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Administrative Office:
GeoBlue®
c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, Pennsylvania 19406

GeoBlue Student International Health Plan

Individual Certificate Number: **See Identification Card**

Issued Under Group Certificate Number: **4ELI-2503-23**

Held By **Riverside Community College District ("Member")**

Effective Date: **July 15, 2023**

Coverage Year: **July 15, 2023 to July 14, 2024**

This Individual Certificate describes the main features of the insurance. It does not waive or alter any of the terms of the Policy(s) or the Group Certificate issued to the Member identified above. If questions arise, the Policy(s) or, if it is silent, the Group Certificate, will govern. The Group Certificate is issued by 4 Ever Life International Limited through a Master Policy issued to the Global Citizens Association, of which the above named Member is a member.

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THE POLICY(S), THE GROUP CERTIFICATE, AND THIS INDIVIDUAL CERTIFICATE ARE ISSUED ON A NON-ADMITTED OR SURPLUS LINE BASIS. THIS MEANS THAT THE TERMS AND CONDITIONS MAY NOT COMPLY WITH STATE INSURANCE LAWS OR REGULATIONS GOVERNING LICENSED AND ADMITTED INSURERS, AND THAT THE INABILITY OF 4 EVER LIFE INTERNATIONAL LIMITED TO PAY CLAIMS IS NOT COVERED BY THE INSURANCE GUARANTY FUNDS OF THE DISTRICT OF COLUMBIA OR OTHER JURISDICTIONS IN THE UNITED STATES OF AMERICA.

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SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES

The Classes eligible for coverage available under this Certificate are shown below. The coverages applicable to a Member's Participants are as shown in the Schedule of Benefits in the copy of the sample Individual Certificate attached to the Member's Group Certificate.

_X_ Class I. An international student, scholar, visiting faculty or other person with a current passport or non-immigrant visa, temporarily located outside his or her Home Country as a non-resident alien and:
a. Is engaged in educational activities of the Member; and
b. Has not obtained permanent residency status in the United States; and
c. Is not a U.S. Citizen.

_X_ Class II. Participants engaged In Optional Practical Training (OPT) or Compulsory Practical Training (CPT) if:
a. The OPT/CPT training follows a course of study; and
b. Is no longer than 12 months in duration; and
c. The Participant maintains their valid Visa.

_X_ Class III. Participants engaged in a sponsored English Language Program or similar program of the Member and maintains a valid F, J or M visa status, and:
a. The Participant has not obtained permanent residency status in the United States; and
b. The Subscriber is not a U.S. Citizen.

_X_ Class IV. Eligible Dependents of any of the above classes

The Insurer maintains its right to investigate eligibility or student status and attendance records to verify that the eligibility requirements have been met. If the Insurer discovers that the eligibility requirements have not been met, its only obligation is to refund premium.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

Enrollment cannot exceed 12 months.

All benefits and limits are stated per Individual Insured or Eligible Dependent (Covered Person).

SCHEDULE OF BENEFITS
TABLE 1

	Limits Individual Insured	**Limits Spouse**	**Limits Dependent Child(ren)**
MEDICAL EXPENSES			
Coverage Year Limit	$250,000	$250,000	$250,000
Coverage Deductible	$0 per Coverage	$0 per Coverage	$0 per Coverage
Coverage Year Out-of-Pocket Limit Out-of-pocket Limit means the amount of Allowed Amount for which the Covered Person is responsible after which the Insurer pays 100% of the Allowed Amount, subject to the limits and provisions of the Certificate.	After the Covered Person reaches a $2,500 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a $2,500 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a $2,500 Out-of-pocket Limit per Coverage Year, the Insurer pays the Allowed Amount at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-pocket Limit.

SCHEDULE OF BENEFITS
TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	PPO Plan In PPO Limits+	PPO Plan Outside PPO Limits
Physician Office Visits*	100% of the Allowed Amount after a $25 Copayment per visit	80% of the Allowed Amount
Treatment at an Urgent Care Facility	100% of the Allowed Amount after a $25 Copayment per visit	80% of the Allowed Amount
Hospital and Physician Outpatient Services	100% of the Allowed Amount after a $100 Copayment per visit	80% of the Allowed Amount
Inpatient Hospital Services	100% of the Allowed Amount after a $100 Copayment per visit	80% of the Allowed Amount
Emergency Hospital Services	100% of Allowed Amount after a $100 Copayment per visit. If admitted to Hospital, then 100% of Copayment Waived	80% of the Allowed Amount

+Payment of Covered Medical Expenses for Preferred Providers is based on the Insurer's Allowed Amount. Preferred Providers have agreed to accept the Allowed Amount as payment in full.

*All Physician Visit Copayments for an Injury or Sickness are waived if treatment is received at Recognized Student Health Center.

If a Covered Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.

If a Covered Person incurs Covered Medical Expenses for services or supplies that are not of the type provided by any Preferred Provider, these Covered Medical Expenses will be treated as if they had been incurred at a Preferred Provider.

SCHEDULE OF BENEFITS
TABLE 3
MEDICAL EXPENSE BENEFITS

The benefits listed below are subject to coverage maximums, Deductible, Coinsurance, and Copayments listed in Tables 1 & 2 above.

MEDICAL EXPENSES	Covered Person
Maternity Care for a Covered Pregnancy	Allowed Amount
Complications of Pregnancy	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount
Outpatient back and spine treatment (including modalities)	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Treatment of specified therapies, including acupuncture and Physiotherapy	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Annual cervical cytology screening for women 18 and older	Allowed Amount
Low dose mammography screening, one baseline mammogram and one mammogram per year.	Allowed Amount
Colorectal cancer screenings	Allowed Amount
Diabetic Supplies/Education	Allowed Amount
Prostate screening tests	Allowed Amount
Diabetic Supplies/Education	Allowed Amount

