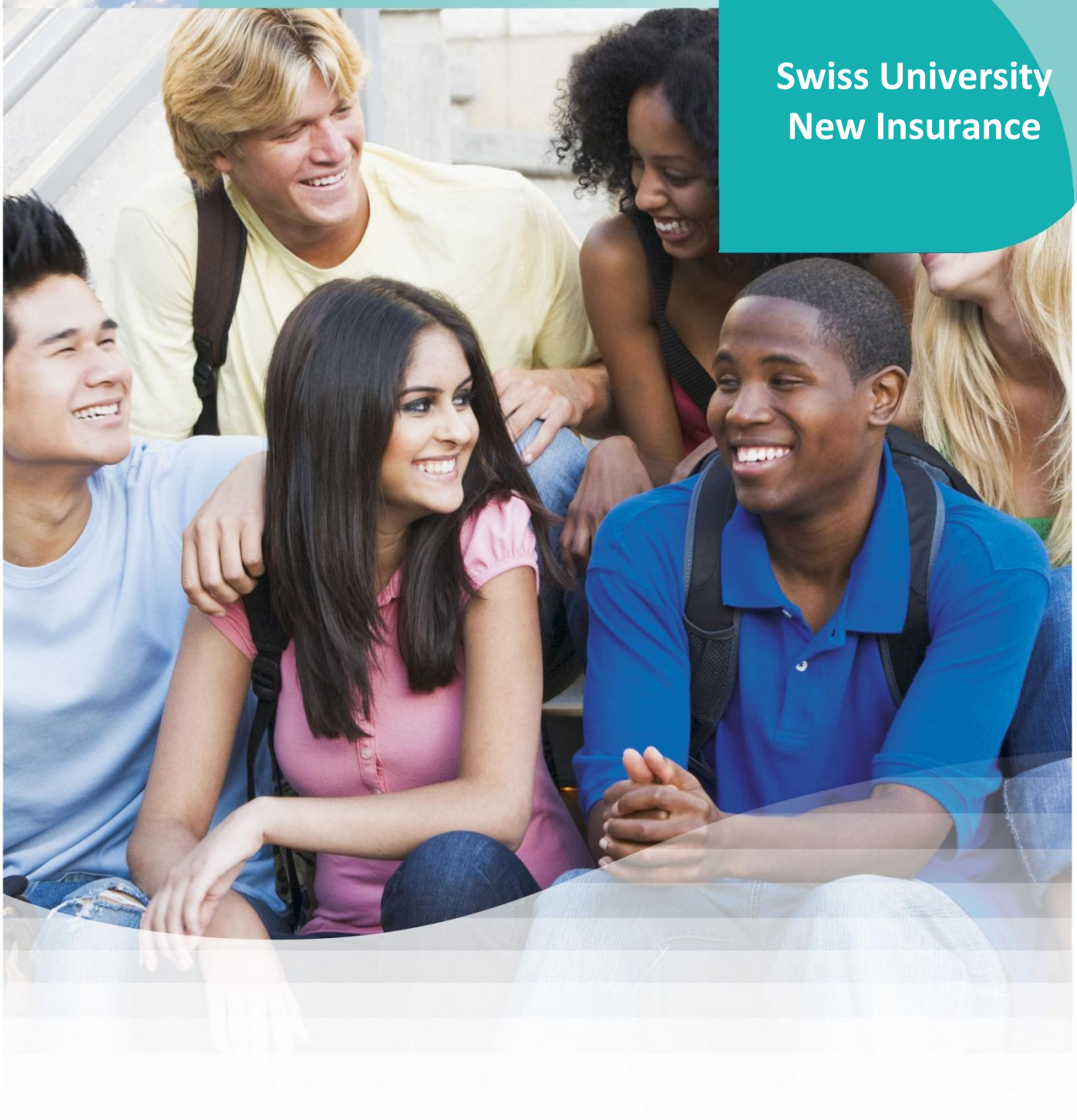


S.U.N.I.

Swiss University New Insurance



MEMBERSHIP GUIDELINES AND GENERAL CONDITIONS OF YOUR INTERNATIONAL HEALTHCARE AND ASSISTANCE INSURANCE PLAN

GMC services INTERNATIONAL



THE ADVANTAGES OF GMC SERVICES INTERNATIONAL

As a leader in group Employee Benefits, we make our 50 years of experience and savoir-faire available to you, allowing you to benefit from the privileged services found in this guide.

