ACCIDENT AND SICKNESS INSURANCE HANDBOOK

FOR

WISE FOUNDATION PARTICIPANTS

For 2015 Plan Participants

Insured by:
Axis Insurance Company
Policy # SRPO-50931-1099

Dear WISE Program Participant,

This insurance coverage, which WISE has elected for you with Axis Insurance Company has been specially developed to cover the insurance needs you will have as a participant in any WISE program, which involves residing abroad. The insurance covers a range of financial risks; while at the same time, our assistance partners ensure that there is always help for you if you have an accident or are in need of emergency assistance.

Although we realize that insurance policy terms are not very exciting, we recommend that you read through this Accident and Sickness coverage handbook. You will find an overview of the scope of coverage and the amounts insured, specific guidelines about what you must do in case you have an accident or illness, and where to file a claim. During your stay in the USA, the emergency assistance provider is available 24 hours a day.

Before your departure, or shortly after your arrival, you will receive an “Insurance Identification Card” which confirms your insurance coverage.

We wish you a pleasant stay in the U.S.A.

Best wishes,

WISE Foundation

ACCIDENT AND SICKNESS INSURANCE For WISE PARTICIPANTS

This insurance coverage handbook contains partly practical guidance, and partly the policy conditions of your insurance. Below you can get an overview of the structure of the handbook.

- ***SECTION A - Definitions***

- ***SECTION B - Description of Coverage and Exclusions***

- ***SECTION C - Assistance/Claims Procedures***

- ***SECTION A: DEFINITIONS***

Certain terms in this handbook will have specific meanings. the definitions apply regardless of the word category used.

"Covered Accident" means an accident that occurs while coverage is in force for a Covered Person and results directly and independently of all other causes in a loss or injury covered by the Policy for which benefits are payable.

"Covered Activity" means any activity that the Participating Organization requires the Covered Person to attend, or that is under its supervision and control listed in the Schedule of Benefits and insured under the Policy.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by the Policy. Coverage under the Participating Organization's Policy must remain continuously in force from the date of the Covered Accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"Covered Loss" or "Covered Losses" means an accidental death, dismemberment or other Injury covered under the Policy.

"Covered Person" means any Insured for whom the required premium is paid, while outside of their home country.

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person per injury or Sickness before an Accident or Sickness Medical Expense Benefit is paid.

"Doctor" means a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family Member or household.

"Home Country" means a country from which the Covered Person holds a passport. If the Covered Person holds passports from more than one country, his or her Home Country will be that country which the Covered Person has declared to the Insurance Company in writing as his or her Home Country.

"Hospital" means an institution that: 1) operates as a Hospital pursuant to law for the care, treatment, and providing of in-patient services for sick or injured persons; 2) provides 24-hour nursing service by Registered Nurses on duty or call; 3) has a staff of one or more licensed Doctors available at all times; 4) provides organized facilities for diagnosis, treatment or surgery, either: (i) on its premises; or (ii) in facilities available to it, on a pre-arranged basis; 5) is not primarily a nursing care facility, rest home, convalescent home, or similar establishment, or any separate ward, wing or section of a Hospital used as such; and 6) is not a place solely for drug addicts, alcoholics, or the aged or any separate ward of the Hospital.

"Immediate Family Member" means a person who is related to the Covered Person in any of the following ways: spouse; parent (includes step-parent); child age 18 or older (includes legally adopted and step child); brother or sister (includes stepbrother or stepsister); parent-in-law; son- or daughter-in-law; and brother- or sister-in-law.

"Injury" means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, and accidental means. All injuries sustained by one person in any one Covered Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.

"In Network" means the Doctors, Hospitals and other health care providers who have been contracted to provide specific medical care at negotiated rates.