MEDICAL EXPENSES	Covered Person
Child Preventive and Primary Care Services	Allowed Amount
Vaccinations and Immunizations as required by the Member	Allowed Amount
Breast Reconstruction due to Mastectomy	Allowed Amount
Medical treatment arising from participation in intercollegiate, interscholastic or club sports	Allowed Amount up to $10,000 Maximum per Coverage Year. Injuries from participation in intramural sports are covered the same as any other injury.
Repairs to sound, natural teeth required due to an Injury	100% of Allowed Amount up to $500 per Coverage Year maximum
Outpatient prescription drugs	50% of actual charge
Prescription contraception and devices for women	FDA-approved contraceptive drugs, devices and products are covered at 100% of reasonable expenses and are not subject to cost sharing
Medical treatment received in the Home Country, if NOT covered by Other Certificate	100% of Allowed Amount up to $1,000 Coverage Year maximum
Hearing Services	Allowed Amount up to $1,000 per individual hearing aid per ear every 3 years for covered Dependent Children.
Scalp Prosthesis	Allowed Amount for scalp hair prosthesis for up to $500 per Coverage Year
Lead Poisoning	Allowed Amount
Low Protein Food Products	Allowed Amount

SECTION 2
DESCRIPTION OF COVERAGES
MEDICAL EXPENSES

A. What the Insurer Pays for Covered Medical Expenses: If a Covered Person incurs expenses while insured under the Certificate due to an Injury or a Sickness, the Insurer will pay the Allowed Amount for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit for the Covered Person or the Maximum Benefit for an Eligible Dependent stated in the Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Copayments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Certificate Exclusions, the Recognized Student Health Center provision and to all other limitations and provisions of the Certificate.

B. Covered General Medical Expenses and Limitations: Covered Medical Expenses are limited to the Allowed Amount incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

No Medical Treatment Benefit is payable for Allowed Amount incurred after the Covered Person's insurance terminates as stated in the Period of Coverage provision. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the Medical Treatment Benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Covered Person was insured under a group plan administered by the Administrator immediately prior to the Coverage Start Date shown on the Identification Card issued to the Covered Person, the Insurer will pay the Medical Treatment Benefits for a Covered Injury or a Covered Sickness such that there is no interruption in the Covered Person's insurance.

1. **Physician office visits.**

2. **Hospital Services:** Inpatient Hospital services and Hospital and Physician Outpatient services consist of the following: Hospital room and board, including general nursing services; medical and surgical treatment; medical services and supplies; Outpatient nursing services provided by an RN, LPN or LVN; local, professional ground ambulance services to and from a local Hospital for Emergency Hospitalization and Emergency Medical Care; X-rays; laboratory tests; prescription medicines; artificial limbs or prosthetic appliances, including those which are functionally necessary; the rental or purchase, at the Insurer's option, of durable medical equipment for therapeutic use, including repairs and necessary maintenance of purchased equipment not provided for under a manufacturer's warranty or purchase agreement.

   The Insurer will not pay for Hospital room and board charges in excess of the prevailing semi-private room rate unless the requirements of Medically Necessary treatment dictate accommodations other than a semi-private room.

   If Tests and X-rays are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services there is no additional Copayment for these Tests or X-rays. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

3. **Emergency Hospital Services:** Emergency Hospital Services are Emergency Medical Care delivered in a Hospital Emergency room as defined in this Certificate.

4. **Urgent Care Center visits:** Care delivered at a facility or clinic that provides immediate, but not emergent, ambulatory medical care to patients. The facility should have "Urgent Care" used in its title or advertising words, that is physically separate from a hospital and is licensed in the state in which it is located.

5. **Recognized Student Health Centers:** The Certificate does not cover the cost of treatment or services that are provided normally without charge by Member's Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Member, including team Doctor and trainers or any other service performed at no cost. No premium charged is charged for any such treatment.

   If there is a charge for visits to, or medical services, treatments and supplies received from, a Recognized Student Health Center for an Injury or a Sickness, benefits for those visits, medical services, treatments and supplies will be paid at 100% of Allowed Amount with no Copayment or Deductible.

   If the Recognized Student Health Center is not able to treat the Covered Person, it will refer the Covered Person to a Preferred Provider. If the Covered Person uses the Preferred Provider, medical benefits are paid according to the "Inside PPO" schedule. If the Covered Person chooses not to use the Preferred Provider, medical benefits are paid according to the "Outside PPO" schedule.

C. Additional Covered General Medical Expenses and Limitations: These additional Covered Medical Expenses are limited to the Allowed Amount incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

1. **AIDS Vaccine:** Coverage shall be provided for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.

2. **Behavioral Health Treatment:** Coverage shall be provided for Behavioral Health Treatment for pervasive developmental disorder or autism as defined in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual. Coverage shall be provided in the same manner and shall be subject to the same requirements as provided for outpatient treatment of mental and nervous disorders.

   Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:
   a. The treatment is prescribed by a Physician.
   b. The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following: (i) A qualified autism service provider; (ii) A qualified autism service professional supervised and employed by the qualified service provider; and (iii) A qualified autism service paraprofessional supervised and employed by a qualified service provider.
   c. The treatment plan has measureable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treatment.
   d. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program.

3. **Breast Reconstruction due to Mastectomy:** If breast reconstruction is provided in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:
   a. Reconstruction of the breast on which the mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   c. Prosthesis; and
   d. Treatment for physical complications of all stages of mastectomy, including lymphedemas.

4. **Cancer Clinical Trials:** For a Covered Person diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, coverage shall be provided for all Routine Patient Care Costs related to the clinical trial if the Covered Person's treating Physician, who is providing covered health care services to the Covered Person under the Plan, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Covered Person. For purposes of this provision, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

   The treatment shall be provided in a clinical trial that either:
   a. involves a drug that is exempt under federal regulations from a new drug application; or
   b. that is approved by one of the following:
      i. One of the National Institutes of Health;
      ii. The federal Food and Drug Administration, in the form of an investigational new drug application;
      iii. The United States Department of Defense; or
      iv. The United States Veterans' Administration.

   The provision of services when required by this provision shall not, in itself, give rise to liability on the part of the Insurer.

5. **Cervical cytology screening for cervical cancer and its precursor states for women:** The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear. (Cervical screenings are not subject to the deductible provision).

6. **Child Preventive and Primary Care Services:** Coverage for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age 12 years, and 3 visits per year for minor children ages 12 years up to 18 years of age, and 1 visit per year for covered children 19 and 20 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, newborn hearing screenings, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy.

7. **Colorectal cancer screenings:** Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines.

8. **Complications of Pregnancy:** Complications of Pregnancy are covered under this Plan as any other medical condition. Benefits for complications of pregnancy shall be provided for all Covered Persons.

