HEALTH INSURANCE SWISS STUDIES®

GENERAL and SPECIFIC CONDITIONS TO COVERAGE

SIMPLY & FAIR

CONTENTS

0 GENERAL INFORMATION

THE INSURER

The health and accident insurer are Rock Mutual Insurance, which has its headquarters based in 2265 Jounieh, Lebanon. Rock Mutual Insurance is a member of: "Association Internationale de la Mutualité" (AIM), and the International Cooperative and Mutual Insurance Federation (ICMIF).

It is governed by binding regulations and accredited re-insurance companies worldwide Canopius, United Kingdom, Floor 29, 22 Bishopsgate London and Caisse Centrale de Reassurance CCR, 157, Boulevard Haussmann, 75008 Paris, France to operate in the areas of illness and accident insurance and assistance and insure all risks described in the CGPA (hereinafter **INSURER**).

Within the current contract, the **INSURER** will be represented by SOS Evasan SA (hereinafter **EVASAN**). As a result, **EVASAN** is authorised to receive on the **INSURER**'s behalf which insures all the risks described in the insurance CONDITIONS SPECIFIC TO SWISS STUDIES "SIMPLY & FAIR" COVERAGE.

ASSISTER, CLAIMS MANAGEMENT, ALARM CENTER

The assistance agent is SWAN TRAVEL INTARNATIONAL ASSISTANCE (hereinafter **SIA**), based at Siwar Center, Business area, Bloc B, Seaside Road, Zouk Mosbeh, Lebanon, which provides all the insurance-assistance services described in the CONDITIONS OF INSURANCE SPECIFIC TO SWISS STUDIES "SIMPLY & FAIR" COVERAGE.
The claims handler is **SIA**.
The insured shall inform **SIA** as soon as the claim first appears by calling the Call Center, which will handle the claim using its best efforts. Any call concerning a claim will be followed by written notification from the insured to SIA within 5 days of the occurrence of the event.
SIA can be contacted by the insured in case of emergency at Telephone+41 (0)22 929 52 52, E-mail: claims@evasan.com 24/24H 7j/7j, 365 days.

The generic term "**INSURER**" refers to **INSUREUR** and **SIA** within the scope of their respective activities.

INSURANCE CONTRACT ADMINISTRATION, INFO CENTRE

The administrator of the insurance contract is SOS Evasan SA (hereinafter **EVASAN**), Route de L' Etraz 12A, CH-1267 Vich (Commercial Register N° CH-660-0168995).

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 in the name and on behalf of **INSUREUR** and **SIA**

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

Tel.: + 41 (0)22 929 52 51 from 8:00AM to 17:00PM (Monday to Friday) or by

Email: *info@evasan.com*

THE RELATIONSHIP BETWEEN INSURERS

1. **INSUREUR** covers the disease as well as, from a medical point of view, its direct economic consequences. The guarantee consists of the reimbursement of treatment costs and other costs that are stipulated within the framework of the health insurance given and this in the territory of the coverage, in particular the country of destination according to the agreed benefits. The extension of the guarantee will be

determined in the insurance policy, in future additional written agreements, in the Insurance Conditions as well as in the applicable legal provisions.

2. **INSUREUR,** insure all the risks described in the INSURANCE CONDITIONS SPECIFIC TO THE "SIMPLY & FAIR" coverage, except for the assistance component, which is provided by **SIA**.
3. **SIA** is responsible for coverage and assistance during a trip or in connection with other events listed in the contract. The extension of the guarantee will be determined in the insurance policy, in the additional written agreements to come, in the SPECIFIC INSURANCE CONDITIONS FOR THE "SIMPLY & FAIR" coverage as well as in the legal provisions in force.
4. INSURANCE CONDITIONS SPECIFIC TO THE "SIMPLY & FAIR" cover are valid if the particulate conditions adapted to the individual cover do not deviate from them.

1 DEFINITIONS

1.1 PERSONS

1.1.1 WHO IS THE INSURER?

1. **INSUREUR**, and **SIA** insures all the risks described in the General Conditions and Special Insurance Conditions (GCPA),
2. The generic term "**INSURER**" means **INSUREUR** and **SIA** in the context of their respective activities described in the SPECIFIC INSURANCE CONDITIONS FOR COVERAGE SWISS STUDIES "SIMPLY & FAIR".

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 regarding 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 **35** 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.

   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 **36** 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.
3. Members of their families within the meaning of **Art. 3 para. 2 OLAMal** who accompany foreign nationals residing in Switzerland for the purpose of training, provided that, throughout the period of validity of

the exception, they benefit from equivalent insurance coverage for treatment in Switzerland. The application must be accompanied by a written certificate from the competent foreign body or insurer giving all the necessary information. The competent cantonal authority may exempt these persons from the obligation to take out insurance for a maximum of three years. Upon request, the exception may be extended for up to three more years. The interested party may not go back on the exception or waiver of an exception without special reasons.

4. Accompanying persons residing in Switzerland who are parents or accompanying persons designated as such by the parents of students exempt from LAMal/KVG are excepted on request. The private servants of the insured beneficiaries mentioned are subject to the compulsory LAMal/KVG insurance if they are not insured in the employer's State or in a third country.

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 undertakes to intervene instead of the policyholder and or the insured, in the event of a default by the latter to cover the financial obligations arising from this 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 based on 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 and stay.
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, academic research, internships, student exchanges, 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.

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 including the holidays in home country.

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. Provided that they are not clearly attributed to an illness or a degenerative phenomenon, the following list of exhaustive bodily injuries are part of an accident, even if they are not caused by an external factor of an extraordinary nature:

a. broken bones.

b. joint dislocations.

c. torn meniscus.

d. torn muscles.

e. pulled muscles.

f. torn tendon.

g. ligament injuries.

h. eardrum lesions.

1.3.6 WHAT IS AN ILLNESS?

An illness means any impairment of physical, mental, or psychological health which is not due to an accident, and which requires medical examination or treatment or causes incapacity to work. It is an alteration of one's health, certified by a competent medical authority.

1.3.7 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.

1.3.8 WHO IS THE MEDICAL ADVISOR?

The Medical Advisor is a Medical Doctor who gives their opinion to the **INSURER** on medical questions as well as on questions relating to remuneration and the application of rates. In particular, the Medical

Advisor examines whether the conditions for payment of a service are met. The Medical Advisor assesses cases independently. The service providers must give the Medical Advisors the information they need to fulfil their tasks. If it is not possible to obtain this information by any other means, the Medical Advisor may examine the insured person himself. They must inform the attending physician beforehand and inform them of the results of the examination. The

Medical Advisors only send the information necessary to the competent persons of the insurers, to be able to decide whether to cover a benefit, to set the remuneration, to calculate the risk compensation or to justify a decision. In doing so, the personal rights of the insured are respected.

1.3.9 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.

1.3.10 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.

1.3.11 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 Benefits.
2. The Fixed Proportion: only if it stipulates differently in the Table of Benefits, 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.

1.3.12 WHAT IS AN 'ALARM CENTRE'?

The telephones structure of intervention and assistance comprising the operators, doctors, technicians, and insurance professionals that SIA makes available, (24 hours a day, every day of the year), who speak English, French and Arabic within the framework of this contract, to the insured. The latter make a formal commitment to contact the central office in the event of an imminent or declared disaster.

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 HEALTH INSURER AND MEDICAL ASSISTANCE SERVICES

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

1. **INSUREUR** covers 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 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. **SIA** covers and provides medical assistance for travel and other events mentioned in the contract. The extent of **SIA** coverage is determined by the insurance policy, any possible future written contracts, the insurance conditions, as well as the applicable legal arrangements.
3. **EVASAN** is responsible for administering the insurance policies, managing the life of the contract, issuing contractual documents and their possible amendments, and renewing the insurance contract.
4. The general arrangements apply as well as the arrangements specific to each coverage.

