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ESSENTIAL & ECONOMIC
SWISS STUDIES

GENERAL CONDITIONS and SPECIAL INSURANCE CONDITIONS

CONTENTS

0 GENERAL INFORMATION

THE INSURER

The health and accident insurer is the Mutuelle Générale de l'Education Nationale (hereinafter MGEN) which has its headquarters based in 3 Square Max Hymans, 75015 Paris, France (N° Siren 775 685 399), authorised by l'Autorité de Contrôle Prudentiel et de Résolution (ACPR) [Prudential and Supervisory Authority] to operate in the areas of illness and accident insurance and insure all risks described in the CGPA (hereinafter insurer), with the exception of insurance risks.

Within the current contract, the insurer will be represented by SOS Evasan SA for the reporting and management of claims. As a result, EVASAN is authorised to receive calls and manage claims on the insurer's behalf.

CLAIMS HANDLING AND ALARM CENTRE

The claims handler is SOS Evasan SA (hereinafter EVASAN), Route de L' Etraz 12c CP 5, CH-1267 Vich - Suisse.

INSURANCE CONTRACT ADMINISTRATION

The administrator of the insurance contract is EVASAN who will manage the duration of the contract, send contractual documents together with any contract modifications, renewals of the insurance contract as well as being the receiver of the insurance premiums payment.

EVASAN can be contacted by the insured party for any administrative questions by

Tel.: + 41 (0)22 929 52 51 from 8:30AM to 12:30PM and from 1:30PM to 5:00PM (Monday to Friday) or by Email: *info@healthmobility.eu*

1 DEFINITIONS

1.1 PERSONS

1.1.1 WHO IS THE INSURER?

1. MGEN, insures all of the risks described in the General Conditions and Special Insurance Conditions (GCPA).

1.1.2 WHO IS THE (INSURANCE) POLICYHOLDER?

1. The physical or moral person who takes out the insurance contract for his own use or on behalf of someone else, who as a result, is held accountable to pay the insurance premium.
2. In the event of taking out an insurance contract on behalf of someone else, only the insured party- with the exclusion of the policyholder- is a beneficiary and can make a claim. The commitments that the policyholder has made in regards to the third party does not oblige the parties in the present contract, even if they had influenced the agreement of the contract. We reserve the right to impose possible express exemptions in the contract.

1.1.3 WHO IS THE INSURED PARTY?

1. The person who can benefit from the compensation from the insurer. Only people or groups of people who are designated beneficiaries on the insurance contract or the named list included are insured.
2. Foreign nationals or foreign groups, who are up to and including 36 years old, who wish to stay on the contractual territory for training or further training, such as students, schoolchildren and interns, or those who are participating in a non-lucrative activity for which the law provides the possibility of being exempt from having to insure themselves for basic mandatory health insurance.
3. In exceptional cases, provided that it is mentioned in the contract and a supplementary fee is paid, the insurer can insure people who are aged between 37 to (up to and including) 65 years old, under the condition that they are authorised to stay in the contractual territory for a year, and are there looking

for work, as part of their studies, internships, refresher training or for other reasons, with the possibility of being exempt from having to insure themselves for basic mandatory health insurance.

1.1.4 WHAT IS A NEXT OF KIN?

Any person who is in direct relation with the insured party, not necessarily a parent.

1.1.5 WHAT IS A THRID PARTY?

1. Any person who is not in an employment relationship with the insurer and who is not related to the insured party and is not his partner, spouse or next of kin.
2. Any other person that the student is assigned to, who also looks after or has temporary or definitive responsibility over the person, such as teachers, instructors, educators, nursery school assistants, nannies, trainers and monitors (non-exhaustive list).

1.1.6 WHAT IS A FINANCIAL GUARANTOR?

The financial guarantor is the person who will intervene on behalf of the policyholder or the insured party, so that he takes care of the financial obligations which come from the present insurance contract.

1.2 CONTRACT AND INSURANCE DOCUMENTS

1.2.1 WHAT IS AN INSURANCE APPLICATION?

1. The offer that the applicant submits to the insurer for the purpose of concluding an insurance contract. This offer is not worth as conclusion of the contract.
2. When the insurer makes the insurance application form available to the policyholder is a simple offer. The insurance application does not replace the insurance policy in any case.

1.2.2 WHAT IS AN INSURANCE CERTIFICATE?

1. The insurance certificate is a declarative document that the insurer gives to the policyholder upon request, to allow him to complete administrative procedures requested by third parties, such as, enrolling at a school and getting an authorisation to temporarily stay on the contractual territory.
2. By this document, which is issued after the insurance premium has been paid, the insurer confirms the acceptance to conclude with the policyholder under the condition that all the essential elements of the contract are subsequently upheld.
3. A certificate does not replace the insurance policy. In case of refund of the premium or invalidation of the contract, the insurer reserves the right to inform any authorities and any third parties concerned.

1.2.3 WHAT IS AN INSURANCE CONTRACT?

1. The reciprocal and concurring manifestation of the will of the policyholder and the insurer covering all the essential points of their relationship. All the declarations that the insurance policyholder, the insured party and their representatives document in the insurance application and in any other written document, as well as the medical reports provided by the insured party during the subscription, form the basis of the contract.
2. The essential elements of the contract, which are cumulative, are the following:
   a) Reading and understanding the General Conditions and Special Insurance Conditions (CGPA);
   b) Filling of the application form and any other related annexes;
   c) Collection of the insurance premium by the insurer;
   d) Acceptance from the insurer to conclude the contract with the policyholder;
   e) Understanding of the language of the contract by the insured party;

3. The insurer reserves the right to reject an insurance application and reject to conclude the contract on the basis of medical criteria. They are not obliged to give a justification.

1.2.4 WHAT IS AN INSURANCE POLICY?

1. The document that confirms the existence of an insurance contract and states the rights and obligations of the parties involved.
2. If the content of the policy or the relative endorsements do not agree with the approved agreement, the policyholder must express this in writing, within 14 days of receiving the insurance policy, failing this, it will be considered that the content has been accepted.

1.3 TERRITORY, COVERAGE AND CLAIM

1.3.1 WHAT IS THE COUNTRY OF ORIGIN, THE DESTINATION, THE COUNTRY OF STAY AND THE TERRITORY?

1. In the framework of the present insurance conditions, the country of **origin** includes the state or the states in which the insured party or beneficiary:
   a) has his legal home; and
   b) has been living permanently before travelling to his destination; and
   c) the state or states of his nationality.
2. The **destination** is the place where the insured party intends to go to during his travel.
3. **The country of stay** is the state in which the insured party is allowed to reside

   during a certain amount of time to carry out the following non-lucrative activities (studies, looking for a job, etc.) permitted in the sense of paragraph 2 or 3 of the article. 1.1.3.
4. The territory is the geographical or political area, as defined by the contract, on which the contractual effects are deployed, and within which both the destination and the country of residence are located. WHAT IS A GUARANTEE PERIOD?

1.3.2 WHAT IS A GUARANTEE PERIOD?

1. The effective duration of the insured party's stay. Any insurance period must start and finish within the duration of the present insurance contract and the start date must feature on the insurance policy.
2. It cannot not exceed 90 consecutive days in the case of assistance services during the trips.