9. **Contraception.** This plan provides coverage for all of the following services and contraceptive methods for women with NO cost sharing:
   a. All FDA-approved contraceptive drugs, devices and products available over the counter, as prescribed by the enrollee's provider;
   b. Voluntary sterilization procedures;
   c. Patient education and counseling on contraception
   d. Follow-up services related to the drugs, devices, products and procedures covered under this benefit, including, but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

10. **Diabetic Supplies/Education:** Coverage shall be provided for equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a health care professional legally authorized to prescribe such item.

11. **Repairs to sound, natural teeth required due to an Injury:** Benefits are payable for dental care for an Accidental Injury to natural teeth that occurs while the Covered Person is covered under this Certificate, subject to the following:
    a. services must be received during the six months following the date of Injury;
    b. no benefits are available to replace or repair existing dental prosthesis even if damaged in an eligible Accidental Injury; and
    c. damage to natural teeth due to chewing or biting is not considered an Accidental Injury under this Certificate.

    In addition, the Certificate provides benefits for up to three days of Inpatient Hospital services when a Hospital stay is ordered by a Physician and a Dentist for dental treatment required due to an unrelated medical condition. The Insurer determines whether the dental treatment could have been safely provided in another setting. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary.

12. **Hearing Aids for Covered Dependent Children:** The Insurer will pay the provider the Allowed Amount for covered Dependent Children who are less than 24 years of age for Medically Necessary Hearing Aids.

13. **Home Country Coverage (While Insured):** Expenses incurred within the Covered Person's Home Country while insured under the Certificate will be considered as Covered Medical Expenses up to the limits stated in the Schedule of Benefits.

    The Insurer will not cover any medical expense incurred in the Home Country after the Home Country medical expense coverage limits described above have been exceeded.

    Payment is subject to the Limitations and Conditions on Eligibility for Benefits provision.

14. **Home Health Care.** The following services provided by a home health agency*:*
    1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
    2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
    3. Services of a medical social service worker.
    4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
    5. Medically Necessary supplies provided by the Home Health Agency.

    A visit of four hours or less by a home health aide shall be considered as one Home Health Visit.

15. **Hormone Replacement Therapy**: If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause.

16. **Jawbone surgery:** Coverage shall include surgical procedures for those covered conditions directly affecting the upper or lower jawbone, or associated bone joints, if each procedure being considered for reimbursement is deemed Medically Necessary by the Insurer. This benefit will not affect any applicable exclusion pertaining to dental services other than as stated herein.

17. **Lead Screening:** The Insurer will pay the provider the Allowed Amount for lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with guidelines set forth by the Division of Public Health.

18. **Low Protein Food Products:** The Insurer will pay the provider 100**%** of the Allowed Amount for low protein food products for the treatment of inherited metabolic diseases, if the low protein food products are Medically Necessary. Inherited Diseases shall mean a disease caused by the inherited abnormality of body chemistry.

19. **Mammography screening, when screening for occult breast cancer is recommended by a Physician:** Coverage is as follows:
    a. female Covered Persons are allowed one baseline mammogram;
    b. female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.)

20. **Oral Anti-Cancer Prescription Drugs.** For orally administered anti-cancer medications, the Deductible, if any, will not apply and the Copayment will not exceed the lesser of the applicable Copayment shown in the Summary of Benefits or <$200> for a 30-day supply for medications obtained at a retail pharmacy.

21. **Osteoporosis:** Coverage shall include services related to diagnosis, treatment, and appropriate management of osteoporosis, including bone mass measurement technologies as deemed medically appropriate.

22. **Outpatient back and spine treatment (including modalities)** Coverage shall be provided for chiropractic care delivered by a currently licensed chiropractor acting within the scope of his or her practice. The coverage shall include initial diagnosis and clinically appropriate and Medically Necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the Plan.

    The Insurer shall reimburse the Covered Person at the same rate as any other medical provider office visit.

    For purposes of this provision, "chiropractor" does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

23. **Phenylketonuria:** Coverage shall be provided for the testing and treatment of phenylketonuria (PKU). Coverage for treatment of phenylketonuria shall include those Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria. Coverage pursuant to this provision is limited to the extent the cost of necessary Formulas and Special Food Products exceeds the cost of a normal diet.

24. **Post Laryngectomy Prosthetic Devices**: Coverage shall be provided for prosthetic devices to restore a method of speaking for the Covered Person incident to the surgical procedure known as laryngectomy. Coverage for prosthetic devices is subject to any Deductible Amount or Coinsurance applied to the laryngectomy. As used in this provision, laryngectomy means the removal of the larynx for Medically Necessary reasons, as determined by a licensed Physician and surgeon.

25. **Pregnancy:** The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
    a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
    b. a minimum of 96 hours of inpatient care following delivery by cesarean section.

    If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:
    a. Parental education;
    b. Assistance and training in breast or bottle feeding; and
    c. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

26. **Prostate screening tests:** Coverage shall be provided for Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.

27. **Reconstructive Surgery:** Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate. However, this benefit shall not be construed to provide coverage for cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

    This does not apply to orthognathic surgery.

28. **Scalp Prosthesis:** The Insurer will pay the provider the Allowed Amount for scalp prosthesis that is Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease.

29. **Second Opinion:** Coverage shall be provided for a second opinion by an appropriately qualified health care professional upon request by the Covered Person or his or her Physician. Reasons for a second opinion to be provided include, but are not limited to, the following:
    a. If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
    b. If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
    c. If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
    d. If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and the Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
    e. If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

    For purposes of this section, an appropriately qualified health care professional is a primary care Physician or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

30. **Skilled Nursing Facility.** Inpatient services and supplies provided by a skilled nursing facility. The amount by which your room charge exceeds the prevailing two-bed room rate of the Skilled Nursing Facility is not considered covered under this plan.

31. **Telehealth:** This plan provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the plan. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

32. **Transgender Services.** Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

    Coverage is provided for specific services according to plan benefits that apply to that type of service generally, if the plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medical Necessary; hormone therapy would be covered under the plan's prescription drug benefits (if such benefits are included).

    Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. Transgender services are subject to prior authorization in order for coverage to be provided.

    Transgender Travel Expense. Certain travel expenses incurred in connection with an approved transgender surgery, when the Hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. Our maximum payment will not exceed $3,000 per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one companion:
    - Ground transportation to and from the Hospital when it is 75 miles or more from your place of residence.
    - Coach airfare to and from the Hospital when it is 300 miles or more from your residence.
    - Lodging, limited to one room, double occupancy.
    - Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

    We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.

