YOUR MEMBER GUIDE

You are covered with ScoreStudies

International Health and Assistance Insurance

Applicable from 1st June 2025

april International | Antaé an april company

April International
INSURANCE MADE EASY

Antaé is an APRIL Company based in Switzerland. **Antaé** is specialised, amongst other things, in the distribution of international mobility solutions such as private medical insurance, travel security, assistance and repatriation, protection for international students coming to Switzerland through the **health insurance coverage**.

APRIL International, part of the APRIL Group, is a leading provider of international health insurance cover for individuals, families, students, and businesses across the globe.

The company specialises in offering personalised support and flexible solutions to its more than 150,000 policy members, and has over 30 years' experience in the industry.

The award-winning provider has offices in 14 countries worldwide and uses its strong expertise and local presence to help smoothly facilitate access to healthcare for members.

Contents

APRIL International has partnered with Allianz Partners to bring you a range of health insurance benefits

The purpose of this policy is to provide healthcare cover to international students, researchers, interns and enrolled in a Swiss education program and resident in Switzerland. The cover is not suitable for Swiss national students who are subject to mandatory local insurance.

You can depend on APRIL International to give you access to the best care possible. As specialists in international health insurance, we can provide you with a service that is fast, flexible and totally reliable.

It is strongly advised that you read all documentation in relation to your plan.

This guide describes in detail how we offer you access to the care you need, when you need it most. It sets out the standard benefits and rules of your policy. Please read this booklet in conjunction with your Insurance Certificate and Table of Benefits to ensure that you fully understand your level of cover.

The risk carrier for your health insurance is Allianz Partners:

Health: AWP Health & Life SA, is a public limited company with capital of 95,551,314 euros, registered in the Bobigny Trade and Companies Register under number 401 154 679. Its registered office is at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France. AWP Health & Life SA is regulated by the Autorité de Contrôle Prudentiel et de Résolution (ACPR) located at 4 Place de Budapest, CS 92459 - 75436 PARIS CEDEX 09.

Assistance: The Insurer is AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland), the Swiss Branch of AWP P&C S.A., Saint-Ouen, France, a limited company governed by the French Insurance Code. Registered in France: No. 519 490 080 RCS Paris. Swiss Branch registered in Zurich, registered No.: CHE-115.393.016, address: Richtiplatz 1, 8304 Wallisellen hereinafter Allianz Assistance.

Any questions?

Need advice?

Feel free to contact us

Depending on your location, you can contact our offices in Paris, Mexico or Bangkok.

Opening hours are from 8:30 am to 6:00 pm (local times)

APRIL International

Your dedicated team can be reached at
+33 1 59 13 39 98

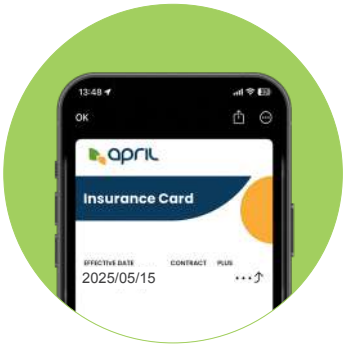
Toll-free number from Switzerland:
0800 564 524

swissmember@april.com

In case of emergency

You can contact us 24/7:

- Europe, Middle East, and Africa:
  +33 1 59 13 39 98
- North America (United States and Canada):
  +1 866 299 2900
- For the rest of the Americas:
  +1 305 381 6977
- Asia and Pacific:
  +66 2022 9180

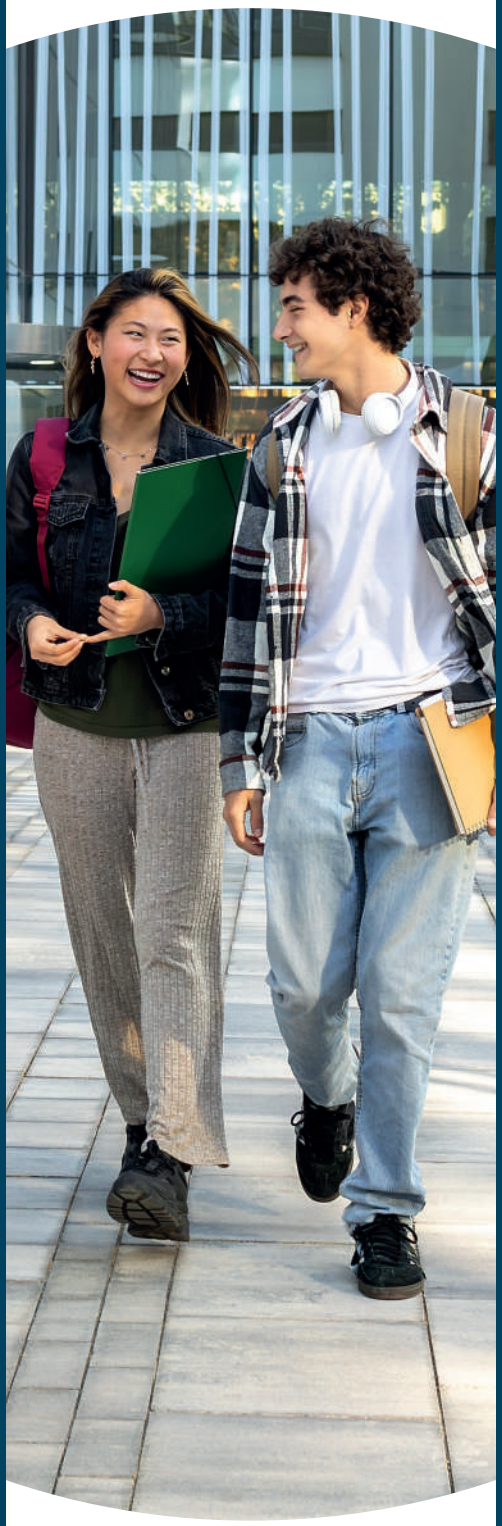


For easy access to your contacts, add your Insurance card to your Wallet

1. Download the Wallet app for Apple or Android,

2. Click on the personalised link provided in your Welcome Pack to add your Insurance card to your Wallet. You can also do this directly from your Easy Claim app.

How to use your cover



1. How to understand your insurance policy

1 Welcome Pack

You will receive your Welcome Pack by email.
It contains:
> Your access to the Easy Claim app and Member Portal,
> Your policy number,
> Your policy documents,
> Your Member Guide,
> Your Insurance Certificate, also available in Easy Claim,
> Your Insurance card in Wallet format.
We recommend that you download it to your mobile phone.

Please note: We encourage you to create your APRIL International account without delay. You will then be able to access all your online services from your Easy Claim app or your Member Portal.

2 Policy start date

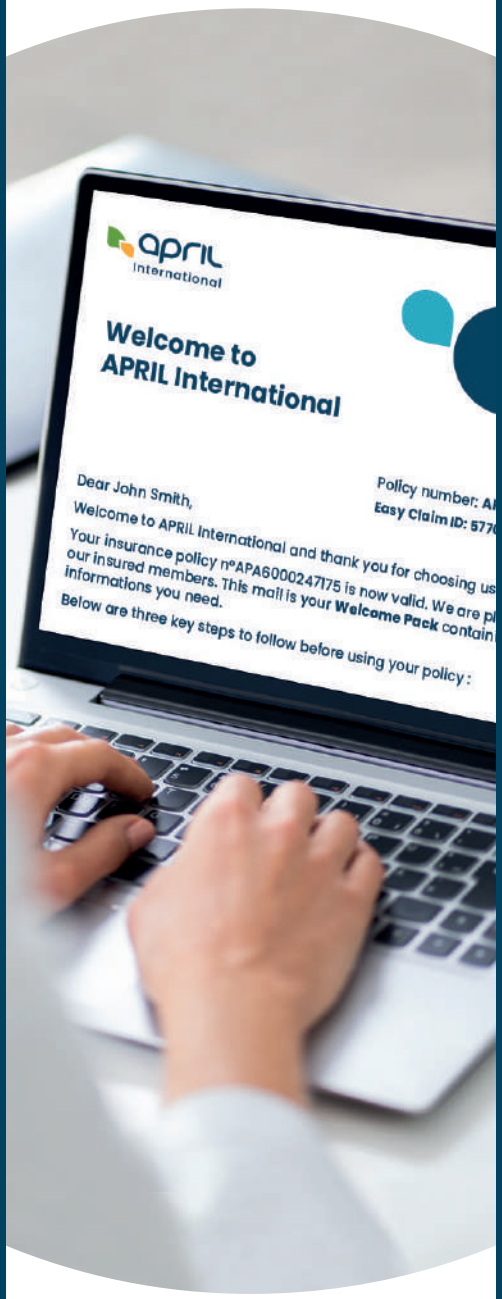
Your policy will come into effect on the date that you have chosen.
From this date, you can:
> Use your policy,
> Access all the features of your Easy Claim app and Member Portal,
> Add your bank details for future reimbursements.

3 Submit your first claim

Use your Easy Claim app or Member Portal to submit your claim. In just a few clicks, you can specify the type of treatment, your provider and upload the invoice. Once your claim has been approved, you'll receive your reimbursement by bank transfer.
If you have any questions, we invite you to:
> Consult our **FAQ**,
> Contact one of our advisers online or by phone at:
0800 564 524

4 Prepare a hospital admission

We invite you to contact us to prepare for your hospitalisation, either via Easy Claim or by calling **0800 564 524**.
This will enable us to direct you to the most suitable hospital and assist you with arranging an advance payment.



Important

Essential steps for efficient processing of your claims:

Please keep your original invoices (and other supporting documents) for a period of 5 years from the date you submitted the claim. We may ask for them to process your request.

In order to receive your reimbursement, please make sure that you have sent us your bank details through your Easy Claim app or your Member Portal.

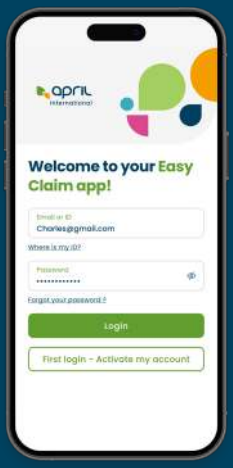
Treatment at a private hospital is not covered unless the necessary treatment cannot be provided at a public hospital and where authorisation is provided by us.

For routine maternity, please note that Pre-approval is required for in-patient treatment only. Pre-approval is also required for long-term care and palliative care.

Please refers to the section "Other benefits under your Core Plan" page 22 of this guide to see the full list of benefits that require pre-approval from us.

Before incurring these expenses, please submit your pre-approval request directly through your Easy Claim app:
> on the app home page, click on "Claims", then on "Pre-approval",
> complete your request and don't forget to add your quote and prescription.

2. Digital services to make insurance easier



1

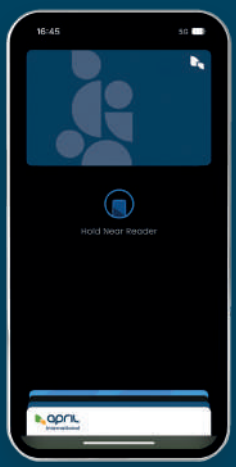
Easy Claim, all your services in the market-leading app

Make your life abroad easier. Download Easy Claim and manage your international health insurance in just a few clicks.

2

Your online Member Portal

Access your Member Portal in just a few clicks from your computer, tablet or smartphone.