1.3.3 WHAT IS A CLAIM?

The harmful, unintentional event that occurred in the period and under the conditions set in the contract and which fulfils, within the legal and contractual limits, the obligation for the insurer to provide its services to the insured.

1.3.4 WHEN WILL THE CLAIM BE AVAILABLE FOR CARE GIVING?

1. The claim will be given in cases of medical necessity, to administer medical treatment to the insured party, following a sudden illness or accident.
2. The realization of the risk begins with the treatment and ends as soon as it emerges from the objective and rational analysis of the results of the indispensable medical examinations that the need for a treatment no longer exists.
3. If the treatment extends to treat an illness or follow treatment after an accident, which does not have a direct link to the original claim, a new claim must be filed.
4. Exams and necessary medical treatments for a pregnancy, birth, as well as medical screening exams which are carried out by law (targeted screening) are also recognised as claims.

1.3.5 WHAT IS AN ACCIDENT?

Any harmful, sudden, unforeseen or involuntary injury caused to the human body by an external and violent source which affects the physical integrity of the insured party and which could be objectively witnessed.

1.3.6 WHAT IS A SUDDEN ILLNESS?

Any non-intentional deterioration in the health state which requires consultation, treatment or medication, which is not the result of an accident and is not the manifestation of a pre-existing health condition.

1.3.7 WHAT IS A PRE-EXISTING HEALTH CONDITION?

Any alteration, affection, illness or physical or psychological infirmity which has objectively existed before the subscription date of the insurance contract and of whom the manifestation, consequences or complications need a treatment, consultation, medical exams or intervention during the duration of the insurance coverage as described in the article. 4.

1.3.8 WHAT IS A WAITING PERIOD?

An initial waiting period time, starts at the same time as the effective coverage period, during which the insured party does not have right to certain insurance claims, outlined in his contract.

1.3.9 WHAT IS A DEDUCTIBLE, A FIXED PROPORTION?

1. **The Deductible:** is the amount determined by the contract which remains the responsibility for the insured party to pay in the event of a claim. This deductible can apply either per claim, per incident, per year (contractual year). See Table of Coverage.
2. **The Fixed Proportion:** only if it stipulates differently in the Table of Coverage, the insured party must cover the fixed proportion equal to 10% of the sum due to the insured party after deduction of the annual deductible. The fixed proportion will apply to each claim.

1.3.10 WHAT IS AN 'ALARM CENTRE'?

It is a telephone assistance and intervention service made of medical operators, technicians and insurance professionals that EVASAN supplies, (24h/24h, 365 days a year), for the insured party within the present contract. The insured party must formally contact the alarm centre in the event of an imminent or declared claim.

1.3.11 WHAT IS HOSPITALISATION?

1. When someone is admitted to a hospital establishment for a period of 24 hours or more and is receiving medical intervention.
2. By medical establishments, we mean hospital facilities (hospital or clinics) managed and directed by qualified professionals with the necessary recognised qualifications.
3. Health spas, nursing homes, medico-welfare establishments, and other institutions which are not for the treatment of people suffering from acute diseases, are not considered as hospitals.
4. By health spas, we mean thermal or spa treatment establishments which are officially recognised as well as convalescent homes managed or supervised by a doctor.

1.3.12 WHAT IS A PLACE OF STABILISATION?

The place where the insured person is transported to, following an incident, with a view of facilitating an evacuation or repatriation.

2 GENERAL ARRANGEMENTS

2.1 RELATIONSHIP BETWEEN ILLNESS INSURER AND EVASAN

2.1.1 WHAT IS THE COVERAGE AND WHAT ARE THE LEGAL BASES?

1. MGEN covers the illnesses and accidents as well as their direct economic consequences from a medical point of view. The coverage consists of compensation for the costs of curative treatment and other services as part of the basic mandatory insurance of treatment applicable on the territory covered, and in particular in the country of stay. The extent of the coverage is determined by the insurance policy, any possible future written contracts, the insurance conditions, as well as the legal arrangements in force.
2. The general arrangements apply as well as the arrangements specific to each coverage.

2.1.2 CONTACT WITH THE INSURER

1. On behalf of MGEN, EVASAN assists the MGEN insured parties under the present contract and provides the EVASAN alarm centre.
2. EVASAN is responsible for managing claim files, receiving claim declarations on behalf of both itself and MGEN. Decisions and responsibility in relation to MGEN insurance coverage are MGEN's responsibility and do not involve EVASAN.

2.2 BASIC RULES APPLICABLE TO COVERAGE

2.2.1 MODIFICATION OF THE CONTRACT BY THE INSURANCE POLICYHOLDER

For any amendment to the contract, a new proposal must be submitted to the insurer, who will conduce another risk assessment.

2.2.2 CHANGING THE NAME AND ADDRESS/CONTACT ADDRESS

Notification of a change in name or address must be carried out by the insured party in writing and addressed to EVASAN within 30 days.

In the meantime, the last known address of the insurer is considered valid.

2.2.3 MOVING FROM GROUP INSURANCE TO INDIVIDUAL INSURANCE

The insured party who leaves a group contract or who must leave an insurance contract because of a group cancellation, can move to an individual contract if he continues to stay in the contractual territory. The insured party must let EVASAN know within 30 days. See chapter '0' above in the Contract Administration section.

He will be insured for the similar conditions as that of the group contract. The conditions covered by the group insurance are credited to that of the individual insurance. A reserve which is being processed in the group insurance will be maintained.

2.2.4 INSURED TERRITORY

1. Insurance conditions **- illness**
   a) The coverage extends to treatment dispensed on the territory of the member countries of the European Union (EU) and the European Free Trade Association (EFTA).
   b) Insured parties who, during their stay in the insured territory, return to their country of origin for short-term holidays, are insured for emergency medical treatment and when a return to Switzerland is not appropriate. There is no emergency when an insured party travels abroad with the aim of following medical treatment. The illness insurance coverage in the present contract can only be

acquired in the measure where the insured party does not have any other form of insurance protection or social or associative protection in the country of origin (art 1.3.1).

2. With regard to health insurance coverage, entitlement to benefits expire as soon as the insured person enters the territory of a country excluded from the insurance coverage.

2.2.5 EFFECTIVE DATE OF COVERAGE

1. The coverage takes effect the next day at 12:00 AM of the date outlined in the insurance policy, but in no case, before the insurance contract has been agreed - nor before the expiry of the waiting period (art 1.3.8). No compensation will be awarded to claims made before the effective date. Claims that occur after the contract has been agreed can be excluded from the insurance coverage, if they pre-date (pre-existence 1.3.7) of the effective date of the coverage or occur during the waiting period.
2. Regarding new born children, the illness insurance coverage takes effect without a waiting time, immediately at birth, provided that one of the parents subscribed to the illness insurance from the insurer for at least three months and that the insurance declaration intervenes retroactively to the first of the month of the birth and two months at the latest after it. The insurance coverage must not be higher or more comprehensive than that available to an insured parent. The new born child can only be added within the applicable pricing conditions which apply for new contracts.
3. Adoption is subject to the same conditions as a birth of a child under the condition that the adopted child is still a minor on the date of adoption. The insurer can request an extra premium which could be equal to the sum of a simple premium.
4. In any case, when the coverage takes effect, it is assumed that the insurance premium has already been paid.