- 24 hour **telephone reception**, 365 days per year
- **Client Service Officers specialized** in the management of your contract and able to answer all of your questions
- Access to the **GMC medical network**
- **Quick processing of reimbursement requests within 48 hours**
- The possibility of receiving your **account statements by e-mail**
- **Our internet site : www.henner.com**
- **Our ISO 9001 certification**



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THE BENEFITS OF YOUR CONTRACT

This policy has been taken out by GMC Services with HAUTEVILLE INSURANCE COMPANY LIMITED (Agreement n°011668/200). On the authority of the Insurer, GMC Services International Administration (GMCI), has been commissioned to manage this policy under the conditions herein below.

WHO CAN BENEFIT FROM THIS COVER?

Those eligible for the present regime are foreign students with residence in Switzerland and who are enrolled in a University or in an Academic or other institute in Switzerland. This enrollment must be certified by producing a certificate of study.
For any request for enrollment or cancellation of membership, please contact GMC Services SA:

Route de Malagnou, 6
1208 GENEVE
Tel.: 022 807 02 70 - Fax: 022 807 02 79
Email: gmc.geneve@henner.com

Subject to acceptance of the risk by GMCI, the cover will take effect as of the date requested by the Student (the full month should be paid regardless of the enrollment date), which shall not be earlier than the date on which the application was submitted unless required by law.

The insurance cover will be valid each year until December 31st, and will automatically be renewed on January 1st. The membership is also cancelled under the following circumstances:

At the request of the Student

- By registered letter sent two months prior to December 31st of every year.
- In the event of definitive departure from Switzerland. It is the responsibility of the Insured to inform GMC Geneva by letter with a copy of the control certificate of inhabitants should the student leave Switzerland permanently.

At the request of GMCI

- By registered letter sent two months prior to December 31st of every year.
- When the Insured no longer meets the conditions to benefit from the regime as stipulated in the insurance contract.
- For false declaration of the behalf of the Insured.



- In the event of the cancellation of the HAUTEVILLE INSURANCE COMPANY LIMITED policy, as of the cancellation date.
- In the event of default of the premium payment, depending on the terms of payment as described below.

With the exception of cancellation of membership due to false declaration or default of premium payment, and without the special approval of GMCI, the insurance cover will cease the last day of the month following GMCI's reception of the request for cancellation by the Insured or GMCI's knowledge of the incident causing cancellation.

WHAT ARE THE PREMIUM PAYMENT RULES?

The Insurance Premium valid for the first year of membership is indicated on the Application Form. It is calculated based on the following age brackets: 0-30 years, 31-40 years, 41-60 years.
The premium may be modified annually on January 1st, depending on the results established for the insured group and the evolution of the healthcare and medical consumption over the course of the previous year.

Premiums are due monthly, quarterly, semi-annually or annually (according to the option of payment chosen) within 15 days of the issuance of the premium invoice.

In the event of default of premium payment within the delays given, a suspension of benefits will occur 14 days after the issuance of the Letter of Formal Notice requesting regularization of the premium payment. Should the premium remain unpaid, the membership is cancelled 30 days following the suspension of benefits. To be noted:

- The Formal Notice includes the collection fees of 15 CHF, borne by the member,
- The cancellation will take effect the first day of the month for which the premium was not paid.

The « Service de l'Assurance Maladie » (Health Insurance Services) of the Canton where the Insured is resident will be informed immediately of the cancellation of cover.

IMPORTANT:
If the member pays by Direct Debit (LSV), the debit will be carried out by GMC Gestion around the 15th of the month for month underway. If the debit is rejected by the bank, it is the member's responsibility to make the payment for the unpaid premium as quickly as possible by bank transfer or by payment slip. In the event of default of payment the suspension of cover and the cancellation of membership will ensue, as described above.



YOUR HEALTHCARE COVERAGE

WHAT IS THE EXTENT OF COVERAGE?

The medical expenses appearing in the Table of Benefits are covered worldwide, except in the United States and Canada.