3

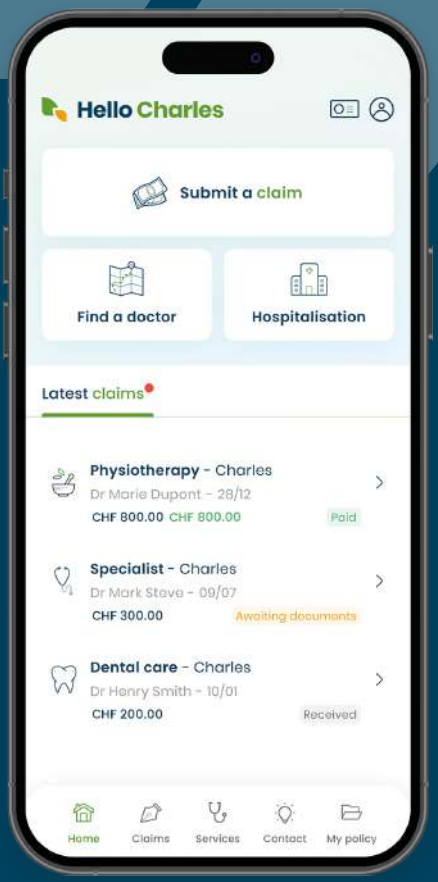
Easy Pay Card

The new digital payment card for expensive healthcare costs.

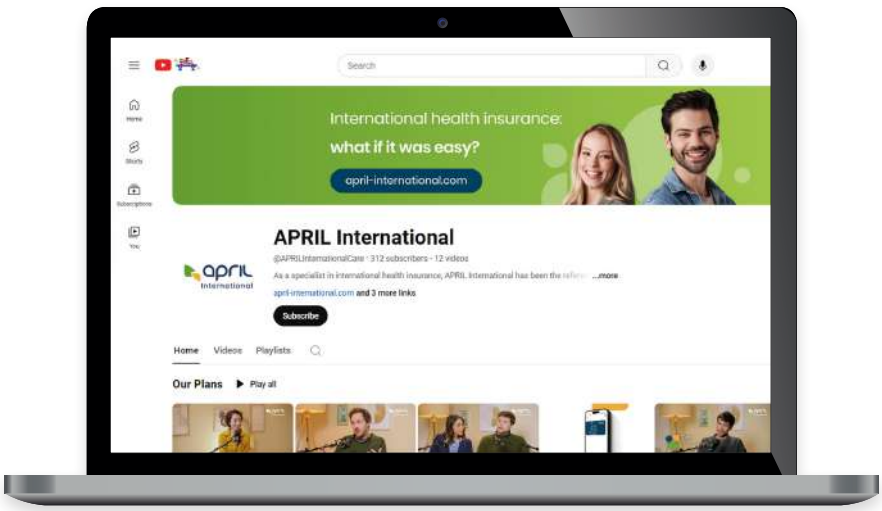
The Easy Claim app

All your healthcare services, in one app

- Submit your medical bills and track your claims
- Speak to a doctor using the telehealth service
- Find a healthcare provider
- Prepare a hospital admission
- View and download all your policy documents
- Check and update your personal details
- Talk to your dedicated advisers



Click here to watch our Easy Claim tutorial videos.



Download the Easy Claim app

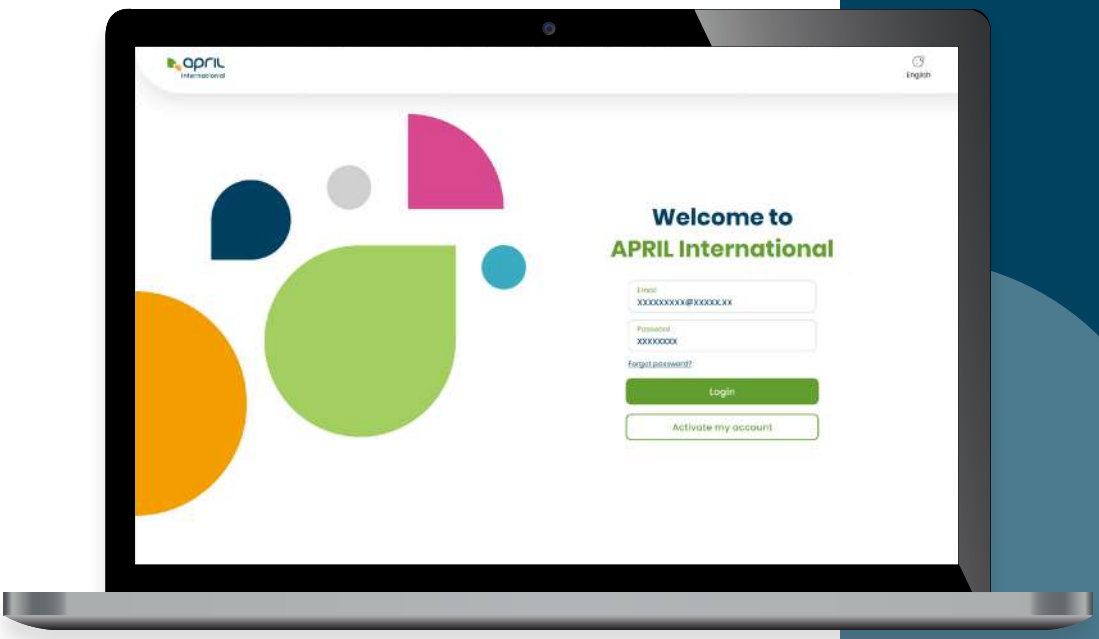
Download on the App Store

GET IT ON Google Play

Your Member Portal

Manage your insurance online

- Submit claims from your computer
- Speak to a doctor using the telehealth service
- View and download all your policy documents
- Check and update your personal details
- Prepare a hospital admission
- Download an Insurance certificate



Access your Member Portal

New!

Easy Pay Card

A digital payment card for your expensive healthcare costs

So that you can benefit from direct billing in areas where medical networks are unavailable, and so you don't have to pay upfront for expensive treatments.

This card can be used for all types of medical procedures covered by your policy:

> Medical imaging: MRI, ultrasound, X-rays, etc.

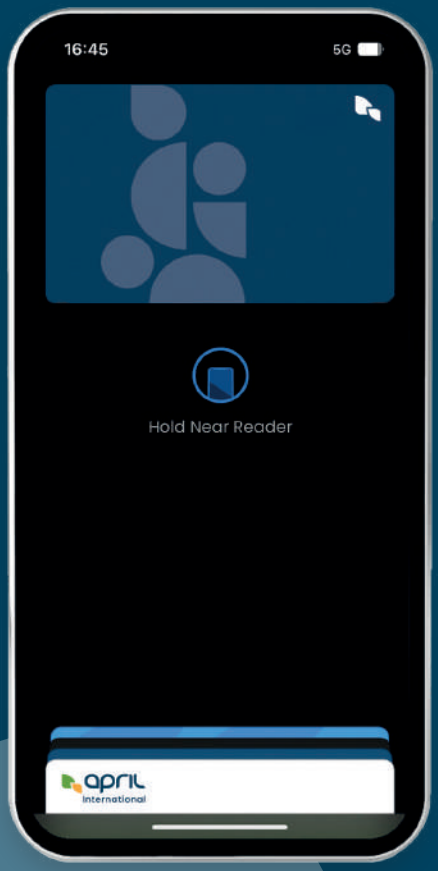
> Prosthesis: dental, medical or hearing device.

> Hospitalisation: in some cases, APRIL can provide you with an Easy Pay Card instead of a Letter of Guarantee.

> Optics: frames, lenses, contact lenses.

Please note that this card will be issued by APRIL only on **presentation of a quote justifying the need for and cost of the expenses**.
It can be used for emergency or planned treatment.

Send a quote



Using the Easy Pay Card

Request an Easy Pay Card
Send us your quote for an expensive treatment.

The Easy Pay Card is generated
The card is immediately credited with the amount corresponding to the planned treatment. You can add the card to your Wallet.

Treatment
Visit the doctor or healthcare facility and settle the invoice with the Easy Pay Card.

Invoice
Submit your medical receipts via the Easy Pay Card platform.

3. 24/7 medical support, wherever you are

2.2 million referenced healthcare professionals worldwide

Search for partner hospitals, doctors and pharmacies on the Easy Claim app.

You are hospitalised as an emergency

You can contact us 24/7 using the emergency numbers on your Insurance card (available on Easy Claim and downloadable to your Wallet).

You are planning a hospital stay

Send us your hospitalisation request on Easy Claim as soon as possible so that we can help you with your care plan: our medical team will advise on the prescribed treatment, direct you to the most appropriate medical facility and arrange payment of your hospital fees.

A doctor just a click away, 24/7

Thanks to the telehealth service included in your policy, in partnership with Medi24, Swiss pioneer in telemedicine.

medi24

Medical referral service

Our team of medical experts can help you prepare for hospitalisation or long-term care by reviewing your treatment plan and recommending suitable facilities.

We ensure the costs are consistent with the proposed treatments and your location. If necessary, we may inform you of any excessive charges and suggest alternative healthcare providers, ensuring you receive the best possible coverage.

A doctor available 24/7

Telehealth

This service allows you to consult a doctor remotely while maintaining medical confidentiality.
Contact a healthcare professional via the Easy Claim app or your Member Portal, this service is available **24/7**, anywhere in the world, in your preferred language.
Convenient and easy to use wherever you are, you no longer need to travel to see a doctor!

How to use this service:

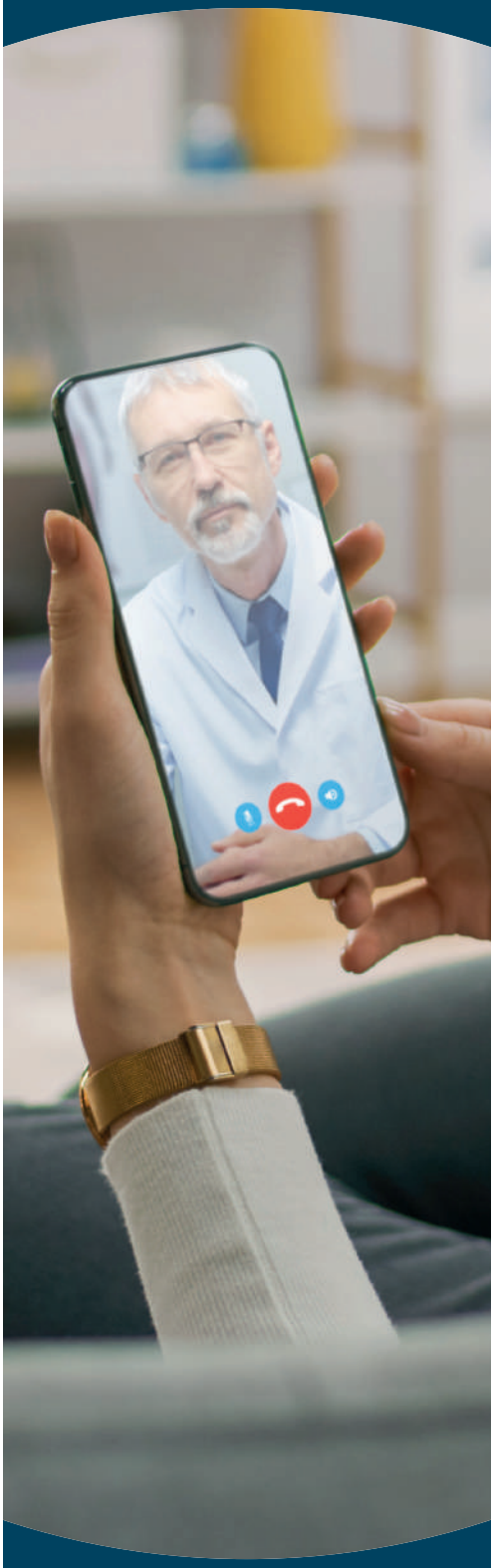
Go to the *"Services"* section on your Easy Claim app or click on the "Telehealth" button on the homepage of your Member Portal.