2.2.6 RELUCTANCE

1. If the applicant, when concluding the insurance contract, failed to declare or incorrectly declared an important fact that he knew or ought to know, the insurer is entitled to terminate the contract in writing within 4 weeks after it became aware of the reluctance.
2. In this case, the obligation for the insurer to offer assistance is removed also for claims which have already occurred when the fact, the object of the reluctance has influenced the occurrence or extent of the claim.

2.2.7 DOUBLE INSURANCE

1. When the same interest is insured against the same risk, and for the same period of time, by more than one insurer, when the insured sums added together are greater than the value of the insurance, the policyholder must inform the insurer of this immediately and in writing.
2. If the insurance policyholder has intentionally not provided this information, or if they have agreed to double insurance with the intention of obtaining illegal profit, the insurer is automatically freed from any contractual obligation in this regard.

2.2.8 MAJOR INCREASE OF RISK

1. A substantial increase in risk which hinges on an important fact for the risk assessment when the extent has been determined when the contract was agreed. Important are all facts likely to affect the determination of the insurer to conclude the contract or to conclude on the agreed terms (in particular: the state of health of the insured, the practice of risky activities, etc..).
2. If the insured party substantially increases the risk himself during the insurance period, the insurer will automatically stop being bound by the contract.
3. If the major increase of risk occurs independently from the insured party, the contract only automatically stops existing if the insured party does not declare the increase in risk. Such a declaration must be

carried out by the insured party in writing and addressed to the insurer. On reception of the written declaration from the insured party, the insurer reserves the right to terminate the contract in the 14 days following the reception of the declaration.

2.2.9 ECONOMIC ASPECTS OF THE COVERAGE

The benefits entered into the insurance conditions field must be effective, appropriate and economical. The effectiveness, adequate and economic nature of the action must be demonstrated through scientific methods.

The insurance provider must limit its assistance to the extent required by the interest of the insured party and the purpose of the treatment. Compensation for assistance which goes past this limit can be refused by the insurer.

Also, the insurer reserves the right to refuse any reiteration of diagnostic procedures that are not of any use, when an insured party consults multiple contractors.

The insurer reserves the right to refer to his medical consultant, an independent professional, to provide independent and objective advice on medical matters as well as on the medical invoices presented. Generally speaking, the service providers must provide the medical advisor with the information and information he needs to complete his task.

In the event that the medical consultant is not able to obtain the necessary information from the provider, the medical consultant can ask to personally examine the insured person.

The medical consultant only sends the insurer's medical team the information they need to decide whether to grant a benefit, to determine compensation or to justify a decision.

In doing so, they respect the personal rights of the insured parties.

2.2.10 PARTIAL PAYOUT

If the insured party does not use any or only part of the services offered by the insurer, the latter is not required to make a refund. If the fees encountered as a result of the incident are less than those cited on the policy, the insured party cannot assert a claim on the difference.

2.2.11 DATA ENTRY - REQUEST FOR INFORMATION

1. The insured party allows the insurer to enter all the data into the information system and to link all necessary information for the settlement of the entitlement to benefits.
2. The insured party benefits from Swiss security (in regards to EVASAN) and from the EU (in regards to the insurer) in the way their personal data is treated and protected.

2.2.12 PAYMENT OF THE INSURANCE CLAIM

1. The insurer only has to pay insurance claims if all the relative evidence has been provided to them in an exhaustive manner.
2. Evidence of expenses must be presented in their original copy. The insurer reserves the right to ask for proof that bills have been paid in advance by the insured party, which the insured party have requested to be refunded by the insurer. In a case where another insurer or institution charges a fee, creating a copy of the bills is sufficient, under the condition that a receipt is provided with the amount that was refunded by the other insurer or institution.
3. It is imperative that the bills must include: **the name and address of the doctor, the surname, name and address of the patient, the treatment period, the diverse forms of treatment and an explicit description of his illness.** Prescriptions should be addressed to the insurer, accompanied by fee statements from the doctor, medicine and equipment bills, as well as copies of medical prescriptions which should mention the illness.

4. A certificate from a medical establishment mentioning the start date and end of stationary treatment, as well as the designation of the illness is imperative. In the event of a doctor refusing to clearly name the illness, the insurer is free to reject any claims or request a complementary medical exam by a doctor of their choice and/or the insurer's medical advisor.
5. All bills must be addressed to EVASAN, once they have been received by the insured party.
6. Illness-related costs in foreign currencies will be converted to Euros or Swiss Francs on the day when the bills are received by the insurer (postmark or return receipt as certified by the electronic transfer).
7. Bank transfer charges in regards to the payment of compensation, as well as translation fees for documents used as evidence by the insured party, are the insured party's expense and will be deducted from the compensation payment.
8. As long as it is required from LAMal, the right to use the 'third party' payment system is reserved.

2.2.13 NON-TRANSFERABLE DEBT OBLIGATIONS

The insured party's debt obligation for the insurance contract is non-transferable and cannot be pledged. In particular, the insured party cannot transfer it to a third party for whatever reason (to a next of kin, debt-collection service, business, buyer, work colleague, authority, etc.)

2.2.14 SUBROGATION

1. The insurer is subrogated to the rights and debt obligations of the insured party or insurance policyholder.
2. This subrogation applies to any third party responsible for the event that triggered the insurer's benefits.
3. In the event of the insured party being entitled to monetary damages from a third party and independent contractual subrogation, this right must be transferred in writing to the insurer for the amount of compensation granted through the insurance contract. In this measure, this right is transferred to the insurer.

In the event where the insured party gives up their right to monetary damages, or the right to coverage of this claim, without agreement from the insurer, when the insurer's obligation to provide compensation for an indemnity which could be removed due to the expiry of the debt obligation or the right of the insured party or beneficiary.

2.2.15 TERMINATION OF THE INSURANCE COVERAGE

1. The guarantee terminates - also for claims already declared - on the date of expiry of the insurance contract (or the insurance policy of which the insured is the beneficiary).
2. If, for imperative medical reasons, the insured party can only leave his destination one month after the coverage has expired, on request in writing from the insured party and with notice from an independent doctor who was commissioned by the insurer, the coverage can be extended as long as the insurer decides apt and it will include the return journey without putting their life in danger. In any case, the coverage cannot be prolonged by more than two months and an additional premium will be requested from the insurer in this case.
3. The insurance coverage expires in the event of change to the personal situation (work etc..) of the insured party, and because of this, his registration to the basic LAMal scheme will become mandatory in Switzerland.

2.2.16 PRESCRIPTION

Any claim under the present contract will be prescribed

– Within 2 years from the date of the event which caused the insured part's claim under the Accident Illness coverage by the MGEN insurer. This is under the condition that the insured event occurred and had been declared before the annual expiry date in the insurance policy.

