Special Terms and Conditions for Global Business supplemental insurance

GK

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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, providing these special terms and conditions do not derogate from them.

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 compulsory health insurance (AOS/OKP) and who chose to retain their insurance coverage in accordance with Art. 7(a) of the Ordinance on Health Insurance (OAMal/KVV) by signing up to optional healthcare insurance in accordance with the Federal Law on Insurance Contracts (LCA/VVG), benefits under Global Business insurance will be paid out in addition to the said insurance.
3. Global Business insurance offers three levels of coverage (basic module):
   – Level 1
   – Level 2
   – Level 3
4. This basic module can be supplemented by the option “Dentaire plus”.

Art. 2 Risks covered

Global Business benefits provide illness, accident and maternity coverage.

Art. 3 Acceptance conditions

1. Admission to Global Business insurance is limited to the group of persons entitled to insurance such as defined in the framework agreement signed between a company and the Insurer. The framework agreement also defines the acceptance conditions that apply to different categories of applicants. Upon admission, applicants must be Swiss residents.
2. Global Business coverage Level 1 is open to persons of all ages. For Level 2 and Level 3, coverage is restricted to persons below age 65. The acceptance conditions for the option “Dentaire Plus”, specified in Art. 6, para. 5 of these terms and conditions, remain reserved.

Art. 4 Special provisions

1. Derogating from Art. 14(d) CGC, the insurance contract will be maintained in case of a transfer of the place of residence abroad, without an agreement being required.
2. Derogating from Art. 6, para.5, and Art. 7, para. 7 of these terms and conditions, no period of non-availability will be applied to dental care and maternity benefits for foreign or Swiss employees who are transferred or hired by their employer to come to Switzerland (“impatriates”), or for foreign or Swiss employees and their family members who are sent abroad by their employer (“expatriates”).
3. If the place of residence is transferred abroad during the contract, Global Business can be maintained without an increase in insurance coverage, 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 insured pursuant to Art. 1, para. 2 of these special terms and conditions of insurance.
4. 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. 3 of these terms and conditions. In the event of a breach of the obligation to notify, the insured person shall reimburse to the Insurer any premiums paid from the date on which the above criteria were no longer fulfilled.

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Art. 5 Termination of the insurance contract

1. Derogating from Art. 13, para. 2 CGC, the insurance contract may be terminated by the insured person after three years of coverage and then on an annual basis, for the end of a calendar year with three months' advance notice, subject to the provisions set out in Art. 9 of these special terms and conditions.
2. If the criteria set out in Art. 4, para. 3 of these terms and conditions are no longer fulfilled, the Insurer will terminate Global Business insurance with retroactive effect to the date on which the insured person domiciled abroad no longer fulfilled the relevant criteria.