The doctor can issue a prescription if needed.

Telehealth is not an emergency service.
If necessary, go to the nearest hospital.

This service is very useful:

> For minor conditions such as flu-like symptoms, headaches, sore throat, etc,
> For information on current treatments,
> To help you prepare for a trip **or to get prescriptions in Switzerland**.



4. Expat Assistance Programme (EAP)**

When challenging situations arise in life or at work, the Expat Assistance Programme provides you with immediate and confidential support. EAP, where provided, is shown in your Table of Benefits.

This professional service is available 24/7 and offers multilingual support on a wide range of challenges, including:

- Work/Life balance
- Family/Parenting
- Relationships
- Stress, depression, anxiety
- Workplace challenges
- Cross-cultural transition
- Cultural shock
- Coping with isolation and loneliness
- Addiction concerns

Support services include:

Confidential professional counselling
Receive 24/7 support with a clinical counsellor through phone, video, email or face to face.

Critical incident support
Receive immediate critical incident support during times of trauma or crisis. Our wide-ranging approach provides stabilization and reduces stress associated with incidents of trauma or violence.

Legal and financial referral services
Whether it's help buying a home, handling a legal dispute or creating a comprehensive financial plan, we will refer you to a third-party advisor who can help answer your questions and reach your goals.

Access to the wellness website and app
Discover online support, tools and articles for help and advice on health and wellbeing.

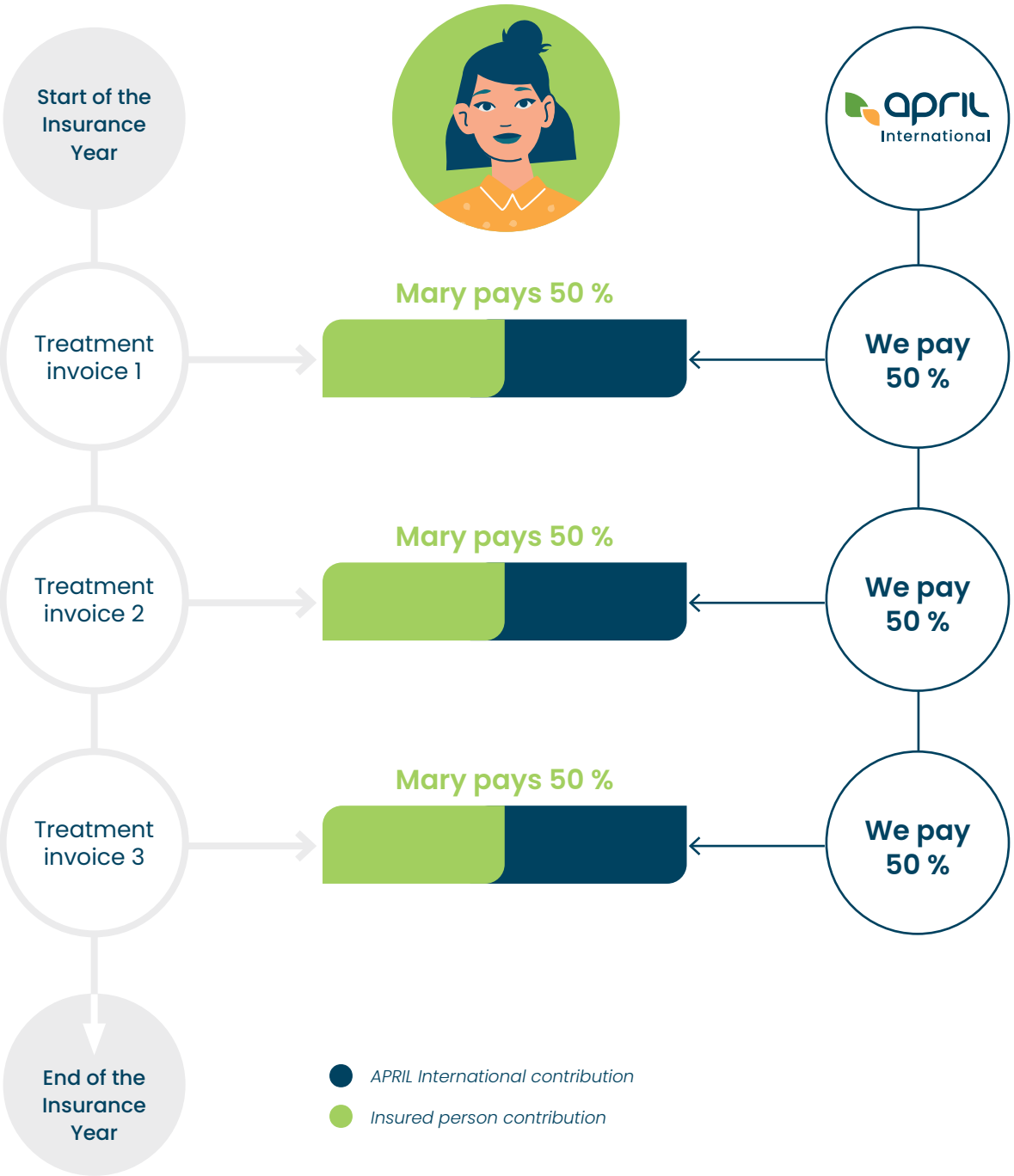
5. What are co-payments?

A co-payment is when you pay a percentage of the medical costs. Your Table of Benefits will show whether this applies to your plan.

In the following example, Mary requires several chiropractic treatments throughout the year.

Her chiropractic treatment benefit has a 50% co-payment, which means that we will pay 50% of the cost of each eligible treatment.

The total amount payable by us may be subject to a maximum plan benefit limit.

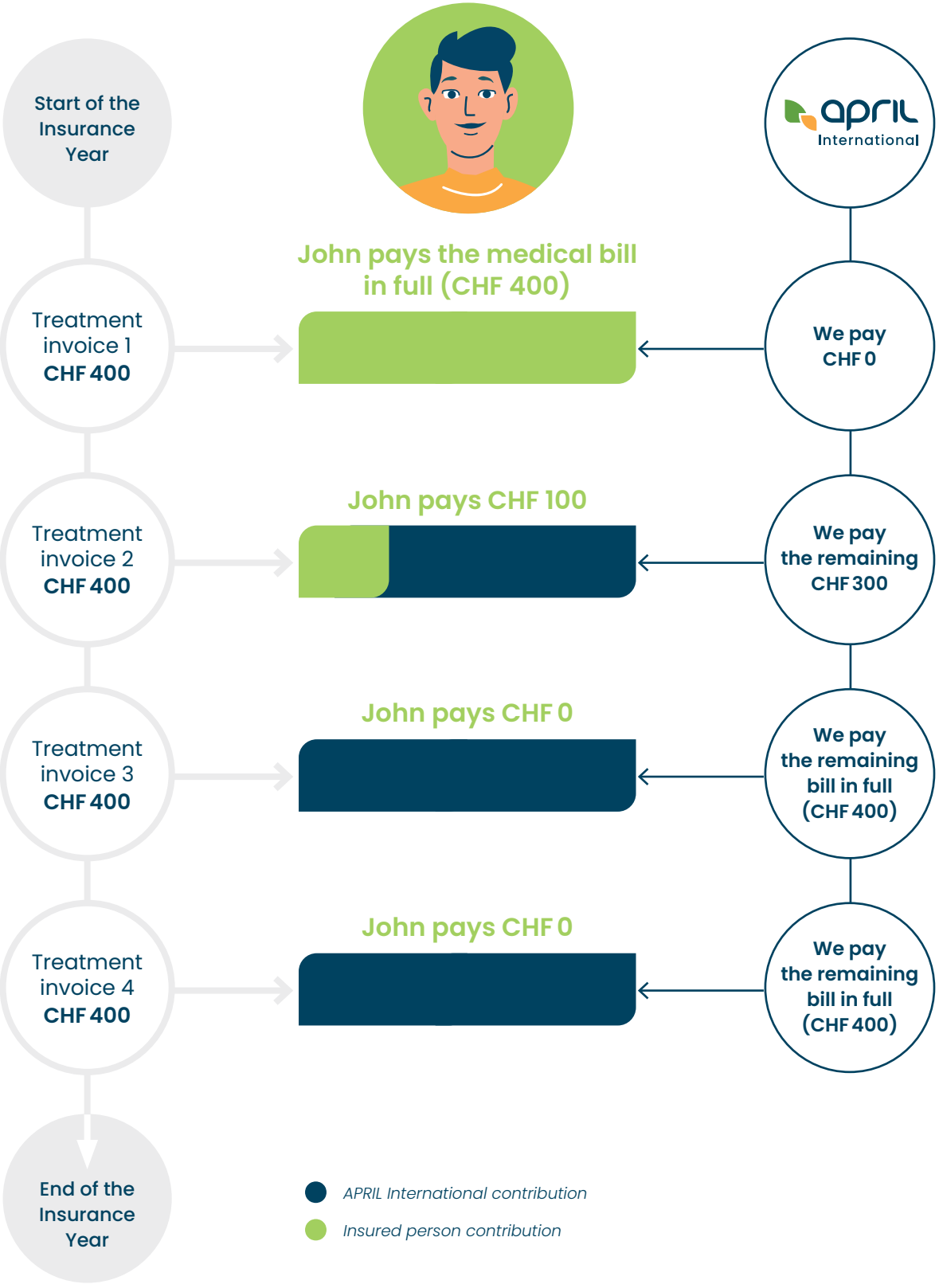


6. What are deductibles?

A deductible (also known in health insurance as an 'excess') is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute.

Your Table of Benefits will show whether this applies to your plan.

In the following example, John needs to receive medical treatment throughout the year.
His plan includes a CHF 500 deductible



Terms and conditions of your cover

Your cover explained

Your Table of Benefits specifies the plan(s) selected and the associated benefits available to you. You will find further details about our benefits in the "Definitions" section of this guide. Not all of the benefits listed in our "Definitions" section are necessarily covered under your policy, which is why it's important to check which ones are listed in your Table of Benefits. Your cover is subject to our policy definitions, exclusions, benefit limits and any special conditions indicated on the Insurance Certificate. If you have any queries about what you are covered for, please don't hesitate to call us.