In the United States and in Canada coverage is only applicable for emergency purposes.

Emergency treatment means medical treatment incurred with respect to a situation or condition placing the insured person in an immediate, life-threatening situation.
This emergency coverage is only valid in the USA and Canada when traveling for less than a total of 90 days in any one period of insurance.

Medical expenses are defined as expenses relating to treatment:

- dispensed by a duly authorized medical physician
- prescribed by a duly authorized medical physician and dispensed by a duly authorized medical practitioner.

For medical expenses incurred in a hospital facility, the hospital must be a public or private properly accredited institution (in the latter case, only for day care surgery).

The amount of coverage as appears in the table below is, in any event, restricted to the difference between actual expenses and any coverage which may be provided for the same treatment by any other medical plan covering any beneficiary of this policy.

Medical expenses that are clearly unreasonable or unusual may be subject to restricted coverage. The unreasonable or unusual nature is assessed on the basis of the practice prevalent in the country concerned.



TABLE OF BENEFITS

Offers YES – Your Economic Solution and WYN – What You Need

You can choose one of the offers below:

- Offer YES - Your Economic Solution with an **annual deductible of CHF 250**
- Offer WYN - What You Need **without deductible**

	Offer YES	Offer WYN
Annual benefit limit per person	CHF 3 000 000	CHF 3 000 000
Medical benefits	**Amount in % of actual costs**	
Medical and surgical hospitalization in a common ward in a public hospital (1)		
Room and board, surgery, anesthesiology/recovery room fees, operating room expenses, medical consultations and visits, nursing and paramedical care, laboratory tests, medical biological treatment, medical imaging and X-rays, prescribed drugs and medicines	100%	100%
Day care surgery in a public or private institution	100%	100%
Home care following a hospitalization	100%	100%
Post-operative expenses prescribed by the physician who performed the surgery, incurred within 30 days of discharge from the hospital	100%	100%
Medically prescribed rehabilitation following a hospitalization	100 % limited to 90 jours per person and per year	
Life-saving organ and/or tissue transplant	100%	100%
Psychiatric hospitalization	100%	100%
Transportation costs of an ambulance when medically necessary	100%	100%
Pregnancy and childbirth		
Labor and delivery in a common ward in a public hospital or at home (1)	100%	100%
Care accorded to a new-born child in good health and his/her stay in hospital with his/her mother (1)	100%	100%
Check-ups (2)	100% limited to 7 sessions before delivery and 1 after delivery	
Ultrasounds (2)	100% limited to 2 ultrasounds	
Counseling for nursing/breastfeeding by midwives or specialized nurses	100% limited to 3 sessions	
Delivery preparation courses by midwives	100% limited to CHF 100	



YOUR HEALTHCARE COVERAGE

Medical benefits	Offre YES Amount in % of actual costs	Offre WYN Amount in % of actual costs
Out-patient expenses		
General physicians' consultations and visits	100%	90%
Specialists' consultations and visits (including acupuncture) (3)	100%	90%
Medically prescribed paramedical care: nurses, physiotherapists, speech therapists, orthoptists, occupational therapists, dieticians, logopedists, chiropractors, osteopaths (3)	100%	90%
Psychotherapy prescribed by a psychiatrist and provided by a psychiatrist or a doctor specialized in psychotherapy, delegated psychotherapy (supervised by a psychiatrist in a medical practice) (3)	100% limited to 10 sessions per person and per year	90% limited to 10 sessions per person and per year
Laboratory tests, medical biological treatment	100%	90%
Medical imaging and X-rays	100%	90%
Prescribed drugs and medicines	100%	90%
Thermal cures prescribed by a physician	100% limited to CHF 10 per day and to 21 days per person and per year	90% limited to CHF 10 per day and to 21 days per person and per year
Preventive care		
Mandatory and medically prescribed vaccinations & inoculations	100%	90%
Routine dental care		
Dental care consultations and visits, conservative care, surgical treatment, parodontology	100% within an annual aggregate limit of CHF 360 per person (in total for routine and major dental care)	90% within an annual aggregate limit of CHF 360 per person (in total for routine and major dental care)
Major dental treatment (1)		
Dental prostheses (including temporary prostheses), dental crowns (including temporary crowns), fixed or removable dentures, inlays, onlays, pinned teeth, implants, repairs	100% within an annual aggregate limit of CHF 360 per person (in total for routine and major dental care)	90% within an annual aggregate limit of CHF 360 per person (in total for routine and major dental care)
Vision care		
Eyeglasses and contact lenses	100% limited to CHF 200 per person every 3-year period	90% limited to CHF 200 per person every 3-year period