Art. 6 Insured benefits

1. In Switzerland

	Level 1	Level 2	Level 3	Details
Hospitalisation	General ward	Free choice of hospital ward with the following co-insurance amounts payable by the insured person: – general ward CHF 0 – semi-private ward CHF 100/day, max. 30 days/ calendar year – private ward CHF 200/day, max. 20 days/ calendar year	Private ward	**Description** – In Switzerland, free choice of hospital facility depending on the applicable coverage level, in general or psychiatric wards, for the treatment of acute conditions, accidents and maternity. – Costs of treatments recognised under LAMal/KVG, of hospital boarding costs and physician's fees in accordance with tariff agreements with the Insurer or cantonal regulations. **Comments** – Hospitals must be recognised facilities within the meaning of LAMal/KVG (listed hospitals), or they must have concluded a tariff agreement with Mutuel Assurances SA for the corresponding wards. – Coverage for hospitalisation in psychiatric facilities is limited to 60 days per calendar year. – Coverage for hospitalisation benefits in a semi-private or private ward is limited to 180 days' hospitalisation in any given calendar year. – The duration of hospitalisation coverage in psychiatric facilities (60 days) is deducted from the hospitalisation benefits in a semi-private or private ward (180-day limitation mentioned above). **Obligation of the insured person** – The insured person shall check that the medical facility, hospital ward or clinic where he is to be treated is a facility recognised by the Insurer.
Outpatient surgery treatment	No benefits	Max. CHF 400/ calendar year	Max. CHF 600/ calendar year	– When the insured person undergoes outpatient surgery in an operating room, the costs of which are covered by the compulsory health insurance (AOS/OKP), with a healthcare provider recognised under LAMal/KVG, the Insurer will cover the following costs: • 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).
Non-reimbursable drugs	90%	90%	90%	**Description** – Medication not covered by the compulsory health insurance (AOS/OKP) and prescribed by a doctor or a healthcare provider recognised under LAMal/KVG. **Exclusion** – Medication included on the list of pharmaceutical products for special application (LPPA/LPPV).
Transport and search costs	90%	90%	90%	**Description** – Transport to the nearest hospital facility or physician provided such transport is medically necessary. **Comment** – 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 treatments	30%, max. CHF 2,000/ calendar year	60%, max. CHF 3,000/ calendar year	90%, max. CHF 4,000/ calendar year	**Description** – Treatments according to the following list (Art. 6, para. 3, list of treatments) carried out by a qualified physician or a natural treatment practitioner recognised by the Insurer. **Obligation of the insured person** – Before each treatment, the insured person shall check that the attending practitioner is recognised by the Insurer for the planned treatment.

	Level 1	Level 2	Level 3	Details
Medical glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	– Cost of frames, lenses or contact lenses.
Thermal cures	No benefits	50%, max. 30 days/ calendar year	90%, max. 30 days/ calendar year	**Description** – Treatment and board during thermal cures in marine cure facilities recognised under the Ordinance on Healthcare Insurance Benefits (OPAS/KLV), provided the benefits are prescribed by a recognised physician within the meaning of LAMal/KVG. **Obligation of the insured person** – 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	No benefits	50%, max. 30 days/ calendar year	90%, max. 30 days/ calendar year	**Description** – Treatment and board during convalescence cures in Switzerland in facilities recognised by the Insurer, provided the convalescence follows hospitalisation. **Obligation of the insured person** – 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.
Home help	50%, max. CHF 1,500/ calendar year	50%, max. CHF 1,500/ calendar year	90%, max. CHF 2,500/ calendar year	**Description** – The cost of home help hired from an official service to attend to the insured person's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning, etc.). **Comment** – No benefits are payable if the insured person is declared disabled by the Federal Disability Insurance (AI/IV), receives a disability allowance or is staying in a hospital, at a cure or convalescence facility. **Obligation of the insured person** – The insured person must request the Insurer's prior consent.
Vaccinations	90%	90%	90%	– Medically prescribed vaccinations (not included in the Ordinance on Healthcare 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%, CHF 600 every three years	90%, CHF 800 every three years	90%, max. CHF 1,000 every three years	– Only check-ups carried out by recognised physicians within the meaning of LAMal/KVG will be reimbursed.
Second opinion	90%	90%	90%	– The cost of a second opinion before hospitalisation provided that the doctor's bill indicates "second opinion".
Preventive healthcare services	50%, max. CHF 200/ calendar year	50%, max. CHF 200/ calendar year	50%, max. CHF 200/ calendar year	**Description** – The cost of preventive healthcare measures in the following areas: • gym; • back exercise school; • tobacco or alcohol detoxification treatments. **Comment** – If several preventive healthcare measures are followed in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 200.
Ultrasound scans in case of pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy	– Ultrasound scans which are not covered by compulsory health insurance.
Childbirth preparation classes	CHF 150 per pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy	– Painless childbirth preparation classes or childbirth preparation classes which are not covered by compulsory health insurance.
One-time breastfeeding allowance	CHF 100 per child	CHF 100 per child	CHF 100 per child	– The mother is entitled to an allowance provided she breastfeeds her baby for at least 30 days and that this period is certified by the doctor or midwife. In case of multiple births, an allowance is paid for each child.