    Details regarding reimbursement can be obtained by calling the customer service number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

33. **Treatment of specified therapies, including acupuncture and physiotherapy:** Charges incurred for the following rehabilitative therapies, if prescribed by a Physician to restore function loss due to an illness or injury covered under this Plan.: physical, occupational, speech, chelation, massage, hearing and cardiac/pulmonary therapy. Additionally, coverage shall also be provided for Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture.

Therapies excluded under this coverage included, but are not limited to: vocational rehabilitation, behavioral training, gym or swim therapy, dance therapy, marital counseling, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.

34. **Vaccination and Immunization Coverage**: The following vaccinations/immunizations are covered as indicated in the Schedule of Benefits if received while covered under the Certificate: Those recommended by the Center for Disease Control (CDC) as published on their Recommended Immunization Schedule.

SECTION 3
PRE-EXISTING CONDITION LIMITATION

There is no limitation for Pre-Existing Conditions as defined under this Certificate.

SECTION 4
GENERAL CERTIFICATE EXCLUSIONS

Unless specifically provided for elsewhere under the Certificate, the Certificate does not cover loss caused by or resulting from, nor is any premium charged for, any of the following:

1. Expenses incurred in excess of Allowed Amount.
2. Services or supplies that the Insurer considers to be Experimental or Investigative.
3. Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage except as described in Covered General Medical Expenses and Limitations and Extension of Benefits.
4. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, unless otherwise noted.
5. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury, unless otherwise noted.
6. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eyeglasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury.
7. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
8. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for in the Certificate.
9. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Certificate and performed while the Certificate is in effect.
10. For diagnostic investigation or medical treatment for reproductive services, infertility, fertility, or for male or female voluntary sterilization procedures, or the reversal male or female voluntary sterilization procedures.
11. Expenses incurred for, or related to, sex change surgery.
12. Organ or tissue transplant.
13. Participating in an illegal occupation or committing or attempting to commit a felony.
14. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Certificate.
16. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, unless otherwise noted.
17. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
18. Diagnosis and treatment of acne.
19. Diagnosis and treatment of sleep disorders.
20. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
21. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
22. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
23. Expenses incurred for any services rendered by a family member or a Covered Person's immediate family or a person who lives in the Covered Person's home.
24. Unless specifically provided for elsewhere under the Certificate, the cost of treatment or services that are provided normally without charge by the Member's Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Member, including team Doctor and trainers or any other service performed at no cost.
25. Loss due to an act of war; service in the armed forces of any country or international authority and Participation in a Riot or Civil Commotion.
26. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.

27. Loss arising from
    a. participating in any professional sport, contest or competition;
    b. while participating in any practice or condition program for such sport, contest or competition;
    c. SCUBA diving, sky diving, mountaineering (where ropes or other climbing gear are customarily used), ultra-light aircraft, parasailing, sailplaning/gliders, hang gliding, parachuting, or bungee jumping.
28. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
29. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
30. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
31. Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
32. Routine hearing tests except as provided under Preventive and Primary Care.
33. Expense covered under any Other Plan.
34. To the extent that such payments would be prohibited by law.

SECTION 5
DEFINITIONS

Unless specifically defined elsewhere, wherever used in the Certificate, the following terms have the meanings given below.

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Certificate.

Age means the Covered Person's attained age.

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Allowed Amount: "Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

A. The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

B. The Allowed Amount for Non-Participating Providers will be determined as follows:
    1. Facilities.
       For Facilities, the Allowed Amount will be the lesser of:
       - 150% of the Centers for Medicare and Medicaid Services Prospective Payment System (PPS) amount;
       - The Facility's charge;
       - an amount based on Our Participating Provider fee schedule or rate.
    2. For All Other Providers.
       For all other Providers, the Allowed Amount will be the lesser of:
       - 150% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type;
       - an amount based on Our Participating Provider fee schedule or rate.
    3. Physician-Administered Pharmaceuticals.
       For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

C. The Allowed Amount for Covered Services incurred outside of the United States will be determined as follows:
    - For Providers or Facilities contracted with GeoBlue, the Allowed Amount for care delivered outside of the United States will be the lesser of the amount billed by the Provider or Facility, as reflected on the verifiably provided bill, or the contracted amount that Provider or Facility has agreed to in writing with GeoBlue.
    - For Providers or Facilities not contracted with GeoBlue, the Allowed Amount for care delivered outside of the United States will be the lesser amount billed by the Provider or Facility, as reflected on the verifiably provided bill, or the most common charge for a particular medical service when rendered in a particular geographic area. The Allowed Amount will not exceed the amount ordinarily charged by most providers for comparable services and supplies in the locality where the service or supplies are received.

    We reserve the right to verify and audit any medical bills prior to reimbursement.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website www.geobluestudents.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

Nothing in the section shall be construed to mean that We would provide coverage for services other than Covered Services.

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:
1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Coinsurance means the ratio by which the Covered Person and the Insurer share in the payment of Allowed Amount for Medically Necessary treatment. The percentage the Insurer pays is stated in the Schedule of Benefits.

Complications means a secondary condition, an Injury or a Sickness that develops or is in conjunction with an already existing Injury or Sickness.

Complications of Pregnancy are conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompression, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. Complications of Pregnancy do not include elective abortion, elective cesarean section, false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarium, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Confinement (Confined) means the continuous period a Covered Person spends as an Inpatient in a Hospital due to the same or related cause.

Congenital Condition means a condition that existed at or has existed from birth, including, but not limited to, congenital diseases or anomalies that cause functional defects.

Country of Assignment means the country for which the Covered Person has a valid visa, if required, and in which he/she is undertaking an educational activity.

Coverage Year: the period of 12 consecutive months commencing with the Effective date of the insurance contract or with anniversary of that date.

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:
1. Administered or ordered by a Physician;
2. Medically Necessary to the diagnosis and treatment of an Injury or Sickness;
3. Are not excluded by any provision of the Certificate; and incurred while the Covered Person's insurance is in force under the Certificate, except as stated in the Extension of Benefits provision. A Covered Medical Expense is deemed to be incurred on the date such service or supply which gave rise to the expense or charge was rendered or obtained. Covered Medical Expenses are listed in Table 3 and described in Section 2.

Covered Person means an Individual Insured and any Eligible Dependents as described in the appropriate eligibility section, for whom premium is paid and who is covered under the Group Certificate.

