the following year, premium level 3 applies.
2. The following premium levels are applicable:

% of premium	Premium levels
100	5
90	4
80	3
70	2
60	1
50	0

Art. 8 Variation of premium scale

1. If, during a given reference period, the insured is not paid any of the benefits (amounts covered by the insurance and lower than the deductible) referred to in Article 3.1, his premium for the following calendar year will be calculated based on the immediately following (lower) premium level, provided he has not already reached the lowest level on the scale.
2. The period from 1 July to 30 June is the reference period for establishing whether an insured has been granted supplemental bonus health insurance benefits. The payment date by the Insurer is the decisive date for the allocation of benefits to the reference period.
3. If, during any given reference period, the insured is granted any amount higher than the deductible referred to in Article 5 by way of the benefits (amounts covered by the Insurer) referred to in Article 3.1, the premium for the following calendar year will be increased by one level. The premium level cannot be increased beyond level 5 or 100% of the ordinary premium.

Art. 9 Rights and obligations of the insured

1. If the Insurer receives an invoice more than six months after the invoice date and the insured has unduly benefited from a reduction in premiums, the Insurer shall be entitled to reduce its benefits by the amount of the unduly saved premium.
2. In the cantons applying a third-party payer system for the reimbursement of benefits, the insured may, within 30 days of receiving the Insurer's statement of account, repay to the Insurer the benefits paid in order to preserve his bonus entitlement.

Annex A

Types of benefits	Reimbursement
The following benefits affect the bonus calculation and are subject to a deductible of CHF 150:	
Alternative medicine	90% unlimited
Restricted drugs	90% unlimited
Non reimbursable drugs	90% unlimited
Accommodation for accompanying person; home for dependents	90% unlimited
Disability medical equipment	90% unlimited
Transport and rescue costs	90% unlimited
Free choice of doctor of outpatient treatment in Switzerland	90% unlimited
Thermal cures in Switzerland	90% unlimited (max. 30 days p.a.)
Convalescence cures in Switzerland	90% unlimited (max. 30 days p.a.)
Home help	90% (max. CHF 2,500 p.a.)
Glasses and contact lenses	CHF 150 per 3-year period
Meals on wheels after hospitalisation	CHF 20 per day, (max. 30 days per year)
Drugs for home delivery	Postage reimbursed
The following benefits do not affect the bonus calculation and are not subject to the deductible of CHF 150:	
Groupe Mutuel Assistance	For emergencies in Switzerland and abroad
Prevention	
Second opinion	90% unlimited
Mammographies	90% unlimited
Vaccinations	90% unlimited
Preventive tests (HIV, Elisa)	90%, unlimited
Check-up (once every 3 years)	90% unlimited
Psychotherapy	2 sessions per year, max. CHF 140
Annual dental check-up	max. CHF 75 per year
Nutrition counselling (max. 3 sessions over 3 years)	CHF 50 per session
Health promotion: back school, gym, tobacco and alcohol detoxification benefits	50%, max. CHF 200 p.a.

Special Terms and Conditions for Premium Supplemental Insurance

SDGA01-E1 – Edition: 01 Aug 2022

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

The purpose of Premium insurance is to provide insured persons with specific benefits over and above compulsory health insurance (AOS/OKP) within the meaning of the Federal Law on Health Insurance (LAMal/KVG).

Art. 2 Risks covered

Benefits provide illness, accident and maternity coverage.

Art. 3 Acceptance conditions

Any person domiciled in Switzerland may apply for Premium insurance, to begin no later than his/her 70th birthday.

Art. 4 Entitlement to benefits and limitations

1. Benefits are payable according to treatment dates. Costs incurred after the expiry of entitlements (benefits subject to a limitation on duration or reimbursed amounts) cannot be carried forward to the next year.
2. 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 end of the payment of benefits.
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.
4. For the benefits “convalescence cures and thermal cures” and “home help and placement costs”, the insured person must apply to the insurer for advance payment.
5. Under no circumstances shall insurance benefits regulated by these terms and conditions be used to cover deductible and co-insurance payments (cost-sharing) under the AOS/OKP.
6. However, insurance coverage extends to the coverage of foreign statutory cost-sharing amounts for treatments provided outside Switzerland in accordance with the EU and EFTA or other international social security conventions and insofar as this is not prohibited by the law of the country in question.

Art. 5 Insured benefits

	Coverage	Description
Non-reimbursable drugs	90%	<ul style="list-style-type: none"> Drugs not covered by the compulsory health insurance (AOS/OKP) and prescribed by a doctor or a healthcare provider recognised under LAMa/KVG or an alternative medicine therapist recognised by the insurer. The insurer keeps a list of recognised alternative medicine therapists. Restrictions: drugs on the list of pharmaceutical products for special application (LPPA/LPPV).
Cost of advice for drugs on the list of specialities delivered by the pharmacist without a prescription	90%	<ul style="list-style-type: none"> Cost of advice provided by pharmacists recognised by the insurer for drugs on lists B+ or B- (Swissmedic classification) that are delivered without a prescription in accordance with Article 45 of the Ordinance on Medicinal Products (OMéd/VAM). The insurer keeps a list of the recognised pharmacies.
Alternative medicine	90%, max. CHF 5,000 per calendar year, of which max. CHF 1,000 for massage treatments	<ul style="list-style-type: none"> Therapies recognised by the insurer and carried out by a qualified doctor, or a natural treatment practitioner recognised by the insurer. The insurer keeps a list of the recognised therapies and therapists.
Convalescence cures and thermal cures	90% max. 30 days per calendar year	<ul style="list-style-type: none"> Treatment and board in the event of a convalescence cure in Switzerland following a stay in hospital, in facilities recognised by the insurer. Treatment and board in the event of a thermal cure in spa facilities recognised under the Ordinance on Healthcare Insurance Benefits (OPAS/KLV). Benefits are payable if the treatment is prescribed by a recognised doctor within the meaning of LAMa/KVG. The insurer keeps a list of the recognised facilities. Subject to revocation of the entitlement to benefits, a request for coverage and a medical prescription must be submitted to the insurer beforehand.
Medical glasses, contact lenses or surgical correction of vision	Glasses and contact lenses <ul style="list-style-type: none"> children under 18, CHF 150 every year adults from 19 years of age, CHF 500 every three years Surgical correction of vision <ul style="list-style-type: none"> 90% participation, max. CHF 800 for the entire duration of the contract. 	<ul style="list-style-type: none"> The specified amount for the costs of medical glasses or contact lenses which are not covered by the compulsory health insurance. The contribution for surgical correction of vision is granted in addition to the costs of medically-prescribed glasses or contact lenses.
Medical aids and appliances	90%	<ul style="list-style-type: none"> The cost of purchasing and renting medically prescribed orthopaedic equipment and auxiliary appliances (excluding dental prostheses) in accordance with the insurer's list of reimbursable costs.
Mammographies	90%	<ul style="list-style-type: none"> Mammographies which are not covered by compulsory health insurance.
Vaccines	90%	<ul style="list-style-type: none"> Costs of vaccines not covered by the AOS/OKP basic health insurance, as well as those recommended by the Federal Office of Public Health (FOPH) when travelling abroad.
HIV preventive test	90%	<ul style="list-style-type: none"> The costs of HIV preventive tests prescribed and carried out by recognised providers within the meaning of LAMa/KVG.
Check-ups	90%, max. CHF 1,800/every three years	<ul style="list-style-type: none"> The costs of a check-up by a doctor. Check-ups include: <ul style="list-style-type: none"> a consultation with extended examination (height, weight, tension, advice and health promotion) an electrocardiogram at rest and during exercise an x-ray of the chest a urinary status hematochemical, glucose and cholesterol tests a skin exam
Transport and search and rescue costs	90% (transportation) 90%, max. CHF 100,000/calendar year (search and rescue)	<ul style="list-style-type: none"> 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 a stay in hospital.
Psychotherapy	90% max. CHF 1,000/calendar year	<ul style="list-style-type: none"> The cost of medically prescribed treatments not covered by the AOS/OKP administered by independent psychologists and non-doctor psychologists approved by the insurer. The insurer keeps a list of the recognised associations.
Home care for sick children	90% max. CHF 300/calendar year	<ul style="list-style-type: none"> For children up to the age of 12, reimbursement of the costs of childcare by the Red Cross or an official institution with the same purpose if the parents have a professional activity outside the home.

	Coverage	Description
Home help and placement costs	90% max. CHF 2,500/calendar year	<ul style="list-style-type: none"> Expenses resulting from the medically necessary recruitment of a home help exercising 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 in the place of the insured person, following hospitalisation due to illness or accident (maternity excluded). All other costs are excluded (general cleaning, etc.). The cost of temporary placement for family members cohabiting with the insured if the latter has to be hospitalised on medical grounds. Temporary placement of family members should be with an official care facility (temporary care unit, crèche, day care centre or day and/or night accommodation). The insured person is required to obtain the insurer's prior consent.
Meals at home following hospitalisation	CHF 20/day, max. 30 days/calendar year	<ul style="list-style-type: none"> Reimbursement of the costs of meals at home provided by an establishment, company or institution on a professional basis and on medical prescription.
Contraception and voluntary sterilisation	90%, max. CHF 500/calendar year	<ul style="list-style-type: none"> Coverage of costs for contraceptive measures that require the intervention of a doctor (contraceptive implant, IUD, delayed progestins) or that are subject to an initial medical prescription (contraceptive pill, vaginal ring, patch). Coverage of surgery costs in case of sterilisation.
Dental care	<p>Dental care 75%, max. CHF 500/calendar year</p> <p>Dento-facial orthopaedics for persons up to 18 years: 75%, max. CHF 3,000/calendar year</p>	<ul style="list-style-type: none"> Reimbursement of the costs of: <ul style="list-style-type: none"> dental treatment by a qualified dentist; yearly prophylactic dental check-up; crowns, bridges and prostheses; laboratory tests. For insured persons up to 18 years of age, the insurance coverage shall also cover dento-facial orthopaedics treatment. Insured persons are immediately entitled to benefits for dental treatment following accidents which occur after the insurance comes into effect. Coverage for prosthetic operations (tooth replacement, crowns, pivot teeth, bridges, partial prostheses or full dentures, etc.) following accidents is effective as soon as the insurance comes into effect; in other cases, not before a minimum insurance period of 12 months has lapsed. For other dental treatments (including dento-facial orthopaedics), insurance benefits are granted at the earliest after three months of insurance. The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%.
Prevention and sports activities	<p>50%, max. CHF 500/calendar year</p> <p>90%, max. CHF 200/calendar year</p>	<p>Prevention</p> <ul style="list-style-type: none"> Coverage of costs for the following services: <ul style="list-style-type: none"> Back exercise school Fitness centres Training sessions for rehabilitation purposes under the guidance of a specially trained sports instructor; Dietary advice (Fr. 50 per session, max. three consultations over three years), Detoxification from tobacco or alcohol. The insurer keeps a list of the recognised facilities/healthcare providers. <p>Sports activities and annual sports subscriptions.</p> <ul style="list-style-type: none"> Reimbursement of the costs of sports club memberships or annual swimming pool and ski passes. The insurer keeps a list of recognised sport disciplines.
Groupe Mutuel Assistance	As explained in the general terms and conditions of insurance of Groupe Mutuel Assistance.	<ul style="list-style-type: none"> Coverage of benefits specified in the general terms and conditions of Group Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).

Art. 6 Lists of healthcare providers

1. Lists of recognised service providers are available on the insurer's website or can be provided on request of the insured person.
2. The lists valid at the time of treatment or when using benefits are decisive.
3. In accordance with Art. 23 of the general terms and conditions for supplemental health and accident insurance (CGC), these lists can be changed by the insurer at any time.

Art. 7 Deductible

Insured persons can choose one of the following options:

- a. no annual deductible;
- b. annual deductible of CHF 200.

Art. 8 Premiums

1. Premiums are identical for men and women.
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 age 0 to 15;
 - from age 16 to 18;
 - from age 19 to 25;
 - from age 26 onwards and up to 85 years, age groups are graduated in five-year brackets.
3. A change in age group will usually result in an automatic adjustment of the premium.

Art. 9 Family discount

1. A family discount may be granted on the premium for children up to the age of 18 if they and at least one of their parents are insured with Premium insurance.
2. The family discount shall be withdrawn as soon as the conditions for granting it as set out in paragraph 1 are no longer met.
3. In accordance with Art. 26(a), para. 2(d) of the CGC, the insurer may change or withdraw the family discount at any time, with effect from the end of the current calendar year.

Special Terms and Conditions for Optimum supplemental health insurance

SO

SOGA01-E1 – Edition: 01 Sep 2023

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

The purpose of Optimum insurance is to provide insured persons with specific benefits over and above compulsory health insurance (AOS/OKP) within the meaning of the Federal Law on Health Insurance (LAMal/KVG).

Art. 2 Risks covered

Benefits provide illness, accident and maternity coverage.

Art. 3 Eligibility

Optimum insurance is open to all persons residing in Switzerland, without any age limit.

Art. 4 Entitlement to benefits and limitations

1. Benefits are payable according to treatment dates. Costs incurred after the expiry of entitlements (benefits subject to duration or reimbursement ceilings) cannot be carried forward to the next year.
2. If a medical treatment or alternative medicine treatment is no longer medically justified or no longer brings any therapeutic improvement, the insurer will inform the insured person of the reduction or the end of the payment of benefits.
3. As provided for in these special terms and conditions, 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.
4. For “convalescence and thermal cures” “home help” and “placement costs” benefits, the insured person must apply to the insurer in advance for payment.

5. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover deductibles and co-insurance payments under the AOS/OKP.
6. 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.