3 ILLNESS INSURANCE COVERAGE TERMS

3.1 GENERAL FRAMEWORK

3.1.1 SUBJECT TO THE PRESENT COVERAGE

1. Illness insurance offered by the insurer gives an equivalent protection to coverage as defined by the federal law and conforms with the article. 2 al.4 OAMal and article 3 al.2 OAMal on the contract territory. During his stay in Switzerland, the insured party will benefit from coverage in the event of illness or accidents (provided they are not being insured by another health accident insurer) and maternity. The purpose of coverage is defined by the federal law on health-insurance (LAMal) and by the relative jurisprudence.
2. Subsidiarity principle: illness coverage outlined in the current contract is intended to supplement all other insurance benefits available to the insured or the policyholder (Ex. Mandatory social insurance, accident-insurance, health insurance from the state of origin, benefits from a service contract, membership in an association to which the insured person contributed or adhered).
3. The claim benefits must be effective, appropriate and economical. In the event of ineffective, inappropriate or costly claims, the insurer reserves the right to objectively and technically reduce the compensation to be paid to the insured party to fairer proportions.

3.1.2 RECOGINISED HEALTH TREATMENT PROVIDERS

1. When treatment is given in Switzerland, only expenses from qualified, appropriate services who are authorised to practice (art. 35-40 LAMal) will be taken into consideration.
2. When treatment is delivered in another state within the contractual territory, only expenses from practitioners with a licence to practice according to the legal conditions which apply to their profession and the legal environment of the country where they carry out treatment, will be taken into consideration.

3.1.3 EXTENT OF THE INSURANCE CONDITIONS

1. The usual pricing conditions applied in the territory where the treatment takes place, will determine the amount of insurance compensation.

Prices for the services from service providers must be based on the following principles.

- Time spent on offering the service;
- The exact codification of the service;
- The amount which is usually charged for the service;
- As applicable, providing evidence of the reason why the service provider has not applied the usual price and has charged a higher price.

For insurance benefits acquired in Switzerland, LAMal insurance price references will provide a basis for calculating the amount of insurance benefits that the insured party will be entitled to.

2. Subject to the negotiation of specific conditions establishing a compulsory network of doctors, the insured party is free to consult the doctor or dentist of their choice. When a doctor is based in a different area than the insured person, the kilometric compensation or travel compensation can be reduced on a pro-rata basis according to the distance that the closest competent doctor would have had to travel to the insured party.

3.1.4 GENERAL EXCLUSIONS OF THE ILLNESS INSURANCE COVERAGE

The insurer will not be obliged to provide compensation in the following situations and their consequences:

1. If the insured party has been reckless or committed a crime or offence which resulted in a claim;
2. Use of drugs, medicine, alcohol and/or hallucinogenic or toxic substances by the insured party which led to or contributed to the claim, except when the basic compulsory health insurance (- LAMal for Switzerland -) specifies otherwise;
3. All damage and health effects which have been caused by the involuntary or voluntary production or use of chemical, biological, biochemical substances or electromagnetic waves for weapons (regardless of any competing causes), as well as damage and effects caused by ABC, nuclear energy or any other ionizing radiation;
4. The occurrence of a claim on a territory which is excluded from the contract or has occurred outside the effective coverage period.

3.2 HEALTH INSURANCE CONDITIONS CATALOGUE

3.2.1 HOSPITALISATION

1. The insurer will provide compensation for a hospital stay when receiving tests, the health state of the insured party or the medical treatment which needs medical treatment.
2. The insured party is free to choose from the list of hospitals from LAMal.
3. The following expenses are covered in the standard and private hospitals in Switzerland or those charged according to the basic tariff (for the other countries in the contractual territory):
   a) Medical hospitalisation in a public or private establishment;
   b) Hospitalisation and surgical operation;
   c) (para) medical fees linked to hospitalisation.
4. If the insured person is receiving treatment in the private division of a hospital, the insurer will allocate him the same amount of compensation as if he was being treated in a public part of the hospital.
5. In the event of the insured party having to stay in hospital, the insurer will provide coverage within the limitations of the compensation for as long as he is awaiting tests and admission circumstances in the hospital. This information must be provided by the practitioner /or doctor who is providing treatment and must obtain this for verification and approval purposes for the medical treatment data by a medical expert.
6. Subject to the negotiation of specific conditions establishing a compulsory network of doctors, the insured party freely choses between public and private hospitals in line with international standards. Such establishments having to be placed permanently under the direction of medical staff, have sufficient diagnostic and therapeutic means, use methods generally recognized by science.
7. The responsibility depends on the written agreement from EVASAN the insurer, when an insured party intends to submit himself to a curative stationary treatment in a medical establishment, which also offers cures or home care, which also satisfies the conditions that have been mentioned.
8. The insurer provides the compensation outlined in the contract for examination methods or treatment and medication generally recognised by the official medicine. In addition, under exceptional circumstances, compensation can be provided for treatment and medication which have been proven to be as effective in practice or which are given in the absence of treatment or medication from the official medicine. In this case however, the insurer reserves the right to reduce his compensation from the amount that he would have owed the insured party, if the insured party has used any other treatment or medicine from the official medicine.

3.2.2 SEMI-HOSPITAL TREATMENT

Arrangements for hospital treatment are applied similarly for treatment in a clinic providing semi-hospital treatment such as a day or night clinic or an institution that provides day operations.

3.2.3 OUTPATIENT TREATMENT

1. In the event of outpatient treatment, the compensation equivalent to LAMal will be paid out with no time limit.
2. The recognised suppliers for outpatient treatment are following persons and institutions:
3. Doctors,
4. Pharmacists,
5. Chiropractors,
6. Midwives,
7. Laboratories,
8. Centres for diagnostic and therapeutic services, on medical prescription,
9. Physiotherapists,
10. Nurses,
11. Speech therapists.
12. The insurer will cover the costs of outpatient treatment, in compliance with the valid prices in the place of residence or of schooling for the insured parties.
13. The insured party is free to choose a practitioner according to the LAMal.
14. Any services that are not equivalent to the LAMal will not be eligible for a refund.
15. If the insured party voluntarily and repeatedly changes practitioner for the treatment of the same illness, the compensation will be granted upon agreement from the insurer.

3.2.4 OUTPATIENT TREATEMENT 'SERIOUS ILLNESSES'

The insurance case consists also of the outpatient treatment following the onset of one of the following serious illnesses: cancer, leukaemia, Parkinson's, Hodgkin disease, Pompe disease, Crohn's disease, Alzheimer's, AIDS, diabetes, tuberculosis, MS, ALS, meningitis, polio, progressive muscular dystrophy, encephalitis, tetanus, viral hepatitis, malaria, typhus, typhoid and para-typhoid infections, diphtheria, cholera, anthrax, cystic fibrosis, kidney disease which needs dialysis, brucellosis, Creutzfeldt-Jakob disease and Ebola.

The insurance case starts with the introduction of medical treatment and ends in conformity with article. 2.2.15 of the CGPA.

3.2.5 OUTPATIENT CARE CENTRES

The insurer will refund tests, treatment and medicine carried out through medical prescription by recognised outpatient care centres or by qualified care givers at the home of the patient. No compensation will be made for the cost of family help. The medical prescription is valid for all or more than a retrospective duration of 1 month and 3 months for long term patients.

3.2.6 PSYCHOTHERAPY AND RELATED TECHNIQUES

For ambulatory and/or stationary psychotherapy, the insurer will only provide compensation under the condition and measure that the insurer has agreed in writing on the basis of a positive (expert) opinion by a designated doctor.