"Medical Emergency" means a condition caused by an Injury or Sickness that manifests itself by symptoms of sufficient severity tat a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

"Medically Necessary" means a treatment, service or supply that is: 1) required to treat an Injury or Sickness; prescribed or ordered by a Doctor or furnished by a Hospital; 2) performed in the least costly setting required by the Covered Person's condition; and 3) consistent with the medial and surgical practices prevailing in the area for treatment of the condition at the time.

"Out of Network" means a provider who has not agreed to any pre-arranged fee schedules. the Insurance Company will not pay charges in excess of the Usual and Customary charges.

"Pre-existing Condition" means - an illness, disease or other condition of the Covered Person that in the 24 month period before the Covered Person's coverage became effective under this Policy: 1) first manifested itself, worsened, became acute or exhibited symptoms that would have caused a person to seek diagnosis, care, or treatment; or 2) required taking prescribed drugs or medicines, unless the condition for which the prescribed drug or medicine is taken remains controlled without any change in the required prescription; or 3) was treated by a Doctor or treatment had been recommended by a Doctor.

"Sickness" means an illness, disease or condition of the Insured that first occurs: a) while coverage under the Policy is in force; and b) during a trip. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

Section B

Description of Coverage and Exclusions

Your travel insurance consists of a number of different benefits. This section is a brief overview of the various benefits and the policy maximums.

Excess Medical Benefits

Insurance Company will pay Covered Accident and Sickness Medical Expenses up to the Maximum Benefit after the Insured satisfies any Deductible, only when they are excess of the amount paid by any other Health Care Plan. The Insurance Company will pay these benefits without regard to any Coordination of Benefits provisions in any other Health Care Plan.

Accident and Sickness Medical Expenses

Should medical treatment be required as a result of a covered accident or sickness during the trip, the Insurance Company will reimburse the medical or surgical expenses incurred, subject to the $50 deductible for "in network" care or GMMI is accessed first; $150 deductible for "out of network" care; and $150 deductible for emergency room care and up to a $200,000 maximum. After the deductible has been satisfied, **services obtained from In-Network providers will be paid at 100% of the preferred allowance**. Services obtained from Out-of-Network providers will be paid at 100% of the Usual and Customary Charges.

Finding an In-Network Medical Provider

Persons insured under this plan may choose to be treated within or outside of the GMMI Network. The **GMMI Network** consists of hospitals, doctors and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates. In order to use the services of a Network Provider, you must present an **Identification card** that is given to all covered individuals in this insurance plan.

Using a network provider does not quarantee eligibility or right to Injury or Sickness benefits under this plan. Providers may be periodically added or deleted as participants in the GMMI Network. Not all doctors practicing at a hospital elect to participate in the GMMI Network. It is your responsibility to verify with GMMI that a provider is a participant prior to services being rendered.

To access GMMI and its network

You can reach for participating
doctors and hospitals 24 hours a day,
7 days a week at www.gmmi.com

Examples of Covered Expenses

Hospital room & board charges (Hospital's average semi-private room rate per day).

Intensive Care Unit charges (up to two times the rate per day for a semi-private room).

All necessary medical and surgical services and supplies while confined in a hospital.

Outpatient Surgical Expenses

Outpatient Medical Care Expenses provided by a hospital following a surgical procedure.

Professional ambulance services to and from a hospital.

Laboratory and x-ray tests and treatments

Physiotherapy, if recommended by a Physician for treatment of a specific disablement and administered by a licensed physiotherapist are included. Limit of 10 visits per injury or illness.

Chiropractic Care covered up to $35.00 per visit, subject to a maximum of 10 visits per covered injury or illlness.

EMERGENCY DENTAL TREATMENT $500

Dental treatment as a result of an emergency, being the alleviation of pain or injury to sound natural teeth. The maximum amount payable for dental treatment during your period of coverage and not caused by the previous deteriorated state of the teeth, gums or jaw is $500.