Art. 5 Insured benefits

	Coverage	Description
Non-reimbursable drugs and restricted medication	90%	<ul style="list-style-type: none"> Medication not covered by the compulsory health insurance (AOS/OKP) and prescribed by a doctor or a healthcare provider recognised under LAMa/KVG or an alternative medicine practitioner recognised by the insurer. Restrictions: medication on the list of pharmaceutical products for special application (LPPA/LPPV). The insurer keeps a list of the approved alternative medicine therapists.
Delivery of medicines at home	Reimbursement of shipping costs.	<ul style="list-style-type: none"> Coverage of shipping costs for prescribed medicines.
Alternative medicine treatments	75%, max. CHF 3,000 per calendar year, of which max. CHF 500 per calendar year for massages	<ul style="list-style-type: none"> Therapies recognised by the insurer and carried out by a qualified doctor or a natural treatment practitioner recognised by the insurer. The insurer keeps a list of the recognised therapies and therapists and reserves the right to exclude certain therapists at any time.
Convalescence and thermal cures	90%, max. 30 days/calendar year	<ul style="list-style-type: none"> Treatment and board in the event of a convalescence cure in Switzerland following a stay in hospital, in facilities recognised by the insurer. Treatment and board for thermal cures in health resorts 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 LAMa/KVG. Subject to revocation of the entitlement to benefits, an application for authorisation accompanied by the medical prescription must be submitted beforehand to the insurer at least 20 days before the start of the cure. The insurer keeps a list of the recognised facilities.
Medical glasses or contact lenses	Glasses and contact lenses <ul style="list-style-type: none"> children under 18, CHF 100/calendar year adults from 19 years of age, CHF 250 every three years 	<ul style="list-style-type: none"> The specified amount for the purchase of medical glasses or contact lenses which are not covered by the compulsory health insurance.
Medical aids and appliances	90%, max. CHF 2,000/calendar year	<ul style="list-style-type: none"> The cost of purchasing and renting orthopaedic equipment and auxiliary appliances (excluding dental prostheses) prescribed by a doctor in accordance with the list drawn up by the insurer.
Mammographies and ultrasounds	90%	<ul style="list-style-type: none"> Mammographies and ultrasounds which are not covered by compulsory health insurance.
Preventive gynaecological examinations	90%	<ul style="list-style-type: none"> Preventive gynaecological examinations which are not covered by compulsory health insurance.
Vaccines	90%	<ul style="list-style-type: none"> Costs of vaccines not covered by the compulsory health insurance (AOS/OKP) Costs of vaccines recommended by the Federal Office of Public Health (FOPH) when travelling abroad and recognised by Swissmedic.
HIV preventive test	90%	<ul style="list-style-type: none"> HIV preventive tests prescribed and carried out by recognised providers within the meaning of LAMa/KVG.
Check-up	90%, max. CHF 1,200 every three years	<ul style="list-style-type: none"> The costs of a check-up by a doctor. Check-ups include: <ul style="list-style-type: none"> a consultation with extended examination (height, weight, tension, advice and health promotion) an electrocardiogram at rest and during exercise an x-ray of the chest a urinary status hematochemical, glucose and cholesterol tests a skin exam
Transport and search and rescue costs	90% (transportation) 90%, max. CHF 75,000/calendar year (search and rescue)	<ul style="list-style-type: none"> Transport to the nearest hospital facility or physician provided such transport is medically necessary. This contribution is only granted for transport by ambulance or by helicopter 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.
Psychotherapy	90%, max. CHF 500/calendar year	<ul style="list-style-type: none"> The cost of medically prescribed treatments not covered by the AOS/OKP that are administered by independent psychologists and non-doctor psychologists approved by the insurer. The insurer keeps a list of recognised associations.
Correction of scars and protruding ears	80%, max. CHF 3,000/calendar year	<ul style="list-style-type: none"> Coverage of costs of correcting scars. For children up to the age of 18, reimbursement of the cost of correcting protruding ears. This coverage also extends to the consequences of illnesses and accidents that already existed when the contract was taken out.

	Coverage	Description
Home help, placement costs, support costs and care for sick children at home	90%, max. CHF 2,500/calendar year, of which max. CHF 250/calendar year for home care for sick children	<ul style="list-style-type: none"> Costs resulting from the medically necessary engagement of a home help exercising 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 in the place of the insured, following hospitalisation due to illness or accident (maternity excluded). All other costs are excluded (general cleaning, etc.). The costs of temporary placement of family members living in the same household as the insured person and dependent on the insured person for reasons of age or health, during the period when the insured must, for medical reasons, be hospitalised or undergo outpatient surgery. Temporary placement of family members should be with an official care facility (temporary care unit, crèche, day care centre or day and/or night accommodation). In the event of hospitalisation of the insured person, the insurer will cover the cost of hospital accommodation for one family member provided such costs are medically necessary. For children up to the age of 12, coverage of childcare costs by the Red Cross or an official institution with the same purpose when the insured child is ill and the parents have a professional activity outside the home. <p>The insured person is required to obtain the insurer's prior consent.</p>
Second opinion	90%	<ul style="list-style-type: none"> Costs resulting from a second medical opinion given by a doctor before hospitalisation. The words "second opinion" must be indicated on the invoice.
Meals at home following hospitalisation or outpatient surgery	CHF 20/day, max. 30 days/calendar year	<ul style="list-style-type: none"> Reimbursement of the costs of meals at home provided by an establishment, company or institution on a professional basis and on medical prescription.
Comfort upgrade, hotel accommodation, transport or parking costs in the event of outpatient surgery	CHF 150/calendar year	<ul style="list-style-type: none"> When the insured undergoes outpatient surgery, the insurer will pay the following costs: <ul style="list-style-type: none"> upgrade invoiced by the facility where the outpatient surgery is performed; accommodation of the insured person and accompanying persons, in a hospital or hotel, for the night preceding and/or directly following the treatment; transport of the insured person from his home to the relevant healthcare provider (journey to and/or from the home with public transport or a taxi); parking costs.
Dental care	75%, max. CHF 150/calendar year	<ul style="list-style-type: none"> Reimbursement of the cost of: <ul style="list-style-type: none"> dental treatment by a qualified dentist; a yearly prophylactic dental check-up; crowns, bridges and prostheses; laboratory tests. Dento-facial orthopaedic treatment is not covered. The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%.
Prevention and sports activities	50%, max. CHF 200/calendar year	<p>Physical training measures</p> <ul style="list-style-type: none"> Coverage of costs for the following services: <ul style="list-style-type: none"> Fitness centres Back exercise school Training sessions for rehabilitation purposes under the guidance of a specially trained sports instructor. The insurer keeps a list of the recognised facilities/healthcare providers. <p>Sports activities</p> <ul style="list-style-type: none"> Coverage of the costs of active membership of a sports club. The insurer keeps a list of recognised sport disciplines. <p>Other preventive measures</p> <ul style="list-style-type: none"> The insurer keeps a list of other recognised preventive measures.
Groupe Mutuel Assistance	As explained in the general terms and conditions of insurance of Groupe Mutuel Assistance.	<ul style="list-style-type: none"> Coverage of benefits specified in the general terms and conditions of Groupe Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured's domicile).

Art. 6 Lists of healthcare providers, therapies and activities

1. The lists of recognised healthcare providers, therapies, sports activities and other preventive measures are available on the insurer's website or can be provided on request of the insured person.
2. The lists valid at the time of treatment or use of a benefit are decisive.
3. In accordance with Art. 23 of the general terms and conditions for supplemental insurance (CGC), these lists can be changed by the insurer at any time. Such a change in the list does not give the policyholder the right to terminate the contract.

Art. 7 Deductible

Insured persons can choose one of the following options:

- a. no annual deductible;
- b. an annual deductible of CHF 150.

Art. 8 Premiums

1. An insured person who reaches the last year of his age group is automatically transferred to the next age group at the beginning of the following calendar year. The applicable age groups are:
 - 0 to 15;
 - 16 to 18;
 - 19 to 25;
 - from ages 26 to 85, age groups are graduated in five-year brackets.
2. A change in age group will in principle result in an automatic adjustment of the premium.

Art. 9 Family discount

1. A family discount may be granted on the premium for children up to the age of 18 if they and at least one of their parents are insured with Optimum insurance.
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, letter d of the general terms and conditions of insurance, the insurer may change or withdraw the family discount at any time, with effect from the end of the current calendar year at the latest.

Special Terms and Conditions for Vitalis supplemental insurance

SP

SPGA01-E8 – Edition: 01 Jul 2000

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 Acceptance conditions

Vitalis insurance is open to all persons up to their 60th birthday.

Art. 2 Entitlement to benefits

Benefits under this insurance are supplemental to compulsory insurance benefits. Vitalis insurance covers the following benefits, subject to the amounts specified in these Special Terms and Conditions:

- a. marine or convalescence cures;
- b. home help;
- c. transport and rescue costs;
- d. disability medical aids and appliances;
- e. preventive health care;
- f. palliative care.

Art. 3 Marine cures and convalescence

1. For marine cures and cures intended to secure full recovery from a sickness, or for convalescence cures after serious diseases, insureds will be granted an allowance of CHF 50 per day up to a maximum ceiling of CHF 1,500 per calendar year provided the cure is medically necessary.
2. Marine and convalescence cures must be taken in Switzerland in marine cure establishments or cure and convalescence homes run by medical staff and recognised by the Insurer and Santésuisse.
3. An application accompanied by a medical prescription must be filed with the Insurer at least 20 days before the start of the cure.

Art. 4 Home help

1. If home help is medically required because of an insured sickness or accident, 50% of the relevant certified costs will be reimbursed up to a maximum ceiling of CHF 500 per calendar year.
2. For the purpose of these Special Terms and Conditions, home help means any person employed by an official institution (medical and social centres, for example) who does the housework instead of the insured.

Art. 5 Transport and rescue

1. 80% of the cost of medically required emergency transport to the nearest doctor or hospital will be covered up to a maximum ceiling of CHF 2,500 per calendar year.
2. 80% of rescue costs will be reimbursed up to a ceiling of CHF 2,500 per calendar year.
3. 80% of the cost of medically required transport enabling the insured to receive hospital treatment will be reimbursed up to a maximum ceiling of CHF 2,500 per calendar year.
4. The above-mentioned transport services must be provided by a cantonally-licensed organisation recognised by the Insurer.

Art. 6 Auxiliary appliances

1. Medically prescribed auxiliary appliances are reimbursed up to CHF 300 per calendar year.
2. The Insurer's list of auxiliary appliances is decisive for reimbursement.

Art. 7 Prevention

The Insurance covers:

- a. the actual cost of the necessary vaccinations before a trip abroad;
- b. preventive health care measures (check-ups) carried out once a year by a recognised doctor;
- c. back school courses delivered by centres or associations which are recognised by the cantons or the Insurer, within a maximum ceiling of CHF 200 per calendar year.

Art. 8 Palliative care

1. The Insurer will pay a contribution towards the cost of palliative care; palliative care means all medical and nursing techniques for persons at the end of life delivered at home by duly qualified personnel under the authority of an institution recognised by the Insurer.
2. In each case, an application must be filed in advance with the Insurer who will decide on the scope of the contribution. The contribution will be set taking into account all the costs involved in treating the insured at home. The contribution can represent up to 90% of the hospital costs for chronically or acutely ill patients in a general ward of a hospital in the insured's canton of residence.

Art. 9 Co-insurance amounts

For disability medical aids and appliances, marine and convalescence cures and preventive measures, the insured is required to pay 10% co-insurance. No co-insurance is due in respect of other benefits.

Art. 10 Non-economical measures

Are deemed non-economical all medical or other acts which overstep the interests of the insured and go beyond the purpose of the treatment. The Insurer reserves the right to reduce benefits where it deems such a reduction is justified.

Art. 11 Premium

The premium is the same for all insureds.

Art. 12 Double insurance

In the event of double insurance, where benefits such as marine and convalescence cures, home help, transport and rescue costs, disability medical aids and appliances and preventive health care measures (vaccinations and Elisa or HIV tests) are covered under both the compulsory health insurance (SC) and the Vitalis insurance (SP), the Vitalis coverage takes precedence.

Special Terms and Conditions for Alterna Supplemental Health Insurance

SA

SAGA01-E8 – Edition: 01 Feb 2022

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

The purpose of this insurance is to provide the insured person with specific supplemental benefits over and above compulsory health insurance benefits within the meaning of the Federal Law on Health Insurance (LAMal/KVG).

Art. 2 Eligibility

Alterna insurance can be taken out by anyone living in Switzerland without age limit.

The insurance is concluded for at least one insurance term in accordance with Art. 12 of the general terms and conditions of insurance. It is then tacitly renewed from year to year.

Art. 3 Termination

After an insurance term, the policyholder may terminate the insurance for the end of a calendar year, subject to three months' advance notice.

Art. 4 Risks covered

Benefits provide illness, accident and maternity coverage.

Art. 5 Insured benefits

The insurer will reimburse the cost of the following therapies provided they are administered by doctors recognised within the meaning of LAMal/KVG.

Before each treatment, the insured shall verify that the practitioner who is to attend him is recognised by the insurer.

1. List of recognised therapies

Naturopathy:

acupuncture, auriculotherapy, bioresonance, electroacupuncture, homeopathy, magnetotherapy, Chinese medicine, phytotherapy, neural therapy.

Manipulation techniques:

etiopathy, anthroposophic medicine, mesotherapy, orthobionomy, osteopathy, Autogenic training.

Psychotherapy:

bio-energetics, medical hypnosis, rebirthing, sophrology, eye movement desensitization therapy (EMDR).

The insurer covers 80% of cost of treatments administered according to the above methods.

2. Non-reimbursable drugs

Non-reimbursable drugs prescribed within the 20 above-mentioned treatments are covered for 80% of the costs, up to CHF 2,000 per year.

Non-reimbursable drugs are drugs that have been authorised by Swissmedic but that appear neither on the list of pharmaceutical products for special application (LPPA/LPPV) nor on the list of specialty drugs (LS/SL). Non-reimbursable drugs are also drugs on the LS/SL list which have been prescribed for an indication other than that provided for by the limitation.