2. **Abroad**
   a. The benefits listed below are valid worldwide, Switzerland excluded, supplementally or in addition to Swiss social insurance, or supplementally or in addition to the catalogue of benefits to which the insured person is entitled pursuant to an international social security agreement with Switzerland.
   b. Subject to cases falling under the mutual benefits' assistance applicable in UE and EFTA member states, insured benefits are equivalent to the benefits covered in Switzerland for similar health problems.
   c. Except for "Medical glasses and contact lenses" and the option "Dentaire plus", voluntary treatments abroad are reimbursed only upon written request of the insured person, subject to the Insurer's prior consent.
   d. The benefits listed below are reimbursed when administered by persons or institutions having received the necessary training, recognition and authorisation of foreign social bodies.
   e. Subject to revocation of the entitlement to benefits, hospitalisation cases and other expensive treatments, which are subject to a financial guarantee request from the healthcare provider, shall be notified to Groupe Mutuel Assistance beforehand using the form "Notification of a financial guarantee request".
      Emergency cases shall be notified to Groupe Mutuel Assistance immediately.
   f. Payment of benefits
      - If several family members are ill or accidentally injured simultaneously, a separate invoice must be requested for each insured person: from the physician, hospital, pharmacist, etc.
      - To obtain reimbursement, the insured person shall provide the original or scanned requisite documents (detailed invoices, medical certificates, prescriptions, etc.). The Insurer reserves the right to request original documents and payment confirmations.
      - 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.
   g. Derogating from Art. 5 para. 2(c) of these terms and conditions, persons residing abroad and who remain subject to compulsory health insurance (LAMal/KVG) or persons who have chosen to retain insurance coverage in accordance with Art. 7(a) OAMal/KVV by signing up to optional healthcare insurance in accordance with the Federal Law on Insurance Contracts (LCA/VVG), do not need the Insurer's prior consent for voluntary treatments in their residence country.
      Letter (e) above remains reserved.

	Level 1	Level 2	Level 3	Details
Hospitalisation	Room with more than two beds	Free choice of hospital ward with the following co-insurance amounts payable by the insured person: – room with more than two beds CHF 0 – room with two beds CHF 100/ day, max. 30 days/calendar year – room with one bed CHF 200/ day, max. 20 days/calendar year	Room with one bed	**Description** – Free choice of hospital facility depending on the applicable coverage level, in general or psychiatric wards, for the treatment of acute conditions, accidents and maternity. – Costs of treatments recognised under LAMal/KVG, hospital boarding costs and physician's fees. **Comments** – Hospitals must be facilities recognised by the competent public health authorities of the country in which the treatment takes place. – Coverage for hospitalisation in psychiatric facilities is limited to 60 days per calendar year. – Coverage for hospitalisation benefits in a semi-private or private ward is limited to 180 days' hospitalisation in any given calendar year. – The duration of hospitalisation coverage in psychiatric facilities (60 days) is deducted from the hospitalisation benefits in a room with two beds or one bed (180-day limitation mentioned above). – Hospitalisation benefits abroad are limited to no more than CHF 3,000 per day. **Obligation of the insured person** – The insured person shall check with the Insurer that the medical facility, hospital ward or clinic where he is to be treated is a facility recognised by the relevant health authorities of the country in which the treatment takes place.
Outpatient surgery treatment	No benefits	Max. CHF 400/ calendar year	Max. CHF 600/ calendar year	– When the insured person undergoes outpatient surgery in an operating room, the costs of which are covered by the compulsory health insurance (AOS/OKP), with a healthcare provider recognised by the competent public health authorities of the country in which the treatment takes place, the Insurer will cover the following costs: • 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).