2.1.2 CONTACT WITH THE INSURER

1. On behalf of the **INSURER**, **EVASAN** assists the insured parties under the present contract and provides its Info centre.
2. **EVASAN** will manage the insurance policies, the duration of the contract, emission of contractual documents together and any their possible modifications, renewals of the insurance contract as well as the reception of the insurance premiums payment in the name and on behalf of **INSUREUR**.

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) including Switzerland.

b) Only sick persons are entitled to compulsory health care benefits (AOS) equivalent to LAMal/KVG.

c) Insured persons in good health only if the benefit is listed in the Ordinance on Care Insurance Benefits (OPAS), such as in the case of pregnancy and childbirth. The scope of the services is not unlimited, it must be limited to what is necessary for the purpose of the processing.

d) 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.

2. Insurance conditions – Medical Assistance

1. Outside a radius of 20 km (incl.) as the crow flies, calculated from the address of stay (art. 1.3.1. al. 3), the insured party is, under the condition of paragraph 4, covered worldwide during his travel.

2. There is no emergency when an insured party travels abroad with the aim of following medical treatment.

   Regarding health insurance and assistance coverage, entitlement to benefits expires 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 00:00 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 newborn 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 newborn 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 help 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 MAXIMUM AMOUNT OF COMPENSATION PER OCCURRENCE PER YEAR

1. Multiple insureds who are victims of the same event covered - If the guarantee is exercised in favour of several insured victims of the same event and insured under the same insurance conditions, the maximum amount of compensation applicable is that provided per person and per year - See the Table of guarantees.

2. Maximum aggregate amount of compensation per year - Guarantees marked with * in the Table of Benefits below are subject to an annual maximum aggregate limit regardless of the number of policyholders or events concerned in the year.

2.2.8 DOUBLE INSURANCE

1. When the same interest is insured against the same risk, and for the same period, 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.

2.2.9 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 substantial increase in 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.

2.2.10 ECONOMIC ASPECTS OF THE COVERAGE

The benefits entered 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 advisor, an independent professional, to provide independent and objective advice on medical matters as well as on the medical invoices presented. The

service providers must provide the medical advisor with the medical information necessary so that the medical advisor is able to complete his/ her assessment.

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

The medical advisor only sends the INSURER's medical team the information they need to decide whether to cover a benefit, to determine compensation or to justify a decision.

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

2.2.11 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 because of the incident are less than those cited on the policy, the insured party cannot assert a claim on the difference.

2.2.12 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 (regarding EVASAN) and from the EU (regarding the INSURER) in the way their personal data is treated and protected.

2.2.13 PAYMENT OF THE INSURANCE CLAIM

1. The INSURER only must 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 regarding 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. If it is required from LAMal/KVG, the right to use the '**third party**' payment system is reserved.

2.2.14 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.)

2.2.15 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 compensation granted through the insurance contract. In this measure, this right is transferred to the **INSURER**.
4. 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.

2.2.16 TERMINATION OF THE MEDICAL ASSISTANCE 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 to their country of usual residence oe legal domicile 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/KVG scheme will become mandatory in Switzerland.

2.2.17 PRESCRIPTION

Any claim under the present contract will be prescribed.

- Within the limit of years stipulated by the LCA from the date of the event which caused the insured part's claim under the Accident Illness coverage by the **INSUREUR.** This is under the condition that the insured event occurred and had been declared before the annual expiry date in the insurance policy.
- Within the limit of years stipulated by the LCA from the date of the event which caused the insured part's claim under the Medical Assitance coverage by the **SIA**. This is under the condition that the insured event occurred and had been declared before the annual expiry date in the insurance policy.
- on the expiry date of the medical assistance policy insured by **SIA**.

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 reduce the compensation objectively and technically 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. 25-31 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/KVG 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 The occurrence of a claim in 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/KVG.
3. The following expenses are covered in the standard division Public 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 establishment.
    b) Hospitalisation and surgical operation.
    c) (para) medical fees linked to hospitalisation.
4. If the insured person is receiving treatment in the public division of a hospital, the **INSURED** will allocate him the same amount of compensation as if he was being treated in a private 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 case of outpatient treatment, benefits equivalent to the LAMal/KVG shall be paid for an unlimited period. Services within the meaning of Art. 33, let. b, OAMal include examinations, treatments and care carried out according to the assessment of care on medical prescription or on medical mandate by:

a. nurses (Art. 49 OAMal);
b. home care and help organisations (Art. 51 OAMal);
c. medico-social institutions.

2. Recognised providers of outpatient services shall include the following persons and institutions:
   a. Doctors,
   b. Pharmacists,
   c. Chiropractors,
   d. Midwives,
   e. Laboratories,
   f. Centres for the provision of diagnostic or therapeutic equipment and equipment, on medical prescription:
   g. Physiotherapists,
   h. Nurses ,
   i. Speech therapists.

   The **INSURER** covers the costs of outpatient treatment in accordance with the rates valid at the place of residence or schooling of the insured.

3. Benefits include:
   a. **Assessment, advice, and coordination**:
      - Assessment of the patient's needs and environment and planning of the necessary measures,
      - Advice to the patient and, where appropriate, to lay providers for care, on how to manage the symptoms of the disease, for the administration of medicines or for the use of medical devices, necessary checks,
      - Coordination of measures and arrangements by specialized nurses related to complications in complex and volatile care situations.

   b. **Examinations and treatments**:
      - Monitoring vital signs (blood pressure, pulse, temperature, breathing, weight),
      - Simple test of glucose in the blood or urine,
      - Sample for laboratory examination,
      - Therapeutic measures for breathing (such as oxygen administration, inhalations, simple breathing exercises, aspiration),
      - Placement of probes and catheters, as well as related care,
      - Care for haemodialysis or peritoneal dialysis,
      - Preparation and administration of drugs and documentation of related activities,
      - Enteral or parenteral administration of nutrient solutions,
      - Monitoring of infusions, transfusions or devices for life control and maintenance or medical treatment,
      - Rinsing, cleaning, and dressing of wounds (including bedsores and ulcers) and body cavities (including tracheostomy and ostomy care), pedicure care for diabetics,

- Care for urinary or bowel evacuation disorders, including rehabilitation for incontinence,
- Assistance with partial or complete medicinal baths, application of wraps, poultices and fangs,
- Care for the day-to-day implementation of the doctor's therapy, such as exercising strategies to manage the disease and training for the management of aggression, anxieties, and paranoid ideas,
- Support for the mentally ill in crisis situations, to avoid acute situations of endangerment of oneself or others.

c. Basic care:

- General basic care for dependent patients, such as: bandaging the patient's legs, putting on compression stockings, remaking his bed, installing him, making him perform exercises, mobilizing him, preventing pressure ulcers, preventing, and treating skin lesions following treatment; help with personal and oral hygiene care; help the patient to dress and undress, as well as to feed,
- Measures to monitor and support the mentally ill in carrying out the ordinary acts of life, such as planning and structuring their days appropriately, establishing and promoting social contacts through targeted training and support in the use of guidance aids and safety measures.
- Services may be provided on an outpatient basis or in a medico-social institution. They can also be provided exclusively during the day or night.