Drugs on the LPPA/LPPV list are excluded.

Art. 6 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect.
2. Benefits are payable according to treatment dates. Costs incurred after entitlements are exhausted (benefits subject to reimbursement ceilings) cannot be carried forward to the next year.

Art. 7 Premiums

An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:

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

Art. 8 Combination discount

1. If certain benefits are also covered by other supplemental insurance product(s) concluded with the insurer, a combination discount on the Alterna insurance premium may be granted.
2. The supplemental insurance products for which a combination discount may be granted are listed in the pre-contractual information documents provided to the Applicant in accordance with Art. 3 LCA/VVG.
3. The combination discount shall be withdrawn as soon as the conditions for granting it as set out in paragraph 1 are no longer met.
4. The insurer may change or cancel these discounts in accordance with Art. 29 of the general terms and conditions of insurance (CGC).

Special Terms and Conditions for supplemental hospitalisation insurance

HC

HCGA01-E9 – Edition: 01 Jan 2014

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

The insurance covers the economic consequences of illness, maternity and accidents.

Art. 2 Insurance classes

Supplemental hospitalisation insurance offers four classes of coverage:

Class 1

Public general or psychiatric ward, in a Swiss hospital, for treatment of acute conditions.

Class 2

Semi-private general or psychiatric ward (room with two beds), in a Swiss hospital, for treatment of acute conditions.

Class 3

Private general or psychiatric ward (room with one bed), in a Swiss hospital, for treatment of acute conditions.

Class 4

Private general or psychiatric ward (room with one bed), in a hospital anywhere in the world, for treatment of acute conditions.

Art. 3 Deductibles

Persons insured in classes 2, 3 and 4 may select one of the following deductibles:

- a. CHF 1,000 per calendar year
- b. CHF 3,000 per calendar year

Art. 4 Acceptance conditions

Supplemental hospitalisation insurance coverage is open to all persons up to age 60.

Art. 5 Beginning of entitlement to benefits

1. Insureds are entitled to benefits as soon as their supplemental hospitalisation insurance becomes effective, on the date specified in the insurance policy.
2. Maternity benefits are subject to a waiting period in accordance with Article 7 of these Special Terms and Conditions.

Art. 6 Insured benefits

1. General

In case of hospitalisation, the Insurer will cover treatment and room and board in accordance with the selected coverage class. Benefits under this insurance are supplemental to compulsory insurance benefits.

2. Hospitalisation in another ward

If an insured with class 1 or class 2 coverage is hospitalised in a superior ward, the following maximum benefits will be granted to him:

- Class 1: CHF 100 per day for room and board and CHF 5,000 per calendar year for treatment costs;
Class 2: 80% of room and board and treatment.

3. Hospitalisation abroad

If an insured falls ill or has an accident abroad and has to

be hospitalised there, the Insurer will grant him, for no more than 60 days per calendar year and within the limits of the selected coverage, the following benefits:

- a. Class 1: maximum CHF 500 per day
- b. Class 2: maximum CHF 1,000 per day
- c. Class 3: maximum CHF 1,500 per day
- d. Class 4: maximum CHF 3,000 per day

Voluntary treatment abroad is not covered unless the Insurer gives its prior consent.

Art. 7 Maternity benefits

1. In the case of pregnancy and childbirth, supplemental hospitalisation insurance benefits will only be paid after the lapse of a 12-month waiting period.
2. Interruptions of pregnancy within the meaning of the law, and any other maternity-related benefits are subject to the waiting period specified in paragraph 1.
3. Where childbirth involves a hospital stay of less than six days in private or semi-private ward, the Insurer will grant insureds with class 2, 3 or 4 coverage an allocation of CHF 200 per day for each day of avoided hospitalisation. Hospital stays which are invoiced on a global lump-sum basis do not qualify for this allocation. Paragraph 1 is reserved.
4. In case of outpatient childbirth or childbirth at home, insureds with class 2 coverage will be granted an allocation of CHF 800 and insureds in classes 3 and 4 an allocation of CHF 1,200 subject to paragraph 1.
5. If an insured person is hospitalised in a ward corresponding to her coverage level, the Insurer will also cover the newborn's hospital costs for the duration of the mother's stay in hospital, provided the child is also insured with the Insurer. Personal expenses are not covered. Paragraph 1 is reserved.

Art. 8 Scope and duration of benefits

Supplemental hospitalisation benefits will be reimbursed subject to the following conditions:

- a. The Insurer will reimburse treatments recognised by the LAMal/KVG, hospital room and board and doctors' fees in accordance with cantonal tariff regulations or the tariff agreement concluded with the Insurer;
- b. If an insured is hospitalised in a hospital with which the Insurer has not concluded a tariff agreement covering room and board and treatment costs (including medical fees), he will be paid the following maximum allocation depending on his chosen coverage class:
 - Class 1: CHF 200 per day
 - Class 2: CHF 400 per day
 - Class 3 or 4: CHF 600 per dayArticle 6 (2) is not applicable.
- c. The Insurer can limit or exclude the payment of supplemental hospitalisation insurance benefits in respect of hospitals, wards or clinics which do not meet the requirements of paragraph (a) of this Article. A list is kept at the disposal of the insureds.
- d. The present insurance does not include coverage for or-

- gan transplants covered by flat rates agreed by the SVK (Fédération Suisse pour Tâches Communes des assureurs maladie, Solothurn). This rule also applies to hospital establishments which are not bound by flat-rate agreements.
- e. In all four classes, the entitlement to benefits ceases as soon as the insured's condition is no longer acute.
 - f. After 60 days of hospitalisation in a psychiatric facility in a single calendar year, benefits under the supplemental hospitalisation insurance are no longer payable.
 - g. In classes 2, 3 and 4, benefits under the supplemental hospitalisation insurance are no longer payable after 90 days' hospitalisation. The duration of any benefits paid abroad or of benefits paid for treatment in psychiatric facilities (60 days) is imputed to the aforesaid 90-day limit.

Art 9 Payment of benefits

- 1. Supplemental hospitalisation insurance claims are payable against presentation of the hospital invoice and doctor's bill. The insured authorises the Insurer's medical advisor to ask the attending doctor for the diagnosis and for any other relevant information with a view to ascertaining the insured's entitlement to benefits.
- 2. Claims are payable to the insured unless the Insurer is contractually required to make direct payment to the hospital.

Art. 10 Obligations of the insured

Before he is hospitalised, the insured shall always check that the hospital, ward or clinic where he is to be treated is an establishment recognised by the Insurer.

Art. 11 Premium

- 1. 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:
 - Children: 0 to 18
 - Adults: 19 to 25
 - from the 26th year, age groups are graduated in five-year brackets.
- 2. Premiums are set taking into account the insured's age upon joining the insurance.

Art. 12 Cost-saving measures

- 1. If, at the Insurer's proposal or by his own decision, an insured waives his entitlement to hospitalisation in a semi-private or private ward and instead stays in a general or comfort ward, the Insurer may grant him an indemnity of up to 50% of the savings estimated by the Insurer but not more than CHF 5,000 per hospitalisation.
- 2. In case of outpatient childbirth or childbirth at home, only Article 7(4) applies.

Special Terms and Conditions for H-Bonus supplemental hospitalisation insurance

HB

HBGA01-E4 – Edition: 01 Jan 2014

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. H-Bonus insurance covers treatments, room and board and doctor's fees when the insured is hospitalised for inpatient treatment in a general, semi-private or private ward.
2. The insured person shall choose the hospital ward in which he wishes to be treated, at the latest upon admission to hospital.
3. Benefits are supplemental to those provided under the compulsory health insurance LAMal/KVG (hereafter, AOS/OKP).
4. The bonus system enables the insured to reduce his premium amount if he has not received any insurance benefits for hospitalisation in a semi-private or private ward.

Art. 2 Eligibility

H-Bonus supplemental insurance is open to all persons under the age of 60.

Art. 3 Risks covered

H-Bonus benefits provide illness, accident and maternity coverage.

Art. 4 Insured benefits

1. Choice of ward and co-insurance
In case of hospitalisation for inpatient treatment (for more than 24 hours), and only in the following:
 - hospitals for treatment of acute conditions;
 - psychiatric facilities or
 - rehabilitation centres;the insured is free to choose the hospital ward, along with the following co-insurance amounts:

Ward	Insured's co-insurance
General ward	CHF 0
Semi-private ward	CHF 100 per day, maximum 30 days per calendar year
Private ward	CHF 200 per day, maximum 20 days per calendar year

In calculating the number of hospitalisation days subject to co-insurance, the days on which the insured enters and leaves the hospital are deemed as full days when invoiced by the hospital facility.

If, during a calendar year, the insured chooses to be hospitalised in a semi-private or private ward, the maximum annual limit of the private ward is taken into account, i.e. CHF 4,000.

2. Coverage of maternity benefits
 - a. In case of pregnancy and childbirth, H-Bonus insurance benefits will only be paid after the lapse of a non-availability period of 12 months.
 - b. Interruptions of pregnancy within the meaning of the Swiss Federal Law on Health Insurance (LAMal/KVG), and any other maternity-related benefits are subject to the waiting period specified in letter (a) above.
 - c. When childbirth is covered by the insurance, the In-

surer will also cover the healthy newborn's hospital costs for the duration of the mother's stay in hospital, provided the child is also insured with the Insurer.

Art. 5 Scope of benefits

1. For H-Bonus benefits to be payable, hospitals shall be recognised within the meaning of LAMal/KVG (listed hospitals) or shall have concluded a tariff agreement with Groupe Mutuel Assurances GMA SA for the corresponding wards.
2. The Insurer will cover only treatment costs recognised under LAMal/KVG, room and board in hospital as well as doctors' fees, in accordance with the agreement concluded with the Insurer or the cantonal tariff regulations.
3. The present insurance does not include coverage for organ transplants covered by flat rates (since these costs are covered by the AOS/OKP) agreed by the SVK (Fédération suisse pour tâches communes des assureurs maladie, Solothurn). This rule also applies to hospital facilities which are not bound by flat-rate agreements.
4. In case of emergency and as long as the insured is unable to choose the ward, the Insurer will ensure the coverage of benefits in a general ward only.

Art. 6 Duration of benefits

1. Hospitalisation benefits are limited to the acute phase of the illness. The entitlement to benefits ceases once the condition is no longer considered acute, such as in the treatment of stabilised or chronic conditions in particular, or if hospitalisation does not serve to improve the insured's health.
2. In the event of hospitalisation in a psychiatric facility, the entitlement to benefits is limited to 90 days per calendar year.
3. In the event of a stay in a rehabilitation centre, the entitlement to benefits is limited to 90 days per calendar year.

Art. 7 Hospitalisation abroad

1. In case of emergency, if an insured falls ill or has an accident and is hospitalised, the Insurer will grant him a maximum daily allowance of CHF 500 per day for no more than 60 days per calendar year. The co-insurance amounts defined in Article 4.1 are not applicable.
2. Voluntary treatments abroad are covered subject to the Insurer's prior consent only.

Art. 8 Obligation of the insured in case of hospitalisation

At the risk of being denied his entitlement to benefits, the insured shall check that the facility, hospital ward or clinic of his choice is recognised by the Insurer.

Art. 9 Entitlement to benefits

1. The insured is entitled to benefits as soon as the insurance policy comes into effect. Article 4, paragraph 2, letters (a) and (b), are reserved.
2. Benefits are imputed by treatment date on the benefit reimbursement ceilings and duration limits allowed in each calendar year. Costs incurred after entitlements are exhausted cannot be carried forward to the following year.
3. Under no circumstances shall the insurance benefits regulated by these terms and conditions be used to cover co-insurance payments and deductibles under the AOS/OKP or other supplemental insurances.

Art. 10 Payment of benefits

1. H-Bonus benefits will be paid against presentation of the hospital invoice and the doctor's bill. The insured authorises the Insurer's medical advisor to ask the attending doctor for the diagnosis and for any other relevant information with a view to ascertaining the insured's entitlement to benefits.
2. Claims are payable to the insured unless the Insurer is contractually required to make direct payment to the hospital.

Art. 11 Premium scale (bonus system)

1. For the calendar year an insured joins, premium level 0 applies.
2. The following premium levels are applicable:

% of premium	Premium levels
100	1
80	0

Art. 12 Variation of premium scale

1. If, during a given reference period, the insured has been granted benefits for a hospital stay in a semi-private or private ward, as set out in Article 4.1, his premium will be calculated at the beginning of the calendar year following the reference period and for three years based on premium level 1 (100% of the premium). If the Insurer is late in receiving the invoice from the hospital, the Insurer will adjust the premium scale subsequently.
2. At the end of this three-year period, and provided that no other insurance benefits were paid for hospitalisation in a semi-private or private ward, the premium for the following calendar year will be calculated based on premium level 0 (80% of the premium).
3. Every time the insured receives benefits for a new hospitalisation in a semi-private or private ward, the three-year period starts again at the beginning of the calendar year following the reference period.
4. The initial reference period which is used to determine the variation of the premium scale begins on the day the insured joins the insurance, as stated in the insurance policy, and ends on the following 30 June.
5. Subsequent reference periods contain 12 months and range from 1 July to 30 June.
6. The first day of hospitalisation is the decisive date for the allocation of benefits to a reference period.
7. In case there are several invoices for one single hospitalisation, only the date of the first day of hospitalisation is taken into account.

Art. 13 Premiums

1. An insured person who reaches the last year of his age group is automatically transferred into the next age group at the beginning of the following calendar year. The applicable age groups are:
 - from 0 to 18;
 - from 19 to 25;
 - from ages 26 to 80, age groups are graduated in 5-year brackets.
2. Premiums take into account the above-mentioned age brackets and the premium scale.
3. Changes in the premium scale (according to Article 12) do not qualify as premium adjustments conferring the right to termination within the meaning of Article 29 of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC).