	Level 1	Level 2	Level 3	Details
Outpatient treatments	90%	90%	90%	– Consultations, tests, X-rays and recognised drugs. – Foreign legal co-insurance amounts according to Art. 7, para. 5 of these terms and conditions.
Transport and search costs	90%	90%	90%	**Description** – Transport to the nearest hospital facility or physician provided such transport is medically necessary. **Comment** – This contribution is granted only 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 treatments	30%, max. CHF 2,000/ calendar year	60%, max. CHF 3,000/ calendar year	90%, max. CHF 4,000/ calendar year	**Description** – Treatments according to the following list (Art. 6, para. 3, list of treatments) carried out by a qualified physician or a natural treatment practitioner recognised by the Insurer. **Obligation of the insured person** – Before each treatment, the insured person must request the Insurer's prior consent. The Insurer will base its decision on the criteria applicable by analogy in Switzerland.
Medical glasses and contact lenses	CHF 150 every three years	CHF 200 every three years	CHF 200 every three years	– Cost of frames, lenses or contact lenses.
Thermal cures	No benefits	50%, max. 30 days/ calendar year	90%, max. 30 days/ calendar year	**Description** – Treatment and board during thermal cures in marine cure facilities recognised by the Insurer according to the criteria applicable by analogy in Switzerland, provided the benefits are prescribed by a recognised physician within the meaning of LAMal/KVG. **Obligation of the insured person** – 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	No benefits	50%, max. 30 days/ calendar year	90%, max. 30 days/ calendar year	**Description** – Treatment and board during convalescence cures in facilities recognised by the Insurer according to the criteria applicable by analogy in Switzerland, provided the convalescence follows hospitalisation. **Obligation of the insured person** – 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.
Home help	50%, max. CHF 1,500/ calendar year	50%, max. CHF 1,500/ calendar year	90%, max. CHF 2,500/ calendar year	**Description** – The cost of home help hired from an official service to attend to the insured person's daily household and housekeeping tasks, provided such home help is medically necessary. All other costs are excluded (general cleaning, etc.). **Comment** – No benefits are payable if the insured person is declared disabled by the Federal Disability Insurance (AI/IV), receives a disability allowance or is staying in a hospital, at a cure or convalescence facility. **Obligation of the insured person** – The insured person must request the Insurer's prior consent.
Vaccinations	90%	90%	90%	– Medically prescribed vaccinations (not included in the Ordinance on Healthcare Insurance Benefits – OPAS/KLV) in Switzerland, and of any vaccinations recommended by the relevant health authorities.
Check-ups	90%, CHF 600 every three years	90%, CHF 800 every three years	90%, max. CHF 1,000 every three years	– Only check-ups carried out by physicians recognised by the relevant health authorities will be reimbursed.
Second opinion	90%	90%	90%	– The cost of a second opinion before hospitalisation provided that the doctor's bill indicates "second opinion".
Preventive healthcare services	50%, max. CHF 200/ calendar year	50%, max. CHF 200/ calendar year	50%, max. CHF 200/ calendar year	**Description** – The cost of preventive healthcare measures in the following areas: • gym; • back exercise school; • tobacco or alcohol detoxification treatments. **Comment** – If several preventive healthcare measures are followed in the course of a single calendar year, the maximum ceiling for reimbursement is CHF 200.

	Level 1	Level 2	Level 3	Details
Ultrasound scans in case of pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy	– Ultrasound scans which are not covered by compulsory health insurance.
Childbirth preparation classes	CHF 150 per pregnancy	CHF 150 per pregnancy	CHF 150 per pregnancy	– Painless childbirth preparation classes or childbirth preparation classes which are not covered by compulsory health insurance.
One-time breastfeeding allowance	CHF 100 per child	CHF 100 per child	CHF 100 per child	– The mother is entitled to an allowance provided she breastfeeds her baby for at least 30 days and that that duration is certified by the doctor or midwife. In case of multiple births, an allowance is paid for each child.