(1) An application for prior agreement is MANDATORY before undergoing these treatments.
(2) In the event of a pregnancy at risk, as many exams as necessary (including ultrasounds). A duly completed prior agreement form and a medical report are mandatory in order to receive such care.
(3) For series of procedures, in the case of more than 5 sessions, an application for prior agreement is mandatory.

Please refer to 'What are the procedures for submitting a prior agreement application?' (Page 15) to learn more on this topic.

Additional options

If you choose the offer WYN, you can upgrate your coverage with the following options:

1) Semi-private (two-bed) room option in a public hospital

Hospitalization and delivery in a semi-private room of a public hospital will be covered by the GMCI.

and / or

2) Dental and vision care option

DENTAL AND VISION CARE OPTION	
These guarantees replace the offer WYN "dental and vision care"	
Medical benefits	**Amount in % of actual costs**
Dental care	
Routine dental care: dental care consultations and visits, conservative care, surgical treatment, parodontology	90% of charges within an annual aggregate limit of CHF 1500 per person
Major dental treatment: dental prostheses (including temporary prostheses), dental crowns (including temporary crowns), fixed or removable dentures, inlays, onlays, pinned teeth, implants, repairs (1)	90% of charges within an annual aggregate limit of CHF 600 per tooth and CHF 1 600 per person and per year
Vision care	
Glasses	90% of charges limited to CHF 400 per person every 2-year period
Frames	90% of charges limited to CHF 150 per person every 2-year period
Contact lenses	90% of charges limited to CHF 200 per person per year
Laser refractive surgery	90% of charges limited to CHF 500 per eye during the entire validity of the contract

(1) An application for prior agreement is MANDATORY before undergoing these treatments.
PLEASE REFER TO '*What are the procedures for submitting a prior agreement application?*' (Page 15) to learn more on this topic.



EXCLUDED RISKS AND BENEFITS

In the case of withholding significant information, omission, false declaration, or intentional misrepresentation made in bad faith, the policy may be cancelled by the Insurer from the commencement date.

Excluded risks

Medical expenses are not reimbursed if consequent to the following events or situations:

- Consequence of a voluntary or intentional sickness or accident committed by the insured, voluntary mutilations or suicide attempt, intentional exposure to extreme danger.
- Consequences of war, civil or not, insurrection, riot, bombing, popular movement or act of terrorism, unless the insured has not taken active part in it.
- Direct or indirect consequences of any action relating to what is commonly designated as Nuclear risk.

The Insurer reserves the right to modify the guarantees for certain territories, provided he notifies the insured at least fifteen days in advance. The insured may refuse this change and terminate his membership by sending a registered letter addressed to GMCI with acknowledgment of receipt within thirty days from the date of receipt of the endorsement sent by the Insurer. The termination is effective the first day of the month following the notification of refusal.

Excluded Benefits

The following expenses are not covered, unless otherwise specified in the Membership Certificate:

1. Any expense outside the area of coverage specified in the contract, except for short term trips (maximum of 90 days in any one insurance period).
2. All kind of experimental or not supervised treatment, controlled or not, which are not in line with the traditional, customary and accepted medical practices, unless approved by the Insurer.
3. Well-being expenses in the event of a hospital stay (television, phone …).
4. Medical treatment for alcoholism, narcotics, drug and substance abuse/dependency or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or condition.
5. Costs related to the acquisition of an organ. Costs associated with locating a replacement organ or any costs incurred for the removal of the organ from the donor, transportation costs of the organ and all associated administration costs.
6. Sex change operations and related treatment expenses.
7. Cosmetic treatment, except when subsequent to an accident or illness which occurs during the period of insurance, rejuvenation and slimming cure.