Only the treatment offered by a psychologist-psychotherapist under the FSP of Swiss law will be taken into account. The latter must be managed by a psychiatrist in charge of their work as a psychologist-psychotherapist.

3.2.7 PREGNANCY

Costs linked to pregnancy and child birth, in particular, routine tests, stay in a birth centre, breastfeeding advice, treatment for new-borns who are in good health and their stay, as long as they stay in the hospital with their mother, are covered according to the usual basic rates.

Ultrasounds are covered within the exclusions outlined in the Table of Coverage.

3.2.8 VOLUNTARY TERMINATION OF PREGNANCY

In the event of voluntary termination of pregnancy, the insurer will cover the same costs as for illness, within the following conditions:

- The termination must have been carried out by a surgeon who is authorised by local law in the country where the termination has taken place. The surgeon must certify the legality of the termination in writing prior to it being covered by the insurer.
- The abortion must have been necessary to protect the physical integrity of the pregnant woman.

3.2.9 LABORATORY AND SCAN COSTS

The insurer will refund the costs for tests prescribed by the doctor to diagnose or manage treatment, as well as featuring on the 'list of standard tests' from the DFI and as long as they are carried out by a pharmacist or a laboratory which have been authorised by LAMal.

Cost of scans, radiology and MRIs are entirely covered if they are prescribed by a doctor for valid reasons.

3.2.10 PSYCHIATRIC HOSPITALISATION

The insurer will refund cost of hospitalisation in a psychiatric hospital in their entirety for a maximum duration of 30 days per contract year.

3.2.11 ORGAN TRANSPLANTS

The costs of organ transplants are covered in their entirety. However, costs related to the procuration of organs will not be covered.

3.2.12 EMERGENCY DENTAL TREATMENT

1. The following costs are covered in the event of urgent dental treatment:
   a) If the treatment was required because of a serious and unavoidable illness in the chewing system or by another serious illness or its consequences;
   b) If the treatment was required to treat a serious illness or its consequences;
2. The cost of urgent treatment for injury to the chewing system caused by an accident provided that they have no other insurance package or third party service provider covering the expense.
3. A deductible which is outlined in the Table of Coverage will be charged to the insured party for each treatment.

3.2.13 MEDICATION

1. The insurer will cover medication according to the Table of Coverage, under the condition that the medication is authorised by the state and is covered by the mandatory health insurance they have. Homoeopathic medication is covered under the condition that it has been proscribed by an official qualified and recognised practitioner.
   In Switzerland, the insurer will cover the cost of medicine that has been prescribed by a doctor and

features on the 'List of medication and price' (LMT) and in the 'List of specialities' (LS) which have been authorised by the state and are the legal basis for treatment.

2. Medication, bandages and equipment must be part of a prescription from an authorised doctor or practitioner, with the exception of any practitioner belonging to the family or next of kin of the insured party or policyholder.
3. The medication must be bought in a pharmacy and not in a drug store or shop.
   Purchasing medication in bulk on the same prescription must be justified by a note from the practitioner on the prescription.
4. Non-medical products are not covered, such as the following: medical alcohol, cotton buds, sun cream, dental hygiene products, shampoo, food products (as well as those which relate to a special diet), mineral water and tonic wine, dry food mixes, spermicidal products, contraceptives, cosmetics, sanitary products, treatment for baldness, insecticide, etc.

3.2.14 REMEDIES

- The following remedies are covered:
  Massage treatments which are authorised by the state or masseur-physiotherapists (including massages, heat therapy, physical therapy and spa therapy);
- Voice therapy, speech therapy and elocution lessons by a registered speech therapist.
- Cost to go to a sauna as well as thermal baths and similar activities are excluded from the coverage.
- The coverage of remedies is subject to prescription from an authorised doctor and the insurer may request for approval from a private medical expert.
- A waiting period of 3 months is applicable, unless the compulsory basic health insurance – LAMal stipulates otherwise.

3.2.15 ALTERNATIVE MEDICINE

The cost of alternative medicine (tests, therapy, medication) are covered within the limitations outlined in the Table of Coverage, under the condition that a medical prescription is provided and the prescription has been written by one of the following:

a) A FMH doctor who is recognised by ASCA, who applies the cost outlined by ASCA (for Swiss cases);

b) A therapist who is officially recognised by FSP (for Swiss cases).

3.2.16 HOME CARE

This is covered when it follows hospitalisation or was prescribed to replace hospitalisation.

The exclusions to this coverage are outlined in the Table of Coverage.

3.2.17 REHABILITATION

Treatment for rehabilitation is covered as long as they follow a period of hospitalisation. See Table of Coverage.

The exclusions to this coverage are outlined in the Table of Coverage.

3.2.18 SCREENING AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

Under the condition that all necessary measures were taken to prevent its occurrence and unless otherwise provided by the compulsory basic insurance – LAMal, the coverage is applied within the limits outlined in the Table of Coverage.

3.2.19 THERMAL TREATMENT

The insurer will make a daily contribution to the cost of thermal treatment prescribed by a recognised doctor/practitioner. For the allocation of a maximum amount of CHF 20.- per day for a maximum of 21 days per contractual year, the following conditions will apply:

a) The treatment must have been medically prescribed;

b) The treatment must have taken place in the country of stay;

c) The treatment must have been prescribed as part of medical treatment and by an approved doctor;

d) The prescription for the treatment must be shown to the insurer before the start of treatment.

The medical prescription for a course of treatment, including diagnosis, must be presented to the insurer two weeks before the start of treatment.

In the event of treatment interruption, the partial cost of treatment cannot be covered, only if the treatment stopped due to illness or other imperative reasons and if they can be justified by a certificate written by the treatment doctor.

3.2.20 PHYSIOTHERAPY, SPEECH AND LANGUAGE THERAPY

The coverage is subject to the exclusions outlined in the Table of Coverage, under the condition that such a therapy has been prescribed by an officially authorised therapist practitioner.

3.2.21 CHIROPRACTORS AND OSTEOPATHS

1. The cost of chiropraxis will only be covered if the insured person has been receiving treatment from a chiropractor who is legally certified in the contractual territory.
2. The cost of osteopathy is covered in the exclusion outlined in the Table of Coverage.

3.2.22 PSYCOTHERAPY

1. Insurance covers the cost of psychotherapy carried out by a qualified and recognized doctor according to methods whose effectiveness is scientifically proven.
2. For the inpatient or outpatient psychotherapy, the insurer will only provide compensation under the condition that the insurer has agreed in writing, based on a positive opinion (from an expert) from the contracted doctor.
3. Only treatment from a psychologist or psychotherapist will be covered in regards to FSP of Swiss law. The latter must also be delegated by a psychiatrist in charge of supervising the work of the said psychologist - psychotherapist.
4. In the first instance, the insurer will cover costs within the limits indicated in the Table of Coverage. The doctor must write a report for the insurer's medical advisor, mentioning the type of illness, its setting, its progression, the result of current treatment and where appropriate, write a therapy prolongation proposal indicating the aim, the setting and probable duration of the illness. This report can only contain the necessary information for the insurer to evaluate the extent of charges.
5. The medical advisor will examine the report and will put forth a suggestion for the course of psychotherapy, indicating the duration of the therapy that will be covered.
6. Psychotherapists who seek to increase self-awareness, personal awareness, or personality development are not covered.