3. The insured person is free to choose the practitioner in accordance with the LAMal/KVG.
4. 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.
5. The insured party is free to choose a practitioner according to the LAMal/KVG.
6. Any services that are not equivalent to the LAMal/KVG will not be eligible for a refund.
7. 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 PRACTISED BY PSYCHOLOGISTS

1. The INSURER shall bear the costs of psychotherapy services provided by psychologists and the costs of related coordination services, if they are provided by psychologist-psychotherapists admitted in accordance with Art. 50c OAMal or by organisations of psychologists-psychotherapists admitted in accordance with Art. 52e KVVO, that the principles laid down in Art. 2 are respected and that the services are provided as follows:

   a. On the prescription of a doctor holding a federal postgraduate title or a recognized foreign postgraduate title in general internal medicine, psychiatry and psychotherapy, child and adolescent psychiatry and psychotherapy or paediatrics or a doctor holding a diploma of interdisciplinary advanced training in psychosomatic and psychosocial medicine from the Swiss Academy for Psychosomatic and Psychosocial Medicine.

   b. in the context of crisis interventions or short-term therapies for patients with serious illnesses, for a new diagnosis or in a life-threatening situation, on the prescription of a doctor holding a postgraduate title referred to in let. or another postgraduate title

   For the benefits referred to the INSURER covers, by medical prescription, the costs for a maximum of 15 diagnostic and therapeutic sessions. Before the number of sessions prescribed, psychologists-psychotherapists send a report to the doctor who prescribes the therapy.

   If psychological psychotherapy is prescribed by a physician holding a federal title or a recognized foreign title of postgraduate training in general internal medicine or paediatrics, a case assessment carried out by a medical specialist holding a postgraduate designation in psychiatry and psychotherapy or child and adolescent psychiatry and psychotherapy must be attached to the report.

2. For the INSURER to continue to cover the costs of psychotherapy after 30 sessions, the attending physician must submit a timely report to the INSURER's medical officer. The report must mention:
   a. The type of disease.
   b. The type, setting, process and results of the treatment initiated.
   c. A proposal for extension of the therapy indicating the purpose, the setting, and the probable duration.
   d. The report may only contain data necessary for the INSURER to assess the obligation to provide coverage.
   e. The medical officer examines the report and proposes to the INSURER to continue the psychotherapy at the expense of the insurance, indicating its duration until the next report, or to discontinue it.
   f. The INSURER shall inform the insured person, with a copy to the attending physician, within 15 working days of receipt of the report by the medical officer whether he continues to cover the costs of psychotherapy and for how long.

3.2.7 PSYCHOTHERAPY PRACTISED BY A DOCTOR

The INSURER covers the costs of psychotherapy performed by a doctor using methods whose effectiveness is scientifically proven.

Psychotherapy is a form of treatment that:

a. concerns mental and psychosomatic illnesses.

b. has a defined therapeutic objective.

c. relies primarily on verbal communication but does not exclude supportive drug treatments.

d. is based on a theory of normal and pathological experience and behaviour as well as on an etiological diagnosis.

e. Includes systematic reflection and an ongoing therapeutic relationship.

f. is characterized by a working relationship of trust as well as regular and planned therapy sessions.

g. can be practiced in the form of individual, family, couple, or group therapy.

For itinerant and/or inpatient psychotherapy, the **INSURER** will only provide its services on the condition and to the extent that the **INSURER** has given its prior written consent based on a positive notice (expertise) established by a doctor authorized by him.

Only care provided by a psychologist-psychotherapist within the meaning of Swiss law will be covered.

3.2.8 CHILDBIRTH PREPATATION

THE INSURER covers a contribution of CHF 150:

a. For an individual or group childbirth preparation course given by a midwife or by an organization of midwives, or

b. For an interview with a midwife or with a midwifery organization for advice regarding the birth, planning and organization of the postnatal period at home and breastfeeding preparation.

3.2.9 BREASTFEEDING ADVICE

1. Breastfeeding advice is covered by the INSURER when it is provided by a midwife or a nurse who has undergone special training in this area.
2. Reimbursement is limited to three (3) sessions.

3.2.10 MIDWIFE SERVICES

THE INSURER covers the following services provided by registered midwives:

1. During a normal pregnancy: four (4) check-ups carried out by a midwife or a midwifery organization.
2. During a high-risk pregnancy: without pathological manifestations, the midwife or the organization of midwives collaborate with the doctor. During a pathological pregnancy, the midwife performs their services according to the medical prescription.
    a. A follow-up consisting of home visits to provide care to the insured and monitor her state of health after a miscarriage or a medically indicated pregnancy termination from the 13th to the end of the 23rd week of the pregnancy.
    b. After the miscarriage or termination of pregnancy, the midwife can make a maximum of ten home visits,
    c. Follow-up, consisting of home visits to monitor the state of health of the mother and child and provide them with care as well as to support, guide and advise the mother in how to care for the child and to feed the newborn,
3. During the 56 days following the birth, the midwife may make a maximum of sixteen (16) home visits in the event of premature birth, multiple birth, first child or Caesarean section or a maximum of ten home visits in all the other cases,

4. During the 10 days following the birth, the midwife can make two (2) visits a day up to a maximum of five (5) times,
5. Midwives can prescribe laboratory tests and they can prescribe, during a control examination, an ultrasound-graphic control.

3.2.11 PREGNANCY

Costs linked to pregnancy and childbirth routine tests, stay in a birth centre, breastfeeding advice, treatment for new-borns who are in good health and their stay, if they stay in the hospital with their mother, are covered by the basic LAMal/KVG tariffs.

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

<u>During a normal pregnancy</u>

- Four exams
  - First consultation: anamnesis, gynaecological and clinical examination,
  - advice, examination of veins and search for leg oedema; prescribing the necessary laboratory tests in accordance with the Test List (LA);
  - subsequent consultations: monitoring of general health, including weight, blood pressure and height of the uterus, urine examination and auscultation of foetal heart sounds, ordering of necessary laboratory tests according to the list of tests (LA); general advice relating to pregnancy and more specifically to pregnancy-related disorders.
  - If the checks have been carried out exclusively by doctors, they inform the insured person that the consultation with a midwife is appropriate during the second trimester.
- During a high-risk pregnancy: Renewal of examinations according to clinical evaluation

<u>Ultrasonography controls</u>

i. During a normal pregnancy:
   - Two ultrasounds between the 12th and 14th week of pregnancy.
   - Two ultrasounds between the 20th and 23rd week of pregnancy.

Ii. During a high-risk pregnancy:
   - Renewal of examinations according to clinical evaluation.

<u>First trimester test:</u>

- Prenatal analysis of the risk of trisomy
- Laboratory tests according to the list of analyses (LA).

<u>Non-invasive prenatal testing:</u>

- Only to detect trisomy
- From the 12th week of pregnancy.
- Risk assessment and indication in case of foetal malformation detected during ultrasound examination.
- Prescription only by specialists in gynaecology and obstetrics with extensive training in maternal-foetal medicine
- Laboratory tests according to the list of analyses (LA).

- If the sex of the foetus is determined for technical reasons, this information cannot be communicated before the end of the 12th week of amenorrhea.
- Laboratory tests according to the list of analyses (LA).

a. Postpartum control an examination:

- Between the sixth and tenth postpartum week: intermediate anamnesis,
- Gynaecological and clinical status including counselling.

b. Control after miscarriage:

- After a medically indicated miscarriage or termination of pregnancy from the 13th to the end of the 23rd week of pregnancy.
- Intermediate history, gynaecological and clinical status, counselling.
- Laboratory analyses and graphic ultrasound control according to clinical evaluation.

3.2.12 VOLUNTARY TERMINATION OF PREGNANCY (IVG)

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.

3.2.13 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 if they are carried out by a pharmacist or a laboratory which have been authorised by LAMal/KVG.

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

3.2.14 PSYCHIATRIC HOSPITALISATION

The **INSURER** will refund cost of hospitalisation in a psychiatric hospital in their entirety for a maximum duration which is outlined in the Table of Benefits.

3.2.15 ORGAN TRANSPLANTS

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

3.2.16 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 if they have no other insurance package or third-party service provider covering the expense.

3. A deductible which is outlined in the Table of Benefits will be charged to the insured party for each treatment.

3.2.17 MEDICATION

1. The INSURER will cover medication according to the Table of Benefits, 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, except for 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.