Benefit Limits

There are two kinds of benefit limits shown in the Table of Benefits. The maximum plan benefit, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a specific benefit limit for example "Nursing at home or in a convalescent home". Specific benefit limits may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances, we will pay a percentage of the costs for the specific benefit e.g. "65% refund, up to CHF 1,000". Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year unless otherwise stated in your Table of Benefits.
Please note that if a change is applied to a benefit limit which spans to more than one year, at policy renewal, the following will apply:

- All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.
- All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.
- In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

Medical necessity

This policy provides cover for medical treatment, related costs, services and/or supplies that are medically necessary and appropriate to treat a patient's condition because of a disease or accident, in line with the definition on "Medical necessity". We will only pay for medical costs which are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. If the prices are higher than what is common locally, we reserve the right to reduce the amount payable by us.

Chronic conditions

Chronic conditions are covered within the limits of your plan(s).

Pre-existing conditions

Pre-existing conditions are covered within the limits of your plan(s).

Co-payments or deductibles

A deductible is an amount which is payable by you and which will be deducted by us from the eligible reimbursable sum, whereas a co-payment is a percentage of the eligible costs incurred, which is payable by you. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount you have to pay will be capped at the amount stated in

your Table of Benefits. Where applied, co-payments and deductibles are payable per person per Insurance Year (unless indicated otherwise in the Table of Benefits).

Please refer to your Table of Benefits to determine if any co-payments or deductibles apply to benefits within your chosen plans. They may apply to the Core, Out-patient or Dental Plans or indeed, to a combination of plans.

Where you are covered

Your Insurance Certificate will confirm your chosen geographical area of cover.

Your Core Plan explained

The following section gives a summary of the range of benefits which we offer. Please note that those available to you will be listed in your Table of Benefits.

In-patient benefits

In the case of in-patient treatment, you will be reimbursed within the limits of your cover for the benefits included under your Core Plan. In-patient benefits include things like hospital accommodation, intensive care treatment, anaesthesia and theatre charges, surgical fees, surgical appliances, prostheses and diagnostic tests. Treatment at a private hospital is not covered unless the necessary treatment cannot be provided at a public hospital and where authorisation is provided by us. Please refer to your Table of Benefits and to the definitions for details of the in-patient benefits available to you. Pre-authorisation is required in advance of all in-patient benefits listed in your Table of Benefits.

In-patient psychiatry and psychotherapy

If cover for psychiatry and psychotherapy is included in your plan, this is provided up to the amount specified in your Table of Benefits on an in-patient basis only, unless otherwise specified.

The disorder must be associated with present distress or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

Other benefits under your Core Plan

Day-care treatment

You will be covered for planned day-care treatment received in a hospital or day-care facility up to the amount specified in your Table of Benefits. This includes the charges for the hospital accommodation and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued. Please note that pre-authorisation is required.

Kidney dialysis

If this benefit is included, cover is also provided for kidney dialysis performed in a hospital, day-care facility or out-patient department. Please note that pre-authorisation is required.

Out-patient surgery

You are covered for surgical procedures performed in a surgery, hospital, day-care facility or out-patient department up to the amount specified in your Table of Benefits. Please note that pre-authorisation is required.

Nursing at home or in a convalescent home

You are entitled to claim for nursing received at home or in a convalescent home, if the nursing is provided immediately after, or instead of, hospitalisation, up to the amount indicated in your Table of Benefits. Please note that pre-authorisation is required. It should also be noted that this benefit is not payable in respect of palliative care or long-term care, which, where provided, will be covered under separate benefits.

Rehabilitation treatment

You are covered for treatment which takes place in a licensed rehabilitation facility, within 14 days of discharge after the acute medical and/or surgical treatment ceases. The level of cover provided will be stated in your Table of Benefits. Please note that pre-authorisation is required.

CT, MRI, PET and CT-PET scans

CT, MRI, PET and CT-PET scans carried out on an in-patient or out-patient basis may be covered within the limits of your Core Plan (please refer to your Table of Benefits). Pre-authorisation is not required for CT and MRI scans, however, it is required for PET and CT-PET scans. Please note that if you wish to avail of direct settlement for MRI scans, submission of a Pre-authorisation Form may be required.

Oncology

You are covered for specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis, up to the amount specified in your Table of Benefits. Pre-authorisation is required for in-patient and day-care treatment only.

Emergency benefits

Local ambulance

Cover is provided for ambulance transport, required for an emergency or due to medical necessity, to the nearest available and appropriate hospital or licensed medical facility, up to the amount specified in your Table of Benefits.

Emergency out-patient treatment

Cover under the emergency benefits is only for acute emergency healthcare needs in which you may incur. Only treatment necessary to commence within 24 hours of the emergency event will be covered, when deemed medically necessary by a doctor and carried out by a registered physician. This includes cover for treatment received in a casualty ward or emergency room, following an accident or any sudden beginning or worsening of a severe unforeseen illness, resulting in a medical condition that presents an immediate threat to the insured's health and which requires urgent medical treatment. Cover includes only emergency treatments and does not extend to follow-up treatment, which will have to be covered under the non-emergency benefits of your plan. This benefit does not include treatments which are necessary due to a pregnancy or any other exclusion. To be considered an emergency, the treatment must be received within 24 hours of the emergency event. Please refer to your Table of Benefits to confirm if any benefit limit applies.

Please note that you will be covered under the terms of your Out-patient Plan for out-patient treatment in excess of the emergency cover benefit limit.

Emergency in-patient dental treatment

This benefit provides you with a refund for emergency dental treatment due to a serious accident requiring hospitalisation, up to the amount stated in your Table of Benefits. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, they will be listed separately in your Table of Benefits.

Emergency treatment outside area of cover

Where applicable, you will be covered for emergencies only, which occur during the academic term, personal or internship trips outside of your chosen area of cover (where relevant). Cover is provided for a maximum period of six weeks per trip up to the benefit amount stated in your Table of Benefits. You will not be covered for any curative or follow-up non-emergency treatment, even if deemed unable to travel to a country within your geographical area of cover. If you are moving outside your area of cover for more than six weeks, please contact us.

Not only are you covered in the event of an accident, but you are also covered for the sudden beginning, or worsening, of a severe illness which results in a medical condition that presents an immediate threat to your health. To be considered as emergency treatment, and thus covered under this benefit, please remember that the medical treatment provided by a physician, medical practitioner or specialist should commence within 24 hours of the emergency event.

Charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded from this benefit.

Maternity cover

Maternity

Maternity refers to medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre-and post-natal care, midwife fees, newborn care as well as three breast feeding advice consultations.

Examinations performed by doctors or midwives or examinations ordered by doctors are covered during and after pregnancy. We cover costs for seven routine examinations (two of which may be uterus scans between the 10th and 12th week as well as between the 20th and 23rd week of pregnancy, with additional uterus scans covered in the case of a high-risk pregnancy as part of this benefit) and post-natal examination (six to ten weeks after giving birth).

Childbirth at home, in a hospital accommodation setting in the canton of residence, or in an in-patient situation, including preparation and aid provided by doctors or midwives, is covered, as well as up to three breastfeeding consultations.

Any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place.

Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures is only covered during the stay in the hospital until discharge following a routine birth. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment including complication are not covered for the newborn. Please also note that the newborn cannot be added to your policy and it is advisable to ensure an adequate insurance cover for the newborn before birth.

Benefit limits for routine maternity are payable on either a "per pregnancy" or "per Insurance Year" basis (this will be confirmed in your Table of Benefits).

For routine maternity, please note that pre-authorisation is required for in-patient treatment only.

Home delivery

Home delivery is covered when shown on your Table of Benefits and up to the limit specified in your Table of Benefits.

Complications of pregnancy

Complications of pregnancy relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered:

> Ectopic pregnancy
> Gestational diabetes
> Pre-eclampsia
> Miscarriage
> Threatened miscarriage
> Stillbirth
> Hydatidiform mole

Please refer to your Table of Benefits to confirm whether a benefit limit or waiting period applies. Please note that pre-authorisation is required for in-patient treatment only.

Complications of childbirth

Complications of childbirth refer only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Please note that complications of childbirth include medically necessary caesarean sections.

Termination of pregnancy

Costs for a lawful termination of pregnancy are included in your cover. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity.

Dental treatment

Cover is limited to accidents and specific diseases as per LAMal/KVG Art. 31, it is highly recommended to request confirmation of cover before seeking treatment.

This cover is limited to treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain or due to a serious accident of a sound and natural tooth. Cover includes temporary fillings, limited to three fillings per Insurance Year, and/or the repair of damage caused in an accident. The treatment must be received within 24 hours of the emergency event. Please note that cover does not extend to dental prostheses or root canal treatment.

Cover for dental treatment under the Core Plan is limited to the amount stated in your Table of Benefits and is limited only to accidents and specific diseases as per LAMal/KVG Art. 31. However, you can be covered under the terms of your Dental Plan for further dental treatment in excess of this cover, if part of your Table of Benefits.

Palliative care and long term care

We will cover the costs of ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life.

Long-term care refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.

Palliative care cover includes in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs. Please note treatments provided in a health resort or spa are excluded.

Please note that cover is limited to the benefit limits stated in your Table of Benefits and that pre-authorisation is required for long-term care and palliative care.

Prescribed stay in a spa

This is a prescribed medical stay requiring mineral water and its by-products, where the establishment provides aftercare and supervision to the patients.

Your Out-patient Plan explained

Your Out-patient Plan includes some or all of the following benefits:

> Medical practitioner fees
> LAMal covered prescribed drugs
> Specialist fees
> Diagnostic tests
> Chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine, lab tests, medications, medical aids prescribed by a chiropractor, acupuncture and podiatry

> Prescribed physiotherapy and speech therapy
> HIV/AIDS test
> Annual gynaecological exam
> Psychiatry and psychotherapy
> Prescribed medical aids
> Prescribed glasses and contact lenses
> Prescribed nicotine replacement therapy products

Please refer to your Table of Benefits to confirm the Out-patient Plan benefits available to you. A waiting period may also apply to certain benefits.

Psychiatry and Psychotherapy

Cover is provided for medically necessary psychiatry and psychotherapy provided by a psychiatrist for up to 40 diagnostic and therapeutic sessions or up to 30 diagnostic and therapeutic sessions if treatment is provided by a psychologist (when prescribed by a psychiatrist or a general practitioner) according to Art. 11b KLV. Cover can be provided if medically necessary for further sessions subject to submission of a medical report, outlining the diagnoses, the course of treatment, outcomes to date, the purpose of the proposed extension and the duration of the extension.

The disorder must be associated with present distress or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

Preventive treatment

We cover preventive treatments in line with OPAS/KLV Art. 12. This includes Vaccination as recommended by the Ministry of Health and the Federal Vaccination Commission. Cover also includes HIV test and gynaecological check-up. For other health checks or treatments which might be covered depending on the family history or personal medical history, we recommend you to confirm cover with us before seeking treatment.

Your Dental Plan explained

If the Dental Plan forms part of your cover, it will be indicated in your Table of Benefits along with the level of refund and any waiting periods which apply. Please note that your Dental Plan may be subject to a maximum plan benefit.

Simple filling refers to the cover of the costs for the consultation and treatment of a cavity using only dental filling material. The treatment process typically involves removing a small amount of additional tooth enamel from the area to prepare a surface sufficient for bonding the material. Once the dental filling has been shaded, applied, and smoothed flush with the surfaces of the tooth and effectively bond the dental filling to the tooth enamel, thus restoring its basic function and appearance.