8. Expenses related to sterilisation (or its reversal), fertilization, vasectomy, venereal disease, gender reassignment, infertility and any related condition or form of assisted reproduction, sexual dysfunction, contraceptive and birth control drugs, including the insertion or the removal of contraceptive devices, costs related to abortion except in case of absolute medical necessity in accordance with local law.
9. Elective / voluntary surgery and/or cosmetic / aesthetic surgery unless required as a direct result of an accident or an illness which occurs during the period of insurance.
10. Medical expenses related to a stay in a thalassatherapy, convalescence home even if the stay is prescribed.
11. Rehabilitation unless it forms an integral part of medical treatment received as an inpatient and is under the control or supervision of a specialist and is undertaken in a recognized rehabilitation unit.
12. Treatments for mental or nervous disorders (psychoanalysis, psychotherapy, psychologists, etc.) unless those listed in the Table of Benefits of your plan.
13. Consultations, treatments and complication related to hair loss or hair transplant, unless the treatment is related to a hair loss due to a serious illness.
14. Non prescribed drugs and OTC (“over-the-counter”) medicines such as medical alcohol, absorbent cotton, sunscreen cream, preventive dentistry products, bandage, shampoos etc.
15. Expenses for preventive medical care (except mandatory and medically recommended vaccinations).
16. Claims arising as a result of the insured person’s participation in professional sport (not including recreational or amateur participation).
17. Any cost for service or supplies ordered or received prior to the effective date of coverage.
18. Any costs arising after expiry of the current period of insurance, unless this policy has been renewed for a subsequent 12 months.
19. Any expense for which there are no original documents and where we receive the invoice more than 24 months after the occurrence of the insured event.
20. Expenses subject to « prior agreement » and for which prior agreement was not requested or granted.
21. Any expense not specifically stated in this policy as being insured and any expense which exceeds the maximum sum insured under this policy.

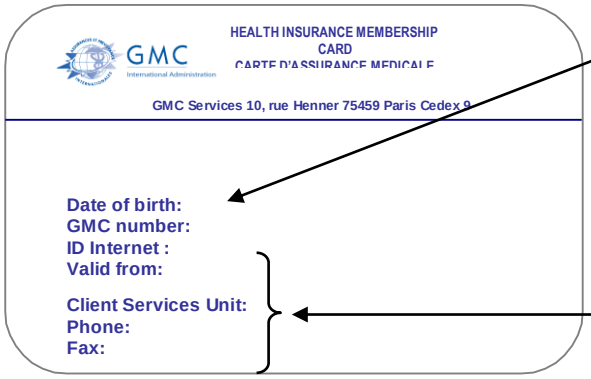


YOUR GMC INTERNATIONAL INSURANCE CARD

This card is sent when you join the plan and enables the holders:

- To provide proof of their insurance coverage to hospitals and clinics throughout the world,
- To gain access to the GMC medical network,
- To have at hand the information enabling them to contact GMCI and identify themselves easily.

Your personal GMCI identification number
To enable us to quickly identify you, please mention your personal GMCI identification number on any documents or correspondence that you send us.



The contact details of your dedicated Client Service Unit

Telephone and fax numbers to use in the event of hospitalization:



In the USA & Canada

In the rest of the world

In the event that you should lose your card, please contact us by email, telephone or fax so that we can issue and send you a new card as quickly as possible.



HOW TO GET REIMBURSED?

HOW TO PREPARE YOUR REQUEST FOR REIMBURSEMENT?

In order to obtain reimbursement as quickly as possible, please ensure you provide us with all of the documents listed below:

- GMCI refund form (1)
- Medical prescriptions
- Original itemized invoices: photocopies cannot be accepted (for optical expenses, the price of glasses and frames must be listed separately)
- Insurance stickers from drug packages, if applicable
- Original statement of any other healthcare system to which you may have subscribed, if applicable
- Agreement from the GMCI Medical Board for treatments and series of procedures subject to prior agreement.

IMPORTANT

We need the following information to be sent when you submit your first reimbursement request, if you did not provide it when you joined the plan:

- Your email address to activate the option for email reception of your statements. The receipt of your statement by email enables you to access your claim records on the website www.henner.com
- Your bank details in order to carry out payments to your account via bank wire transfer:
  - name of the bank
  - full branch address
  - name of the account holder
  - telephone number of the account holder
  - full account number
  - Swift code (or BIC code)
  - currency of the account
  - IBAN code if your account is located in Europe and in Tunisia, branch code if located outside Europe.