Custodial Care is services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:
- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Durable Medical Equipment means medical equipment which:
1. Is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
2. Can withstand long term repeated use without replacement;
3. Is not useful in the absence of Injury or Sickness; and
4. Can be used in the home without medical supervision.

The Insurer will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Dependent: An Eligible Dependent may be the Individual Insured's lawful spouse/partner and/or his/her unmarried children under age 26 who are chiefly dependent upon the Eligible Participant for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Eligible Participant during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who:
1. With a similar visa or passport, accompanies the Eligible Participant while that person is engaged in international educational activities; and
2. Is temporarily located outside the Covered Person's Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

As used above:
1. The term "spouse" means the Eligible Participant's lawful spouse as defined in defined in the state or jurisdiction where the marriage occurred. This term includes a common law spouse if allowed by the jurisdiction where the Group Certificate is issued.
2. The term "partner" means an Eligible Participant's spouse or domestic partner.
3. The term "domestic partner" means a person of the same or opposite sex who:
    a. is not married or legally separated;
    b. has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage;
    c. is not currently registered as domestic partner with a different domestic partner and has not been in such a relationship for at least six months;
    d. occupies the same residence as the Eligible Participant;
    e. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
    f. has entered into a domestic partnership arrangement with the named Insured.
4. The term "domestic partnership arrangement" means the Eligible Participant and another person of the same or opposite sex has any three of the following in common:
    a. joint lease, mortgage or deed;
    b. joint ownership of a vehicle;
    c. joint ownership of a checking account or credit account;
    d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
    e. designation of the domestic partner as a beneficiary of the employee's will;
    f. designation of the domestic partner as holding power of attorney for health care; or
    g. shared household expenses.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:
1. Permanently placing the Covered Person's health in jeopardy, or
2. Causing other serious medical consequences; or
3. Causing serious impairment to bodily functions; or
4. Causing serious and permanent dysfunction of any bodily organ or part.

Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time shall not be included in this definition of a medical emergency, unless symptoms suddenly become so severe that immediate medical aid is required.

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Experimental or Investigative means treatment, a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. The Insurer will make the final determination as to what is Experimental or Investigative.

Home Country means the Covered Person's country of domicile named on the enrollment form or the roster, as applicable. However, the Home Country of an Eligible Dependent who is a child is the same as that of the Eligible Participant.

Hospital means a facility that:
1. Is primarily engaged in providing by, or under the supervision of doctors of medicine or osteopathy, Inpatient services for the diagnosis, treatment, and care, or rehabilitation of persons who are sick, injured, or disabled;
2. Is not primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care;
3. Provides 24 hours nursing service; and
4. Is licensed or approved as meeting the standards for licensing by the state in which it is located or by the applicable local licensing authority.

Immediate Family Member means Your spouse; Partner; parent; child(ren), including children who are, or are in the process of becoming, adopted; Your siblings; Your grandparent or grandchild(ren). Adopted, half and step members are also included as an Immediate Family Member.

Individual Certificate is the document issued to each Individual Insured outlining the benefits under the Group Certificate.

Infertile or Infertility is the condition of a presumably healthy covered person who is unable to conceive or produce conception after:
1. For a woman who is under 35 years of age: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
2. For a woman who is 35 years of age or older: six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. To be covered, the Injury must first be treated while the Covered Person is insured under the Certificate. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

Inpatient means a person confined in a Hospital for at least one full day (18 to 24 hours) and charged room and board.

The Insurer means 4 Ever Life International Limited, a Bermuda insurer not admitted in any U.S. jurisdiction.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:
1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Low Protein Food products shall mean a food product that is especially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include a natural food that is naturally low in protein.

Medically Necessary services or supplies are those that the Insurer determines to be **all** of the following:
1. Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition.
2. Provided for the diagnosis or direct care and treatment of the medical condition.
3. Within standards of good medical practice within the organized community.
4. Not primarily for the patient's, the Physician's, or another provider's convenience.
5. The most appropriate supply or level of service that can safely be provided. For Hospital stays, this means acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Certificate.

Member means and Intuitional Member of the Global Citizens Association which has elected that its Participants and, if applicable, the dependents of those Participants be covered under the Group Certificate which has been accepted by the Insurer for coverage under the Group Certificate

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Morbid Obesity means:
1. Your **body mass index** (BMI) exceeds 40; or
2. Your BMI exceeds 35 and you have one of the following conditions:
   a. Coronary heart disease; or
   b. Type 2 diabetes mellitus; or
   c. Clinically significant obstructive sleep apnea; or
   d. Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Non-hospital Residential Facility means a facility certified by the District or by any state or territory of the United States as a qualified nonhospital provider of treatment for drug abuse, alcohol abuse, mental illness, or any combination of these, in a residential setting. The term "non hospital residential facility" includes any facility operated by the District, any state or territory, or the United States, to provide these services in a residential setting.

Other Plan means any of the following which provides benefits or services for, or on account of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to states for medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Outpatient means a person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician's office, Ambulatory Surgical Facility, or similar centers, and who is not charged room and board for such services.

Outpatient treatment facility means a clinic, counseling center, or other similar location that is certified by the District or by any state or territory as a qualified provider of outpatient services for the treatment of drug abuse, alcohol abuse, or mental illness. The term "outpatient treatment facility" includes any facility operated by the District, any state or territory, or the United States to provide these services on an outpatient basis.

Participant means a person who:

1. Is engaged in international educational or cultural activities; and
2. Is temporarily traveling outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status in the country that they are traveling to; and
4. Is enrolled in the Member's program and have been validly enrolled and meet the eligibility requirements as specified by the Member.

Participation in Riot or Civil Commotion. "Participation" means promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen. "Riot or Civil Commotion" means all forms of public violence, disorder, or disturbance, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damaged to persons or property or unlawful act or acts is the intent or consequence of such disorder.

Physician means a currently licensed practitioner of the healing arts acting within the scope of his/her license. It does not include the Covered Person or his/her spouse, parents, parents-in-law or dependents or any other person related to the Covered Person or who lives with the Covered Person.

Physiotherapy means a physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation or massage.

Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Pre-existing Condition means any disease, illness, sickness, malady or condition which was diagnosed or treated by a legally qualified physician prior to the effective date of coverage with consultation, advice or treatment by a legally qualified physician occurring within 6 months prior to the Coverage Date for the Covered Person.