EMERGENCY MEDICAL EVACUATION

For insured persons who become ill or injured during the period of coverage and an Emergency Medical Evacuation is required to the nearest medical facility where appropriate medical treatment can be obtained or to the insured person's home country all eligible expense are covered. An Emergency Medical Evacuation must be recommended by a legally licensed physician who certifies that the severity of the injry or illness necessitates such an Emergency Medical Evacuation, and arranged by the Assistance Provider and approved in advance by The Insurance Company.

MEDICAL REPATRIATION BENEFIT

After a covered hospitalization or treatment, if the Covered Person is unable to continue his or her active participatioin in a WISE Program or required continuing follow-up treatment, the Insurance Company in conjunction with the local attending Physician and/or the Covered Person's habitual doctor will organize the Covered Person's return to his or her country of residence or country of citizenship if the gravity of the situation so dictates, the Insurance Company will provide the appropriate medical personnel to accompany the Covered Person during the return journey. If the Insurance Company's medical personnel and the local attending medical practitioner consider the Covered Person to be available for medical repatriation from the medical point of view, but the Covered Person refuses to be repatriated, the Insurance Company will not be liable for any medical expenses incurred after the date of possible medical repatriation.

The Insurance Company will pay the Usual and Customary expenses up to the maximum shown in the Schedule of Benefits for covered expenses incurred if Injury or Sickness occurs during the course of a covered trip and results in a Covered Person's necessary Repatriation.

Covered expenses are those for transportation and medical treatment, including medical services and supplies necessarily incurred in conjunction with the Repatriation. All transportation arrangements must be by the most direct and economical route possible. All expenses must be recommended by the attending physician, required by the standard regulation of the conveyance transporting such persons and arranged and authorized by the Insurance Company in advance.

REPATRIATION (RETURN OF MORTAL REMAINS)

The Insurance Company will pay the reasonable Covered Expenses incurred, to return the Insured Person's remains to his/her current Home Country, if he or she dies.

Covered Expenses include, but are not limited to, expenses for embalming, a minimally necessary container appropriate for transportation, shipping costs, and the necessary government authorizations.

All Covered Expenses in connection with a Return of Mortal Remains must be pre-approved and arranged by an Assistance Provider representative appointed by the Insurance Company.

Emergency Reunion Benefit - Up to $1,000 per day subject to a maximum of 10 days.

In the event the Covered Person has either been: 1) confined in a Hospital for at least 7 days due to a covered Injury or Sickness, where the attending Doctor believes it would be beneficial for the Covered Person to have a Family Member at his or her side. The Insurance Company will pay the expenses incurred for travel and lodging for that Family Member, up to the Benefit Maximum shown.

Covered expenses include an economy airline ticket and other travel related expenses not to exceed the Daily Benefit Maximum and the Maximum Number of Days shown. All travel arrangements must be made by the Insurance Company's Assistance Provider and approved in advance by the Insurance Company in order for expenses to be considered eligible.

"Family Member" means a person who is related to the Covered Person in any of the following ways: spouse; parent (includes step-parent); child (includes legally adopted and step-child); brother or sister (includes step-brother or step-sister); parent-in-law; son- or daughter-in-law; and brother- or sister-in-law.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS $10,000 maximum

If Injury to the Covered Person results, within 365 days from the date of a Covered Accident, the Insurance Company will pay the Benefit Amount shown below for that loss. If multiple losses occur, only one Benefit Amount, the largest, will be paid for all Covered Losses due to the same Accident.

SCHEDULE OF COVERED LOSSES

Covered Loss	**Benefit Amount**
Life	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Two or more Member	100% of the Principal Sum
One Member	50% of the Principal Sum
Hemiplegia	75% of the Principal Sum
Paraplegia	75% of the Principal Sum
Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Uniplegia	25% of the Principal Sum

Exposure and Disappearance

Coverage includes exposure to the elements, if as a result of stranding, sinking, or wrecking of a vehicle in which the Insured was traveling.

An Insured is presumed dead if:

1. he or she is in a vehicle that disappears, sinks or is stranded or wrecked on a covered trip; or
2. the body is not found within sixty days of the Covered Accident.