(1) This form is available and downloadable in PDF format on www.henner.com.

Keep in mind that an incomplete file delays reimbursements. Please provide us with all of the requested documents including your GMCI ID number.



WHAT IS THE DEADLINE TO ADDRESS A CLAIM FILE?

To be payable, request for reimbursement must be sent to GMCI within 24 months of the date of treatment.

WHERE TO SEND YOUR REQUEST FOR REIMBURSEMENT?

Please send your request for reimbursement to the address below:

GMC Services
International Administration – UG 14
10, rue Henner, 75459 PARIS Cedex 09
FRANCE

Tel: +33 1 40 82 44 95
Fax: +33 1 53 25 22 97
E-mail: gmcg.ug14@henner.com

THE PROCESSING OF YOUR MEDICAL EXPENSES

When sending a complete file, the reimbursement will be processed within 48 hours, excluding postal and bank transfer delays.

Please note that refunds are always processed in a convertible currency. When the currency of your bank account is different from the currency of the medical invoice, the conversion will be made based on the exchange rate of the day of the claim's processing.

In order to minimize banking fees for reimbursement transfers, we would recommend that you group your reimbursement claims before sending them to us.



THE PRIOR AGREEMENT FORM

An application for Prior Agreement is MANDATORY prior to certain treatments and series of procedures.

WHAT IS THE PURPOSE OF THE PRIOR AGREEMENT?

The purpose of the Prior Agreement application is to facilitate, whenever necessary, the direct contact between our advising physicians and your attending physician, without encroaching upon his prerogatives and his responsibility, with regard to the following aspects:

- Consistency between diagnosis and treatment plan
- Adequate treatment plan for the identified pathology
- Sustainable medical treatment and supplements to healthcare programs if need be
- Prices: make sure that the prices given, even when high, are usual and customary for the country in which the care is given.

This procedure, which requires us in certain cases to request additional information from you, has been set up with your interests in mind and can be useful in your discussions with the local physicians and healthcare facilities. Please note that planned treatment and/or healthcare may not be covered should they not comply with the international medical consensus.
Our advising physicians, selected for their international experience, can call upon a network of specialized consultants when deemed necessary. They are available to assist you or to explain the reasons for their medical decisions.

Plan payments can be refused if the insured person does not follow the instructions defined in the Membership Guidelines or if a prior agreement is not obtained from the Insurer.



WHICH EXPENSES ARE SUBJECT TO PRIOR AGREEMENT?

Expenses subject to prior agreement	Forms tu use (1)
• Treatment given in series (acupuncture, nurses, physiotherapists, speech therapists, orthoptists, occupational therapists, dieteticians, logopedists, chiropractors, osteopaths, psychiatrists, etc.) whenever more than 5 sessions	"Prior Agreement Application Series of procedures and Prostheses"
• Major dental treatment	"Prior Agreement Application Dental Care"
• Hospitalization (including childbirth) • Eye surgery	"Prior Agreement Application for Hospitalization"

(1) These forms are available and downloadable in PDF format on *www.henner.com*

Hospitalization and procedures in case of emergency (accident or sudden & unexpected illness) are not subject to the prior agreement procedure.

HOW TO APPLY FOR A PRIOR AGREEMENT?

The prior agreement form must be completed and signed by the attending practitioner and it includes a detailed description of the diagnosis, the nature of the care to be given and an estimate of costs.

The form must be sent **no less than 15 days prior to the date** scheduled for the beginning of the treatment or the hospitalization, in an envelope marked confidential to:

GMCI Medical Department
10, rue Henner -
75459 PARIS cedex 09
FRANCE

Fax:+ 33 1 40 82 43 85
Email: gmc.medical@henner.com

The reply from the GMCI Medical Board will be sent to your email address registered in our database (failing which to your postal address) within 5 days after receiving your file.



WHAT TO DO IN THE EVENT OF HOSPITALIZATION?

GMCI provides the beneficiaries with direct payment facilities in the case of hospitalization (including childbirth).

FOR EMERGENCY HOSPITALIZATION

Our Client Service Officers must be contacted and informed of your hospitalization as soon as possible, so that GMCI can issue a guarantee of direct payment.