Preferred Provider means a Hospital, Physician, or other health care provider who has agreed to participate in the PPO and who has agreed to accept negotiated rates for charges for Covered Medical Expenses. Preferred Providers have agreed to accept the negotiated rate as payment in full.

Preferred Provider Organization (PPO) means the network(s) of Preferred Providers stated on the Covered Person's identification card.

A **Primary Plan** is a Group Health Benefit Plan, an individual health benefit plan, or a governmental health plan designed to be the first payor of claims for a Covered Person prior to the responsibility of this Plan.

Recognized Student Health Center means a health facility of an educational institution that provides basic health services for students for a minimum of 20 hours per week during the school semester. Basic services must include staffing by a licensed medical provider (M.D., C.N.P. or R.N.) for the purpose of assessment and treatment of minor Sicknesses and Injuries and/or referral to a PPO Provider and is approved as a Recognized Student Health Center by the Administrator.

Registered Nurse means a graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." or "R. P.N." after his/her name.

Sexually transmitted disease: Any disease transmitted by sexual contact; caused by microorganisms that survive on the skin or mucus membranes of the genital area; or transmitted via semen, vaginal secretions, or blood during intercourse.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person starting while insured under the Certificate.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, Charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be Charges made for treatment of Substance Abuse.

Total Disability or Totally Disabled

1. With respect to a Covered Person who otherwise would be employed, Total Disability or Totally Disabled means the Covered Person's complete inability to perform all the substantial and material duties of his/her regular occupation while under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability.
2. With respect to a Covered Person who would not otherwise be employed, Total Disability or Totally Disabled means the Covered Person's inability to engage in the normal activities of a person of like age and sex while:
   a. Under the care of, and receiving treatment from, a Physician for the Injury or Sickness causing the inability, or
   b. Hospital Confined or home confined at the direction of his/her Physician due to Injury or Sickness, except for trips away from home to receive medical treatment.

United States (U.S.) means the 50 states of the United States of America, and the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by the Insurer, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

We, Us and Our means 4 Ever Life International Limited.

Written Request means a request on any form provided by the Administrator for particular information.

You, Your means a Covered Person.

11:59 PM means 11:59 PM at the Covered Person's location.

12:01 AM means 12:01 AM at the Covered Person's location.

SECTION 6
EXTENSION OF BENEFITS

During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this Certificate cease for You or Your Dependent due to cancellation of the Policy (except if the Policy is canceled for nonpayment of premiums) and You or Your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

1. the date You exceed the Maximum Benefit, if any, shown in the Schedule of Benefits;
2. the date You are covered for medical benefits under another group plan;
3. the date You or Your Dependent is no longer Hospital Confined; or
4. 30 days from the date the Group Certificate is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when Your Medical Benefits cease or Your Dependent's Medical Benefits cease.

SECTION 7
ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

Participant: Participant means any person who satisfies the definition of a Participant and the requirement of an applicable class as shown in Section 1 – Eligible Classes. He/she must not be insured under the Group Certificate as a dependent. When both spouses are Eligible Participants under the Group Certificate, only one spouse shall be considered to have any Eligible Dependents.

Enrollment for Coverage: A Participant and their Eligible Dependents will be eligible for coverage under the Certificate subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is elected by a Participant, a Participant may also enroll his/her Eligible Dependents for coverage on the later of:

1. The effective date of his/her insurance; or
2. Within 31 days from the date on which the Dependent arrives in the Country of Assignment.

When an Eligible Participant's Coverage Starts: Coverage for a Participant that will be covered by the Group Certificate starts at 12:01 AM on the latest of the following:

1. The Coverage Start Date shown on the Insurance Identification Card;
2. The date the requirements in Section 1 – Eligible Classes are met; or
3. The date the premium and completed enrollment form, if any, are received by the Insurer or the Administrator.

Thereafter, the insurance is effective 24 hours a day, worldwide. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

Both 1 and 2 above are subject to the benefit periods, Deductibles, and Coinsurance as defined in the respective policies.

When an Eligible Participant's Coverage Ends: Coverage for an Eligible Participant will automatically terminate on the earliest of the following dates:

1. The date the Policy terminates;
2. The termination of the Group Certificate;
3. The date on which the Participant ceases to meet the Individual Eligibility Requirements;
4. The end of the term of coverage specified in the Eligible Participant's enrollment form;
5. The date the Eligible Participant permanently leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant cancellation of coverage (the request must be in writing);
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision; or
8. The end of any Period of Coverage.

Coverage will end at 11:59 PM. on the last date of insurance. A Covered Person's coverage will end without prejudice to any claim existing at the time of termination.

When an Eligible Dependent's Coverage Starts: An Eligible Dependent may only be added or dropped from coverage in the case of a qualifying event defined as marriage, death, loss of coverage, divorce, entry into or departure from the Country of Assignment. An Eligible Dependent's coverage starts at 12:00 AM on the latest of the following:

1. The effective date of the Eligible Participant's insurance;
2. The effective date shown on the insurance identification card;
3. The date the completed enrollment form and premium are received by the Insurer.

Thereafter, the insurance is effective 24 hours a day, worldwide. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

When an Eligible Dependent's Coverage Ends. An Eligible Dependent's coverage automatically ends on the earliest of the following dates:

1. The date the Policy terminates;
2. The termination of the Group Certificate;
3. The date the Eligible Participant is no longer covered under the Group Certificate;
4. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements;
5. The end of the term of coverage shown on the enrollment form, if any;
6. 11:59 PM. on the date he or she permanently departs the Country of Assignment for his or her Home Country;
7. The date the Eligible Participant requests cancellation of coverage (the request must be in writing);
8. The premium due date for which the required premium has not been paid, or
9. The date on which the Eligible Dependent ceases to meet the eligibility requirements.

Coverage will end at 11:59 PM on the last date of insurance. An Eligible Dependent's coverage will end without prejudice to any claim.

Renewing Coverage: Coverage under this Certificate is not automatically renewable. Eligible Participants may re-apply for coverage as long as they meet the current eligibility requirements, re-apply for coverage, and payment of the applicable premium to the Insurer by the Eligible Participant is received. There is a 31 day grace period in which to pay the premium due. Renewals may be subject to a minimum premium payment.

SECTION 8
COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

Coverage of Newborn Infants: A newborn child of the Eligible Participant will automatically be a Covered Person for 31 days from the moment of his/her birth if the birth occurs while the Certificate is in force, and subject to the particular coverages and amounts of insurance as specified for Eligible Dependents in the Schedule of Benefits.