COMA Benefit

The Insurance Company will pay benefits if a Covered Person becomes Comatose withing 30 days of a Covered Accident and remains in a Coma for at least 30 days.

The Insurance Company reserves the right, at the end of the first 30 days of Coma, to require proof that the Covered Person remains Comatose. This proof may include, but is not limited to, requiring an independent medical examination at the Insurance Company's expense.

The Insurance Company will pay 1% of the AD&D benefit maximum, in periodic payments. Periodic payments will end on the first of the following dates:

1. the end of the month in which the Covered Person dies.

2. the end of the 11th month for which this benefit is payable.

3. the end of the month in which the Covered Person recovers from the Coma.

At the end of the 11th month if the Covered Person has not recovered from the Coma 100% of the principal sum will be payable in a lump sum.

A person is deemed "Comatose" or in a "Coma" if he or she is in a state of complete and total unconsciousness, as a result of a covered accident.

DISABILITY BENEFITS:

Permanent Total Disability (Benefits terminate at age 70)

The Insurance Company will pay the Disability Benefit of $10,000 if a Covered Person is Permanently and Totally Disabled as a direct result of, and from no other cause but, a Covered Accident occurring within 52 weeks, from the date of loss:

1. the applicable Benefit Waiting Period of 365 days from the date total disability begins; and

2. the Covered Person provides satisfactory proof of Permanent Total Disability to The Insurance Company.

"Total Disability" or "Totally Disabled" means, due to an injury from a Covered Accident, a Covered Person:

1. if employed, cannot do any work for which he or she is, or may become, qualified by reason of education, experience or training; and

2. if not employed, cannot perform the normal and customary activities of a healthy person of like age and sex.

"Permanent Total Disability" or "Permanently Disabled" means a Covered Person is Totally Disabled and is expected to remain so disabled, as certified by a Doctor, for the rest of his or her life.

Permanent Total Disability must be the result of the same Covered Accident that caused the Total Disability.

Felonious Assault and Violent Crime Benefit

The Insurance Company will pay an additional benefit of $2,500.00 subject to the following conditions, when the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be reported before this benefit is payable.

Benefits will not be paid for treatment of an Injury sustained or a Covered Loss incurred during any:

1. violent crime or felonious assault committed by the Covered Person; or

2. felonious assault or violent crime committed by a Family Member, Participant, or Member of the Same Household.

To qualify for benefit payment, the Covered Accident must occur during any of the following:

1. actual or attempted robbery or holdup;

2. actual or attempted kidnapping;

3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the assault occurred.

General Exclusions

The Insurance Company willl not pay benefits for any loss or Injury that is caused by, or results from:

1. Injury or Sickness that occurs while the Covered Person is legally intoxicated (as determined by that state's law) or while under the influence of any drug unless administered by the advice and consent of a doctor.

2. Intentionally self-inflicted injury; suicide or attempted suicide.

3. Piloting or serving as a crew member or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline; or flight in any aircraft owned or leased by the Participating Organization (except as provided by the policy).

4. War or any act of war.

5. Sickness, disease or infection of any kind, except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning (except as provided by the policy).

6. Commission of, or attempt to commit, a felony, an assault or any other criminal activity.

7. An accident of the Covered Person is the operator of a motor vehicle.*

8. While taking part in mountaineering where ropes or guides are normally used; hang gliding, parachuting, bungee jumping, racing by horse, motor vehicle, or motorcycle, snowmobiling, motorcycle/motor scooter riding, scuba diving involving underwater breathing apparatus unless PADI or NAUI certified, spelunking or parasailing.