Simple extraction refers to the cover of extracting a tooth without surgical intervention including the consultation. This does not include the extraction of a wisdom tooth.

Dental cleaning refers to the cover of the consultation and treatment costs to remove dental plaque from teeth with the intention of preventing cavities (dental caries), gingivitis, and periodontal disease.

The ScoreStudies insurance plan is taken out by the contracting party, the Association des étudiants ScoreStudies, for the benefit of any eligible individual who may enroll in the plan while residing temporarily in Switzerland.

General terms

The following are important general terms that apply to your policy with us:

1. Applicable law: Unless otherwise required under mandatory legal regulations, your membership is governed by the Swiss law in particular the federal law for insurance contracts "Versicherungsvertragsgesetz", VVG. Any dispute that cannot otherwise be resolved will be dealt with by the courts at the place of residence of the insured person in Switzerland (or the person with an entitlement to claim).

2. Economic sanctions: Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

3. The Insurer is AWP Health & Life SA, a public limited company with capital of 95,551,314 euros, registered in the Bobigny Trade and Companies Register under number 401 154 679. Its registered office is at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France. AWP Health & Life SA is regulated by the Autorité de Contrôle Prudentiel et de Résolution (ACPR) located at 4 Place de Budapest, CS 92459 - 75436 PARIS CEDEX 09.

4. Legal action: All legal actions arising under this policy shall have a time limit of five years from the date of the event that gave rise to the action (Article 46 VVG).

5. The Insured Person is **eligible for insurance** for this cover for as long as:

(a) he/she has a foreign citizenship and

(b) he/she has his/her address in Switzerland in one of the cantons in which we are recognised as LaMal equivalence and

(c) he/she has been residing in Switzerland for less than six years and

(d) he/she has a residence permit as a student/trainee/doctorant or au pair and

(e) is not married to a person with a B activity residence permit, a C residence permit or a Swiss national.

(f) he/she has a valid exemption from the statutory health insurance as per Art. 2.4 KVV.

(g) he/she shall remain insured under the social security system of their country of origin. Please note it is your responsibility to verify that you fulfil the criteria for a valid exemption.

Please note that you will have to inform us of any changes in relation to the above mentioned criteria.

6. Data Protection and release of medical records: Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data.
To read our Data Protection Notice visit: https://www.april-international.com/en/legal/privacy-policy

7. Cooling off period:

(a) You can cancel the contract in relation to all insured persons, within 30 days of receiving the full terms and conditions of your policy or from the start date of your policy, whichever is later. In relation to premium changes see relevant details under Paragraph 8 ("Premium").

(b) You cannot backdate the cancellation of your membership after the cooling off period.

(c) Should you wish to cancel, please send us an email to: swissmember@april.com.

(d) If you cancel your contract within this thirty (30) days period, you will be entitled to a refund of the cancelled insured person(s)' premium (see relevant details under Paragraph 8, "Premium").

8. Premium:

If you are responsible for paying your insurance premium:

(a) Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their region of cover, the policyholder's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance.

(b) By accepting cover, you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You may choose between monthly, quarterly, half-yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your invoice, you should contact us immediately. We are not responsible for payments made through third parties.

(c) The following payment dates apply:

Payment frequency:	**Due date:**
Monthly	First day of each month
Quarterly	First day of each quarter
Half-yearly	First day of the 1st month of the Insurance Year ***and*** First day of the 7th month of the Insurance Year
Annual	First day of the Insurance Year

(d) If your insurance starts in the current year, the premium payment for the first installment or the entire contribution (depending on the chosen payment frequency) is due on the first day of your insurance cover.

(e) If the initial or subsequent premium is not paid in time in full, we shall suspend your cover fourteen (14) days after we have provided you with a final written reminder (Articles 20 – 21 VVG). If we do not take legal action to recover the premium, your policy shall be deemed automatically cancelled two (2) months after the expiry of the 14 day notice period (Articles 20 – 21 VVG) and no further termination letter will be issued to you.

(f) The premium can be adjusted annually due to evolving health costs and the costs of claims. We will inform you of the new premium two months before the renewal of your policy. Should you wish to cancel your cover with us, you will be able to do so by notifying us in writing within 30 days of receiving the new rates.

(g) In the case of premature termination or termination of the insurance contract, Article 24 VVG shall apply.

(h) Claims against us cannot be offset against the premium.

(i) Your premium should be paid in CHF. If you are unable to pay your premium for any reason, please contact us on: **+33 1 59 13 39 98**. Changes in payment terms can be made at policy renewal, via written instructions, which must be received by us one month before the start of the new Insurance Year.

If your school/university is responsible for paying your insurance premium

In certain cases, your school/university may be responsible for paying the premiums for your membership under the Company Agreement. Your school/university may also pay other taxes

and charges associated with your cover (such as Insurance Premium Tax). However, you may be liable to pay taxes in respect of the premiums paid by your school/university. For details, please check with your school/university.

Please note the following additional conditions:

(a) If the initial or subsequent premium is not paid in time in full, we shall suspend your cover fourteen (14) days after we have provided your school/university with a final written reminder (Articles 20 – 21 VVG). If we do not take legal action to recover the premium, your policy shall be deemed automatically cancelled two (2) months after the expiry of the 14 day notice period (Articles 20 – 21 VVG) and no further termination letter will be issued.

(b) In the case of premature termination or termination of the insurance contract, Article 24 VVG shall apply.

(c) Claims against us cannot be offset against the premium.

9. Lifecycle of your policy:

(a) Please note that upon expiry of your policy, your right to reimbursement ends. Any eligible expenses incurred during the period of cover shall be reimbursed up to two years after the treatment date. However, any on-going or further treatment that is required after the expiry date of your policy will no longer be covered.

(b) The insurance contract runs for one Insurance year. When the policy is due for renewal, we may offer you renewals terms and only as long as the eligibility criteria are met (Art. 5 General Terms). The offer is deemed as accepted by paying part or the full amount of the insurance premium. The acceptance of the renewal terms constitutes as a new contract.

(c) If you wish to cancel your policy when leaving Switzerland, please contact us within three months of your departure. Please submit your cancellation request and relevant documentation within this timeframe to swissmember@april.com. Once we have received your request, we will cancel your policy and we will refund you with any premium payment due.

(d) It will not be possible to backdate cancellations if claims have been processed or if Pre-authorisations have been issued. The policy will be cancelled at the earliest 24h after the last treatment date.

(e) Please inform us in the event that you do not or no longer hold a valid exemption from the statutory health insurance as per Art. 2.4 KVV. Please note that in this case we reserve the right to cancel the insurance contract.

(f) As explained in paragraph 5, your cover will not be renewed or continued when you reach the limit of six years after your arrival in Switzerland. Please note that your exemption to the Swiss LAMal/KVG insurance can only be granted for a maximum of six years after your arrival date in Switzerland (Art. 2.4 KVV). "Versicherungsvertragsgesetz"

(g) We waive the statutory right to terminate the contract or in the event of a claim under Article 42 VVG. Your right to termination remains unaffected.

(h) In the unfortunate event that a policyholder passes away, please we should be informed in writing within 28 days.

(i) If cover is terminated prematurely, we will immediately inform the authority which issued the exemption from the statutory health insurance as per Art. 2.4 KVV.

(j) Your insurance cover is terminated automatically, if you no longer fulfil the eligibility criteria for insurance as set out in Art. 5 General Terms.

10. Claims process:

We would like to inform You that the data collected for the processing of your Claim is processed electronically by our company for the purposes of monitoring the processing of Claims and may only be communicated to the insurer, their reinsurers and the APRIL holding company, as well as to our partner service providers for the implementation of your cover. The information collected is essential for the registration, management and execution of subscriptions by APRIL International

Care France, the insurers or their agents. You have the right to access, rectify, object to and delete your personal data (see paragraph 6).

(a) All claims should be submitted no later than five years after the treatment date. Beyond this time, we are not obliged to settle the claim (Article 46 VVG).

(b) Your claim will be processed within four weeks of receipt (Article 41 VVG).

(c) When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.

(d) Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.

(e) We will only reimburse (within the limit of your policy) eligible costs after considering any pre-authorisation requirements, deductibles or co-payments outlined in the Table of Benefits.

(f) If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.

(g) You agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you do not support us in getting the information we need.

11. Complaints: Our Helpline is always the first number to call if you have any comments or complaints: +33 1 59 13 39 98. If we can't resolve the problem on the phone, please email or write to us:

> APRIL International Care France - Service Courrier - 1, rue du Mont - CS 80010 - 81700 Blan - FRANCE

> Our offices: APRIL International Care France - 14, rue Gerty Archimède - 75012 PARIS - FRANCE

> Email: reclamation.expat@april-international.com

We will handle your complaint according to our internal complaint management procedure. For details see: https://www.april-international.com/en/legal/complaints. You can also contact our Helpline to obtain a copy of this procedure.

If we have been unable to resolve the matter to your satisfaction and you wish to take it further, you can refer your complaint to the Stiftung Ombudsman der Privatversicherung und der SUVA / Ombudsman de l'assurance privée et de la SUVA.

> Address: Postfach 2646, 8022 Zürich

Please note that this does not affect your statutory rights under Swiss law or your right to refer the matter before the Swiss courts.

12. Correspondence: When you write to us, please email us or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

13. Who can make changes to your policy: No one, except an appointed representative is allowed to make changes to your policy on your behalf. Changes are only valid when confirmed in writing by us.

14. Changing your postal address or email address: We will send all correspondence to the address we have on record for you unless requested otherwise. You need to inform us in writing as soon as possible of any change in your home, business or email address.

15. Circumstances outside our control (force majeure): We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things that are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage and expropriation by governmental authorities.

16. The amounts we will pay: Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

17. Subsidiarity and third-party benefits:

(a) We provide our insurance obligations / benefits following reimbursement of benefits by social insurers or other private insurers or other liable parties. If other private insurers are also liable to provide benefits following reimbursement of other parties, we shall render benefits based on the insured amount in proportion to the total of the insured amounts (by all liable insurers). If a social insurer is compulsorily liable and we have provided initial insurance cover, we retain the right of reimbursement from either you or the social insurer.

(b) If liable third parties have an obligation to provide benefits for the consequences of illness or accident, we only guarantee to provide our benefits as advance payments and under the condition that the insured person transfers their claims against liable third parties to us up to the amount of the benefits rendered by us. If the insured person makes any agreement with liable third parties, in which they partly or wholly waive their claims to insurance benefits or compensation, without our consent, their entitlement to benefits from us becomes null and void.

18. Fraud and non-disclosure:

(a) Incorrect disclosure/non-disclosure of any material facts, by you, which affects our assessment of the risk and which should be captured on the relevant application form may result in the cancellation of the insurance contract. We will write to inform you of the cancellation of your policy within four weeks of the date of discovery of the non-disclosure (Article 6 VVG).

(b) If the contract is cancelled due to incorrect disclosure or non-disclosure of any material facts (according to Article 6 VVG), premium will be refunded.

(c) If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/ devices have been used by you or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim.

(d) In the event of fraudulent claims, the contract will be cancelled by us in writing from the date of our discovery of the fraudulent event and the amount of any fraudulent claims paid can be reclaimed by the insurer (Article 40 VVG).