3.2.23 PROPHYLAXIS - PREVENTION

The insurer takes into account costs of measures or preventative exams requested for treatment in a prescription by a doctor, such as infant vaccinations and preventative gynaecological exams.

The cost of prevention, screening and prophylaxis are covered exclusively for insured parties who are specially concerned and within the limits of the mandatory basic insurance, in particular:

a) preventative gynaecological tests;

b) screening for sexually transmitted diseases, within the situations listed in the catalogue of treatment from LAMal.

Vaccinations which have been medically prescribed are covered in the limitations outlined in the Table of Coverage.

3.2.24 EQUIPMENT

1. Equipment is considered the lenses and frames of glasses, up to the amount billed (at the earliest, four years after the purchase of the last glasses frame), contact lenses, bandages for hernia, rubber gloves, sole inserts for foot correction, plaster, corrective braces, braces for torso, arm and leg support, hearing aids, electronic voice boxes, prosthetic arms, legs or feet.
2. Costs are covered according to the list of means and devices of the compulsory basic legislation of care.
3. Entitlement to benefits related to optics commences 9 months from the effective date of the contract (waiting period).
4. The glasses, glasses frames and lenses must be prescribed by an ophthalmic doctor.
5. The costs of all other equipment, medical equipment, sanitary articles (orthopaedic shoes, massage equipment, pressure measuring articles, breathing devices, heat lamps, warming cushions), as well as costs related to upkeep, use and maintenance of equipment, are not refundable within the conditions of basic mandatory insurance for treatment.

3.2.25 AMBULATORY TRANSPORT AND RESCUE COSTS

1. Under the limits of the coverage outlined in the Table of Coverage, the insurer takes into account the following transport costs;

a) Ambulatory transport

b) Rescue costs

in the following conditions;

   a) the insured party calls upon a registered supplier who is authorised by basic mandatory care legislation;

   b) that the transport covers travel to the closest medical establishment for appropriate treatment;

2. The transport fees are only covered when the health state of the patient does not allow them to use any other type of public or private transport.
3. In addition to the benefits listed above, the insurer will reimburse within the limits of the Table of Coverage, transport costs and rescue costs in the following cases;

   a) illness or accident which occurred because of the insured party, voluntary mutilation or suicide attempts;

   b) smoking or alcoholism;

   c) ethylism, drunkenness at the time of an accident, where the insured person had a level of alcohol equal or higher to 0.50g per litre of blood.

4. The insurer covers, within the contractual limits mentioned, the cost of transport and rescue to the extent that they have not already been covered by another insurer as part of their provision of assistance.

3.3 COVERAGE LIMITATIONS

1. In addition to the general exclusions and limitations, the insurer is freed from their contractual obligations in the following cases:
   a) illnesses, and related consequences. The consequences of accidents caused by war or from damage from national military service and which are not specifically mentioned in the coverage;
   b) diseases or accidents deriving from misconduct, including their consequences, in compliance with the LAMal;
   c) in the event of transgression of legal arrangements, insurance conditions, fraud or abuse;
   d) treatment administered by doctors, dentists and in the hospital establishments that the insurer excluded from the conditions for refund by notifying the insured party or their designated representative. As well as for claims which are being processed and are related to this notification, the insurer will not be responsible for refunding fees occurring in the three months following this notification;
   e) curative out-patient treatment in a spa or spa town. This limitation becomes obsolete if the insured person spends their stay there, or when a spa treatment is necessary during a short stay and following an illness or accident arising on site and is not linked to the aim of the stay;
   f) treatments enjoyed by a partner, direct ascendant or descendant or next of kin;
   g) cosmetic operations of any type and their consequences or complications;
   h) valuations, certificates, descriptions of treatment drawn up by the insured party themselves;
   i) when the treatment given has not been effective, appropriate and/or economical, and has not conformed with the medical opinion given by an independent medical advisor from the insurer;
2. If the amount of curative treatment or any other types of care for which benefits have been agreed exceeds the medically necessary costs, the insurer reserves the right to reduce compensation to an acceptable amount. The insurer is also authorised to such a reduction when the fees billed for necessary spa treatment or any other type of treatment are greater than an acceptable amount.

3.4 DUTIES OF THE INSURED PARTY

3.4.1 NOTIFICATION IN THE EVENT OF A CLAIM

This notification will take 2 forms;

1. In one of the 3 cases of claims below, the insured party is **obliged to call the Alarm Centre** (open 24h and 365 days a year), and it has to be done at the first occurrence of the claim.

a) In the event of hospitalisation: the insurer must be notified of any claim which results in hospitalisation. In this particular case where the insured party shows complete inability to inform or indirectly inform the Alarm Centre and if their condition is life threatening, so the notification will be given with in the shortest amount of notice that is objectively possible, by the insured party or the policy holder, the next of kin, the police, a hospital or any other person involved in the claim, will be considered a valid notification.

b) In the event of having to get dentures or having to have maxillofacial surgery, the insured party must inform the insurer before the start of treatment, with a complete and precise description of the treatment as well as a quote, which will need to be submitted to the insurer's medical service.

c) In the event of having psychotherapeutic treatment, this must be agreed in advance with the insurer in writing.

Telephone: +41229295252 **and mention:**

- Your insurance contract number
- The nature of the claim
- Your mobile phone number and email address

2. The insured party or the insurance policy holder must send their **reimbursement request either by post or *declare it online.***

Post address: SOS Evasan CP 5 – VICH 1267 (Switzerland)

Declaring claim online: a simple, quick and completely safe procedure (encrypted data transfer). Fill out the fields relating to your claim and send it directly to this address: www.evasan.com/file-a-claim/

The insured party will receive a claim reference number and information about all the documents that they will need to provide. EVASAN will immediately get in contact with the insured party. Declarations transmitted can only be consulted by EVASAN claim managers, in complete confidentiality.

3.4.2 DUTY TO COOPERATE

The policy holder or legal representative must provide all information specified in the insurance proposal form. If they do not respond to some questions, the proposal will be considered as non-valid.

The insured party must immediately declare accidents submitted to mandatory insurance. They must provide the INSURER with information on the following:

- The time, place, circumstances of the accident
- The doctor who is treating them or the hospital;
- Any people who were involved and their insurers;
- In the event of illness, the insured party must let the insurer know within ten days.
- Changes in address, name changes, as well as death must be communicated in writing to EVASAN within 30 days so that they can transfer the information to the health insurer within the same amount of time;
- Prescriptions for medical measures (convalescence, treatment, etc.) must be sent to the insurer by the service provider or by the insured party before the start of treatment. Excluding emergency cases.

3.4.3 DOCUMENTS AND INFORMATION TO PROVIDE IN THE EVENT OF A CLAIM

1. 60 days at the latest after the claim or 30 days after the documents are issued or, failing these 20 days since their reception duly evidenced by the insured party (postmark or official confirmation), the insured party must send the original documents mentioned below to the INSURER at their own expense.
   a) an accident statement and/or verbal report from the police, fire-fighters and any emergency service;

b) a full medical file as well as the medical report which was written by the consulted doctor or the hospital establishment which was visited following the claim event;

c) prescriptions from the pharmacy and other prescriptions.

d) original invoices for medical treatment, hospitalisation and the purchase of medication which the insured party has received.