***This exclusion can be waived by The Insurance Company for an additional cost, if application is made by any properly licensed covered individual. Please see WISE for more information.**

Additional Excluded Medical Expenses

In addition to the exclusions above, the Insurance Company will not pay Medical Expense Benefits for any loss, treatment, or services resulting from or contributed by:

1. Routine physicals, check-ups, routine ob-gyn visits, pap smears or wellness visits.

2. Routine dental care and treatment.

3. Cosmetic surgery except for reconstructive surgery needed as a result of an Injury.

4. Mental and nervous disorders.

5. Pregnancy, childbirth, miscarriage, abortion or any complications of any of these conditions.

6. Routine nursery care.

7. Eye refractions or eye examinations for the purpose of prescribing corrective lenses or for the fitting thereof; eye glasses, contact lenses, and hearing aids.

8. Services, supplies, or treatment including any period of Hospital confinement which were not recommended, approved, and certified as necessary and reasonable by a doctor; or expenses which are non-medical in nature.

9. Treatment or service provided by a private duty nurse.

10. Treatment by an Immediate Family Member of Member of the Covered Person's household.

11. Expenses incurred during holiday travel outside the U.S.

12. Injury sustained while participating in: professional athletics, amateur or interscholastic athletics.

13. Pre-existing Conditions as defined.

14. Sexually transmitted disease or immune deficiency disorders and related conditions. This exclusion applies to, but is not limited to, the care or treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immuno-deficiency Virus (HIV Infection, or any illness or disease arising from these conditions. For DC residents, this exclusion does not apply to the care or treatments of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immuno-deficiency Virus (HIV) Infection, or any illness or diseases arising from these conditions.

15. Injury or Sickness where the Covered Person's trip to the host country is undertaken for treatment or advice for such Injury or Sickness.

16. Injury or Sickness where the Covered Person is traveling against the advise of a medical professional.

17. Injury or Sickness covered by Worker's Compensation, Employer's Liability Laws or similar occupational benefits.

18. Expenses payable by any automobile insurance policy without regard to fraud. (This exclusion does not apply in any state where prohibited.)

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Axis Insurance Company from providing insurance, including, but not limited to, the payment of claims.

SECTION C

ASSISTANCE AND CLAIMS PROCEDURE

The Claims Administrator for this program is GMMI.

Obtaining a claim form:

The first step in filing a claim is to obtain and complete a claim form. You can download the form for medical claims from the WISE Foundation website at www.wisefoundation.com. If you have an Accidental Death or Dismemberment Claim, please contact The WISE Foundation or GMMI Toll free at 1-855-209-8027 or Local 954-308-3934. You can also e-mail GMMI at customerservice@GMMI.com.

Completing and filing a claim form:

Medical claims: When filing a claim for medical benefits, it is best if you submit a completed claim form, and your itemized medical bills.

If you have insurance through an additional insurance company such as your host site, car insurance if the claim involves an injury sustained while riding in a car or if you were injured by someone driving a car, etc. you will need to submit a copy of this primary insurance company's Explanation of Benefits (EOBs) at the same time you submit your claim form and your itemized medical bills.

Claim processing delays can occur if the claim form is not fully completed, if you send in "balance due" statements instead of itemized bills, which detail all the charges incurred for your treatment(s), of if you fail to send in your primary insurance EOBs, if you have insurance through another company.

Please note that medical benefits under this policy are **"excess of any and all other insurance that is in force"**. Because of this provision, it is required that you first submit your claim to your primary health insurance carrier, worker's compensation insurance carrier or automobile insurance carrier for them to process any and all benefits available.

Once that process is completed, you can then file for **Excess Insurance** benefits under this policy. In the event you do not have any other insurance coverage, this plan will pay primary. You will need to complete the "Other Insurance" section of the claim form, detailing your primary health, worker's compensation or automobile insurance information. If you don't have primary insurance, you will need to certify that on the claim form. It is a crime to falsify information on a claim form when filing for insurance benefits.

Please note there is no coverage available under this policy if the accident or sickness you have incurred was:

Covered by any Worker's Compensation, Employer's Liability Laws or similar occupational benefits, or,

For expenese payable by any automobile insurance policy without regard to fault. (This exclusion does not apply in any state where prohibited).