Coverage of Adopted Children: An adopted child of the Eligible Participant is covered on the same basis as described above for a newborn. Coverage starts on the date of placement for adoption, provided the Eligible Participant's coverage is then in force. Coverage terminates if the placement is disrupted and the child is removed from placement.

Newborn children are covered for the Medically Necessary treatment of medically diagnosed congenital defects, birth abnormalities and premature birth.

Expenses for routine nursery care means the charges of a Hospital and attending Physician for the care of a healthy newborn infant while Confined. Care includes treatment of standard neo-natal jaundice.

In order to continue the coverage of a newborn child beyond the 31st day following his/her date of birth or of an adopted child beyond the 31st day following his/her placement:

1. Written notice of the birth or of placement of the child must be provided to the Insurer or to the Administrator within 31 days from the date of birth or placement; and
2. The required payment of the appropriate premium, if any, must be received by the Insurer.

If 1. and 2. above are not satisfied, coverage of a newborn child or of the adopted child will terminate 31 days from the date of birth or placement.

SECTION 9
CLAIM PROVISIONS

Notice of Claim: Written notice of any event which may lead to a claim under the Certificate must be given to the Insurer or to the Administrator within 30 days after the event, or as soon thereafter as is reasonably possible.

Claim Forms: Upon receipt of a written notice of claim, the Insurer will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If these forms are not furnished within 15 days after the notice is sent, the claimant may comply with the Proof of Loss requirements of the Certificate by submitting, within the time fixed in the Certificate for filing proofs of loss, written proof showing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Certificate provides any periodic payment contingent upon continuing loss, this proof may be furnished within 90 days after termination of each period for which the Insurer is liable. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided

1. it was not reasonably possible to provide proof in that time; and
2. the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity

Time for Payment of Claim: Benefits payable under the Certificate will be paid immediately upon receipt of satisfactory written proof of loss, unless the Certificate provides for periodic payment. Where the Certificate provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss.

Payment of Claims: Benefits for accidental loss of life under the Accidental Death & Dismemberment coverage will be payable in accordance with the beneficiary designation and the provisions of the Certificate which are effective at the time of payment. If no beneficiary designation is then effective, the benefits will be payable to the estate of the Covered Person for whom claim is made. Any other accrued benefits unpaid at the Covered Person's death may, at the Insurer's option, be paid either to his/her beneficiary or to his/her estate. Benefits payable under other coverages shall be payable to the provider of the service. Benefits payable under the Accidental Death & Dismemberment coverage, other than for loss of life, will be paid to the Covered Person.

If any benefits are payable to the estate of a Covered Person, or to a Covered Person's beneficiary who is a minor or otherwise not competent to give valid release, the Insurer may pay up to $1,000 to any relative, by blood or by marriage, of the Covered Person or beneficiary who is deemed by the Insurer to be equitably entitled to payment. Any payment made by the Insurer in good faith pursuant to this provision will fully discharge the Insurer of any obligation to the extent of the payment.

Choice of Hospital and Physician: Nothing contained in this Certificate restricts or interferes with the Covered Person's right to select the Hospital or Physician of his or her choice. Also, nothing in this Certificate restricts the Covered Person's right to receive, at his/her expense, any treatment not covered in this Certificate.

Physical Examination and Autopsy: The Insurer may, at its expense, examine a Covered Person, when and as often as may reasonably be required during the pendency of a claim under the Certificate and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

BlueCard® Program and Other Inter-Plan Arrangements

4 Ever Life International Limited and Worldwide Insurance Services/GeoBlue have relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to Non-Participating Providers. Whenever You obtain healthcare services the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when You receive covered services from hospitals, doctors, and other Providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, You may also obtain care from Non-Participating Providers. Our payment calculation/practices in both instances are described below.

It is important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this Plan.

- **Out of Area Services.** We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever You obtain healthcare services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Us and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside of Our service area, You may obtain care from healthcare Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from Non-Participating healthcare Providers. Our payment practices in both instances are described below.

- **BlueCard® Program.** Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, We will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever You access covered healthcare services outside of Our service area and the claim is processed through the BlueCard® Program, the amount You pay for covered healthcare services is calculated based on the lower of:

- The billed covered Charges for Your covered services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue to Your healthcare Provider. But sometimes it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and other credits or Charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation or modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price We use for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, We would then calculate Your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers.**

  Your Liability Calculation. When covered health care services are provided by Non-Participating health care Providers, the amount You pay for such services will generally be based on either the Host Blue's Non-Participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  Exceptions. In certain situations, We may use other payment bases, such as billed covered Charges, the payment We would make if the health care services had been obtained within Our network, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by Non-Participating health care Providers. In these situations, You may be liable for the difference between the amount that the Non-Participating health care Provider bills and the payment We will make for the covered services as set forth in this paragraph.

  If You obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's services will be considered Non-Participating Provider care, and You may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on Your ID card or go to www.geobluestudents.com for more information about such arrangements.

Providers available to You through the BlueCard Program have not entered into contracts with 4 Ever Life International Limited. If You have any questions or complaints about the BlueCard Program, please call Us at the customer service telephone number listed on Your ID card.

We, or Our authorized Administrator, will provide written notice to the insured Participant within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any Provider contract, if We determine that the insured Participant or his/her insured Dependents may be materially and adversely affected, and provide the insured Participant with a current list of Participating Providers.

If the insured Participant needs a new Provider listing for any other reason, he/she may call the customer service telephone number listed on the ID card or go to www.geobluestudents.com for a new Provider listing.

SECTION 10
GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Covered Person consists of the Master Policy issued to the Global Citizens Association, this Certificate and the Member's Group Certificate, which are deemed incorporated by reference and made a part of the Master Policy. All statements contained in the contract will be deemed representations and not warranties. No statement made by an applicant for insurance will be used to void the insurance or reduce the benefits, unless contained in a written application and signed by the applicant. No agent has the authority to make or modify the Certificate, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Certificate will be valid unless evidenced by an endorsement or amendment of the Certificate, signed by one of the Insurer's officers and delivered to the Participating Organization.