Definitions

The following definitions apply to the benefits in our Healthcare Plans. The benefits you are covered for are listed in your Table of Benefits. If your plan includes any benefit not listed below, the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:

A

Accident is a sudden, unexpected, unintentional event which causes harm due to an exceptional external cause to the human body which results in an impairment of physical, mental or psychological health or death (ATSG, Article 4 "Unfall").

Acute refers to sudden onset of symptoms or a medical condition.

C

Chronic condition is defined as a sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

> Is recurrent in nature.
> Is without a known, generally recognised cure.
> Is not generally deemed to respond well to treatment.
> Requires palliative treatment.
> Leads to permanent disability.

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practiced by approved therapists.

Complications of childbirth refers only to post-partum haemorrhage and retained placental membrane. Where your plan also includes the benefits 'Routine maternity' or 'Routine delivery and newborn care', 'Complications of childbirth' includes medically necessary caesarean sections.

Complications of pregnancy relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

Co-payment is the percentage of the costs that you must pay. E.g. if a benefit has a 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per insurance year.

D

Day-care treatment is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible is the part of the cost that is payable by you and that we deduct from the amount we will pay. Where deductibles apply, they are payable per person per Insurance Year, unless your Table of Benefits states otherwise.

Dental prostheses include crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Diagnostic tests are investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.

Dietician fees relate to charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practice in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

Disease is any impairment of physical, mental or psychological health which is not the result of an accident and which requires a medical examination, treatment or results in an incapacity to work. The congenital conditions are the diseases which are existing upon birth of a child (ATSG, Article 3 "Krankheit").

Domicile is the residence of a person who is located in the place where they are with the intention of staying permanently and is defined in the Swiss Civil Code (Schweizerisches Zivilgesetzbuch, Articles 23 – 26, SR 210).

E

Emergency is the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Emergency in-patient dental treatment is limited to accidents and specific diseases as per KVG/LAMal; it is highly recommended to request confirmation of cover before seeking treatment.

Emergency out-patient treatment is treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes an Out-patient Plan, it will cover you for out-patient treatment in excess of the limit on 'Emergency out-patient treatment' benefit. In that case, the Out-patient plan terms will apply.

Emergency treatment outside area of cover is treatment for medical emergencies that occur during business or holiday trips outside your area of cover. Cover is provided for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness that presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You must tell us if you are going to be outside your area of cover for more than six weeks.

H

Home country is a country for which you hold a current passport or which is your principal country of residence.

Hospital is any establishment that is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation refers to a stay in a standard private room, semi-private room or general ward as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered. Please note that the hospital accommodation benefit only applies where no other benefit included in your plan covers the required in-patient treatment. In this case, hospital accommodation costs will be covered under the more specific in-patient benefit, up to the benefit

limit stated. Psychiatry and psychotherapy, organ transplant, oncology, routine maternity, palliative care and long-term care are examples of in-patient benefits which include cover for hospital accommodation costs, where included in your plan.

I

Infertility treatment refers to all invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. It also covers treatment such as InVitro Fertilisation (IVF), for diagnosed cases of infertility. We will cover the cost of treatment for the insured member who receives it, up to the limit indicated in the Table of Benefits. You can't claim under an insured spouse/partner's cover for costs that exceed your benefit limit.

All non-invasive investigative procedures undertaken to establish the cause of infertility are covered within the relevant benefit limits of the Out-patient Plan (if you have one). Examples of benefits that cover non-invasive investigations procedures are "Diagnostic tests", "Medical practitioner fees" and "Specialist fees".

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to CHF39,000 per child for the first three months following birth. Out-patient treatment is paid under the terms of the Out-patient Plan.

In-patient treatment refers to treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate is a document outlining the details of your cover and is issued by us. It confirms that an insurance relationship exists between you and us.

Insurance Year applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends exactly one year later.

Insured person is you as stated on your Insurance Certificate.

In writing: the declaration must be provided in a document or another form suitable for permanent safekeeping in written characters. This includes, for example, letter, fax or email. The person making the declaration must be named and the end of the declaration must be marked as such.

L

LAMal covered prescribed drugs refers to products, prescribed by a physician, including but not limited to, insulin, hypodermic needles or syringes which have been prescribed for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescribed drugs must be clinically proven to be effective for the condition, recognised by the pharmaceutical regulator in a given country and covered under LAMal.

Laser eye treatment refers to the surgical improvement of the refractive quality of the cornea using laser technology, including the necessary pre-operative investigations.

Local ambulance is ambulance transport that is required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

M

Medical necessity refers to medical treatment, services or supplies that fulfil all of the following:

(a) Essential to identify or treat your condition, illness or injury.

(b) Consistent with your symptoms, diagnosis or treatment of the underlying condition.

(c) In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover).

(d) Required for reasons other than the comfort or convenience of you or your doctor.

(e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover).

(f) Considered to be the most appropriate type and level of service or supply.

(g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition.

(h) Provided only for an appropriate duration of time.

In this definition, the term "appropriate" means taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, "medically necessary" also means that diagnosis can't be made or treatment can't be safely and effectively provided on an out-patient basis.

Medical practitioners are doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Medical practitioner fees refers to fees charged for non.surgical treatment performed or administered by a medical practitioner.

Midwife fees refers to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

N

Newborn care The following essential examinations, diagnostic procedures and treatments as required following birth:

> Customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures
> One hearing examination
> Screening tests for PKU, congenital hypothyroidism and G6PD
> Vitamin K, hepatitis B and BCG vaccinations

Cover doesn't include further preventive diagnostic procedures, such as routine swabs or blood typing. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant). For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to CHF 39,000 per child for the first three months following birth: this limit applies before any other benefit in your plan. Out-patient treatment is paid within the terms of the Out-patient Plan.

Nursing at home or in a convalescent home refers to nursing received immediately after or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where it is medically necessary for the insured person to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure-centres and health resorts.

O

Obesity is diagnosed when a person has a body mass index (BMI) of over 30.

Oncology refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis.

Oral and maxillofacial surgical procedures refers to surgical treatment on the mouth, jaws,

face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.
Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of impacted teeth
- Surgical removal of cysts
- Orthognathic surgeries for the correction of malocclusion

Organ transplant refers to the following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics is the use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria are very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

(a) Increased overjet > 6mm but <= 9 mm.

(b) Reverse overjet > 3.5 mm with no masticatory or speech difficulties.

(c) Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position.

(d) Severe displacements of teeth > 4 mm.

(e) Extreme lateral or anterior open bites > 4 mm.

(f) Increased and complete overbite with gingival or palatal trauma.

(g) Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis.

(h) Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments.

(i) Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties.

(j) Partially erupted teeth, tipped and impacted against adjacent teeth.

(k) Existing supernumerary teeth.

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/ material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/ or standard removable appliances However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

Orthomolecular treatment refers to alternative treatment that aims to restore the individual biochemical balance through supplements. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity.

Out-patient treatment refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

P

Palliative care refers to ongoing treatment that aims to alleviate the physical/psychological suffering associated with progressive, incurable illness and to maintain quality of life. It includes in-patient, day-care and out-patient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation, nursing care and prescription drugs.

Post-natal care refers to the routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime and which are captured on the Application Form (Articles 4 and 5 VVG). Such pre-existing conditions are subject to full disclosure and medical underwriting. If such pre-existing conditions are not disclosed, your policy will be cancelled (Article 6 and Article 98 VVG).

Pregnancy refers to the period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care includes common screening and follow-up tests required during pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Prescribed glasses and contact lenses refers to the cost of purchasing lenses or glasses to correct vision, following the receipt of a prescription from an optometrist or ophthalmologist. Cover is limited to the benefit limit stated on the Table of Benefits.

Prescribed medical aids refers to any device that is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long-term wound aids such as dressings and stoma supplies.

We do not cover costs for medical aids that form part of palliative care or long-term care (see the definitions of "Palliative care" and "Long-term care").

Prescribed nicotine replacement therapy products, where provided, refers to cover for nicotine replacement therapy products only, prescribed by a licensed physician, for the purposes of the cessation of smoking, and up to the maximum benefit amount stated on your table of benefits.

Prescribed physiotherapy refers to treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 24 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescribed stay in a Spa refers to a prescribed medical stay requiring mineral water and its by-products. The establishment must provide aftercare and supervision to the patients. For any admission in a water-cure establishment, pre-authorisation is required.

Preventive treatment refers to treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the "Preventive treatment" benefit is listed in your Table of Benefits.

Psychiatry and psychotherapy refers to the treatment of mental, behavioural and personality disorders, including autism spectrum and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary. All day-care or in-patient admissions must include prescription medication related to the condition.

R

Rehabilitation is treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment.

Routine maternity refers to medically necessary costs hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of "Newborn care" for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction). Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the "Complications of childbirth" benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the "Home delivery" benefit.

S

Sound Natural Tooth means teeth which are whole or properly restored, are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.

Specialist is a licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

Specialist fees refer to non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

Speech therapy refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Surgical appliances and materials are those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

Therapist refers to a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Treatment refers to a medical procedure needed to cure or relieve a disease or injury.

V

Vaccinations refer to:

- AI basic immunisations and booster injections that are required or recommended by the Authorities (Health Ministry, Foreign Ministry) in Switzerland or the destination of the travel.
- Vaccination against Covid-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.
*We cover any Covid-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) that demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the Covid-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country from where you normally reside in order to get the vaccination. Please note that cover is not intended t o give you priority access to vaccines.

Video consultation services provide direct access to a doctor via a telecommunication platform. This benefit covers the costs of video consultations, as indicated in your Table of Benefits and offers medical advice, diagnosis and issuance of a prescription, if needed, for non-urgent medical care. Access to teleconsultation services and prescriptions will depend on your geographical location and local country regulations. You can make an appointment to speak to a medical practitioner in English, subject to availability. Some third-party providers may offer additional core languages. Cost of medicines are not included, but delivery of medicine or referrals may or may not be included under this benefit, even when prescribed or recommended during the video consultation.

VVG refers to Versicherungsvertragsgesetz, a federal law for insurance contracts in Switzerland.

W

Waiting period is a period of time that begins on your policy start date, during which you are not entitled to cover for particular benefits. Your Table of Benefits shows which benefits are subject to waiting periods.

We/Our/Us is APRIL International.

Y

You/Your refers to the eligible individual stated on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement .

ACQUISITION OF AN ORGAN

Expenses for the acquisition of an organ such as, but not limited to donor search, typing, harvesting, transport and administration costs.

CHEMICAL CONTAMINATION AND RADIOACTIVITY

Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

COMPLEMENTARY TREATMENT

Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN

Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded under your plan.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER

Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

COSMETIC TREATMENT

Any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes. The following exceptions apply:

> Reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or initial surgery was also covered by this policy.

> Gender reassignment surgery, if you meet the criteria for gender dysphoria services.

DENTAL VENEERS

Dental veneers and related procedures.

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

Any form of treatment or drug therapy that in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

Treatment required as a result of failure to seek or follow medical advice.

FEES FOR THE COMPLETION OF A CLAIM FORM

Fees for the completion of a Claim Form or other administration charges.

GENETIC TESTING

Genetic testing, except:

a) where specific genetic tests are included within your plan

b) where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over;
c) where testing for genetic receptor of tumours is covered.