3.2.18 SUPPLEMENTARY MEDICAL SERVICES - NATURAL MEDICINE

1. NATURAL MEDICINE treatments compliment article 3.2.16 ALTERNATIVE MEDICINE and cover natural medicine (Ayurveda, medicinal massages, naturopathy, and traditional Chinese medicines), limited medicines, convalescence cures and covers within the limitations defined below, the treatments which will not be considered.

1. ENTITLEMENTS: The INSURER covers all services listed below in Table of Benefits. The sub-limits and proportion can be defined for certain services.
   a) Traditional Chinese medicine
   b) Acupuncture, laser acupuncture and acupressure.
2. RIGHT TO ENTITLEMENTS This is subject to agreement from the INSURER who can be contacted via the Alarm Centre (24h/24h, 365 days a year): Telephone: +41 (0)22 929 52 52,
   a) If agreement has not been reached or requested by the insured party from the INSURER, the INSURER will reserve the right to reject claims submitted.
   b) The INSURER reserves the right to contest invoices and legal fees that they consider excessive and therefore can reduce the compensation. Cost of care which results in ineffective, inadequate, and non-economical treatment are considered excessive.
   c) The agreement of the present insurance coverage for "NATURAL MEDICINE" is only possible under the condition that no treatment for a pre-existing health problem started before the contractual start of the insurance policy.
   d) To prove his right to compensation, the insured party must submit original bills to the INSURER, which are from a qualified doctor or therapist who practises in Switzerland. This document must be accompanied with a statement of treatment written by the practitioner, which falls within the

legal cost system in Switzerland. The treatment that has been carried out must feature in detail on the bill.

e) The compensation will be paid by the INSURER under the condition that they have been curative treatment and if the insured party is relying on treatment by therapists who are appropriately qualified and are members of an official professional association authorised in Switzerland.

f) Before any consultation, the insured party must make contract with the INSURER to check that the chosen therapist complies with the criteria in paragraph 1 of the present article.

g) The services referenced which are given for other purposes or comfort are excluded from the insurance coverage.

3. DURATION OF RIGHT TO ENTITLEMENTS: The entitlements outlined in the above article 3.2.17. 'NATURAL MEDICINES' automatically finish on the day the present contract finishes or is cancelled and this also applies for benefits which are being provided.

4. EXCLUSIONS: The following benefits are always excluded:

a) When they are the consequences of alcoholism or drug use.

b) When they are the result of a pre-existing health problem which existed before the present insurance coverage started (mental or nervous illnesses for example);

c) When they are the result of an accident which occurred because of recklessness, a suicide attempt or self-mutilation.

d) If they are linked to aesthetic surgery, starvation diet, comfort and cell treatment.

e) defined in article 3 paragraph 1 for which there is no agreement from the INSURER (or no notification from the insured party or without obtaining agreement from the INSURER).

3.2.19 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 Benefits.

3.2.20 REHABILITATION

Treatment for rehabilitation is covered if they follow a period of hospitalisation. See Table of Benefits.

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

3.2.21 SCREENING AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

Under the condition that all necessary measures were taken to prevent its occurrence. The coverage can be applied within the exclusions outlined in the Table of Benefits.

3.2.22 THERMAL SPA TREATMENT

Treatment and accommodation costs in the event of a thermal spa treatment in an establishments recognised by the Order of Thermal Spa Treatment Establishments on the Health Benefits Insurance *(" The healthcare insurance benefits ordinance (OPAS)").*

The INSURER will make a daily contribution to the cost of thermal treatment prescribed by a recognised doctor or practitioner. Only when all the following conditions apply:

The treatment must have been medically prescribed by a medical doctor recognised within the definition and meaning of the LAMal.

a) The treatment must have taken place in the country of stay.

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

c) 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.

3.2.23 SPEECH THERAPY

1. Speech and language therapists registered in accordance with Art. 50 OAMal and organizations of speech therapists and speech therapists, who treat following a medical prescription, patients suffering from language, speech, voice, flow, and swallowing disorders from one of the following causes:
    a. Neurological disorders caused by infection, trauma, intoxication, tumours, vascular disorders, hypoxia, degenerative disorders or as postoperative sequelae.
    b. Phoniatric disorders, partial or total malformation of the lips, tongue, palate, jaw or larynx and alteration of the orofacial musculature or of the function of the larynx of infectious, traumatic, tumoral, functional or as postoperative sequelae.
2. The INSURER covers, following a medical prescription, up to twelve (12) speech therapy sessions, the first treatment having to take place within eight weeks of the medical prescription.
3. A new medical prescription is required to cover a greater number of sessions.
4. If speech therapy must be continued at the INSURER's expense after a treatment equivalent to 30 one-hour sessions over a period of one year, the attending physician refers the matter to the medical advisor; he sends him a duly substantiated proposal concerning the continuation of the therapy. The medical advisor proposes whether or not to continue the therapy at the expense of the INSURER, indicating to what extent.
5. The attending physician sends the medical adviser a report on the treatment and the indication of the therapy at least once a year.

3.2.24 NEUROPSYCHOLOGY

1. THE INSURER covers the costs of diagnostic services provided following a medical prescription provided by a registered neuropsychologist in accordance with Art. 50b OAMal
2. The INSURER, following the medical prescription, the costs of up to six (6) sessions.
3. A maximum of two (2) medical prescriptions are possible per year and per patient.

3.2.25 PHYSIOTHERAPY

The INSURER covers the following services of physiotherapists admitted in accordance with Art. 47 KVAO or physiotherapy organisations admitted pursuant to Art. 52 KVG, where they are provided on medical prescription and in the context of the treatment of musculoskeletal or neurological diseases or the systems of internal organs and vessels, if physiotherapy allows them to be treated:

a. measures relating to physiotherapeutic examination and evaluation.

b. Therapeutic measures, advice, and instruction:

1. Active and passive physiotherapy,
2. Manual therapy,
3. Physiotherapy detonating,
4. Chest physiotherapy (including aerosol inhalations),
5. Medical training therapy,
6. Physiotherapy lymphological,
7. Physiotherapy in water,
8. Hippotherapy in cases of multiple sclerosis, cerebral palsy and Down syndrome,
9. Cardiovascular physiotherapy,
10. Pelvic floor physiotherapy.
11. Physical measures:

c. Hot and cold therapy,

d. Electrotherapy

e. Light therapy (ultraviolet, infrared, coloured rays),

f. Ultrasound

g. Hydrotherapy

h. Muscle and connective tissue massages.

12. Medical training therapy begins with an introduction to training on devices and ends within three months at most. It is preceded by an individual physiotherapeutic treatment.

13. The insurance covers, by medical prescription, at most the costs of 9 sessions, the first treatment having to take place within five weeks of the medical prescription.

14. A new medical prescription is necessary for the management of a greater number of sessions.

15. For the attending physician to continue to be covered after a treatment equivalent to 36 sessions, he must send a report to the insurer's medical officer and submit a duly reasoned proposal. The medical officer proposes whether to continue the therapy at the cost of insurance, indicating to what extent and when the next report must be submitted.

3.2.26 CHIROPRACTORS AND OSTEOPATHS

The insurance covers the following benefits prescribed by registered chiropractors in accordance with Art. 44 KVAO or registered chiropractors' organisations in accordance with Art. 44a OAMal:

a. Analyses.
b. Medicines
c. Proprietary medicinal products of the following therapeutic groups in the list of medicinal products:
    a. Diagnostic or therapeutic means and devices.
    b. Imaging examinations.
    c. Physiotherapy services.

Chiropractic costs are covered only if the insured has recourse to an authorised chiropractor under a certificate of capacity legally recognized in the contractual territory.

Osteopathic costs are covered within the limits indicated in the table of guarantees.