Special Terms and Conditions for Hôpital senior insurance

HSGA01-E7 – Edition: 01 Nov 2022

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 insurance covers the economic consequences of illness and accident (maternity excluded).
2. The insurance refunds benefits in the event of inpatient hospitalisation for stays in an acute care, psychiatric or rehabilitation facilities.

Art. 2 Insurance classes

Hôpital senior insurance offers four classes of coverage:

Class 1

General ward with room and board supplement for a room with two beds in a Swiss hospital facility recognised by the insurer for this benefit, subject to any hospital provisions.

Medical care in the general ward without free choice of doctor.

Class 2

General ward with room and board supplement for a room with one bed in a Swiss hospital facility recognised by the insurer for this benefit, subject to any hospital provisions.

Medical care in the general ward without free choice of doctor.

Class 3

Semi-private ward in a Swiss hospital facility recognised by the insurer (room with two beds).

Class 4

Private ward in a Swiss hospital facility recognised by the insurer (room with one bed).

Art. 3 Deductibles

Persons insured in classes 3 and 4 may select one of the following deductibles:

- a. no deductible;
- b. CHF 2,000 per calendar year, for the premium to be reduced by 10%;
- c. CHF 5,000 per calendar year, for the premium to be reduced by 25%.

Art. 4 Eligibility

Hôpital senior insurance is open to all persons residing in Switzerland, without any age limit.

Art. 5 Insured benefits

1. Hospitalisation

1. General

In case of hospitalisation, Hôpital senior will cover treatment (including medical fees) and room and board costs in accordance with the selected coverage class. Benefits under Hôpital senior insurance are supplemental to compulsory insurance benefits.

2. Hospitalisation abroad

If an insured falls ill or has an accident abroad and has to be hospitalised there, the insurer will grant him, for no more than 60 days per calendar year and within the limits of the selected coverage, the following benefits:

- a. Class 1: maximum CHF 500 per day
- b. Class 2: maximum CHF 500 per day
- c. Class 3: maximum CHF 1,000 per day
- d. Class 4: maximum CHF 1,500 per day.

Voluntary treatment abroad is not covered unless the insurer gives its prior consent.

3. Hospitalisation in another ward

If an insured with class 3 coverage is hospitalised in a ward covered by class 4, the following maximum benefits will be granted to him: 80% of room and board and treatment costs.

2. Groupe Mutuel Assistance

The insurer covers the benefits specified in the general terms and conditions of Groupe Mutuel Assistance (repatriation and transport if the insured event occurs more than 20 km from the insured person's domicile).

Art. 6 Scope, duration and entitlement to benefits

Hôpital senior benefits are reimbursed subject to the following provisions:

- a. The insurer will pay the cost of treatments recognised under the LAMal/KVG, room and board in a hospital facility as well as doctors' fees, in accordance with the cantonal tariff regulations for the general ward or the agreement concluded with the insurer.
- b. The list of recognised facilities is available on the insurer's website or can be provided upon request of the insured person. The list valid at the time of treatment is decisive. The list can be modified by the insurer at all times.
- c. If an insured is hospitalised in a hospital with which the insurer has not concluded a tariff agreement for room and board and treatment costs, the following maximum benefits will be granted to him, within the limits of the selected benefits' category, the inpatient hospitalisation benefits actually invoiced within the meaning of Art. 5, para. 1 chapter 1 of these special terms and conditions:
Classes 1 and 2: CHF 200 per night of hospitalisation;
Class 3: CHF 800 per night of hospitalisation;
Class 4: CHF 1,000 per night of hospitalisation;
Art. 5, para. 1 chapter 3 is not applicable.
- d. This insurance does not include coverage for organ transplants covered by flat rates agreed by the SVK (Fédération suisse des tâches communes des assureurs maladie, Solothurn). This rule also applies to hospitals which are not bound by flat-rate agreements.
- e. The entitlement to benefits ceases as soon as the insured's condition is no longer acute.
- f. After 60 days of hospitalisation in a psychiatric facility in a single calendar year, benefits under Hôpital senior insurance are no longer payable.
- g. After 90 days of hospitalisation in a single calendar year, benefits under Hôpital senior insurance are no longer payable. The duration of any benefits paid abroad or of any benefits paid for treatment in psychiatric facilities (60 days) is imputed to the aforesaid 90-day limit.
- h. Benefits are imputed by treatment date in one calendar year. Costs incurred after entitlements are exhausted cannot be carried forward to the following year.

Art. 7 Payment of benefits

1. Insurance benefits are payable against presentation of the hospital invoice and the doctor's bill. The insured authorises the insurer's medical adviser to ask the attending doctor for the diagnosis and for any other relevant information with a view to ascertaining the insured's entitlement to benefits.
2. Benefits are payable to the insured unless the insurer is contractually required to make direct payment to the hospital.

Art. 8 Obligations of the insured

Before he is hospitalised, the insured shall check that the hospital, ward or clinic where he is to be treated is a facility recognised by the insurer.

Art. 9 Premiums

1. Premiums are set in accordance with a progressive index depending on the insured's age. The index is 100 up to and including 55 years of age and increases by 7 points for each year of age; the determining age is the age reached during a calendar year.
2. Premiums are identical for men and women.

Art. 10 Cost-saving measures

If, at the insurer's proposal or by his own decision, an insured in classes 3 or 4 waives his entitlement to hospitalisation in a semi-private or private ward and stays instead in a general or comfort ward, the insurer may grant him an indemnity of up to 50% of the savings estimated by the insurer, but not more than CHF 5,000 per hospitalisation.

Special Terms and Conditions for H-Capital lump-sum hospitalisation benefit insurance

KH

KHGA02-E6 – Edition: 01 Feb 2022

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

The insurance covers the economic consequences of illness and accidents, but not maternity.

Art. 2 Acceptance conditions

1. H-Capital insurance coverage is open to all persons, without any age limit.
2. Coverage starts at the beginning of a month, but no sooner than three months after the insured's birth.

Art. 3 Entitlement to benefits

1. The lump-sum amount in the event of hospitalisation is granted if the insured person is hospitalised for inpatient treatment of an acute condition lasting more than 24 hours and during which a bed is occupied overnight.
2. The benefit is paid in the following cases:
 - hospitalisation in the general ward or psychiatric facility of a recognised Swiss hospital, for treatment of acute conditions;
 - hospitalisation abroad;
 - hospitalisation in a recognised marine cure establishment or rehabilitation facility within the meaning of the Federal Law on Health Insurance (LAMal/KVG);
3. The lump-sum benefit cannot be granted more than once a year.
4. In the event of hospitalisation extending over two calendar years, the lump-sum amount is paid out only once.
5. Benefits are not payable in the following cases:
 - maternity;
 - outpatient treatment;
 - hospitalisation in connection with treatment that is not recognised by the Federal Law on Health Insurance (LAMal/KVG);
 - semi-hospitalisation;
 - hospital stays within the context, exclusively, of the Federal Law on Accident Insurance (LAA/UVG), the Federal Law on Disability Insurance (LAI/IVG) or the Federal Law on Military Insurance (LAM/MVG).

Art. 4 Annual lump-sum benefit

The following annual lump-sum benefits can be insured:

CHF 300; CHF 500; CHF 600; CHF 900; CHF 1,000; CHF 1,200; CHF 1,500; CHF 2,000; CHF 2,500; CHF 3,000; CHF 3,500.

Art. 5 Insured benefits

1. In case of hospitalisation for inpatient treatment of acute conditions in accordance with Article 3, H-Capital insurance will pay the annual lump-sum benefit (Article 4) subject to Article 3(3).
2. Benefits of the "H-Capital" insurance are covered by à fixed-lump insurance.

Art. 6 Payment of benefits

1. Benefits will be paid against presentation of the hospital invoice. The insured authorises the insurer's medical advisor to ask the attending doctor for the diagnosis and for any other relevant information with a view to ascertaining the insured's entitlement to benefits.
2. The lump-sum benefit is payable to the insured. In the event of his/her death, the benefit will be paid to his/her beneficiaries in the following order: his/her spouse; failing him/her, his/her children; failing them, his/her parents; failing them, the other legal heirs.
The insured may modify the order of beneficiaries by an application to the health insurer.

Art. 7 Premium

1. Premiums are graduated by gender and age group.
2. An insured person who reaches the maximum age for his age group during the year is automatically transferred to the next higher age group at the beginning of the following calendar year. The applicable age groups are:
 - from 0 to 18;
 - from 19 to 25;
 - from the 26th year onwards, age groups are graduated in five-year brackets.

Special Terms and Conditions of insurance for daily allowance benefits in the event of hospitalisation

BH

BHGA01-E8 – Edition: 01 Feb 2022

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 Eligibility

Anyone up to the age of 60 may be insured for a daily allowance benefit paid for the duration of a stay in a hospital facility.

Art. 2 Insured benefits

1. Insurance for a daily allowance benefit in the event of hospitalisation includes benefits of up to CHF 200 per day.
2. Benefits are covered by fixed-sum insurance.
3. Daily allowance in the event of hospitalisation is paid for a maximum of 90 days per calendar year.
4. When the insurer has paid 360 daily allowance benefits over a period of four calendar years, the entitlement to benefits expires. When the entitlement to benefits expires, insurance coverage ends.

Art. 3 Entitlement to benefits and period of non-availability

1. Entitlement to insurance benefits takes effect after a period of non-availability of six months.
2. In the event of maternity, compensation is only paid after 12 months of insurance.
3. Insurance benefits end when the insurance contract is terminated. The entitlement to benefits for an ongoing claim shall remain unaffected.

Art. 4 Premium

1. An insured person who reaches the maximum age for his age group during the year is automatically transferred to the next higher age group at the beginning of the following calendar year. The relevant age groups are as follows:
 - from 0 to 18 years,
 - from 19 to 25 years,
 - from the 26th year to the 71st year of age, age groups are graduated in five-year brackets.Premiums take into account the above-mentioned age groups.
2. The premium rate also takes into account the age at which the insured person joins the insurance.

Special Terms and Conditions for Mundo Insurance

MUGA01-E7 – Edition: 01 Feb 2022

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 Eligibility, duration of insurance

1. All Swiss residents are eligible for coverage, without age restriction.
2. The insurance is concluded for at least one insurance term in accordance with Art. 12 of the general terms and conditions of insurance. It is then tacitly renewed from year to year.

Art. 2 Territorial validity

1. Mundo insurance coverage is valid worldwide, Switzerland excepted.
2. Deviating from paragraph 1, Mundo insurance is valid in Switzerland for voluntary vaccination.
3. The insurance does not cover any follow-up treatment after the insured returns home for treatment started when he was on holiday or travelling abroad.

Art. 3 Beginning of insurance coverage

The insurance contract is valid from the effective date specified on the insurance policy.

Art. 4 Termination of insurance contract

After an insurance term, the policyholder may terminate the insurance for the end of a calendar year, subject to three months' advance notice.

Art. 5 Insured sum

The insured sum is maximum CHF 100,000 per calendar year.

Art. 6 Insured benefits

The insured sum shall serve to reimburse the following costs in the event of an illness or accident:

1. recognised outpatient treatment, within the meaning of the Federal Health Insurance Law (LAMal/KVG);
2. hospitalisation for recognised treatment, within the meaning of LAMal/KVG;
3. foreign statutory co-insurance amounts payable by the insured pursuant to the EU/EFTA Agreement on the Free Movement of Persons or other international social security agreements;
4. the cost of necessary vaccinations recommended by the Federal Office of Public Health for persons travelling abroad, provided such costs are not covered by the ordinance on compulsory health insurance;
5. necessary transport to the nearest hospital facility for treatment;
6. repatriation transport costs, including for a dead person, subject to the insurer's prior consent;
7. search and rescue costs for an insured person who is sick or whose physical integrity is in jeopardy;

8. if an insured person is hospitalised for more than seven days, the following costs for the visit of a family member:
 - documented costs of a round trip in economy class plus public transport fares to the facility where the insured is hospitalised;
 - documented costs for room and board not exceeding CHF 250 per day up to maximum CHF 2,000;
9. a lump-sum amount of CHF 5,000 is granted in the event the insured dies abroad as a result of an illness or accident. The beneficiaries are as follows:
 - a. the surviving spouse or registered partner of the insured person, if there are none;
 - b. the children of the insured person, in equal shares, if there are none;
 - c. the parents of the insured person (direct ascendants), in equal shares, if there are none;
 - d. the grandparents of the insured person, in equal shares, if there are none;
 - e. the brothers and sisters of the insured person, in equal shares, if there are none;
 - f. the legal heirs of the insured person, excluding the public community.
10. The policyholder may at any time designate or exclude beneficiaries by notifying the insurer in accordance with Art. 37 of the general terms and conditions of insurance. If the designated beneficiary(ies) is (are) predeceased, the provisions of paragraph 9 apply.
11. The costs referred to in paragraphs 1 to 8 above are covered by indemnity insurance. The lump-sum amount in the event of death is covered by fixed-sum insurance.

Art. 7 Exclusions

There is no entitlement to the insured sum in the following cases:

1. if the insured voluntarily decides to have treatment abroad;
2. for illnesses that are already being treated, but have not yet stabilised, at the time of departure;
3. for personal expenses such as beverages, telephone calls, TV rental, etc.

Art. 8 Entitlement to benefits in case of death abroad

To justify the entitlement to benefits, a death certificate or any other requisite document must be presented to the insurer.

The insurer may deduct any amounts owed to it by the deceased from the death benefit payable to the beneficiaries. If a death certificate is not presented beforehand, the entitlement to death benefits expires, without further notice, two years after the insured's death.

Art. 9 Notification of an illness or accident

The insured or his close relations shall promptly notify any illness or accident to the insurer, indicating whether it is an insured event under the Mundo policy.