2. In addition, the policy holder and insured party must provide the insurer with any other information and any other proof which can be used as necessary evidence to document the claim or compensation request as well as the reimbursement amount, that they may be aware of.

3. On request from the insurer, the insured party must provide any information, at his own expense, on the facts and any supplementary documents which prove or determine the circumstances which have resulted in the claim, to establish the consequences or to assess the authenticity of the claim declaration. When they complete their request in writing, the insurer can give the insured party within a maximum of 10 days to provide the information or documents required, if this takes any longer the insurer is freed from the obligation to provide assistance.

4. On request from the insurer, the insured person may be asked to be examined, to the expense of the insurer, by a chosen medical advisor.

3.4.4 MEDICAL CONFIDENTIALITY, DATA TRANSMISSION AND DATA PROTECTION

1. When accepting the current arrangements, the insured person must disclose medical information to the insurer, all doctors and (para) medical personnel who examine him or treat him, both before and after the claim. Where need be, the insured person must go through this process after the occurrence of a claim and/or sign an ad hoc permissions form that the insurer can use as applicable. Any refusal to do this from the insured party will result in the forfeiture of his contractual rights.

2. The insurer shall comply with any applicable arrangements in regards to data protection and will comply to the LPGA agreement, LAMal and the data protection law (LPD).

3. Any person who carries out administrative work or illness insurance controls is bound to confidentiality towards third parties.

3.4.5 CONSEQUENCES OF NOT RESPECTING DUTIES

1. If the duties mentioned above are not honoured, it will result in the following consequences:

   a) If the information submitted aimed to fool the insurer, the insurer is automatically freed from the contract, and no longer needs to provide compensation and has the right to claim back any compensation that the insured party has already received.

   b) If the information submitted contains an intentional mistake or extreme negligence on the part of the insured party, the INSURER is no longer obliged to provide compensation if they notify the insured party within 4 weeks of noticing the mistake and its consequences.

   c) In the event of any other violations, the insurer reserves the right to reduce compensation for the corresponding amount caused by the insured party's disrespect for his duties.

2. The policy holder and/or the insured parties are only responsible for fulfilling their contractual duties.

3. Under the penalty of the contract being withdrawn, the insured party and the policy holder must not interfere in the management of the claim by the insurer without his prior authorization.

4 ADMINISTRATIVE ARRANGEMENTS

4.1 COMMUNICATIONS AND NOTIFICATIONS

1. Notifications for EVASAN in the present terms of the contract, must come in a written form.
2. Agents, brokers and other insurance intermediaries are not permitted to receive the notification that is destined to EVASAN. Only communications regarding administration and the life of the contract in chapter one, Contract Administration section, can be received as the insurance intermediary (Agent or broker) as specially mentioned by the insurance policy holder.

4.2 PAYMENT OF INSURANCE PREMIUMS

1. The reception of the insurance premium by the insurer is an essential element of the contract, regardless of the method of payment.
2. The premium can be paid in advance. The premium is billed from the date that the coverage takes effect.
3. On request, the policy holder can also pay the premium via fractioned payments under the condition that a higher price for it has to be paid. In the event of fractioned payments, these must be received before the 10th of each month.
4. The compensation of insurance premiums with insurance compensation is forbidden.
5. If the contract terminates on request of the insured party before the expiry date, the refund of the premium can only be performed if the contract was not claimed from and there were no claims declared by the insured person.
6. When the refund of the premium is allowed, it will be carried out in a pro-rata basis of the insurance period that has not expired.
   However, no refund is due in cases of reluctance, attempted abuse or abuse to the detriment of the insurer.
7. If the entire initial or subsequent premium is not paid on time, the insurer will suspend the coverage fourteen (14) days after the last reminder letter.
8. If the debtor had not paid the premium within 20 days of the date at which the payment was due, the insurer has the right to terminate the contract with immediate effect and to advise all authorities about the insurance matter, as well as, their right to travel abroad. The insurer must do this by a letter that is sent by registered mail to the known address of the debtor. The insurer will not be responsible for compensation for claims occurring the day after the twentieth day.
9. Not paying the premium before the due date will automatically result in the insurer starting a procedure to recover costs from the debtor (policyholder or insured party).
10. If the insurer does not take legal action to recover the premium, the policy will automatically be canceled two (2) months after the expiry of the 14-day notice period and no other cancellation letter will be sent to you.
11. If the insured party incurs onerous administrative fees due to negligence or through his own fault, he must cover the cost.

4.3 ADJUSTING THE PREMIUM

The premium can be changed annually due to changes in the cost of medical care and claims.

When the contractual year expires, the insurer reserves the right to increase the premium, in particular, when the overall economy of the contract is being reviewed.

1. Insurance policy holders will be made aware of an increase in insurance premiums at least one (1) month before the start of the new contractual year and will take effect the same year.
2. In the event of an increase in premiums, the insurance policy holder has the right to cancel the contract according to the cancellation conditions and must inform the insurer in writing within 30 days of receipt of the new rates.

4.4 MODIFICATION OF THE INSURANCE CONDITIONS

1. The insurer can process a change in the terms of the insurance contract or its termination in the following cases:
   a) the permanent modification of the legal provisions in the field of public health;
   b) the invalidity or annulment of certain conditions by an administrative or judicial authority;
   c) the amendment or repeal of the laws and regulations on which the provisions of the insurance contract are based;
   d) the amendment of legislation, administrative practice or judicial practice affecting the terms, interpretation or validity of the contract or of certain of its provisions.
2. The insurance policyholder must be made aware of any new conditions at least 1 month before they enter into force, with the exclusion of events of major force, or for urgent legal, administrative or judicial reasons.
3. In the absence of the insurance contract cancellation by the insured party, it will be considered that he has accepted the new conditions.
4. The insurer reserves the right to change the wording of certain contractual conditions, when he wants and without prior warning, when he wishes to correct typographical errors or obvious material mistakes, to lift uncertainty of interpretation or to specify a point that has already been covered in the text, or to improve the insurance conditions for the insured party exclusively.

4.5 SAFEGUARD CLAUSE

The invalidity of a clause contained in these terms of insurance, does not call into question the validity of other clauses.

5 FINAL CLAUSES

5.1 DURATION OF THE INSURANCE CONTRACT

1. The insurance contract is agreed **for the duration of a year.**
2. Except in the event of one of the parties terminating the contract, the insurance contract will automatically be renewed from year to year, as long as all the conditions written in article 2 paragraph 4 OAMal are respected.
3. **The insurance contract starts from the day after (at 12.00AM) of the date outlined on the insurance policy and ends twelve months after (at 12.00AM).**

5.2 INSURANCE CONTRACT CANCELLATION

1. Each party is entitled, by registered mail addressed to the other party, to terminate the insurance contract by giving 3 months' written notice before expiry of the insurance policy.
2. In the event of an increase in the premium or change in the insurance conditions, the policy holder can send a registered letter to the address outlined in chapter 0 in the Contract Administration section and can cancel the insurance contract within one month since the notification by the insurer about these changes. The cancellation will take effect from the date that the changes come into force.
3. If the contents of the policy or the changes do not correspond to the agreement between the insured person and the insurer, the policyholder must, if applicable, request correction within four weeks of receipt of the general conditions of the police. If the insured person does not make a request for correction of the content, the content will be considered accepted by the insured person.