HOME VISITS

Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

INJURIES CAUSED BY PROFESSIONAL SPORTS

Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

LOSS OF HAIR AND HAIR REPLACEMENT

Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR

Treatment required as a result of medical error.

MUSIC OR VIDEO THERAPIES

Music or video therapies.

NEGLIGENCE OR DELIBERATE CAUSE OF AN ACCIDENT

In case of gross negligence or deliberate cause of an accident, particularly in the case of abusive use of alcohol and other drugs, benefits may be reduced or refused in serious cases.

OBESITY TREATMENT

Investigations into and treatment for obesity.

ORTHOMOLECULAR TREATMENT

Please refer to the definition of Orthomolecular treatment above.

PARTICIPATION IN WAR OR CRIMINAL ACTS

Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

PLASTIC SURGERY

Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

PRODUCTS SOLD WITHOUT PRESCRIPTIONS

Products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.

SEX CHANGE

Sex change operations and related treatments.

SPEECH THERAPY

Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION

Investigations into, treatment of and complications arising from:

- Sterilisation.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

SURROGACY

Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

TRAVEL COSTS

To and from medical facilities (including parking costs) for eligible treatment, except any travel costs covered under local ambulance benefit.

TREATMENTS NOT INDICATED IN YOUR TABLE OF BENEFITS

The following treatments, medical conditions or procedures, or any adverse consequences thereof, are not covered, unless otherwise indicated in your Table of Benefits:

- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan
- Prescribed glasses and contact lenses
- Prescribed nicotine replacement therapy products
- Vaccinations
- Preventive treatment
- Routine health checks
- Laser eye treatment
- Oculomotor therapy
- Occupational therapy

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

Treatment outside the geographical area of cover, unless for emergencies or authorised by us.

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

VITAMINS OR MINERALS

Products classified as vitamins or minerals, special infant formula and cosmetic products unless covered by LAMal/KVG.

Assistance benefits

Provided by Allianz Assistance

General Terms and Conditions of Insurance

ScoreStudies Assistance

Information for customers pursuant to the Swiss Federal law governing insurance contracts (VVG)

The following information for customers provides a clear and concise overview of the identity of the Insurer and the most important points contained in the insurance contract (Art. 3 of the Swiss Federal law governing insurance contracts [VVG]).

Who is the Insurer?

The Insurer is AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland), the Swiss Branch of AWP P&C S.A., Saint-Ouen, France, a limited company governed by the French Insurance Code. Registered in France: No. 519 490 080 RCS Paris. Swiss Branch registered in Zurich, registered No.:CHE-115.393.016, address: Richtiplatz 1, 8304 Wallisellen hereinafter Allianz Assistance.

What risks does the insurance cover and what is the scope of the insurance cover?

The insured risks and the scope of the insurance cover are set out in the Insurance Policy and the following General Terms and Conditions of Insurance (AVB).

Which persons are covered by the insurance?

The individuals defined in the application and named in the Insurance Policy.

What are the important exclusions?

- Events that have already occurred at the time of joining the group insurance policy or registering the event, or events that were discernible for the insured person at the time of joining the group insurance policy or registering for the event.
- Events connected with epidemics or pandemics.
- Events in connection with participation in risky actions, where the individual knowingly exposes him/ herself to danger.

This list contains only the most common exclusions. Further exclusions are set out in the following General Terms and Conditions of Insurance and the VVG.

How much is the premium?

The level of the premium depends on the insured risks in each case and on the cover required. The level of the premium is defined at the time of application and is set out in the Insurance Policy.

What are the duties of the policyholder and/or the insured individuals?

- To fulfil their contractual and legal duties of notification, information and conduct in full (e.g. immediate notification of a case of loss/damage to Allianz Assistance).
- To do all that they can to help minimise and clarify the loss/damage (e.g. authorising third parties to issue the relevant documents, information, etc. to Allianz Assistance to clarify the case of loss/damage).

This list contains only the most common duties. Further duties are set out in the following General Terms and Conditions of Insurance and the VVG.

When does the insurance cover begin and end?

The start and end dates for the insurance are set out in the application and listed in the Insurance Policy.

How does Allianz Assistance handle information/data protection?

We care about your personal data. This summary notice and our full privacy notice explain how we protect your privacy. To read our full privacy notice go to https://www.allianz-travel.ch/en_CH/data-protection.html#.

We will collect your personal data from a variety of sources including: data that you provide to us and/or that we receive from certain third parties such as intermediaries and distribution partners. We will need your personal data if you wish to purchase our products and services and we will process your personal data for a number of purposes including entering into, administering and performing contracts with you, protecting our legitimate interests or those of third parties and complying with any legal obligations. We may share your personal data with service providers who carry out business operations on our behalf, other Allianz Group companies, other insurers, co-insurers, reinsurers, insurance intermediaries, public authorities and to comply with any legal obligations. Your personal data may be processed outside of Switzerland, e.g. in the European Economic Area (EEA) or in non-European countries. If we transfer your personal data outside the EEA to other Allianz Group companies, we will do so on the basis of Allianz's approved Binding Corporate Rules (BCRs). Where Allianz's BCRs do not apply, we will take steps to ensure that an adequate level of protection is provided for personal data transfers outside the EEA. If you have any questions about how we use your personal data, or if you wish to exercise a data subject's right, i.e. to access or restrict the processing of your personal data, to withdraw your consent where you have previously given it, to request the correction or deletion of your data, or to make a complaint, you can contact us at any time at privacy.ch@allianz.com.

General Terms and Conditions of Insurance

The insurance protection provided by AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland), the Swiss Branch of AWP P&C S.A., Saint-Ouen, France, a limited company governed by the French Insurance Code. Registered in France: No. 519 490 080 RCS Paris. Swiss Branch registered in Zurich, registered No.:CHE-115.393.016, address: Richtiplatz 1, 8304 Wallisellen (hereafter referred to as Allianz Assistance) is defined by the Insurance Policy and the following General Terms and Conditions of Insurance.

1. Insured person

The insurance covers the individual named in the Insurance Policy.

2. Territorial validity

The region of cover will be stated on the Insurance Policy.

3. Entry into force and period of insurance cover

The insurance cover takes effect on the date stated on the Insurance Policy and lasts for the period stated on the Insurance Policy.

4. Covered events and benefits

1. Assistance
   1. Medical repatriation
      1. If necessary, Allianz Assistance organises repatriation on medical grounds as follows:
         (a) To Switzerland if hospital care or medical treatment prove impossible or inappropriate at the place of the occurrence or in the home country.
         (b) To the nearest country (Switzerland or home country) if hospital care or medical treatment prove to be impossible or inappropriate at the place of the occurrence.
         (c) Within Switzerland if medical reasons justify it.
      2. Costs of repatriation by ambulance, scheduled aircraft or air ambulance to the designated hospital are covered in full by Allianz Assistance.
      3. The decision on repatriation will be taken solely by Allianz Assistance, failing which the beneficiary will lose his rights. Allianz Assistance organises medical repatriation on the basis of the orders of the medical examiners mandated by Allianz Assistance and of the doctors who examined and treated the insured person at the place of the occurrence.
      4. No repatriation will be organised if hospital care or medical treatment at the place of the occurrence is approved by the medical examiners of Allianz Assistance.

4.1.2 Repatriation of mortal remains

1. If the insured person dies in Switzerland or abroad, Allianz Assistance will pay the costs of repatriating the body or the ashes to the domicile in the insured person's home country.
2. Allianz Assistance will further pay the additional costs incurred for compliance with the international agreement on the transport of human remains (zinc coffin, other instructions), together with the costs of cremation outside the home country.

4.1.3 Parental presence in case of hospitalisation over 7 days

1. In the event of hospital admission outside of Switzerland or the home country that is expected to last for more than 7 days or in case of death of the insured person outside of Switzerland, Allianz Assistance organises travel to the place concerned for one relative. Costs of transport and subsistence (hotel and breakfast) will be paid up to a maximum of CHF 4,000. -per event.
2. Travel must in all cases be organised with the prior agreement of Allianz Assistance.
3. Relatives are solely responsible for observance of the customs formalities in the home countries and destination.

4.1.4 Theft of documents

1. In the event of the theft of personal documents (passport, visas, ID card) outside of Switzerland which makes it temporarily impossible for the person concerned to continue the journey or return to their residence in Switzerland, the additional costs of the stay (hotel, breakfast, local transport) will be paid by Allianz Assistance up to a maximum of CHF 1,500. -per event.
2. The benefit will be guaranteed only if the insured person has immediately filed a complaint with the police force of the country in which he/she is located; the declaration of theft must be forwarded to Allianz Assistance.

4.1.5 Transmission of urgent messages

1. If the insured person is unable to move or to communicate, Allianz Assistance will take care of the transmission of urgent messages to the relatives to inform them of the nature of the problem and the measures which have been taken.
2. Should it prove impossible to contact the Relatives, Allianz Assistance may contact the embassy of the insured person's home country.
3. Allianz Assistance declines all liability for any direct or indirect prejudice resulting from the information provided.

4.2 Search and rescue

Allianz Assistance coordinates the necessary search and rescue operations.
The accompanying costs are covered by Allianz Assistance up to a maximum of CHF 30,000. -per insured person and any one event.

4.3 Postponement of travel in the event of any change of the dates of university examinations

1. If the university establishment decides to change the dates of examination, so making it necessary to postpone the return flight (to home country) or delay departure (to home country), Allianz Assistance will pay the additional costs of postponement / delayed departure up to the sum of CHF 150. -per insured person and per year, provided that the travel booking was made before the university establishment decided to change the date of the examinations.
2. The insured person shall forward to Allianz Assistance at the earliest opportunity the following supporting documents: attestation by the university establishment of the change of examination dates, confirmation of the initial booking, attestation stating the new travel dates and the costs of postponement charged by the service provider.

5. Obligations in the event of loss/damage

1. The insured person has a duty to do everything possible to minimise the loss/damage and to clarify it.
2. The insured person has a duty to comply fully with his/her contractual or legal obligations with regard to notification, information or conduct (including immediate prompt notification of the insured event via the telephone number highlighted in section 5.6).
3. If the loss/damage has arisen as a result of illness or injury, the insured person must

ensure that the medical personnel providing treatment are freed from their duty of confidentiality with regard to Allianz Assistance.

4. If the insured person is also able to assert claims (for which Allianz Assistance has indemnified the insured person) against third parties, he/she must safeguard these claims and cede them to Allianz Assistance.
5. The following documents must be provided to Allianz Assistance upon request, by sending to the following address Allianz Assistance, Richtiplatz 1. 8304 Wallisellen, Switzerland (in relation to the insured event):
   - Proof of insurance (Insurance Policy)
   - Transport tickets (airline tickets, railway tickets)
   - Receipts for unforeseen costs, in the original
   - Booking confirmation
   - Documents and/or official certificates that confirm that the loss/damage has happened (e.g. detailed medical certificate with diagnosis, death certificate, police report, etc.)
   - Invoices for the insured additional costs in the original.
6. In order to be able to claim Allianz Assistance benefits under section 4.1.1 to 4.1.3 and 4.2, please inform us immediately of the occurred insured event or illness. You can contact Allianz at **+353 1 630 1303** or via the toll-free number from Switzerland: **00 800 66 302 302**.

6. Violation of obligations

If the person with the right to claim violates his/her obligations, Allianz Assistance can refuse or reduce its benefits.