Art. 10 Payment of benefits

1. If several family members fall sick 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.
2. To obtain reimbursement, the insured shall provide all requisite documents (original detailed invoices, medical certificates, prescriptions, payment confirmations, etc.).
3. For foreign invoices, the applicable exchange rate is the official Swiss Franc rate for the currency concerned on the last day of treatment.
4. The insurer recognises the customary tariffs applied in the country or region where treatment is administered. The insurer reserves the right to reduce benefits if invoices are exaggeratedly high.

Art. 11 Premiums

When an insured person reaches the last year of his age group, he will be automatically transferred into the next age group at the beginning of the next calendar year.

The applicable age groups are:

- from 0 to 18;
- from 19 to 25;
- from age 26, age groups are graduated in five-year brackets.

Art. 12 Combination discount

1. If certain benefits are also covered by other supplemental insurance product(s) concluded with the insurer, a combination discount on the Mundo insurance premium may be granted.
2. The supplemental insurance products for which a combination discount may be granted are listed in the pre-contractual information documents provided to the Applicant in accordance with Art. 3 LCA/VVG.
3. The combination discount shall be withdrawn as soon as the conditions for granting it as set out in paragraph 1 are no longer met.
4. The insurer may change or cancel these discounts in accordance with Art. 29 of the general terms and conditions of insurance (CGC).

Art. 13 Place of performance and jurisdiction

1. The obligations arising from the contract shall be performed in Switzerland and in Swiss francs.
2. In case of dispute, the policyholder or the beneficiary may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the insurer's registered office.

Special Terms and Conditions for Dental Care Insurance (Dentaire Plus)

DP

DPGA02-E7 – Edition: 01 Aug 2006

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. Category DP ("Dentaire Plus" dental care insurance) provides dental care benefits, against payment of the corresponding premiums, in accordance with these Special Terms and Conditions.
2. Benefits payable under this insurance are supplemental to compulsory insurance benefits.

Art. 2 Eligibility, acceptance

1. DP insurance coverage, in classes 1, 2 and 3, is open to all persons under 60. Class 0 coverage is open only to persons between 0 and 18 years' old.
2. Acceptance is based on a form issued by the Insurer and signed by the applicant or the applicant's legal representative, together with a medical certificate issued by a dentist holding a federal diploma or an equivalent degree recognised in Switzerland.
3. The Insurer will pay the dentist's fee for the certificate, up to a maximum of CHF 75.

Art. 3 Benefits

1. DP insurance covers:
 - a. dental and facial orthopaedic treatment;
 - b. dental treatment by a qualified dentist;
 - c. laboratory costsup to the following limits per year:

Class 0:	75% of the amount invoiced based on the tariff, up to maximum CHF 15,000 per calendar year for the benefits described under (a) above, up to the insured's 18th birthday.
Class 1:	75% of the amount invoiced based on the tariff, up to maximum CHF 1,000 per calendar year for the benefits described under (a), (b) and (c) above.
Class 2:	75% of the amount invoiced based on the tariff, up to maximum CHF 3,000 per calendar year for the benefits described under (a), (b) and (c) above.
Class 3:	75% of the amount invoiced based on the tariff, up to maximum CHF 15,000 per calendar year for the benefits described under (a), (b) and (c) above.
2. Only treatment provided by recognised practitioners, within the meaning of LAMal/KVG, is covered.
3. Benefits up to the insured amount are granted in the event of dental damage caused by an illness or an accident.

Art. 4 Entitlement to benefits

1. An insured shall be immediately entitled to benefits for dental treatment following accidents which occur after the policy comes into effect.
2. Subject to Article 4(1) and (3), benefits are payable by the Insurer after a waiting period of three months.
3. For classes 1 to 3, benefits for orthodontic treatment (tooth replacement, crowns, pivots, bridges, partial or full prostheses, etc.) are granted immediately after the DP insurance

comes into effect in the case of accidents; in all other cases, the entitlement to benefits is subject to a 12 month waiting period.

4. When an insured withdraws from DP coverage, he loses all claims under the insurance, including for subsequent treatment.
5. Where dental benefits under SC, SB, GL, GM and GP supplemental insurances overlap with DP (Dentaire Plus) dental benefits, the latter are payable first.

Art. 5 Prophylaxis

In classes 1 to 3, a contribution of CHF 75 is payable once a year for a prophylactic dental check-up.

Art. 6 Benefits abroad

Subject to the Insurer's prior consent, treatment abroad will be covered provided the foreign medical practitioners have equivalent qualifications to Swiss qualifications and that the costs do not exceed what would have been charged in Switzerland.

Art. 7 Exclusions

1. There is no entitlement to benefits for the replacement of any teeth which were already missing when the DP insurance was contracted, or for the subsequent replacement or modification of any teeth which had already been replaced at that time, except in the case of accidents occurring after the policy comes into effect.
2. DP insurance does not cover any dental treatment which is required as a result of an accident which took place before the insurance was contracted.
3. The Insurer reserves the right to exclude treatment which was already contemplated when the insurance proposal was signed.
4. For treatment in respect of which the AI/IV or AMF/MV compulsory accident insurance or a third party are required to pay benefits, the Insurer will not pay any DP benefits even if the insured is required to bear a portion of the cost of such treatment.

Art. 8 Reference tariff

The reference tariff for the calculation of benefits under these Special Conditions is the official LAA/UVG tariff (nomenclature and point values).

Art. 9 Claims procedure

1. As the debtor of the invoice, the insured remains liable for payment vis à vis the dentist.
2. The Insurer grants benefits on the basis of detailed invoices only, taking into account the positions covered by the insurance (invoice for the reimbursement of medical and dental costs issued by SSO - Société suisse d'odontostomatologie). At the Insurer's request, especially in complex cases, the insured shall provide all requisite indications enabling the Insurer to calculate benefits. If such indications are not

provided, the Insurer shall set the amounts based on its own estimate. If the invoice does not show the work done, the Insurer shall not be obliged to pay benefits.

3. Accidents must be declared in writing to the Insurer within six days. If there is a delay in declaring an accident, the Insurer may unilaterally decide not to pay any benefits for the relevant case.

Art. 10 Premium

Age groups are graduated in five-year brackets. An insured person who reaches the last year of his age group during the year will be automatically transferred into the next age group at the beginning of the following calendar year.

Art. 11 Cancellation of exclusions

The insured may apply for an exclusion to be cancelled by presenting a certificate, issued at his expense, confirming that the diseased teeth have been repaired, replaced or extracted.

Art. 12 Transfer to another insurance class

1. For class 0, coverage ceases at the end of the calendar year coinciding with the insured's 18th birthday. On 1 January of the year after his class 0 coverage ceases, the insured will automatically be transferred to class 1 provided he is not already insured under class 1, 2 or 3; in that case, the waiting period referred to in Article 4(2) and (3) of these Special Conditions is not applicable.
2. The insured may refuse such transfer by written notice to the Insurer within 30 days of the receipt of the new policy.

Special Terms and Conditions for Acrobat Accident Insurance

AB

ABGA02-E8 – Edition: 01 Oct 2021

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

Acrobat coverage protects the insured against the economic consequences of an accident.

Art. 2 Insured events

1. Are insured non-occupational accidents and school accidents, including accidents which occur during games and sports, and accidents involving the use of motor vehicles with the requisite permits.
2. Also insured are all occupational accidents and illnesses covered by the compulsory accident insurance (LAA/UVG).

Art. 3 Injuries equated with an accident

1. Supplementing the provisions of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), are also equated with accidents: cartilage tears (meniscus) provided they occur and are first treated no less than two years after the start of the insurance; the sequels of frostbite, heat stroke, sunstroke and the effects of ultraviolet rays except sunburn; and drowning.
2. Benefits are also payable for bodily injuries suffered by the insured during therapeutic treatments and examinations prescribed as a result of an insured accident.

Art. 4 Eligibility

Acrobat insurance is open to all persons under age 18 residing in Switzerland.

Art. 5 End of insurance contract (insured person reaches the age limit)

Supplementing the provisions of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), the insurance contract and the entitlement to benefits shall cease at the end of the year which coincides with the insured's 18th birthday.

Art. 6 Automatic transfer (from age 19)

1. If an insurance contract is terminated for the reasons contemplated in Article 5, insureds with level 1 or level 2 coverage (see Article 7) will be automatically transferred to ProVista (ID) insurance, under the variant covering the same assured sums. Insureds with level 1P coverage (see Article 7) will be automatically transferred to ActiVita (AJ) insurance. The new insurance is effective as of 1 January following the end of the Acrobat insurance.
2. The insured may refuse the transfer to such insurance (ID), AJ respectively, by notice to the Insurer within 30 days of his receipt of the new policy.

Art. 7 Coverage level

1. The insurance contract may be concluded for one of the two following levels of coverage:
 - Level 1 – Acrobat^{light}
 - Level 1P – Acrobat^{eco}
 - Level 2 – Acrobat^{standard}.
2. The level specified on the insurance policy is conclusive for the entitlement to benefits.

Art. 8 Types of benefits

1. Acrobat pays the following benefits in accordance with the chosen coverage level (see Article 7(1)):
 - a. treatment and miscellaneous costs (Article 10);
 - b. a lump-sum hospitalisation benefit (Article 10);
 - c. a lump-sum disability benefit (Article 11);
 - d. a lump-sum death benefit (Article 12).
2. The insured benefits for each coverage level are listed in Annex B.
3. Recovery costs and other costs are covered by indemnity insurance. Capital lump-sum amounts in the event of hospitalisation, disability or death, are a fixed-sum insurance.

Art. 9 Entitlement to benefits

1. The contractual benefits shall be paid for accidents occurring after the policy comes into effect.
2. Benefits are conditional to the presentation of a medical certificate, death certificate or inheritance certificate. Only original documents will be accepted.

Art. 10 Treatment costs and other costs

1. Treatment costs are insured supplementally to Swiss or foreign social insurances including LAMal/KVG, LAA/UVG and LAI/IVG in particular.
2. The Insurer is only liable for the difference between the social insurance benefits referred to in the preceding point and the benefits stipulated in points 3.1 to 3.12 below. Unless otherwise provided, LAA/UVG health care tariffs are applicable.
3. The following benefits are payable (see Annex B which forms an integral part of these Special Conditions):
 1. **Medical costs in Switzerland (general ward)**
The cost of any necessary medical treatment, including tests and medicine (excluding LPPA/LPPV pharmaceutical products for special application), given or prescribed by medical practitioners (doctors, dentists and chiropractors), and the cost of treatment, room and board in the general ward of a Swiss hospital recognised by the Insurer.
 2. **Medical expenses for emergency treatment abroad**
The cost of necessary in and out-patient medical treatment, including tests and medicine, for accidents occurring abroad.

3. Home care and treatment

Following hospitalisation, and by prior application to the Insurer, the cost of medically necessary home help hired from an official service. On the basis of the same tariff, a contribution may be allocated to one of the parents who suspends his or her professional activity to care for the insured.

4. Medical aids, appliances and patient-room furniture

The cost of first purchase of prostheses, spectacles, hearing aids and orthopaedic aids, and the corresponding repair or replacement costs (new value) if such aids and appliances are damaged or destroyed during an insured accident which causes the insured a physical injury requiring treatment. Rental costs for patient-room furniture are also covered.

5. Transport, search and rescue expenses

Following an accident, transport costs to the nearest hospital facility or doctor provided such transport is medically necessary.

This contribution is only granted for transport by ambulance, helicopter or by a rescue action.

Public transport costs (bus or train) for outpatient treatment are also reimbursed if such treatment is designed to avoid hospitalisation.

The cost of unplanned search and rescue actions designed to save the life of an insured who is provably in distress or to avoid a rapid and significant aggravation of his condition.

6. Plastic surgery

The costs of necessary plastic surgery operations following an insured accident.

7. Supplementary benefits for accidents abroad

- If the insured is hospitalised abroad and cannot be transferred to Switzerland on medical grounds, transport costs to the hospital for close relatives if hospitalisation lasts longer than three days.
- If the insured dies abroad, the cost of transporting the body, by normal airline or a special motor vehicle, to the deceased's domicile in Switzerland.

8. Remedial measures (catching up at school)

If the insured is unable to attend school for over two months, the certified cost of remedial lessons given by a qualified, specially trained teacher.

9. Sports membership

If, as a result of an accident, the insured is prevented from practising a sporting activity, the Insurer will reimburse the insured for any sports packages or subscriptions taken out prior to the accident that cannot be used, on a pro rata basis and on presentation of original medical evidence.

Compensation for these costs is limited to a maximum of CHF 500 per accident.

In addition to the benefits enumerated in points 3.1 to 3.9 above, Acrobat level 1P covers the supplemental benefit contemplated in point 3.10 below.

10. Medical costs in Switzerland (private ward)

The costs under point 3.1 in the private ward of a Swiss hospital recognised by the Insurer.

In addition to the benefits enumerated in points 3.1 to 3.10 above, Acrobat level 2 covers the following supplemental benefits:

11. Emergency medical care abroad and repatriation

The benefits covered under Terms and Conditions of Intervention of Groupe Mutuel Assistance which form an integral part of these Special Terms and Conditions.

12. Lump-sum benefit in case of hospitalisation

A lump-sum of CHF 500 is paid per calendar year in the event of hospitalisation lasting longer than 24 hours in a recognised Swiss hospital or abroad.

The lump-sum is payable at the request of the insured against presentation of the hospital bill.

To determine the entitlement to insurance benefits, the Insurer's medical advisor is authorised to ask the attending doctor for a diagnosis or for any other relevant information.