3.2.27 OCCUPATIONAL THERAPY

1. The INSURER covers the prescribed services provided by occupational therapists insofar as:
    a. They provide the insured, in the event of somatic ailments, thanks to an improvement in bodily functions, autonomy in the performance of ordinary life activities, or
    b. They are carried out in the context of psychiatric treatment.
2. The INSURER covers, by medical prescription, the costs of a maximum of nine (9) sessions, the first treatment having to take place within eight weeks of the medical prescription.
3. A new medical prescription is required to cover a greater number of sessions.
4. For the sessions to continue to be reimbursed after a treatment equivalent to 36 sessions, the attending physician must send a report to the INSURER's medical adviser and submit a duly substantiated proposal. The medical advisor proposes whether to continue the therapy at the expense of the INSURER, indicating to what extent and when the next report must be presented.

3.2.28 PODIATRY

The **INSURER** covers the costs of the services provided following a medical prescription by podiatrists registered in accordance with Art. 50d OAMal if the following conditions are met:

1. Benefits are provided to persons with diabetes mellitus who have one of the following risk factors for developing diabetic foot syndrome:
    a. Polyneuropathy, with or without peripheral arterial occlusive disease (PAOD),
    b. Prior diabetic ulcer,
    c. Amputation performed due to diabetes mellitus with or without neuropathy or angiopathy.
2. The services provided are as follows:
    a. Control of the foot, skin and nails,
    b. Protective measures, including atraumatic callus removal and atraumatic nail care,
    c. Advice and instructions to the patient concerning the care of the feet, nails and skin and concerning the choice of shoes and orthopedic aids,
    d. Examination of the fitting of the shoe.
3. The guarantees cover the costs for the following maximum number of sessions per calendar year:
    a. For people with diabetes mellitus with polyneuropathy:
    b. For people with diabetes mellitus who have had a diabetic ulcer or have had an amputation due to diabetes mellitus: 6 sessions.
4. A new medical prescription is required for reimbursement of medical foot care after the end of a calendar year.

3.2.29 NUTRITIONAL ADVICE

Dieticians admitted pursuant to Art. 50a OAMal and dietetic organisations admitted in accordance with Art. 52c OAMal provide, on prescription or medical mandate, dietary advice to insured persons suffering from the following diseases:

a. Metabolic disorders.
b. Obesity (body mass index over 30) and conditions that arise from or are associated with overweight.

Obesity and overweight in the context of "individual multi-professional structured outpatient therapy for overweight or obese children and adolescents"

c. cardiovascular diseases.
d. Diseases of the digestive system.
e. diseases of the kidneys.
f. states of malnutrition or undernutrition.
g. food allergies or allergic reactions due to food.

1. The **INSURER** shall cover, on prescription of the attending physician, a maximum of six sessions of nutritional advice. The medical prescription can be renewed if new sessions are necessary.

2. If nutritional advice is to be continued at insurance expense after twelve sessions, the attending physician shall refer the matter to the medical officer and shall send him a duly substantiated proposal for the continuation of the nutritional advice. The medical officer proposes to the insurer whether to continue the nutritional counselling sessions at the expense of the insurance, indicating to what extent.

3.2.30 SERVICES PROVIDED BY PHARMACISTS

The INSURER covers the costs of the following services provided by pharmacists:

a. Advice when filling a medical prescription containing at least one medicine from the list of specialties.
b. Filling a medical prescription outside working hours usual, in case of emergency.
c. Replacement of an original preparation or a generic prescribed by a doctor by a more advantageous generic.
d. Assistance prescribed by a doctor, when taking a medication.

3.2.31 PREVENTIVE MEASURES

The insurance covers the following preventive medical measures (Art. 26 LAMal/KVG):

a. Prophylactic vaccinations.
b. Measures aimed at the prevention of diseases.
c. Examinations concerning the general state of health.
d. Measures for the early detection of diseases in certain risk groups:
   - Screening mammography.
   - Colon cancer screening.
   - Gynaecological examination, including cervical-vaginal cytological screening samples.
e. Measures for the early detection of diseases in the whole population; this also includes measures aimed at all persons of a certain age group or only at men or women.

3.2.32 PROPHYLAXIS - PREVENTION

1. The INSURER covers the following preventive medical measures or examinations ordered by a doctor:
   a. Prophylactic vaccinations.
   b. Disease prophylaxis measures.
   c. Health check-ups.
   d. Measures for the early detection of diseases in certain risk groups.
   e. Measures for the early detection of diseases in the whole population.
      i. Screening mammography
      ii. Colon cancer screening
      iii. Gynecological examination, including cervico-vaginal cytological screening samples.
   f. Passive immunization using antibodies against COVID-19
2. The costs of prevention, screening and prophylaxis are covered exclusively, for insured persons who are particularly at risk and within the limits of compulsory basic healthcare insurance, in particular:
   a. Preventive gynaecological examinations.
   b. Screening for sexually transmitted infections, in the situations provided for in the catalogue of LAMal benefits.

3.2.33 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.

3.2.34 TRANSPORTATION COSTS & RESCUE

1. Under the limits of the coverage outlined in the Table of Benefits, the **INSURER** considers 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 Benefits, 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) ethylic, drunkenness at the time of an accident, where the insured person has a level of alcohol equal or higher to 0.50g per litre of blood.
4. The **INSURER** covers, within the contractual limits mentioned, the transport and rescue costs under the condition that they would not have been granted by **SIA**, within the framework of assistance coverage for the latter. (See Table of Benefits).

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;/KVG.

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 (plastic surgery) 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 cost of spa treatment or care for the insured party exceeds the medically necessary amount, 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 must 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 SA, Route de l'Etraz 12A, CH - 1267 VICH

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.
5. The present article does not affect the application to '**third parties**' when it has been taken out by the insured party.

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.

4 INSURANCE COVERAGE ARRANGEMENTS - ASSISTANCE

4.1 GENERAL FRAMEWORK

4.1.1 SUBJECT TO THE PRESENT COVERAGE

1. **SIA** provides, within the legal and contractual limits, assistance to people in difficulty whilst travelling within the contractual territory, if these people are also simultaneously covered by illness insurance.
2. Regarding assistance, **SIA** will immediately provide assistance to the insured person, if he finds himself in difficulty following a fortuitous event, within the conditions outlined in the present contract.
3. However, providing urgent help does not predetermine the supply of financial help, which the **INSURER** decides after having obtained the documents and necessary information.
4. When applying assistance services, **SIA** is obliged to provide the means but not the result.

4.1.2 ASSISTANCE COVERAGE PERIOD

4.1.2.1 Definition

1. The coverage period relates to the effective duration of the travel and stay of the insured party on the territory covered. It cannot exceed **90 consecutive days**.
2. Any coverage period must start and finish within the duration of the insurance contract and the start date must feature on the insurance policy.

4.1.2.2 Flexibility

1. The insured party can start several chronologically distinct periods of insurance coverage within the period of validity of the contract, provided that their overall duration does not exceed 90 days.
2. The insured party has the responsibility to provide the following documents to the **INSURER** to prove the effective duration of the trip: passport which has been stamped with the official entry and exit from the destination territory or any other official justification from a competent authority on the territory; failing that, a nominative transport ticket which includes the date and validity (plane, train, bus ticket etc.). If the insured party or the insurance policy holder does not provide evidence to justify his trip and his entry into the covered territory, the start date for the coverage which is featured on the insurance policy will prevail.

4.1.2.3 Option: Supplement premium for a grace period

Adding a supplement to the premium mentioned in the insurance policy, the insurance coverage that the insured party has, can be prolonged by **5 days,** under the condition that he is objectively prevented from (e.g. : closure of airports due to natural catastrophe) returning to his country of origin, before the end of his coverage period- or if his legal trip is linked to the activities described in the article. 1.1.3. the right to prolong- his country of stay.