The contact details of these officers are on the back of your insurance card. They can be contacted 24 hours a day.

Please provide:

- The name, address, e-mail address and telephone number of the healthcare facility
- Your contact details
- If available: the exact nature of the care to be provided and the itemized provisional costs of such care
- If available: the admission and discharge dates anticipated by the hospital.

GMCI will **immediately** send the guarantee of direct payment to the healthcare facility.

Hospitalization and procedures in case of emergency (accident or sudden and unexpected illness) are not subject to the prior agreement procedure.

FOR SCHEDULED HOSPITALIZATION

The "PRIOR AGREEMENT APPLICATION – HOSPITALIZATION" must be sent to the GMCI Medical Board **no later than 15 days prior to the date scheduled for the hospitalization.**

The prior agreement application must indicate:

- The name, address and telephone number of the health care facility
- The exact nature of the care to be provided and the itemized provisional costs of such care
- The admission and discharge dates anticipated by the hospital.

After your application for prior agreement request has been submitted and the approval of the Medical Board obtained, GMCI will issue and send a guarantee of direct payment to the healthcare facility, with a copy sent to your email address.



OUR WEBSITE WWW.HENNER.COM

GETTING CONNECTED

- Click on Member Access on the welcome page of www.henner.com
- It is a completely safe connection
- Enter your GMCI Identification number and password:
- When you first log in, your password will be programmed as your date of birth in the following format: DD/MM/YYYY (example: 14/02/1979)
- You will be asked to change your password when you first log in.



ONLINE SERVICES

Our online services enable you to:

- Consult and/or download the refund form
- Consult and/or download the Prior Agreement applications
- Find a health care professional via the GMC medical network
- Sign up for the online refund statement
- Consult and/or download your reimbursement statements
- Make your suggestions



GMCI'S MEDICAL NETWORK

GMCI provides its members with a network of institutions and practitioners under agreements that mostly include:

- An undertaking to moderate charges: charges are pre-agreed with the service providers
- Arrangements to settle fees directly: direct settlement of expenses covered by the policy
- Medical cooperation: exchange of information with GMCI's medical advisory board when prior agreement requests are made.

The agreements under this network currently cover some 190 countries and allow us to provide optimized facilities to welcome and look after the health of our members. This will be done in coordination with our medical advisory board of course.



YOUR ASSISTANCE AND MEDICAL REPATRIATION COVERAGE

The benefits of Mondial Assistance described below are covered worldwide while traveling outside the beneficiary's country of origin.

NATURE OF BENEFITS

Medical repatriation or transportation

• If the beneficiary's state of health requires medical care or specific examinations that cannot be provided on site, Mondial Assistance arranges and covers:
  ○ either the transportation to a regional hospital or to a country nearby that might provide the care. Afterwards, the beneficiary will be repatriated by a regular airliner to the beneficiary's country of origin or country of residence,
  ○ or the repatriation to the beneficiary's country of origin or country of residence if no appropriate medical centre exists nearby.
• If hospitalization cannot be effectuated in a hospital close to the domicile, Mondial Assistance arranges and covers transportation from this hospital to the domicile, when the beneficiary's state of health permits it.
• Depending on the seriousness of the case, the beneficiary, according to the medical necessity, is repatriated or transported under medical surveillance by the most appropriate means:
  ○ special air ambulance or regular airliner,
  ○ train, sleeper, boat, ambulance.
• Evacuation from a ski slope up to the amount of CHF 345.
Mondial Assistance cannot, in any circumstance, act as a substitute for the local emergency services or cover the costs thusly incurred.

Repatriation or transportation of body
• Mondial Assistance organizes and covers transportation of the beneficiary's body from the place of placement in a coffin to the place of inhumation in the beneficiary's country of origin or country of residence. • Mondial Assistance covers the related expenses for transportation of the body, including the cost of a simple-style coffin (limited to CHF 915). • In the event that, for administrative reasons, temporary or definitive inhumation is required on site, Mondial Assistance arranges and covers the two-way transportation of a family member to travel from his/her domicile in the beneficiary's country of origin or country of residence, to the place of inhumation, as well as the accommodation costs within the daily limit of CHF 69 taxes included, limited to a total of CHF 690.