Art. 11 Lump-sum disability benefit

These benefits are granted to insureds with Acrobat level 1 or level 2 coverage.

a. Capital

The insured capital in case of disability is CHF 200,000.

b. Entitlement

A disability lump-sum benefit is payable in the case of accidents causing probable permanent injury. The lump-sum benefit is determined based on the degree of disability and the scale in letter (c) below.

c. Degree of disability

1. The degree of disability is set according to the following rules:
 - loss of a phalanx of the thumb or of at least two phalanges of another finger 5%
 - loss of a thumb 20%
 - loss of a hand 40%
 - loss of the lower arm (at or below the elbow) 50%
 - loss of a big toe 5%
 - loss of a foot 30%
 - loss of a lower leg (at the knee or below) 40%
 - loss of a leg (above the knee) 50%
 - loss of an ear lobe 10%
 - loss of the nose 30%
 - scalp 30%
 - very serious disfigurement 50%
 - loss of a kidney 20%
 - loss of the spleen 10%
 - loss of the genitals or of the reproductive function 40%
 - loss of sense of smell or taste 15%
 - loss of hearing in one ear 15%
 - loss of sight in one eye 30%
 - total deafness 85%
 - total blindness 100%
 - recurrent dislocation of the shoulder 10%
 - serious impairment of mastication 25%
 - very serious and painful functional impairment of the spinal chord 50%
 - paraplegia 90%
 - tetraplegia 100%
 - very serious pulmonary impairment 80%
 - very serious impairment of the kidneys 80%
 - impairment of partial psychological functions, such as memory and the ability to concentrate 20%
 - post-traumatic epilepsy with crises, or under permanent medication without crises 30%
 - very serious logo-organic disorder, very serious motor or psycho-organic syndrome 80%
2. The total functional disability of a limb or an organ is equated with a total loss of that limb or organ.
3. In case of a partial functional disability, the percentage is reduced proportionally.

4. In cases not mentioned above, the degree of disability is determined in accordance with the scale of compensation for damage to integrity set out in Annex 3 of the Ordinance on Accident Insurance (OLAA/UVV) and the related SUVA tables. If the degree of disability cannot be determined in accordance with the above rules, it will be established by analogy on the basis of medical findings, taking into account the seriousness of the injury.
5. If several organs or parts of the body are affected by the same accident, the relevant percentages will be added together. Notwithstanding, the degree of disability may not exceed 100%.
6. Psychological disorders or disorders of the nervous system are not covered unless it can be proven that they are the result of an organic impairment of the nervous system caused by the accident.
7. The degree of disability is fixed when the insured's condition is presumed to be final, but no later than 5 years after the accident.

d. Progression

1. If the degree of disability is lower than 25%, a percentage of the insured sum corresponding to the degree of disability is payable.
2. If the degree of disability is higher than 25%, benefits (as a percentage of the contractual insured sum) will increase in accordance with the table in Annex A.

Art. 12 Lump-sum death benefit

These benefits are granted to insureds with Acrobat level 1 or level 2 coverage.

1. If the insured dies as a result of the accident, a lump sum death benefit of CHF 10,000 will be paid, with the exception of children under the age of 2 years and 6 months at the time of death, in which case the lump sum is limited to CHF 2,500.
2. The beneficiaries are:
 - the insured's mother and father, in equal shares, or failing them:
 - his sisters and brothers, in equal shares, or failing them:
 - his grandparents, in equal shares.
3. If the insured has none of the above survivors, the Insurer shall only pay the portion of the burial costs which are not covered by another insurer up to the amount of the lump-sum death benefit indicated in point 1.
4. Any disability benefits already paid for the consequences of the same accident shall be deducted from the death benefits.
5. A beneficiary who deliberately causes the death of the insured forfeits his rights to benefits.

Art. 13 Premiums waiver

1. The Insurer shall assume all periodic premium payments for the Acrobat insurance until the end of the contract (see Article 5) if, as a result of an accident which occurred during the validity of the insurance, one of the insured's parents dies or is declared more than 50% disabled.
2. The premium waiver starts on the day following the occurrence of the disability or death; a waiver application must be filed with the Insurer together with the requisite official documents (decision of the AI/IV office, death certificate and family record booklet).

Art. 14 Third-party services

Deductibles, coinsurance amounts and any taxes for which the insured is liable under any social insurance (LAMal/KVG, LAA/UVG or LAI/IVG) will not be reimbursed.

Art. 15 Negligence of the insured person

The Insurer agrees not to reduce benefits for accidents caused by imprudence or gross negligence on the part of the insured.

Art. 16 Combined effect of causes independent of the accident

If the physical impairments are only partially due to an insured accident, benefits will be fixed proportionately based on a medical report.

Art. 17 Premium

The premium is specified in the insurance policy.

Annex A

Degree of disability	Indemnity in %	Degree of disability	Indemnity in %	Degree of disability	Indemnity in %
26	28	51	105	76	230
27	31	52	110	77	235
28	34	53	115	78	240
29	37	54	120	79	245
30	40	55	125	80	250
31	43	56	130	81	255
32	46	57	135	82	260
33	49	58	140	83	265
34	52	59	145	84	270
35	55	60	150	85	275
36	58	61	155	86	280
37	61	62	160	87	285
38	64	63	165	88	290
39	67	64	170	89	295
40	70	65	175	90	300
41	73	66	180	91	305
42	76	67	185	92	310
43	79	68	190	93	315
44	82	69	195	94	320
45	85	70	200	95	325
46	88	71	205	96	330
47	91	72	210	97	335
48	94	73	215	98	340
49	97	74	220	99	345
50	100	75	225	100	350

Annex B

Benefits	Acrobat ^{standard} (Level 2)	Acrobat ^{light} (Level 1)	Acrobat ^{eco} (Level 1P)
Outpatient treatment Hospitalisation in Switzerland and abroad Restricted and non-reimbursable drugs	The cost of outpatient treatment administered or prescribed by a doctor, chiropractor or dentist and hospitalisation costs in private ward are insured supplementally to social insurance benefits, especially LAMa/KVG, LAA/UVG and LAI/IVG	The cost of outpatient treatment administered or prescribed by a doctor, chiropractor or dentist and hospitalisation costs in general ward are insured supplementally to social insurance benefits, especially LAMa/KVG, LAA/UVG and LAI/IVG	The cost of outpatient treatment administered or prescribed by a doctor, chiropractor or dentist and hospitalisation costs in private ward are insured supplementally to social insurance benefits, especially LAMa/KVG, LAA/UVG and LAI/IVG
Home care and treatment	Maximum CHF 200 per day if administered by an official medical assistance service or by a parent who suspends his/her professional activity	Maximum CHF 200 per day if administered by an official medical assistance service or by a parent who suspends his/her professional activity	Maximum CHF 200 per day if administered by an official medical assistance service or by a parent who suspends his/her professional activity
Medical aids, appliances and furniture	Rental cost and cost of first acquisition of patient-room furniture. Repair and replacement costs (new value)	Rental cost and cost of first acquisition of patient-room furniture. Repair and replacement costs (new value)	Rental cost and cost of first acquisition of patient-room furniture. Repair and replacement costs (new value)
Transport, search and recovery costs	Maximum CHF 50,000 per case	Maximum CHF 50,000 per case	Maximum CHF 50,000 per case
Accidents abroad: supplemental benefits	Repatriation of the body, maximum CHF 10,000 Transport costs for close relatives if hospitalisation lasts longer than 3 days (max. CHF 250 per day and CHF 2,000 per event)	Repatriation of the body, maximum CHF 10,000 Transport costs for close relatives if hospitalisation lasts longer than 3 days (max. CHF 250 per day and CHF 2,000 per event)	Repatriation of the body, maximum CHF 10,000 Transport costs for close relatives if hospitalisation lasts longer than 3 days (max. CHF 250 per day and CHF 2,000 per event)
Emergency medical assistance and repatriation	Groupe Mutuel Assistance	No benefits	No benefits
Plastic surgery	Maximum CHF 20,000	Maximum CHF 20,000	Maximum CHF 20,000
Cost of remedial measures by a qualified person	Maximum CHF 3,000 if the insured is unable to attend school for more than 2 months	Maximum CHF 3,000 if the insured is unable to attend school for more than 2 months	Maximum CHF 3,000 if the insured is unable to attend school for more than 2 months
Sports membership	Maximum CHF 500 per case	Maximum CHF 500 per case	Maximum CHF 500 per case
Lump-sum death benefit	CHF 10,000	CHF 10,000	No benefits
Lump-sum disability benefit	CHF 200,000 (350% progression)	CHF 200,000 (350% progression)	No benefits
Lump-sum benefit in case of hospitalisation	CHF 500 per year	No benefits	No benefits
Premium waiver	Waiver in case of death or disability of one parent, until the end of the contract or the insured's 18th birthday.	Waiver in case of death or disability of one parent, until the end of the contract or the insured's 18th birthday.	Waiver in case of death or disability of one parent, until the end of the contract or the insured's 18th birthday.
Territorial validity	Worldwide	Worldwide	Worldwide

Special Terms and Conditions for ActiVita Insurance

AJGA01-E5 – Edition: 01 Jun 2006

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. ActiVita insurance covers the economic consequences of accident.
2. It provides benefits supplemental to those provided under the compulsory insurances (LAMal/KVG, LAA/UVG and LAM/MVG).
3. Illnesses (including occupational illnesses within the meaning of the LAA/UVG) are excluded from the coverage.

Art. 2 Scope of coverage

1. Where health impairments are only partly due to an insured accident, benefits are determined proportionally based on a medical assessment.
2. Relapses and after-effects of accidents that occurred before the contract was concluded are not insured.
3. Relapses during the five years following the occurrence of the insured accident under this contract are covered provided the policy is still valid when the relapse occurs.
4. Accidents and their consequences occurring after the contract has expired are not covered by the insurance.

Art. 3 Eligibility

ActiVita insurance may be contracted by any person domiciled in Switzerland up to the date of his 60th birthday.

Art. 4 Insured benefits

The Insurer provides the following benefits:

1. Inpatient treatments
 1. General
In case of hospitalisation, the Insurer covers the cost of treatment and accommodation in a private ward of a recognised hospital in Switzerland as long as the accident victim's condition is deemed acute.
 2. Inpatient rehabilitation treatments
In the case of inpatient rehabilitation treatments, the Insurer covers the cost of treatment and accommodation, for a maximum of 120 days per accident, in a private ward of a recognised hospital in Switzerland.
 3. Hospitalisation abroad
If an insured has an accident abroad and requires acute hospitalisation treatment, the Insurer covers the cost of treatment and accommodation up to a maximum of 90 days per accident, but not more than CHF 3,000 per day.
2. Search, rescue and emergency transport
In the event the insured suffers an accident, the Insurer will cover the rescue costs as well as emergency transport to the doctor or nearest hospital.
In addition, the Insurer refunds the costs incurred in searching for a missing person, if there is every reason to believe that this person went missing without any intention and that, in all likelihood, his life is seriously threatened following an accident.
For all of these costs, total compensation is limited to CHF 60,000 per accident.

3. Repatriation on health grounds
If necessary:
Telephone number: 0848 808 111 (+41 848)
With the Insurer's prior approval, repatriation transport costs are covered.
Are also reimbursed the costs of repatriating the mortal remains of the insured, up to a maximum of CHF 10,000.
4. Transport costs when undergoing a medical treatment
The Insurer reimburses the cost of transport, in Switzerland, required when undergoing an outpatient medical treatment following hospitalisation, when the consequences of this accident prevent the insured from getting around on his own.
The maximum coverage for these costs is CHF 1,500 per accident.
5. Plastic surgery
With the Insurer's prior approval, coverage can be extended to plastic surgery treatments, in Switzerland, that would be required following an insured accident.
Coverage is limited to a maximum of CHF 60,000 per accident.
6. Fitness membership
If, following an accident, the insured can no longer practice a sport, the Insurer reimburses, on a pro rata basis and upon presentation of the original medical documents, the cost of sports subscriptions or memberships taken out before the accident and which can no longer be used.
The maximum coverage for these costs is CHF 500 per accident.
7. Emergency hotline
If necessary:
Telephone number: 0848 808 111 (+41 848)
In the event of an accident involving the insured person and requiring that the insured or a third party undergoes a medical treatment or examination, the insured person may benefit from legal advice by phone in response to his urgent questions.
8. Caretaking for your home
If necessary:
Telephone number: 0848 808 111 (+41 848)
In the event of an accident requiring hospitalisation for more than 24 hours, the following services are covered by the Insurer and provided by a partner appointed by him, up to an amount of CHF 1,500 per accident and as long as hospitalisation is medically justified:
 - checking fridges and freezers;
 - checking electric facilities;
 - emptying the letter box and forwarding the letters to the insured or to a person appointed by the latter;
 - taking care of pets and feeding them;
 - watering the plants;
 - airing the rooms.No benefits can be provided if the keys to the insured's domicile are unavailable in Switzerland.
Annex B specifies the conditions for the intervention of the partner appointed by the Insurer.

Art. 5 Coverage for sports activities

Coverage also includes non-occupational sports activities, as long as these are not considered as hazardous activities with- in the meaning of Article 6 below.

Art. 6 Hazardous activities

1. Hazardous activities refer to activities in which the insured knowingly exposes himself to a particularly strong haz- ard, without taking or being able to take precautions that would reduce the risk to a reasonable level. In case of doubt, LAA/UVG rules shall apply by analogy.

Hazardous activities include, in particular:

- motor racing (including training sessions);
- boxing matches, full-contact, etc.;
- extreme karate;
- motor boat racing (including training sessions);
- speed skiing (to attain speed records);
- base-jump;
- scuba diving below 40 metres.

The Insurer provides no benefits in the event of hazardous activities.

2. The following do not constitute hazardous activities, pro- vided they are carried out in normal conditions:
 - bungee jumping;
 - scuba diving (above 40 metres);
 - hydrospeed;
 - base-jump;
 - river rafting;
 - parachuting and paragliding.