4.1.3 GENERAL EXCLUSIONS TO THE ASSISTANCE INSURANCE COVERAGE

The following items are excluded from the coverage and no compensation will be due by the **INSURER** in the following situations and their consequences:

a) any consecutive claim caused by a major force, in case of an exceptional situation (armed conflict, revolution, nuclear radiation, etc.) or natural catastrophe that has been caused by an event of abnormal natural force (e.g., volcanic eruptions, meteorite fall, tsunami, earthquakes);

b) practice of hazardous activities by the insured party, which substantially change the risk covered.

c) when the insured party abusively requests an evacuation or repatriation to be organised when suffering from an infection or mild injury which could be treated on the site and which would not have stopped him from continuing his travel or stay;

d) consecutive accidents with symptoms of epilepsy and malaria.

e) running away and kidnapping.

f) non-observance of official prohibitions, as well as disrespect for the official rules of safety, linked to the practice of a sportive activity and/or hobby.

g) practice of a high-risk sport at any level (e.g. parachuting), or a motor sport, the use of motor bikes that are 49cm3 and above, all forms of hunting.

h) costs linked to exceeding luggage weight restrictions when being repatriated on a passenger plane and customs fees.

i) The occurrence of a claim on a territory which is excluded from the contract or has occurred outside the effective coverage period.

4.2 ASSISTANCE INSURANCE CONDITIONS

Assistance is offered under the following conditions:

a) Search and rescue.

In the event of a claim, SIA will cover part of the search and/or rescue charges by the competent authorities involved. The fees for rescue and recovery will be covered by SIA in the following cases:

1. Rescuing an injured person.
2. Searching for someone who is lost when his disappearance is following an accident, for as long as required, according to the circumstances and his life expectancy and hope of finding him alive.
3. Rescuing someone who has not been injured due to an abnormal external factor (falling into the crack of a glacier) but is susceptible to have health problems, and when the insured party is not able to break free himself. Exhaustion, loosing sense of direction or bad meteorological conditions alone, are not included in the coverage.
4. Recovering the body of a deceased insured party.
5. However, fees to find the body of a deceased person who is insured will not be compensated for.
6. Use of a helicopter is covered when all other means are unreachable or difficult to reach (especially in the mountains) or when time plays a definitive role.
7. If the case does not fall under the previous category, as a rule, a usual means of transport will be sufficient when road conditions are normal.
8. It is responsibility of the rescuer to judge on the spot the reasonable measures to be implemented (depending on the technical problems posed by the clearance, the nature and severity of the injury, the route to be used for transport, etc.). In this respect, it must be considered that a layperson is often unable to judge the nature and severity of the injuries.

b) Medical evacuation and repatriation

1. When the state of the insured party, victim of a sudden illness or accident, requires it and the doctors in charge give their opinion, SIA will organise and take care of the evacuation of the insured party to the nearest hospital centre. SIA will cover the charges in the event of a medical evacuation.
2. When the state and situation of the insured party, victim of a sudden illness or of an accident, and under the condition that the authorised doctors agree, SIA will organise and will cover the costs of the repatriation of the insured:
    a. Under medical supervision in a hospital close to the place of residence in Switzerland of the insured.
    b. Without medical accompaniment to the place of residence in Switzerland or the country of legal domicile of the insured following hospitalization.
3. By default, repatriation flights are covered when medical treatment is insufficient abroad and it needs to be carried out in the home state of the insured party, unless the latter or his next of kin opt for repatriation to his habitual residence. The choice and suitable mode of transport (air, ground or by boat) will be decided by SIA, who will reasonably cover the costs of the repatriation which have been used for transport.
4. Medical evacuation and/or, if necessary, the repatriation will only be provided through the agreement of SIA's medical service, in close collaboration with the attending doctor or doctors in the place of stabilisation.

c) Repatriation of human remains.

1. In the event of death of the insured party his during travel or stay, SIA will organise the repatriation of the human remains from the place of death to the place of burial in his home state or habitual residence. The repatriation will be carried out in conformity with national legislation and the international conventions and under the condition that the transfer is possible.
2. INSUREUR will cover the cost of transport of the human remains up to a maximum amount. SIA will take charge of any necessary transport formalities of the human remains.
3. When it is absolutely necessary to make the transport possible, SIA will cover the following costs within the limits stipulated in the Table of Benefits: the costs to preserve, handle, put the body in a coffin, specific transport needs, preservation treatment which is compulsory by law and conditioning and the cost of the simplest coffin, which is in accordance with the transport provider and conforms to the local and international legislation. The following are excluded: burial costs, embalming and the funeral ceremony or other.

d) Medical assistance

During his evacuation, if necessary, his repatriation, the insured party is supported and assisted by medical personnel and/or by paramedics who are specialised in his state, selected by SIA's doctors.

e) Remote medical advice

When the insured party requires remote medical advice, SIA will supply it, at the expenses of SIA, with a qualified independent doctor to respond to questions linked to his health state. The opinion given by the doctor and the consequences of this advice are unrelated to SIA.

f) Indication of local medical specialists

If a first exam reveals that the insured party is found in a critical state and that this state needs specialist intervention, SIA will communicate with the insured party, on his request or that of the doctor who is treating him in the place of the incident, the name of the doctor of this specialism, provided there is one in the region where the insured party is found and for this reason SIA will not take any responsibility for the medical act carried out by the named doctor and any possible consequences.

g) Sending emergency medication

SIA will organise and cover the cost of sending medication required for the insured party's treatment if they are not available in the country where the incident takes place if they are available in Switzerland and their usage is authorised in the place of their usage. The cost to send medication will be covered by SIA.

h) Sending urgent messages

SIA will cover the cost of sending urgent messages on behalf of the insured party to any person identified by him, who is found in his state of residence or place of habitual residence when he is not able to get in contact with the desired person of his own accord.

i) Repatriation of other insured persons involved in the same incident

SIA will organise and cover the costs of repatriation of all the insured parties affected by the same incident who cannot return using the mode of transport initially booked.

j) Covering travel for a next of kin

When the insured must be hospitalised for at least seven (7) days before being evacuated or repatriated, SIA organises and covers the certified costs of the close relative for a return trip in economy class and public transport to the place of hospitalisation of the insured. The close relative's attested living expenses, board and accommodation are borne by SIA up to the amount indicated in the Table of Benefits.

4.3 EXCEPTIONAL CIRCONSTANCES

1) The transportation of people (notably airlines) is likely to oppose travel for people suffering from certain illness or for pregnant women, the applicable restrictions until the start of travel, and may need to be modified without notice (for example: medical exam, medical certificate, etc.). Consequently, the repatriation of these people can only be carried out when the transport provider has not refused, and evidently, in the absence of unfavourable medical advice regarding the health of the insured party or expected child.

2) When it is expected that the insured party will have to stay in a Swiss or a foreign hospital, distanced from his homeland (for ten days or more) and that the costs of the transfer are permissible and are not disproportionate regarding the circumstances, the transfer costs can also be settled under exceptional circumstances, taking family ties into consideration.