Early return
• In the event of accident or unforeseeable illness that involves a vital prognosis affecting a family member or in the event of the death of a family member (spouse or declared cohabitant, descendant or collateral, father, mother and children) who remains in a country of residence, Mondial Assistance arranges and covers the beneficiary's two-way transportation (train in first class or airplane in economy class) to enable the latter to be at the bedside of his/her relative or to attend the funeral.
Ancillary services
• Telephonic medical service: Mondial Assistance provides beneficiaries with a 24-hour telephonic service for medical consultation (questions of a medical nature, indications of adresses of doctors or medical centres) • Companion for the hospitalized beneficiary: If hospitalization exceeds 8 days and if nobody is at the bedside of the beneficiary, Mondial Assistance covers the costs of transportation (train in first class or airplane in economy class) for departure from the country of residence, and the accommodation costs for one person designated by the beneficiary up to the amount of CHF 69 per night, limited to a total of CHF 690. • Shipment of medicines: Mondial Assistance takes all measures to find and ship the medicines necessary for treatment, if, after an unforeseeable event, the beneficiary cannot procure them on site or obtain equivalent medicines. The cost of these medicines and those of the shipment remains the beneficiary's responsibility.

HOW TO ACTIVATE THE ASSISTANCE SERVICES?

Rules to follow imperatively for an assistance case:

- The arrangement of any of the aforesaid assistance by the beneficiary or his/her family circle may be reimbursed only if Mondial Assistance is advised beforehand. **The assistance services shall only be acquired if Mondial Assistance has given the beneficiary a prior authorization.**
- Any request for one of these benefits must be made directly by the beneficiary by the following means:
  - by telephone : **+ 33 1 40 25 50 87**
  - or by fax: **+ 33 1 40 25 54 55**

  by indicating:
  - the Mondial Assistance agreement number: **611 792,**

- the name and number of the subscribed policy,
- the beneficiary's surname and given name,
- the name of the benefit desired,
- the telephone number where the beneficiary can be reached.

EXCLUSIONS

1. Convalescences and ailments (illness, accident) incurred during treatment that is not yet resolved,
2. Diagnosed and/or treated pre-existing illnesses with hospitalization six months before the request for assistance,
3. Trips made for a diagnosis and/or treatment,
4. Conditions of pregnancy, apart from unforeseeable complications or pre-authorization given by the insurer, and, in all cases, as of the 36th week of amenorrhoea,
5. Conditions resulting from the use of drugs, narcotics and related products that are not medically prescribed, and from the use of alcohol,
6. Consequences of attempted suicide,
7. Costs of emergency aids, research, primary transportation, except for costs of evacuation from a ski slope up to the amount of CHF 345 taxes included,
8. Injuries intentionally caused by a beneficiary, and those due to his/her participation in a crime, offence or physical fight, except in the event of legitimate self-defence,
9. Events occurring during participation in hazardous sports (raids, trekking, climbing…) or during competitive sports, challenges, matches, contests, rallies or their preparatory tests are excluded, as well as the organization and coverage of all research costs.

No reimbursement is made for less than 24 CHF taxes included.

Mondial Assistance shall not be held liable for a failure or complication in the performance of its obligations as a result of an event of *force majeure* or foreign wars, revolutions, mass demonstrations, riots, strikes, seizures or constraints by the police, official prohibitions, piracies, explosions of devices, nuclear or radioactive effects, critical climatic impediments and unforeseeable events of natural origin. However, Mondial Assistance shall extend every effort to assist the beneficiary.



HOW TO CONTACT US?

Your main office of contact is mentioned on your membership card, however, any of our worldwide offices can give you the support that you need.

A highly qualified, multilingual staff is available to answer any of your requests regarding coverage, prior agreement or reimbursement of medical expenses.

Your contacts are highly knowledgeable in matters involving foreign social security and healthcare plans and can provide assistance for your particular needs.

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Reception and information non-stop from 8:30 am to 6:00 pm (local time)

Around the clock service for urgent hospitalization: 24/7, 365 days per year

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Advice, study, placing and administration of employee benefits plans (healthcare costs, contingency plans, funeral coverage), for companies, authorities and private individuals, in France and worldwide.

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