Art. 7 Obligations of the insured

1. Before each hospitalisation for rehabilitation treatment, the insured shall check that the facility, hospital ward or clinic where he is to be treated is a facility recognised by the Insurer.
2. When the insured intends to receive any of the benefits mentioned in Articles 4.3, 4.7 and 4.8, he shall immedi- ately report the accident by calling the following num- ber: 0848 808 111 (+41 848 808 111, when calling from abroad).

Art. 8 Premiums

An insured person who reaches the last year of his age group is automatically transferred to the next age group at the be- ginning of the following calendar year. The applicable age groups are:

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

Art. 9 Extension of Acrobat (AB) coverage

1. The insured may take out ActiVita insurance without hav- ing to undergo a health examination providing that this insurance is replacing an Acrobat insurance of Groupe Mutuel Assurances GMA immediately after its expiry, due to the age limit of the insured. Any existing medical exclu- sion in Acrobat insurance will be carried over to the new contract.
2. In this case, and by way of derogation from Article 2.2 of these Special Terms and Conditions, relapses and af- ter-effects covered under Acrobat insurance are insured.

Annex A – Summary of benefits

	Benefits	Covered
Worldwide	Inpatient treatments in a private ward	– unlimited in Switzerland – max. CHF 3,000/day abroad
	Costs of search, rescue and emergency transport	max. CHF 60,000 per case
	Repatriation on health grounds	unlimited
	Emergency hotline	24/7
In Switzerland	Inpatient rehabilitation treatments	max. 120 days per case
	Transport costs when undergoing a medical treatment	max. CHF 1,500 per case
	Plastic surgery (inpatient and outpatient treatments)	max. CHF 60,000 per case
	Caretaking for your home	max. CHF 1,500 per case
	Refund of a fitness membership	max. CHF 500 per case

Annex B – Caretaking for your home

Types of benefits/services provided by the partner appointed by the Insurer

Benefits provided are decided upon in agreement between the insured person (or a third party on his behalf) and the service provider appointed by the Insurer.

The list of services mentioned in Article 4.8 of these insurance conditions is decisive.

The insured person (or a third party acting on his behalf) shall notify immediately and in writing the service provider appointed by the Insurer of any complaints regarding the services delivered.

Civil liability of the partner appointed by the Insurer

The insured is covered for damages resulting from an incorrect execution of the mandate assigned according to the insurance policy concluded by the Insurer's service provider. Both physical injury and material damage are covered up to a maximum of CHF 10,000,000; patrimonial damages are covered up to a maximum of CHF 1,000,000 per case. The insured waives his right to any claims towards the service provider appointed by the Insurer.

The service provider appointed by the Insurer accepts no responsibility for damages due to technical defects on equipment or appliances, as well as due to theft/burglary or an assault.

The service provider appointed by the Insurer accepts no re-

sponsibility for services that were not provided or that were provided late due to accidents, poor services delivered by third parties (e.g. telecommunication network and electric power supply) or traffic disruptions.

Telephone recording

The insured acknowledges that the service provider appointed by the Insurer will record, if necessary, the telephone conversations held with him.

Governing law and jurisdiction

Swiss law shall apply to all legal relations between the insured and the service provider appointed by the Insurer; the place of jurisdiction is the headquarters of the service provider appointed by the Insurer.

Special Terms and Conditions for ProVista Insurance

IDGA02-E9 – Edition: 01 Oct 2021

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 insurance

ProVista grants protection against the economic consequences of death or disability caused by an accident. Occupational illnesses within the meaning of the Federal Law on Accident Insurance (LAA/UVG) are not covered.

Art. 2 Injuries equated with an accident

1. In addition to the provisions of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), the following injuries are equated with an accident: lesions of the meniscus which appear and are treated for the first time no sooner than two years after the beginning of the insurance, as well as the sequels of frostbite, heat stroke, sunstroke and health disorders caused by ultraviolet rays, sunburns excepted; drowning is also equated with an accident.
2. Benefits are also paid for bodily harm suffered by the insured in connection with indispensable therapeutic treatment and tests prescribed as a result of an insured accident.

Art. 3 Acceptance conditions

This insurance is open to all persons under the age of 65 residing in Switzerland.

Art. 4 Types of benefits

1. The Insurer grants the following benefits:
 - a. a lump-sum amount in case of disability (Article 6)
 - b. a lump-sum amount in case of death (Article 7)
2. ProVista insurance is a fixed-sum insurance.

Art. 5 Entitlement to benefits

1. The insured benefits are specified in the insurance policy.
2. The contractual benefits are paid for accidents occurring after the insurance comes into effect.
3. Benefits are paid subject to the presentation of a medical certificate, death certificate or a certificate of inheritance. Only original documents are accepted.

Art. 6 Disability benefits (category I)

a. Entitlement

The disability lump-sum benefit will be paid in the case of accidents leading to a probable permanent disability. The amount of the disability lump-sum benefit is determined by the degree of disability, the agreed insured sum and the scale in Annex A.

b. Degree of disability

The degree of disability is set in accordance with the following rules:

1. Fixed degrees
In case of a total loss, or the total loss of use, of
 - both arms or both hands, both legs and both feet, one arm or one hand and, simultaneously, one leg or one foot 100%
 - an entire arm 70%
 - a forearm or a hand 60%
 - a thumb 22%

- an index finger 15%
- any other finger 8%
- a leg above the knee 60%
- a leg at or below the knee 50%
- a foot 40%
- sight in both eyes 100%
- sight in one eye 30%
- sight in one eye, if the sight in the other eye was already completely lost before the accident 70%
- hearing in both ears 60%
- hearing in one ear 15%
- hearing in one ear, if the hearing in the other ear was already completely lost before the accident 45%
- one kidney 20%
- the spleen 5%
- sense of smell 3%
- sense of taste 3%
- in case of complete incapacity for work following mental illness 100%

2. In case of a partial loss, or the partial loss of use, of these members and organs, the degree of disability is reduced proportionately.
3. If several members or organs are affected at the same time, the degree of disability is determined by adding all the relevant percentages, with the proviso that the total may not exceed 100% per accident.
4. In cases not mentioned above, the degree of disability is determined in accordance with the scale of compensation for damage to integrity set out in Annex 3 of the Ordinance on Accident Insurance (OLAA/UVV) and the related SUVA tables. If the degree of disability cannot be determined in accordance with the above rules, it will be established by analogy on the basis of medical findings, taking into account the seriousness of the injury.
5. If a permanent disability caused by an accident is aggravated by pre-existing bodily defects, the benefit cannot exceed the amount that would have been paid if the person had been sound and healthy before the accident. If the member or organ injured in the accident was already partially or totally mutilated, or its use partially or totally lost, the pre-existing degree of disability, calculated in accordance with the above principles, is deducted when determining the benefit. The provisions of point 1 above concerning the loss of sight or loss of hearing are reserved.
6. Psychological or nervous disorders only entitle the insured to benefits if he can show that they were caused by organic damage to the nervous system resulting from the accident.
7. If the accident has caused serious and permanent cosmetic damage which does not entitle the insured to a disability lump-sum benefit under letter (a) above, but nevertheless constitutes psychological damage likely to affect the insured person's economic future or social situation, the Insurer shall pay compensation equal to
 - 10% of the insured amount agreed in the policy if this mutilation affects the face;

- 5% of the insured amount agreed in the policy when the mutilation affects other parts of the body.

The compensation due for such damage is limited to CHF 20,000 per case.

8. The degree of disability is determined at the time when the insured person's condition is presumed to be definitive, but no later than five years after the accident

c. Progression

If the degree of disability does not exceed 25%, the insured sum is paid in the percentage corresponding to the degree of disability.

If the degree of disability is higher than 25%, benefits are increased in accordance with the scale in Annex A.

Art. 7 Death benefits (category D)

1. If the accident causes the death of the insured, the agreed lump-sum death benefit is paid. The beneficiaries are:
 - a. the surviving spouse; if there is none;
 - b. the children, in equal shares, if there are none;
 - c. the beneficial heirs, excluding any public bodies.
2. By way of derogation to Article 7, paragraph 1, the policyholder can at all times designate or exclude beneficiaries by notifying the Insurer, according to Article 37 of the General Terms and Conditions of Insurance. If the specified beneficiary/ies have predeceased, the provisions in Article 7, para. 1, shall apply.
3. If the marriage or registered partnership was contracted after the accident, the entitlement to benefits is subject to the condition that the promise of marriage or of a registered partnership had been published before the accident or that the marriage or registered partnership had lasted at least two years before the death of the insured.
4. If there are no beneficiaries, the funeral costs will be paid up to 10% of the sum insured in case of death.
5. For children, the amount of the capital sum benefit is specified in the insurance policy, but maximum:
 - CHF 2,500 before the age of two years and six months;
 - CHF 20,000 from the age of two years and six months up to age of 12 years.
6. A beneficiary who deliberately causes the insured's death forfeits his rights to any benefits.

Art. 8 Premium waivers in case of death or disability of the head of the family

1. For insured children, the Insurer covers the full payment of the periodical premiums up to the age of 15 if the head of the family has become disabled, with a degree of disability exceeding 50%, or is deceased.
2. The premium waiver starts on the day following the occurrence of the disability or death, and must be requested, accompanied by the relevant official documents (decision of the Federal Disability Office, death certificate and family record booklet).

Art. 9 Combined effect of causes unrelated to the accident

If the injuries are only partly due to an insured accident, benefits are set proportionately based on a medical report.

Art. 10 Personal liability

The Insurer waives the right to reduce benefits in case of accidents caused by reckless behaviour or gross negligence on the part of the insured.

Art. 11 Reduction of the sums insured

1. When the insured reaches the age of 70, the sums are limited as follows:
 - CHF 10,000 in case of death;
 - CHF 30,000 in case of disability.
2. The insured sums are automatically reduced on 1 January after the aforesaid age limits are reached.

Art. 12 Premium rates

1. Premiums are indicated in the insurance policy.
2. Premiums are graduated depending on the insured's gender, age group and the insured sum.

Annex A

Degree of disability	Benefit in%	Degree of disability	Benefit in%	Degree of disability	Benefit in%	Degree of disability	Benefit in%
26	28	45	85	64	170	83	265
27	31	46	88	65	175	84	270
28	34	47	91	66	180	85	275
29	37	48	94	67	185	86	280
30	40	49	97	68	190	87	285
31	43	50	100	69	195	88	290
32	46	51	105	70	200	89	295
33	49	52	110	71	205	90	300
34	52	53	115	72	210	91	305
35	55	54	120	73	215	92	310
36	58	55	125	74	220	93	315
37	61	56	130	75	225	94	320
38	64	57	135	76	230	95	325
39	67	58	140	77	235	96	330
40	70	59	145	78	240	97	335
41	73	60	150	79	245	98	340
42	76	61	155	80	250	99	345
43	79	62	160	81	255	100	350
44	82	63	165	82	260		

Special Terms and Conditions for KidsProtect Insurance

KPGA01-E4 – Edition: 01 Feb 2022

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

KidsProtect insurance provides for the payment of a monthly pension when an insured is diagnosed with cancer within the meaning of Article 2 of these Special Terms and Conditions.

Art. 2 Definitions

1. Cancer means an illness caused by the presence of one or more malignant tumours according to their histology and characterized by the uncontrolled growth and spread of malignant cells as well as the invasion of normal tissue. Leukaemia and lymphomas are included in this definition.
2. Cancers that begin with a benign tumour and for which surgery, radiotherapy or immunotherapy are eventually administered are also included in the definition contained in paragraph 1 above.
3. Diagnosis means the first observation of the cancer by a doctor authorised for this purpose and recognised within the meaning of the Swiss Federal Law on Health Insurance (LAMal/KVG).
4. Treatment means surgery as well as radiotherapy, chemotherapy or immunotherapy.
5. Subsequent tests designed to identify recurrence of the illness are not considered as treatment.

Art. 3 Eligibility

KidsProtect insurance is open to all persons domiciled in Switzerland who are not suffering from cancer, or who have not suffered from cancer in the past, and who are under the age of 17.

Art. 4 Covered risk

KidsProtect benefits are granted when an insured person is diagnosed with cancer under the conditions set out in these Special Terms and Conditions during the period of coverage.

Art. 5 Period of non-availability

1. Insurance coverage begins three months after the date of entry into force specified in the insurance policy. Therefore, cancers having occurred or that were medically diagnosed (including with a self-screening test) before the contract was concluded, and up to three months after the above-mentioned date of entry into force, are not covered by the insurance.
2. Cancer that occurred or was medically diagnosed before the contract was concluded, and up to the end of the period of non-availability, results in the contract being declared null and void. Any premiums paid will be returned to the policyholder.

Art. 6 Scope of benefits

1. The insured benefit corresponds to the payment of a provisional monthly pension.
2. Up to 15 monthly pensions are paid.
3. The amount of the guaranteed monthly pension is mentioned in the insurance policy.
4. Benefits are covered by fixed-sum insurance.

Art. 7 Entitlement to benefits

1. After the waiting period, the insured is entitled to a pension providing the insurance coverage is effective.
2. The pension is payable when cancer is diagnosed by an authorised doctor during the waiting period and as long as treatment, within the meaning of Art. 2.4 of these Special Terms and Conditions, is underway or that palliative treatment is required because of the severity of the illness as detected by the insurer's medical adviser.
3. Benefits are granted providing that a duly completed medical certificate is submitted every month to the insurer's medical adviser.
The insurer makes this form available to the policyholder so that it may be filled in by the authorised doctor.
4. If the beginning and/or the end of the entitlement to benefits occurs during the course of a month, the benefit is due for the entire month.

Art. 8 Recipient of benefits

The benefit is paid:

- a. in equal parts to the father and mother who exercise parental authority over the insured child, or;
- b. to the father or mother who exercises parental authority alone over the insured child, or;
- c. failing this, the benefit is paid to the policyholder.