4.4 SPECIFIC COVERAGE EXCLUSIONS

In addition to the exclusions and limitations outlined in the COVERAGE SPECIFIC INSURANCE CONDITIONS, "YSIMPLY & FAIR"

, the following situations and their consequences are excluded from insurance and assistance coverage, and no compensation is due by **SIA**:

a) When the insured party abusively requests for the organisation for his evacuation or repatriation when suffering from an ailment or mild disease which could be treated in loco, and which would not have stopped him from carrying on the travel or the stay.

b) Travel costs or transport costs encountered through requests from the patient or because of family ties - which are not outlined in the medical plan - will only be considered in exceptional circumstances.

c) Accidents following the symptoms of epilepsy and malaria.

d) The removal and transplantation of organs, tissues, or cells.

e) The consequences of taking medication that has not been prescribed by a doctor.

f) Escape and kidnapping.

g) Taking part in sport at a professional level or in the form of an official competition organised by a sport federation and for which a license is issued, as well as training at competitions.

h) Non-observance of official prohibitions, as well as disrespect for the official rules of safety, linked to the practice of a sportive activity and/or hobby.

i) The practice, of a motor sport at any level.

j) The use of motorbikes of 49 cm3 and more.

k) Any form of hunting.

l) When the insured party intends to move to the area where the claim occurred (seeking asylum, marriage, family reunification, etc.).

m) The cost of a meal in a restaurant as well as fees linked to excessive weight of luggage during repatriation by plane and the customs fees will not be covered by **the INSURER.**

4.5 COVERAGE LIMITATIONS

1. In addition to the general exclusions and limitations, the **INSURER** reserves the right to reject compensation requests and where appropriate terminate the contract in the following cases:

   a) Failure to communicate the claim immediately to the Alarm Centre by the insured party or any third party.

   b) Failure to get approval from **SIA** regarding the organisation who oversees the assistance, treatment, or hospitalisation.

c) Lack of communication or delay in communication from the insured party of information and necessary documents by SIA to process the claim.

d) Any pre-existing health state. In addition, SIA reserves the right to reduce compensation when the health condition of the insured party is not pre-existing but reveals important risk factors such as diabetes, hypertension, hypercholesterolemia etc.

e) Incidents, inconveniences, and complications linked to pregnancy in which the risk was known or reasonably predictable before the first day of travel.

f) The insured party's failure to announce the existence of another insurance contract covering the same risks or if the insured party commits disinclination.

g) The absence of measures which could reasonably be taken by the insured party to avoid the essential increase in risk, avoiding the occurrence of the claim.

h) Any refusal to collaborate with SIA with reference to the article 4.4.

2. Any refusal by the insured party, or by the person who decides on his behalf, of contractual assistance services (e.g., offer of repatriation) for the event of a claim, will mean the automatic suspension of the assistance coverage. Costs incurred due to the refusal of services will also belong to the insured party. In the event of a change of mind before the end of the coverage period, the costs related to the refusal of initial benefits (e.g., expenses related to an extension of hospitalization, etc.) and to the change of decision will be charged to the insured person.

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.

4.6 DUTIES OF THE INSURED PARTY

4.6.1 IMMEDIATE NOTIFICATION IN THE EVENT OF AN ASSISTANCE CLAIM

1. To benefit from medical assistance during travel, you must call the Alarm Centre (open 24/7, 365 days a year) immediately following the first occurrence of the claim event and before any medical consultation:

Telephone: +41 (0)22 929 52 52; Fax: +41 (0)22 929 52 55; Email: claims@evasan.com

2. Attention: The necessity to call immediately and in advance is an essential obligation in the present contract.
3. This will allow SIA, the Alarm Centre, and any third-party contractor to come and help the insured party as soon as possible, to provide advice and medical assistance. Disrespect of this obligation will immediately remove the insured party's rights to compensation or any other possible benefit.
4. If the insured party proves that he is totally unable to inform or to make the Alarm Centre aware of the arrival of the first symptoms prior to any treatment, because his life condition is threatened, a notification as early as possible from the policy holder, next of kin, the police, a hospital, or any person related to the claim will be considered valid.

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

1. At the latest, 60 days after the claim or 20 days after the documents are issued or, failing it, 10 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 his own expense. Beyond these time deadlines, the insured party will no longer be entitled to a reimbursement.

a) an accident statement and/or verbal report from the police, fire-fighters, and any emergency service.

b) the complete medical file as well as the medical report as established by the doctor consulted or the hospitals visited next to or in connection with the incident.

c) prescriptions from the pharmacy or other prescriptions.

d) the original bills for the medical procedures received by the insured and the bills for the purchase of medicines.

2. In addition, the policy holder and the insured party must send the INSURER any information or supporting documents needed.
   Also, the insured party must send any information to the INSURER, at his own expenses, to support the facts and any supporting documents that could determine the circumstances of the claim, to establish the consequences or prove the authenticity of their claim. When the INSURER responds in writing, they can impose a deadline of 10 days to provide the information or documents required, if they receive the documents any later than this, his request for compensation will be declined.
3. At INSURERs request, the insured party may be asked to be examined by a doctor, chosen by the INSURER, at the INSURER's expense.

4.6.3 MEDICAL CONFIDENTIALITY

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.

5 This condition is an essential and determinant condition of the present contract, and its disrespect will automatically result in the withdrawal of the contractual rights of the insured partyDMINISTRATIVE ARRANGEMENTS

6.1 COMMUNICATIONS AND NOTIFICATIONS

1. Notifications for the INSURER and assistance provider 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 the INSURER and assistance provider. 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.

6.2 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. The policyholder pays a provisionally fixed premium at the start of each insurance period (advance premium) corresponding to the presumed effective premium. The period of insurance is defined in the policy.

2. If payment by instalments has been agreed, instalments falling due during the insurance year are due.
3.
4. The premium can be paid in advance. The premium is billed from the date that the coverage takes effect.
5. On request, the policy holder can also pay the premium via fractioned payments under the condition that a higher price for it must be paid. In the event of fractioned payments, these must be received before the 10th of each month.
6. The compensation of insurance premiums with insurance compensation is forbidden.
7. 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.
8. 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.
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 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.
11. If the insured party incurs onerous administrative fees due to negligence or through his own fault, he must cover the cost.

6.3 ADJUSTING THE PREMIUM

The INSURER can adapt the premium rate according to the evolution of costs, claims and legal changes.

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

1. Insurance policyholders will be made aware of an increase in insurance premiums at least 60 days before the start of the new contractual year and will take effect the same year.
2. The INSURER must inform the policyholder of the new provisions of the contract before the expiry of the insurance period.
3. In the event of an increase in premiums, the insurance policy holder has the right to cancel the contract according to the cancellation conditions. The INSURER must receive the cancelation notice within a delay of 30 days.
4. If the policyholder does not cancel the contract, the adjustments made to the premiums will be deemed as accepted.

6.4 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.
   e) Development of modern medicine.
   f) Establishment of new or expensive forms of therapy, such as operating techniques, drugs and the like.
2. The new conditions apply to the policyholder if they are adapted according to the first paragraph during the validity of the insurance.
3. The INSURER notifies the policyholder of these adaptations listed above in writing. If the policyholder does not accept them, he can cancel the contract as from the application date the adaptations.
4. The insurance policyholder must be made aware of any new conditions at least **3 months** 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 assumed 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 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.

6.5 SAFEGUARD CLAUSE

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

6 FINAL PROVISIONS

7.1 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, if all the conditions written in article 2 paragraph 4 OAMal are respected.
3. The insurance contract starts from the day after (at 00.01AM) of the date outlined on the insurance policy and ends twelve months after (at 23.59PM).

7.2 INSURANCE CONTRACT CANCELLATION

1. Each party is entitled, by registered mail addressed to the other party, to terminate the insurance contract and/or to prevent its tacit renewal 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. In this case, the cancellation will take effect from the date that the changes come into force.
3. 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, with retroactive effect from the date that he noticed the mistake. In a case where the contractor rejects a change to the proposed contract or if he does not accept it within one day after reception, the INSURER reserves the right to terminate the contract within 14 days.
4. If, within an insurance contract for multiple insured parties (group contract or collective contract), the conditions for cancellation will only be given to certain people and cancellation of the contract will only be limited to these named people.

   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 the 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.