7. Not covered events / benefits

1. Cases and events which are not stipulated in these General Terms and Conditions of Insurance.
2. Events occurring on the territory of the USA or for repatriation to the territory of the USA.
3. Events which had already occurred at the time of conclusion of the insurance contract.
4. Claims caused by medical conditions which were known or could have been foreseen before departure.
5. Excessive consumption of alcohol, pharmaceuticals or narcotics.
6. Active participation in strikes, disorders of all kinds, brawls or fights.
7. Perpetration of crimes or deliberate offences, and in case of attempting such feats.
8. Participation in risky ventures, competitions, endurance trials or other risky activities.
9. In the event of war, acts of terrorism, disorders of all kinds (revolution, rebellion, domestic disorders, acts of violence against persons or property committed during gatherings or riots), epidemics, pandemics, natural disasters and incidents involving atomic, biological or chemical substances. However, if an insured person is overtaken by such events – except epidemics, pandemics and incidents involving atomic substances -at a time when he is already abroad, the cover shall remain valid for 14 days following the time at which such events first occurred.
10. Travel for the purpose of medical treatment or plastic surgery.
11. When the damaging event was deliberately caused by the insured person.
12. Repatriation (for medical reasons or in case of death) to or from countries or zones to which the DFAE (Swiss Federal Department of Foreign Affairs) advises against travel and countries in a state of war, revolution, rebellion or other internal disorder.
13. Benefits of section 4.1.1 to 4.1.3 and 4.2, if Allianz Assistance has not agreed in advance to provide the benefits.

8. Definitions

1. **Assistance** refers to the aid given to the insured person on the occasion of travel when an accident or some other insured incident occurs. A range of human, technical and, secondarily, financial resources are then deployed to assist the insured person.
2. **Home country** is a country for which you hold a current passport or which is your principal country of residence.
3. **Relatives** are members of the same family (spouse, father and mother, children, parents-in-law, grandparents, brothers and sisters).

9. Multiple insurance clause

1. If an insured person has an entitlement under a different contract of insurance (voluntary or compulsory insurance), the cover is limited to the Allianz Assistance share to be calculated in accordance with the statutory regulation on multiple insurance. Overall costs will only be reimbursed one single time.
2. If Allianz Assistance has nevertheless provided benefits for the same loss/damage, these shall be regarded as an advance payment, and the insured person shall cede his/her entitlement to claim against the third party (third-party, voluntary or compulsory insurance) to Allianz Assistance to the same extent.

10. Period of limitation

The period of limitation for claims resulting from the insurance contract are 5 years from the time of the event upon which the duty to provide the benefit is based.

11. Place of jurisdiction and applicable law

1. Actions against Allianz Assistance may be filed in the court at its registered office, or at the Swiss place of residence of the insured person or the person with an entitlement to claim.
2. The Swiss law governing the insurance contract (the Bundesgesetz über den Versicherungs.vertrag, or VVG) is applied as a supplement to these provisions.

12. Contact address

Allianz Assistance, Richtiplatz 1. 8304 Wallisellen, Switzerland.

Terms and conditions

In this document you will find important information about your insurance coverage. Please read this document in conjunction with your Benefit Guide.

1. Your insurance coverage

The purpose of this ScoreStudies insurance policy is to provide health insurance in accordance with Art. 2 Para. 4 of the Health Insurance Ordinance (KVV) to international pupils, students, researchers and interns who are training or studying in Switzerland and who live in Switzerland. The insurance cover is not suitable for Swiss students. These must have KVG insurance cover from a Swiss health insurer.

Your insurance cover corresponds to the insurance cover of the statutory health insurance in Switzerland. Treatment costs are insured during the stay in your area of coverage in accordance with Articles 25-31 of the Health Insurance Act 832.10 under the conditions of Articles 32-33 of the Health Insurance Act 832.10 and its ordinances, in particular the Ordinance on Health Insurance Benefits (KLV 832.112.31). This applies to health insurance benefits in case of illness or accident (if no other accident insurance covers the insured event) as well as pregnancy.

The additional insurance cover supplements the above-mentioned benefits and is described in the special insurance conditions, which you will find in your Benefit Guide.

2. Alternative health insurance coverage according to KVG and exemption

To be exempt from compulsory health insurance in Switzerland, you need alternative insurance cover. In accordance with Art. 2 Para. 4 of the Health Insurance Ordinance (KVV), we must offer you comprehensive insurance cover as in Articles 25-31 of the Health Insurance Act (KVG) 832. An exemption from the KVG obligation can be granted by the Canton for 3 years, with a possible extension for another 3 years.

With the ScoreStudies plan, we are committed to providing at least the same level of cover as you would have with a KVG insurance policy.

Your Table of Benefits lists the plan(s) and associated benefits that are available to you. For further details of our benefits, please refer to the "Definitions" section of the Benefit Guide. Not all the benefits listed in the "Definitions" section need to be insured under your chosen cover. For this reason, it is important to check which benefits are listed in your Table of Benefits. Your cover is subject to our policy definitions, exclusions, maximum benefit amounts and any special conditions stated in your insurance policy.

If you have any questions about your insurance cover, please do not hesitate to contact us: **+33 1 59 13 39 98**.

2.1 What is insured under Articles 25 to 31 of KVG 832 and where can I find further information?

Insurance benefits insured under Articles 25 to 31 of KVG 832 can be found **here**.

The ordinance that describes the scope of insurance coverage in more detail is called KLV 832.112.31 and is available **here**.

Your alternative insurance covers the costs of all medicines prescribed by a doctor and listed in the "Specialties List (SL)". The full list can be found **here**.

Various vaccinations are insured in accordance with the guidelines and recommendations of the Confederate Commission for questions on vaccinations (EKIF -Eidgenössische Kommission für Impffragen). Please click **here**.

Your alternative insurance cover also includes medically prescribed aids and items, such as bandages, inhalation devices and respiratory therapy devices or incontinence aids, up to a certain maximum amount, which is listed in the published "List of aids and devices" (Miegel). Please click **here** for further information.

3. Information about your insurance cover

3.1 Scope of the insurance cover

The scope of the insurance cover results from:
> the Insurance Certificate
> the Table of Benefits,
> the written agreements,
> the insurance conditions in this document and the Benefit Guide,
> the statutory provisions on insurance law and
> other statutory provisions.

3.2 Scope of benefits

The scope of the benefits of the "Alternative Health Insurance Coverage" for the prescribed health care pursuant to Art. 2 Para. 4 KVV, is governed by the Health Insurance Act (KVG) 832 and its implementing ordinances, including the Health Insurance Benefits Ordinance (KLV).

Any additional insurance cover that supplements the KVG basic insurance and goes beyond its benefits will be listed separately in your Table of Benefits.

There are two different types of reimbursement amounts in the Table of Benefits. The maximum reimbursement amount indicated for some benefits is the maximum total amount reimbursed for all benefits of the plan together, per insured person and per Insurance Year. In addition, there are specific reimbursement amounts for individual insurance benefits, e.g., for nursing at home or in a convalescent home. Specific reimbursement amounts can be "per Insurance Year", "for life" or "per event", such as "per trip", "per session" or even "per pregnancy". In some cases, we will pay a percentage of the costs for the specific benefit e.g., "65% reimbursement, up to CHF 1000".
If a specific reimbursement amount or a "Full Reimbursement" is indicated for a benefit, reimbursement will always be made within the maximum reimbursement amount indicated, insofar as this applies to the plan. All amounts are per insured person and per Insurance Year, unless otherwise stated in your Table of Benefits.

Please note that if the maximum reimbursement amount is changed to cover more than one year, the following applies when the contract is renewed:

> All eligible costs from the first year are subject to the maximum reimbursement amount of that year.
> All eligible costs from the second year are subject to the maximum reimbursement amount of the second year, minus the amount already reimbursed in the first year.

If the maximum reimbursement amount was reduced in the second year and this amount was already exhausted or exceeded by the costs incurred in the first year, the excess amount is unfortunately not reimbursable.

3.3 Medical necessity

This policy provides cover for medical treatment, related costs, services and/or supplies which are medically necessary and appropriate to treat a patient's condition because of an illness or accident, in line with the definition of "Medical necessity". We will only pay for medical costs which are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. In accordance with articles 32.1 and 56 of the Federal Health Insurance Act (KVG) if the prices are higher than what is common locally, we reserve the right to reduce the amount payable by us. Please refer to the "Medical necessity" definition below for further details

Medical necessity refers to those medical treatment , services or supplies that fulfil all of the following:

(a) Essential to identify or treat a patient's condition, illness or injury.
(b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
(c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time. This does not apply to complementary treatment methods if they form part of your cover.

(d) Required for reasons other than the comfort or convenience of the patient or his/her physician.

(e) Proven and demonstrated to have medical value.

(f) Considered to be the most appropriate type and level of service or supply.

(g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition. This does not apply to complementary treatment methods if they form part of your cover.

(h) Provided only for an appropriate duration of time.

In this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, "medically necessary" also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an out-patient basis.

3.4 Exclusions

Although we cover most medically necessary treatments, Treatment costs, illnesses, procedures and accidents in the "Exclusions" section of your Benefit Guide may not be covered unless they are listed in the Table of Benefits or are covered under the KVG.

4. Regulations in the event of an insured event

1. Insured event

The insured event is the medically necessary treatment of the insured person due to an illness or an accident. Examinations and medically necessary treatments due to pregnancy and childbirth and medically necessary out-patient preventive examinations for the early detection of diseases are also considered as insured events. The term insured event also includes the lawful termination of pregnancy.

2. Beginning and end of the insured event

The insured event starts with the beginning of your treatment and ends when you don't need any further treatment on the basis of your medical diagnostics. If treatment has to be extended due to an illness or consequences of an accident which has no causal connection with the illness or consequences of an accident for which the person was previously receiving treatment, this shall be deemed to be a new insured event.

3. Time when the insured expenses arise

The date or time when the insured person was treated or received a benefit is relevant for the occurrence of insured expenses. We cover the insured costs only as long as the insurance cover is in place, whereby the treatment date is decisive.

5. Medical service providers

1. In-patient treatment in Switzerland

You are free to choose any hospital registered within your canton. Click on the following link to see a comprehensive list of service providers available in your region:
https://www.gdk-cds.ch/fileadmin/docs/public/gdk/themen/spitalfinanzierung/GDK-UEbersicht_Spitallisten_Spitaltarife.pdf

(Please note that this document is only available in French and German).

2. Out-patient treatment in Switzerland

You are free to choose any licensed service provider as long as the costs are reasonable and customary. Please click on the following link for more information about licensed service providers:
https://www.admin.ch/opc/de/classified-compilation/19950219/index.html#id-1-4

(Please note that this page is only available in French, German and Italian).

3. Payment to the medical service provider

In general, the insured person is responsible for payment to the medical provider. For in-patient care cases we will, where possible and with sufficient notice, arrange for direct settlement with the medical provider, subject to any co-payments, deductibles and benefit limits, i.e. where possible, we will settle the bill for you by dealing directly with the hospital. Please refer to the "How to claim" section in the Benefit Guide to learn more.

6. Area of cover

The geographical area of cover you have chosen will be confirmed in your Insurance Certificate. Please note that emergency treatment outside the geographical area of cover is fully covered under the terms of your policy.

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