4. Under the legal or contractual clauses for the invalidity, retroactive cancellation, immediate cancellation of the insurance contract within a different amount of time, if the insured party and/or policyholder makes a non-intentional mistake, the insurer will allow them to:

   a) cancel the insurance contract within a month after having noticed the mistake;

   b) suggest a change to the insurance contract, within a month of having recognised the mistake. The changes will entry into force with retroactive effect from the date that the insurer noticed the mistake. In a case where the contractor rejects a change to the proposed contract or if he does not accept it within 14 days after reception, the insurer reserves the right to terminate the contract within 14 days.

5. If, within an insurance contract for multiple insured parties, the conditions for cancellation will only be given to certain people and cancellation of the contract will only be limited to these named people. The insurance contract will continue until its end, for the benefit of the insured persons non concerned by the early cancellation of the contract.

   If the insurance policyholder terminates the insurance contract in its entirety or for certain insured parties, he must prove that the insured parties involved are aware that the contract has been cancelled and that they accept this. Otherwise, the cancellation will be considered invalid. If all or certain insured parties who were part of a cancelled contract, would like to renew the contract, they can do this by writing to EVASAN via post or email within the 2 months that follow the cancellation by the policy holder, to renew their contract.

   The insurance contract will automatically terminate with the death, bankruptcy or insolvency of the policy holder. The insured parties are however entitled to renew the insurance contract within the conditions outlined in paragraph 5 above, the deadline of 2 months will be counted from the date of death, declaration of bankruptcy or official certificate of insolvency by the policy holder.

5.3 APPLICABLE LAW, CONCILIATION AND COMPETENT JURISDICTIONS

1. The insurance contract is governed by the present general insurance conditions and terms of the insurance (CGPA).
   In addition to the mandatory legal provisions, Swiss law in the insurance contract (LCA) is applied in a suppletive manner.
2. In the event of legal proceedings, Swiss courts are authorised to assess the interpretation or execution of the present contract. The provisions specific to the Lugano Convention of 16 September 1988 remain reserved, as applicable.
3. It follows that the insured party would have the possibility to assign his private foreign insurer in front of the Swiss authority, even if the insurance contract agreed in another country would refer to substantive law and a foreign court.
4. Before engaging in a judicial or arbitrary procedure in relation to the contract and insurance conditions, each party must engage with each other, 10 days following the rise of the dispute, in writing, to reach an amicable solution.
5. In the event of failure of the attempt to reconcile, EVASAN will organise internal, free opposition proceedings for the insured party. Opening of the latter does not suspend any legal or contractual deadlines. Also reserved is the possibility for the parties to agree, with written agreement, an arbitration procedure to one or three arbitrators.
6. In the event of divergences between the different language versions, the French version of the insurance conditions specific to 'SWISS STUDIES' insurance coverage shall prevail.

5.4 ENTRY INTO FORCE

The present insurance conditions enter into force on 01.07.2018, removing any right to previous insurance conditions covering the same product.

5.5 TABLE OF COVERAGE

I. INSURANCE COVERAGE (MGEN)	
A. OUTPATIENT	
SERVICE	**MAXIMUM AMOUNT COVERED**
1. Prescription of pharmaceuticals and medical equipment	Actual fees equivalent to LAMal
2. General practitioner consultations and prescriptions meds covered according to LAMal	Actual fees equivalent to LAMal
3. Consultations with specialist	Actual fees equivalent to LAMal
4. Analyses	Actual fees equivalent to LAMal
5. Ambulatory surgery	Actual fees equivalent to LAMal
6. Home care or at the convalescence centre	CHF 20.- per day, max 30 days/year
7. Rehabilitation	CHF 20.- per day, max 30 days/year
8. Emergency treatment without hospitalisation	Actual fees equivalent to LAMal
9. IRM, tomography and scanning	Actual fees equivalent to LAMal
10. Consultations with chiropractor, osteopath and acupuncturist	- Chiropractic: Actual fees equivalent to LAMal - Osteopath: 50% with max 4 sessions Max CHF 200.- per year - Acupuncture, laser acupuncture and acupressure with max 4 sessions Max CHF 200.-per year
11. Prescribed physiotherapy and speech-therapy consultations	Actual fees equivalent to LAMal
12. Screening and treatment for sexually transmitted diseases	Max CHF 2000.-/3years
13. Psychiatry	Actual fees equivalent to LAMal
14. Psychotherapy	50% of the expensed related with max CHF 2000.-/year
15. Physiotherapy consultations and cure Speech-therapy consultations and cure Orthopaedic consultations and cure Art 3.2.22	Max CHF 350.-/ year

B. MEDICAL TRANSPORTATION	
1. Ambulatory	Max CHF 1000.-/year Except in the case of the art 3.2.25.3 CGPA for which the following limits apply: 50% of the expenses related with Max CHF 500.-/year
2. Rescue	Max CHF 2000.- Except in the case of the art 3.2.25.3 CGPA for which the following limits apply: 50% of the expenses related with Max CHF 500.-/year
3. In the specific cases of art 3.2.27	50% of the related expenses, Max CHF 500.-/year
C. HOSPITALISATION	
1. Public hospital room or semi-private in a communal area	Actual fees equivalent to LAMal
2. Surgery (including anaesthetic and operating room)	Actual fees equivalent to LAMal
3. Expenses for medicines related to a hospitalisation	Actual fees equivalent to LAMal
4. Surgical and prosthetic equipment	Actual cost equivalent to LAMal
5. Analyses	Actual cost equivalent to LAMal
6. Organ transplant	Actual fees equivalent to LAMal
7. Day hospitalisation	Actual fees equivalent to LAMal
8. MRI, tomography and scan-tomography, tests	Actual fees equivalent to LAMal
9. Oncology	Actual fees equivalent to LAMal
10. Prescribed stay in a spa resort	CHF 20.- per day - max 21 days/year
11. Prescribed medical assistance	Actual fees equivalent to LAMal
D. PREGNANCY	
1. Pregnancy	4 or more exams during pregnancy and one exam after pregnancy
2. Pregnancy and birth complications	Actual fees equivalent to LAMal
3. Hospital birth	Actual fees equivalent to LAMal

4. Home birth	Actual fees equivalent to LAMal
5. Legal abortion	Actual fees equivalent to LAMal
E. OPTICAL	
1. Glasses and contact lenses on prescription art 3.2.26	CHF 350.-/ 3 contractual years
F. DENTISTRY	
1. Emergency dental treatment with hospitalisation (Dental prosthetics in the event of an accident only)	75% in the event of an accident or after a serious illness to the chewing apparatus
2. Emergency dental treatment without hospitalisation	75% in the event of an accident or after a serious illness to the chewing apparatus

DEDUCTIBLE (MGEN): A deductible per year of insurance applies according to the choice of the insured party (see policy): CHF 0 – CHF 100 – CHF 300 – CHF 500

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