3. List of “alternative medicine” treatments

Naturopathy	Manipulation techniques	Other
Acupuncture	Acupressure	Bio-energetics
Aromatherapy	Anthroposophic medicine	Eurythmy
Auriculotherapy	Autogenic training	Rebirthing
Bioresonance	Energy balancing	Sophrology
Biotherapy	Etiopathy	Tomatis Method
Chromotherapy	Kinesiology	
Colon hydrotherapy	Lymphasizing	
Cupping	Massage therapies	
Electroacupuncture	Mesotherapy	
Geobiology	Metamorphosis	
Herbal medicine	Myofascial release therapy	
Homeopathy	Orthobionomy	
Iridology	Osteopathy	
Laser therapy	Polarity	
Magnetic field therapy	Postural integration	
Magnetotherapy	Reflexology	
Moratherapy	Reiki	
Naturopathy	Rolfing	
Nutritional counseling	Shiatsu	
Oxygenotherapy	Trager	
Phytotherapy		
Sympathicotherapy		

4. Groupe Mutuel Assistance

a. 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 person’s domicile, in Switzerland or abroad).

b. Derogating from Art. 4, para. 2 of the general terms and conditions of Groupe Mutuel Assistance insurance, the coverage of insured persons living abroad according to Art. 4, para. 1 of these terms and conditions is not limited to 60 consecutive days in their residence country.

5. Option “Dentaire plus”

a. For an additional premium, insurance coverage may be extended to include the dental treatments listed below. With this option, the percentage and restrictions to the coverage of dental expenses are the following:
– class 1: 75%, max. CHF 3,000/calendar year
– class 2: 75%, max. CHF 15,000/calendar year.
The insured option and insurance class are specified in the insurance policy.

b. The option “Dentaire Plus” is open to persons up to age 60.

c. Acceptance will be based on a form issued by the Insurer, signed by the Applicant or his/her legal representative, and accompanied by a certificate issued by a dentist trained in Switzerland, or with an equivalent qualification recognised in Switzerland.

d. The Insurer will cover up to CHF 75 the expenses of the dentist who issued the certificate.

e. The option “Dentaire plus” covers the following expenses only:
1. dental treatment by a qualified dentist;
2. yearly prophylactic dental check-up;
3. dento-facial orthopaedic treatment;
4. laboratory tests.

f. Insured persons are immediately entitled to benefits for dental treatment following accidents, which occur after the insurance comes into effect.

g. 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.

h. For all other dental treatments, insurance benefits are granted following a non-availability period of three months.
i. The basis for the calculation of reimbursable benefits is the official LAA/UVG tariff (nomenclature and point value); surcharges may not exceed 50%.
j. Treatments abroad are covered, provided the foreign medical staff is trained to the equivalent of the Swiss training and that costs do not exceed those that would have been charged in Switzerland.