Once you have received and completed the claim form, it should be mailed, along with all the required information to:

GMMI, Inc.
1300 Concord Terrace, Suite 300
Sunrise, Florida 33323 USA

or, for an electronic claim submission, please email the above information to:

customerservice@GMMI.com

Accidental Death or Dismemberment Claims:
In addition to the AD&D claim form, the following items will also need to be submitted if applying for AD&D benefits:

1) A certified copy of the final death certificate (AD&D only claims),

2) A copy of the final autopsy report (AD&D only claims),

3) Any police reports, medical records or any newspaper clippings, itemized medical bills.

TRAVEL ASSISTANCE PROGRAM

In addition to the insurance protection provided by the Insurance Plan, Axis Insurance Company has arranged with GMMI / Europ Assistance to provide you with access to its travel assistance services. These services include:

• **Medical Assistance** including referral to a doctor or medical specialist, medical monitoring when you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation and return or mortal remains.

• **Personal Assistance** medical benefits verification and medical claims assistance.

By requesting assistance you agree to assign to the Insurance Company your rights to recover from any of your responsible insurers any expenses the Insurance Company incurred.

This information provides you with a brief outline of the services available to you. These services are subject to the terms and conditions of the policy under which you are insured. A third party vendor may provide services to you. GMMI/Europ Assistance makes every effort to refer you to appropriate medical and other service providers. It is not responsible for the quality or results of service provided by independent providers.

In all cases, the medical provider, facility, legal counsel or other professional service provider suggested by GMMI/Europ Assistance are not employees or agents of GMMI/Europ Assistance and the choice of provider is yours alone. GMMI/Europ Assistance assumes no liability for the services provided to you under this arrangement, nor is it liable for any negligence or other wrongful acts or omissions of any of the legal or health care professionals providing services to you. Travel assistance services are not available if your coverage under the policy providing insurance benefits is not in effect.

GMMI Service Assistance Overview

Approach

• Offered on Axis Insurance Company Accident and Health Global Medical products for insureds.

• GMMI/Europ Assistance provide 24-hour access to assistance services.

Emergency Medical Services

• Medical Monitoring

• Emergency Medical Transport

• Repatriation of Remains

• Hospital Admission Deposit

When you call GMMI/Europ Assistance, please be prepared:

1. Name of caller, phone no., fax no., relationship to patient;

2. Patient's name, age, sex and policy number;

3. A description of the patient's condition;

4. Name, location, and telephone numer of hospital;

5. Name and telephone numbers for the treating doctor; where and when the doctor can be reached;

6. Health insurance information, worker's compansation, or automobile insurance information if the patient had an accident.

ATTENTION Medical Personnel or Police

In the event of medical emergencies, assistance will be provided to a covered person. **Call Toll free 1-855-209-8027 or Local 954-308-3934.**

Call GMMI/Europ Assistance when:

• You require a referral to a hosptial or doctor

• You are hospitalized

• You need to be evacuated or repatriated

• You need to guarantee payment for medical expenses

• You experience local communication problems

GMMI/Europ Assistance can be reached Toll free at 1-855-209-8027 or Local 954-308-3934.

Complaints board

If disagreement between the insured and the Insurance Company should arise concerning the insurance coverage, and repeated contacts by the insured to GMMI does not yield a satisfying result, the insured can appeal the claim to the Insurance Company.

Remember this is a summary of your benefits. In the event of a disagreement the policy will always take precedence, and will be on file with WISE Foundation.

INSTRUCTIONS TO
DOCTORS and/or HOSPITALS

The bearer of this is covered for Accidents and Sicknesses that occur during the Period of Coverage. Covered expenses include those listed in **SECTION B -** Description of Coverage and Exclusions.

To verify eligibility or benefits please call the claims administrator, ***GMMI at 1-855-209-8027.***

The policy number is on the patient's Insurance Identification Card.

This brochure provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued to the WISE – Worldwide International Student Exchange. Please keep this information as a reference.