7.3 APPLICABLE LAW, CONCILIATION AND COMPETENT JURISDICTIONS

1. The insurance contract is governed by the present general insurance conditions. 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 through reconciliation.
5. In the event of failure of the attempt to reconcile, the **INSURER** 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 'SIMPLY & FAIR' insurance coverage shall prevail.

7.4 EFFECTIVE DATE

The present insurance conditions are effective as from 01.07.2024, removing any right to previous insurance conditions covering the same product.

7.5 TABLE OF BENEFITS

A. INSURANCE COVERAGE (INSUREUR)	
OUTPATIENT	
SERVICE	**MAXIMUM AMOUNT COVERED**
1. Medical prescription and medical equipment	Actual fees equivalent to LAMal/KVG
2. Consultations with a doctor or therapist	Actual fees equivalent to LAMal/KVG
3. Tests and scans	Actual fees equivalent to LAMal/KVG
4. Outpatient surgery	Actual fees equivalent to LAMal/KVG
5. Treatment at home or in a residential care centre in the event of hospitalisation.	CHF 25.- per day, MAX 30 days/year
6. Urgent medical care outside the residence area in Switzerland and urgent medication equivalent to LAMal abroad	Actual fees equivalent to LAMal/KVG
7. Ultrasound and mammography	Actual fees equivalent to LAMal/KVG
8. MRI, tomography, and scan-tomography	Actual fees equivalent to LAMal/KVG
9. Emergency treatment without hospitalisation	Actual fees equivalent to LAMal/KVG
10. Palliative care and long-term care	Actual fees equivalent to LAMal/KVG
11. GP consultations and medicine prescribed that is covered by LAMal /KVG	Actual fees equivalent to LAMal/KVG

12. Specialist consultation	Actual fees equivalent to LAMal/KVG
13. Consultations with a chiropractor	Actual fees equivalent to LAMal/KVG
14. Traditional Chinese medicine (acupuncture, laser acupuncture and acupressure)	10 sessions capped at a Max CHF 2'000.- per contractual year
15. Remedies	Actual fees equivalent to LAMal/KVG
18. Consultations prescribed by a physiotherapist or speech therapist	Actual fees equivalent to LAMal/KVG
19. Vaccinations medically prescribed	Actual fees equivalent to LAMal/KVG
20. Disease Prevention	Actual fees equivalent to LAMal/KVG
21. Early disease detection measures — Digital mammography, breast MRI — Colon cancer screening — Skin examination — Screening and care for sexually transmitted diseases	Actual fees equivalent to LAMal/KVG
22. Examinations concerning general health	Actual fees equivalent to LAMal/KVG
23. HIV/AIDS Test- Screening and treatment for sexually transmitted diseases	Actual fees equivalent to LAMal/KVG
24. Psychiatrist — Consultations — Hospitalisation	Actual fees equivalent to LAMal/KVG
25. Psychotherapy practised by psychologists	Actual fees equivalent to LAMal/KVG
26. Psychotherapists practiced by doctors	Actual fees equivalent to LAMal+ agreement from the INSURER
27. Thermal treatment	CHF 25/day - MAX 21 days/year
28. Consultations and orthoptic treatment	Actual fees equivalent to LAMal/KVG
29. Congenital infirmity not covered by disability insurance (Art. 3 para. 2 LPGA81)	Actual fees equivalent to LAMal/KVG
30. Laboratory and scan cost	Actual fees equivalent to LAMal/KVG
31. Equipment other than optical equipment	Actual fees equivalent to LAMal/KVG

32. Cost of organising remote medical advice	Actual fees equivalent to LAMal/KVG

HOSPITALISATION

1. Standard division Public Hospitals in Switzerland	Actual fees equivalent to LAMal/KVG
2. Surgery, including anaesthetic and operating room	Actual fees equivalent to LAMal/KVG
3. Psychiatric hospitalisation	Actual fees equivalent to LAMal MAX 30 days
4. Surgical and prosthetic equipment	Actual fees equivalent to LAMal/KVG
5. Hospital treatment following accidents due to hazardous sport activity if it was played within the normal conditions	Actual fees equivalent to LAMal/KVG
6. Organ transplant	Actual fees equivalent to LAMal/KVG
7. Day hospitalisation	Actual fees equivalent to LAMal/KVG
8. Emergency treatment outside residence area	Actual fees equivalent to LAMal/KVG
9. Ambulance transport in Switzerland	Max CHF 2,000. -/year Except in cases which the conditions apply: 50% of actual cost/MAX CHF 500.-
10. MRI, tomography and scan-tomography, tests	Actual fees equivalent to LAMal
11. Oncology	Actual fees equivalent to LAMal
12. Stay in thermal spa resort in Switzerland	25 CHF per day -Max. 21 days/per year
13. Convalescence therapies in Switzerland	25 CHF/day - Max. 30 days/year
14. Prescribed medical assistance	Actual fees equivalent to LAMal/KVG
15. Complimentary costs of hospital stay- private bedroom abroad	Actual fees equivalent to LAMal/KVG

MEDICAL TRANSPORTATION

1. Ambulatory	Max CHF 2'000/year Except in the cases of the limits apply: 50% of actual cost / Max CHF 500.-
2. Rescue fees	Max CHF 5'000.- except the cases outlined

3. In the specific cases outlined	50% of actual costs Max CHF 500
PREGNANCY	
1. Pregnancy	Actual fees equivalent to LAMal/KVG
2. Pregnancy and birth complications	Actual fees equivalent to LAMal/KVG
3. Home birth	Actual fees equivalent to LAMal/KVG
4. Pre-natal examination (according to the catalogue of conditions by LAMal/KVG)	Actual fees equivalent to LAMal/KVG
5. Ultrasound	Actual fees equivalent to LAMal/KVG
6. Post-natal examination (according to the catalogue of conditions by LAMal)	Actual fees equivalent to LAMal/KVG
7. Voluntary termination of pregnancy	Actual fees equivalent to LAMal/KVG
OPTICAL	
1. Glasses and contact lenses on prescription.	CHF 350.-/ 3 contractual years
DENTISTRY	
1. Emergency dental treatment with hospitalisation (Dental prosthetics in the event of an accident only)	100% in the event of an accident or after a serious illness for a chewing device
2. Emergency dental treatment without hospitalisation	100% in the event of an accident following a serious illness for a chewing device
3. Dentofacial and orthodontic orthopaedic treatment	Actual cost up to 21 years old
The INSURER (within the framework of the services listed above waive the application of the Quote part as defined in art 1.3.9. An annual deductible applies based on the choice of the insured party (see policy) CHF 0 - CHF300	
B. ASSISTANCE SERVICES	
ASSISTANCE before the trip	
1. Useful information	Actual costs
ASSISTANCE during the trip	

1. Medical evacuation and medical repatriation	Max. CHF 100'000. - *
2. Search and rescue fees for sea and mountains	Max. CHF 40'000.-**
3. Medical support	Actual costs
4. Remote medical advice	Actual costs
5. Advice from local specialist doctors	Actual costs
6. Medicine supply	Actual costs
7. Travel for next of kin in the event of hospitalisation (greater than 7 days)	Round-trip ticket + CHF 150/ Night (Max 7 days)
8. Repatriation of human remains + Fees for first preservation+ Funeral expenses	Max. CHF 40'000
9. Extension of stay (after the expected date of return)	Max. CHF 150.- / Night (max. 5 days)
10. Early return in the event of hospitalisation or death of a family member — In the event of an attack	Return ticket. Return ticket.
11. Accompaniment of students under 18 years old	Round-trip ticket

Attention –Reminder

The above B coverages are applicable only for the duration of the trip (a confirmed duration which must be confirmed by the invoice issued by the travel agency or by any other means of proof at the expense of the insured), with a maximum of 62 days from the date of departure.

* With an aggregate maximum limit per year of CHF 500'000.-

** with an aggregate maximum limit per year of CHF 250'000.-