Art. 7 Entitlement to benefits

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. It is not possible to accrue benefits insured in Switzerland and abroad.
3. Derogating from Art. 17, para. 4 CGC, insured persons who wish to provide the Insurer with a payment address abroad may exceptionally do so.
4. If a medical treatment or alternative medicine treatment is no longer medically justified and brings no therapeutic improvement, the Insurer will inform the insured person of the reduction or the end of the payment of benefits.
5. As provided for 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 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.
6. Scope and duration of hospitalisation benefits
   a. Hospitalisation benefits are limited to the acute phase of the treatment. Once the patient's condition is no longer considered acute, including for the treatment of stabilised or chronic conditions, or where hospitalisation does not serve to improve the insured person's health, the entitlement to benefits will cease.
   b. A person insured under Global Business Level 2 is free to choose the preferred hospital ward, along with the daily co-insurance amounts and annual limitations specified in Art. 6 of these terms and conditions.
      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 facilities.
      If, during a calendar year, the insured chooses to be hospitalised in a semi-private or private ward, the maximum annual limit for the private ward is taken into account (CHF 4,000).
   c. If, at the Insurer's proposal or by his own decision, a person insured under Global Business Level 3 waives his entitlement to hospitalisation in a semi-private or private ward and opts instead for a general ward, the Insurer may grant an allowance up to 50% of the savings estimated by the Insurer and up to maximum CHF 5,000 per hospital stay. This benefit is not granted in case of outpatient childbirth or home birth.
7. Maternity coverage
   a. Benefits for inpatient treatment during pregnancy and childbirth are first payable after a twelve-month insurance period.
   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 non-availability period specified in paragraph (a) above.
   c. In case of outpatient childbirth or home birth, persons insured under Level 1 will receive an allowance of CHF 800, persons insured under Level 2 will receive an allowance of CHF 1,000 and persons insured under Level 3 will receive an allowance of CHF 1,200, subject to the non-availability period mentioned under letter (a) above.
   d. If an insured person is hospitalised in a ward corresponding to her coverage level, the Insurer will also cover the newborn's hospital costs during the mother's stay in hospital provided that, within 30 days of the child's birth, insurance for the child is contracted with the Insurer. Personal expenses are not covered. The non-availability period mentioned in letter (a) above remains reserved.
8. Organ transplants
   Organ transplants are not covered under this insurance.
9. Option "Dentaire plus"
   The benefits set out in Art. 6, para. 5 of these terms and conditions are covered only if such coverage is expressly specified in the insurance policy.

Art. 8 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. Except for the option "Dentaire plus", the applicable age groups are:
   - 0 to 18;
   - 19 to 25;
   - from age 26, age groups are graduated in five-year brackets.
2. For the option "Dentaire plus", age groups are graduated in five-year brackets (from 0 to 5, from 6 to 10, etc.). Premiums are graduated in accordance with the foregoing age groups.

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

1. When an insured person leaves the circle of insured persons under a group insurance plan, he will be automatically transferred to the following similar insurance coverage plans of Mutuel Assurances SA:
   - Supplemental hospitalisation insurance, class 1 - general ward (HC category) and supplemental health insurance, class 1 (SC category) and Mundo insurance (MU category), for persons insured previously under Global Business insurance, Level 1;
   - H-Bonus supplemental hospitalisation insurance (HB category) and supplemental health insurance, class 3 (SC category) and Mundo insurance (MU category), for persons insured previously under Global Business insurance, Level 2;
   - Supplemental hospitalisation insurance, class 4 - private ward without deductible (HC category) and supplemental health insurance, class 4 (SC category) and Mundo insurance (MU category), for persons insured previously under Global Business insurance, Level 3;
   - Dental care insurance (Dentaire plus) class 3, including supplemental class 5 (DP category), for persons insured previously with "Dentaire plus", class 1 of Global Business insurance;
   - Dental care insurance (Dentaire plus) class 4, including supplemental class 5 (DP category), for persons insured previously with "Dentaire plus", class 2 of Global Business insurance.

   The rates of the above coverage plans will then be applied to the relevant insured persons.
2. The same rule applies to the family members of a deceased employee insured within the group insurance plan.
3. Any existing medical exclusions will be maintained.
4. The entry into force of the contract concluded before the departure from the circle of insured persons qualifying for insurance under a group insurance plan is taken into account for calculating the periods of non-availability.
5. Any benefits received before an insured person leaves the circle of insureds under the group insurance plan 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 shall notify the Insurer within 30 days and in writing of his departure from the circle of insured persons under the group insurance plan.
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 insured person, who will be the debtor of their payment.
9. The insured person can terminate the contract or other insurance plans, or choose a lower class for one of these coverage plans without undergoing a medical examination, within 30 days after receiving his new policy.
10. If Global Business expires according to Art. 5, para. 2 of these terms and conditions, the insurance coverage will cease without the insured person being transferred automatically to similar coverage plans according to Art. 9, paras. 1 to 6.