Time Limit on Certain Defenses: No claim for loss incurred after 1 year from the effective date of the Covered Person's insurance will be reduced or denied on the grounds that the disease or physical condition existed prior to the effective date of the Covered Person's insurance. This provision does not apply to a disease or physical condition excluded by name or specific description.

Legal Actions: No action at law or in equity may be brought to recover under the Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Certificate. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Assignment: No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or by its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will relieve the Insurer of its liability under the Certificate.

Beneficiary: The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Certificate unless the designation of the beneficiary is irrevocable.

Mistake in Age: If the age of any Covered Person has been misstated, an equitable adjustment will be made in the premiums or, at the Insurer's discretion, the amount of insurance payable. Any premium adjustment will be based on the premium that would have been charged for the same coverage on a Covered Person of the same age and similar circumstances.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Not in Lieu of Workers' compensation. The Certificate does not satisfy any requirement for Workers' Compensation.

Subrogation: If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Certificate due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Insurer will be entitled to a refund of all benefits the Insurer has paid from such recovery. Further, the Insurer has the right to offset subsequent benefits payable to the Covered Person under the Certificate against such recovery.

The Insurer may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. The Insurer shall have a right to recovery of the full amount of benefits paid under the Certificate for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Insurer will not be responsible for the Covered Person's attorneys' fees or other cost.

Upon request, the Covered Person must complete the required forms and return them to the Insurer or to the Administrator. The Covered Person must cooperate fully with the Insurer in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to the Insurer to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Insurer to institute legal action against the Covered Person for failure to repay the Insurer, the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Certificate in excess of the amount necessary, the Insurer shall have the right to recover such payments. The Insurer shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, the Insurer has the right to offset such overpayment against any other benefits payable to the Covered Person under the Certificate to the extent of the overpayment.

Currency: All premiums for and claims payable pursuant to the Certificate are payable only in the currency of the United States of America.

Grievances

For the purposes of this section, any reference to "You", "Your" or "Covered Person" also refers to a representative or Provided by You to act on Your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems with the services provided.

Start with Customer Services

We are here to listen and help. If You have a concern regarding a person, a service, the quality of care, or contractual benefits, You can call Our toll-free number shown on your identification card and explain concerns to one of our Customer Service representatives. You can also express that concern in writing. Please write to Us at the following address:

Worldwide Insurance Services, LLC
Attn: Appeals Department
933 First Avenue
King of Prussia, Pennsylvania 19406

We will do Our best to resolve the matter on your initial contact. If We need more time to review or investigate your concern, We will get back to You as soon as possible, but in any case within 30 days.

If You are not satisfied with the results of a coverage decision, You can start the appeals procedure.

Appeals Procedure

The Insurer has a two-step appeals procedure for most coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing

within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register your appeal by telephone. Call or write to the Administrator at the toll-free number or address shown on your identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, you will be responded to in writing with a decision within fifteen calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, We will notify You in writing to request an extension of up to 15 calendar days and to specify an additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of Your Physician would cause You severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing Inpatient Hospital stay. The Insurer or its designee's physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, We will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If You are dissatisfied with Our level one appeal decision, you or your authorized representative may request a second review for appeals involving Medical Necessity or clinical appropriateness. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by an appeals committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the appeals committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician or Dentist reviewer in the same or similar specialty as the care under consideration, as determined by the Insurer's or its designee's Physician or Dentist reviewer. You may present your situation to the committee by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a committee review. For required pre-service and concurrent care coverage determinations, the committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, We will notify You in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or Your appeal involves non-authorization of an admission or continuing Inpatient Hospital stay. The Insurer's or its designee's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Following a second level appeal, a final determination will be made and a letter will be sent to you.

Dispute Resolution

All complaints or disputes relating to coverage under this Certificate must be resolved in accordance with the Insurer's grievance procedures. Grievances may be reported by telephone or in writing. All grievances received by the Insurer that cannot be resolved by telephone conversation (when appropriate) to the mutual satisfaction of both the Covered Person and the Insurer will be acknowledged in writing, along with a description of how the Insurer propose to resolve the grievance.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Covered Person and his/her Insured Dependents or the Member because the Covered Person's, the Member's, or any person's action on the Covered Person's or the Member's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

All grievances not resolved by the Insurer's grievance procedures, and all other controversies and claims arising out of or relating to the Policy, or any coverage provided thereunder, shall be determined by final and binding arbitration administered by the American Arbitration Association ("AAA") under its Commercial Arbitration Rules and Mediation Procedures ("Commercial Rules") including, if appropriate, the International Commercial Arbitration Supplementary Procedures and the Supplementary Rules for Class Arbitrations. The award rendered by the arbitrator shall be final, non-reviewable and non-appealable and binding on the parties and may be entered and enforced in any court having jurisdiction. There shall be one arbitrator agreed to by the parties within twenty (20) days of receipt by respondent of the request for arbitration or in default thereof appointed by the AAA in accordance with its Commercial Rules. The seat or place of arbitration shall be Philadelphia, Pennsylvania.

The Insurer will meet any Notice requirements by mailing the Notice to the Member at the billing address listed on our records. The Member will meet any Notice requirements by mailing the Notice to:

4 Ever Life International Limited
c/o Worldwide Insurance Services LLC,
933 First Avenue
King of Prussia, Pennsylvania 19406
Toll free: 1.844.268.2686

Privacy Statement

4 Ever Life International Limited wants You to know how We protect the confidentiality of you non-public personal information. We want You to know how and why We use and disclose the information that We have about you. The following describes our policies and practices for securing the privacy of our current and former customers.

Information We Collect

The non-public personal information that we can collect about you includes, but is not limited to:

1. Information contained in applications or other forms that you submit to Us, such as name, address, dates of birth, gender and in some cases, social security number;
2. Information about your transactions with our affiliates or other third-parties, such as balances and payment history;
3. Information we receive from a consumer-reporting agency, such as credit-worthiness

Information We Disclose

We disclose the information that We have when it is necessary to provide our products and services. We may also disclose information when the law requires or permit us to do so.

Confidentiality and Security

Only our employees and others who need the information to service your account have access to Your personal information. We have measures in place to secure our paper files and computer systems.

Right to Access or Correct Your Personal Information

You have a right to request access to or correction of your personal information that is in our possession.

Contacting Us

If You have any questions about this privacy notice or would like to learn more about how we protect your privacy, please contact the group administrator, agent or broker that handled this insurance. We can provide a more detailed statement of our privacy practices upon request.