Art. 9 Exclusions

In addition to the provisions of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), the following are not covered by the insurance:

- a. cancers that occurred or were medically diagnosed before the contract was concluded as well as during a period of three months following the entry into force of the insurance (waiting period);
- b. cancers for which treatment defined in Article 2.4 will not be foreseen to exceed three months according to the observations of the medical adviser or medical expert appointed by the insurer; cases of death of the insured during this three-month period remain reserved.
Subsequent tests designed to identify recurrence of the illness are not considered as treatment;
- c. cancers diagnosed for insureds who are HIV-positive;
- d. retinoblastomas; except for cases where the entitled person provides evidence of the absence of hereditary influence in this form of cancer;
- e. aggravation of the illness resulting directly or indirectly from the fact that the insured, or his legal representative, refused to follow or to have followed the prescribed medical treatment.

Art. 10 End of the insurance contract

In addition to the provisions of the General Terms and Conditions for Supplemental Health and Accident insurance (CGC), the insurance contract and entitlement to benefits are terminated:

- a. at the end of the calendar year in which the insured turns 17, subject to his right to any benefits for a current claim;
- b. 60 months after the date of diagnosis of the cancer or upon expiry of the entitlement to benefits. The first limit reached is decisive;
- c. upon request of the policyholder in the event the insured person is HIV-positive, and this from the time the notification was sent by the policyholder to the insurer;
- d. upon termination of the insurance contract. Entitlement to benefits for an ongoing claim remains unaffected.

Art. 11 Obligations in case of a loss

In addition to the provisions of the General Terms and Conditions for Supplemental Health and Accident Insurance (CGC), any diagnosis of cancer (including pre-malignant tumours or cancers in situ) shall be notified to the insurer within 30 days.

General Terms and Conditions of Insurance Groupe Mutuel Assistance

AG

AGGA02-E3 – Edition: 01 Nov 2014

Art. 1 General

Under the collective agreement between Groupe Mutuel and Groupe Mutuel Assurances GMA SA (hereafter GMA SA), an insured who is subject to the Federal Law on Accident Insurance or who has contracted a supplemental insurance explicitly comprising “Groupe Mutuel Assistance” coverage is insured for the benefits described below. “Groupe Mutuel Assistance” benefits are insured by GMA SA.

Art. 2 Purpose of the insurance

The purpose of this insurance is to provide insureds who are travelling or staying outside of Switzerland (see Article 5) with the medical, legal, financial and personal assistance defined in these general terms and conditions of insurance in the event of an incident or a medical emergency.

Art. 3 Definitions

- a. Insurer: the term “Insurer” within the meaning of these general terms and conditions refers to the insurer who provides the insured the “Groupe Mutuel Assistance” coverage.
- b. Emergency call centre: the emergency call centre made available to insureds by GMA SA, is opened 24 hours a day, 365 days a year.
- c. Illness: any sudden, unforeseen alteration in a person’s state of health as ascertained by a competent medical authority. Chronic illness: an illness which develops slowly and lasts for a long time. Serious illness: an illness with a negative vital prognosis.
- d. Accident: any event caused by an extraordinary, violent, sudden and unforeseen external cause. Food poisoning is treated as an accident.
- e. Emergency call centre doctors: the doctors who process the requests for assistance received by the emergency call centre and decide on the appropriate action and means in accordance with these general terms and conditions.
- f. Medical transport: transport requiring medical escort; it is arranged and decided by the emergency call centre doctors.

Art. 4 Validity

1. The validity of the insurance coverage is tied to the validity of the insurance policy contracted with the Insurer. Coverage terminates when the insured ceases to be insured or on the expiry date of the contract between Groupe Mutuel and GMA SA; the Insurer shall inform the insured in good time.
2. “Groupe Mutuel Assistance” coverage is only valid for trips outside of Switzerland of a duration not exceeding 60 consecutive days.

Art. 5 Territory

“Groupe Mutuel Assistance” coverage is valid worldwide, including in the insured’s country of domicile beyond a 20 km radius from the insured’s main residence.

Art. 6 Travel information desk

Before their departure, insureds may contact the emergency call centre for important medical or administrative inquiries concerning passports, visas, vaccinations, taxes, customs, foreign exchange and other services.

Art. 7 Doctor networks outside of Switzerland

Insureds may call the emergency call centre to obtain the particulars of a doctor in the region where he is travelling. Most doctors in our foreign network speak English and a second foreign language in addition to their own mother tongue.

Art. 8 Remote medical service

If, during his trip, an insured needs medical advice which he cannot obtain locally, he can call the emergency call centre; a doctor will then assist him or consult a colleague who can. Diagnoses cannot be made over the phone; the telephone calls should be merely regarded as advice.

Art. 9 Medical evacuation and/or repatriation

If the medical team provided by the emergency call centre decides that the insured’s state of health necessitates medical treatment or specific tests which cannot be carried out locally, the emergency call centre shall arrange for and cover:

- transport to a regional hospital facility or to a country where the insured can be treated until his condition allows him, if necessary, to be medically repatriated by the emergency call centre on a normal airline to a hospital near his home in Switzerland; or
- repatriation to Switzerland if there is no appropriate medical facility in the vicinity.

Medical repatriation and evacuation benefits are provided at no cost and are not limited in amount.

Art. 10 Sending in a specialist

In certain cases, if medical repatriation is impossible because of the insured’s condition, the emergency call centre may arrange for a specialist of its choice to be sent at its cost to assess the patient’s condition, cooperate with the attending physician and arrange for a possible medical repatriation.

Art. 11 Supervision of treatment

Should the emergency call centre doctors decide that the insured can be treated where he is, they will nevertheless remain at the attending doctor’s and the insured’s disposal if necessary. Non medical seated transport is not generally covered unless otherwise decided by the emergency call centre doctors. If, for personal reasons, an insured decides to undergo treatment in another country, the emergency call centre will provide the necessary information to help him consult a specialist. The

insured shall bear the full cost of treatment and transport.

Art. 12 Cash advances for admission to hospital and inpatient treatment

If an insured is hospitalised and does not have with him sufficient means of payment (cash, cheque or credit card) and his family, employer, insurer or any other guarantor cannot be immediately reached, the emergency call centre will guarantee or transfer up to CHF 5,000 to the hospital by way of deposit for his admission.

Art. 13 Sending drugs

In case of an emergency, the emergency call centre may send any essential drugs that are not available locally. The emergency call centre will cover the cost of carriage by regular airline or courier service; the insured remains liable for the cost of the drugs themselves.

Art. 14 Third-party transport costs

If an insured travelling outside of Switzerland alone is hospitalised for more than 7 days, the emergency call centre will issue to the person of his choice, who must be domiciled in the same country of residence as the insured, a transport voucher for a return airplane ticket in economy class to visit him. The visitor remains liable for his own accommodation costs.

Art. 15 Child repatriation

If, following an insured event, no one can look after the insured's underage children abroad, the emergency call centre can arrange and pay for their return, with an escort if necessary, to the insured's home or to the home of a relative.

Art. 16 Repatriation of the body

If the insured dies outside of Switzerland, the emergency call centre will bear the cost of transporting the body, by regular airline or by a special vehicle, up to CHF 10,000.

The emergency call centre will ensure that the consulate and the undertakers complete the necessary formalities; the cost of such formalities and any other expenses (including the purchase of a coffin) shall be for the family or the employer's account.

Art. 17 Search and rescue costs

Search and rescue costs will be reimbursed up to CHF 10,000 if the insured was in a situation of provable distress justifying the cost.

Art. 18 Legal, technical and personal assistance

If, during a trip outside of Switzerland, an insured imperatively requires the services of a lawyer, interpreter, technician or other, he can contact one of the emergency call centre's non medical professionals in the region where he is travelling, and this worldwide. He need only apply to the emergency call centre by phone or fax, specifying the type of assistance required. The insured is liable for the full cost of any services provided by the emergency call centre's network.

The emergency call centre may also assist insureds with a number of other services such as: finding a motor vehicle repatriation service, informing the competent services in case of stolen or lost luggage or credit cards, locating spare parts or other items, etc. In all such cases, the insured shall bear the full cost of the services concerned on a case by case basis.

Art. 19 Urgent messages

The emergency call centre shall inform the insured's family and employer about his request for assistance, keeping them abreast of the rescue operations (at no additional charge). Non urgent messages for the insured or his correspondent may be kept by the emergency call centre for 10 days.

Art. 20 Decisions, means and payment

In case of a medical emergency, the emergency call centre doctors will, once alerted, contact the insured's attending physician to establish the seriousness and urgency of the case.

The decision concerning the means to be employed will take into consideration the options for treating the patient where he is, the distances to be travelled and the time frame; the insured's family doctor or the employer's medical advisors will be consulted wherever possible.

The emergency call centre doctors alone shall decide which services are necessary, who shall bear the cost and, in particular, what means of transport are to be employed, with or without medical or paramedical escort.

In any event, the insured will not be subsequently entitled to claim reimbursement or indemnification for insured benefits which he did not apply for during the trip or which were not arranged by or in agreement with the emergency call centre.

Art. 21 Exclusions

In the following cases, the benefits contemplated under these general terms and conditions of insurance are not due:

- a. Benign conditions or lesions which can be treated abroad and which do not prevent the insured from pursuing his trip.
- b. If the insured's condition allows him to travel normally, in a passenger seat and without medical escort, unless the doctors of the emergency call centre accept to cover the cost.
- c. Convalescence and conditions which are in course of treatment and not yet overcome, relapses from prior illnesses with a risk of sudden aggravation, and trips made for the purpose of obtaining medical treatment.
- d. Pregnancy, except in the event of clear and unforeseen complications. Unborn children are covered; they must be declared within 10 days of birth at the latest.
- e. The consequences of suicide or attempted suicide.
- f. Mental illnesses which have already been treated.
- g. If the insured participates in or voluntarily exposes himself to foreign war activities, civil unrest, riots, insurrections and reprisals.
- h. Use of drugs other than those prescribed by a doctor, including all alcohol-related pathologies.
- i. The direct or indirect consequences of atomic reactions.
- j. If the insured participates in sports competitions or exercises a reputedly dangerous professional activity.

Art. 22 Obligations of the insured in case of a claim

1. The insured shall immediately notify the emergency call centre of any event or condition affecting him, dialling 0848 808 111 (from abroad: +41 848 808 111); the number is on his insurance card.
If he does not comply with this rule, the insured forfeits his entitlement to benefits. The insured is liable for any additional expenses which the emergency call centre would not have incurred if the insured had declared the case immediately.
2. The insured undertakes to use his best efforts to limit losses and to clarify the relevant circumstances.
3. The insured must fully comply with his legal and contractual obligations to notify and inform, and duly observe the rules of good conduct (including, inter alia, prompt notification of the insured event to the specified contact address).
4. In the event of an illness or an accident, the insured shall release his attending physicians from their professional secrecy vis à vis the emergency call centre and GMA SA, and shall remain at the disposal of any doctors and representatives delegated by the emergency call centre for the purpose of establishing his state of health.
5. The insured shall safeguard any benefits he may be entitled to claim from the emergency call centre or GMA SA in respect of third parties, and assign them to GMA SA.
6. In any event, the decision whether or not to transport the insured, as well as the choice of date, means of transport and admission arrangements will be taken and made by the emergency call centre's medical team.
7. If the emergency centre decides to take over transport in accordance with Article 9 of these general terms and conditions of insurance, the insured shall remit to GMA SA his unutilised original return ticket or the corresponding refund.

Art. 23 Restrictions

No requests presented by a contracting party under these general terms and conditions will be deemed valid unless GMA SA is notified of the clause on which the request is based within 30 days of the occurrence of the insured event.

Art. 24 Subrogation

GMA SA is subrogated, up to the amount of the benefits provided, to the insured's rights and claims against any third parties liable for the insured event occasioning GMA SA's intervention. If the benefits provided under these general terms and conditions are fully or partially covered by compulsory or private insurance, GMA SA shall be subrogated to the rights and claims of the insured against such insurance.

Art. 25 Disclaimer

GMA SA declines all liability if, following a strike or for other reasons beyond its control, including cases of force majeure (war, invasions, enemy attack, declared or undeclared hostilities, civil war, rebellion, revolution, insurrection, riots or civil unrest, closed airports, or prohibitions under local law), it is unable to provide services at all, or cannot provide them in good time.

Art. 26 Notices

Notices by GMA SA to the insured shall be sent in writing to the insured's last known address. The same applies for notices by the insured which shall be sent to:
Groupe Mutuel Assurances GMA SA
Rue des Cèdres 5
P.O. Box - CH-1919 Martigny

Art. 27 Statute of limitations

Claims based on "Groupe Mutuel Assistance" coverage become statute-barred two years after the event giving rise to the claim.

Art. 28 Jurisdiction

In case of differences and disputes arising in connection with these general terms and conditions of insurance, the insured may choose the jurisdiction of the courts of his place of residence in Switzerland, or of the registered office of the Insurer. If the insured is domiciled outside of Switzerland, the courts of the canton of Valais shall have exclusive jurisdiction.

Art. 29 Governing law

The Federal Law of 2 April 1908 on Insurance Contracts is applicable.



**For non binding
personal advice**

0848 803 111
groupemutuel.ch

groupe**mutuel**

Groupe Mutuel Holding SA Rue des Cèdres 5 CH-1919 Martigny **0848 803 111 / groupemutuel.ch**

Insurance companies of Groupe Mutuel Holding SA: Avenir Assurance Maladie SA / Easy Sana Assurance Maladie SA / Mutuel Assurance Maladie SA
Philos Assurance Maladie SA / SUPRA-1846 SA / AMB Assurances SA / Groupe Mutuel Assurances GMA SA / Groupe Mutuel Vie GMV SA
Foundations administered by Groupe Mutuel Services SA: Groupe Mutuel Prévoyance-GMP / Mutuelle Neuchâteloise Assurance Maladie
Opsion Vested Benefits Foundation / Fondation Collective Opsion

