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c/o Worldwide Insurance Services, LLC
933 First Avenue
King of Prussia, PA 19406

GeoBlue Student Overseas Plan

Issued Under Group Certificate Number: **4ELI-2573-A-24**

Held By: **Santa Clara University ("Member")**

Effective Date: **August 1, 2024**

Coverage Year: **August 1, 2024 – July 31, 2025**

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.

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
ELIGIBLE CLASSES

This is a Blanket Accident and Sickness Plan, and all of the Member's Participants who meet the eligibility requirements of the classes listed below, are eligible to be covered under this plan Effective Date, or the date he or she becomes eligible, as long as the Member has paid the required premium.

The Classes eligible for coverage available under this Individual 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: Eligible Student Participants enrolled in the Member's sponsored or approved travel program who are temporarily traveling outside of the United States.

__X__ Class II: Eligible Study Abroad Staff Participants providing direct support to the Member's sponsored or approved travel program who are temporarily traveling outside of the United States.

__X__ Class III**.** Eligible Dependents of any of the above classes

The Insurer maintains its right to investigate eligibility, student status and attendance records, or employment 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.

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

SECTION 2
COVERAGE AREA and COVERED EVENTS

Coverage Area
Benefits under this insurance are available in the following locations:

- Any country outside of the United States.

Note: whenever coverage provided under this Plan would be in violation of any U.S. economic or trade sanctions, such coverage shall be null and void.

Covered Events
We will pay benefits described in this Certificate when a Covered Person suffers a loss or Injury as a result of a Covered Accident or Sickness during one of the Covered Activities listed in the Schedule of Benefits. We will only pay benefits if the Insured is engaged in one of the hazards described below when the Covered Accident occurs. Unless otherwise specified, We pay benefits only once for any one Covered Accident or Sickness, even if it is covered by more than one hazard.

- **Educational Travel**
  We will pay the benefits described in this Certificate only if a Covered Person suffers a loss or incurs a Covered Expense as the direct result of a Covered Accident or Sickness while traveling:
  1. outside the United States;
  2. while covered under this Plan; and
  3. engaging in a Trip authorized by the Member.

SCHEDULE OF BENEFITS
TABLE 1

	Limits Individual Insured	Limits Spouse	Limits Dependent Child(ren)
MEDICAL EXPENSES			
Maximum benefit per Coverage Year	$250,000	$250,000	$250,000
Per Coverage Year Deductible	$0	$0	$0
EMERGENCY MEDICAL EVACUATION	Maximum Benefit up to $250,000 per Coverage Year	Maximum Benefit up to $250,000 per Coverage Year	Maximum Benefit up to $250,000 per Coverage Year
EMERGENCY FAMILY TRAVEL ARRANGEMENTS	Maximum Benefit up to $5,000 per Coverage Year	Maximum Benefit up to $5,000 per Coverage Year	Maximum Benefit up to $5,000 per Coverage Year
EMERGENCY REUNION	Maximum Benefit up to $1,500 per Coverage Year	Maximum Benefit up to $1,500 per Coverage Year	Maximum Benefit up to $1,500 per Coverage Year
REPATRIATION OF MORTAL REMAINS	Maximum Benefit up to $50,000 per Coverage Year	Maximum Benefit up to $50,000 per Coverage Year	Maximum Benefit up to $50,000 per Coverage Year
ACCIDENTAL DEATH & DISMEMBERMENT	Maximum Benefit: Principal Sum up to $10,000	Maximum Benefit: Principal Sum up to $5,000	Maximum Benefit: Principal Sum up to $1,000
POST DEPARTURE TRIP INTERRUPTION			
Transportation Benefit	Deductible does not Apply. Maximum Benefit up to $1,500 per Coverage Year		
Lodging & Incidentals Benefit	Deductible does not Apply. Maximum Benefit up to $2,000 per Coverage Year and limited to $200 per day per for a Maximum of 10 calendar days.		

SCHEDULE OF BENEFITS
TABLE 2
MEDICAL EXPENSE BENEFITS

COVERAGE A – MEDICAL EXPENSES	Certificate Limits
Physician Office Visits	100% of the Allowed Amount
Inpatient Hospital Services	100% of the Allowed Amount
Hospital and Physician Outpatient Services	100% of the Allowed Amount
Emergency Hospital Services	100% of the Allowed Amount

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	100% of the Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount for a maximum period of 30 days per Coverage Year
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount for a maximum period of 30 visits per Coverage Year
Treatment of specified therapies, including acupuncture and Physiotherapy	100% of the Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Annual cervical cytology screening for women 18 and older	100% of the Allowed Amount

MEDICAL EXPENSES	Covered Person
Low dose mammography screening, one baseline mammogram and one mammogram per year	100% of the Allowed Amount
Colorectal cancer screenings	100% of the Allowed Amount
Diabetic Supplies/Education	100% of the Allowed Amount
Prostate screening tests	100% of the Allowed Amount
Child Preventive and Primary Care Services	100% of the Allowed Amount
Breast Reconstruction due to Mastectomy	100% of the Allowed Amount
Repairs to sound, natural teeth required due to an Injury	100% of the Allowed Amount up to $500 per Coverage Year maximum
Dental Treatment (including extractions) to alleviate pain	100% of the Allowed Amount up to $500 per Coverage Year maximum
Outpatient prescription drugs including oral contraceptives and devices	100% of the Allowed Amount. Limited to a 31-day supply for initial fill or refill

SECTION 3
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 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 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.

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.

   Note: When outside the United States, this benefit will provide coverage for private rooms if that is all that is available or if the choice is between a ward or a more than two person room and a 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.

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.

1. **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.

2. **Annual 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).

3. **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.)

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

5. **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.

6. **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.

7. **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.

8. **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 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; 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.

9. **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.

10. **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.

11. **Dental Treatment (including extractions) to alleviate pain:** Benefits are payable for dental care for Relief of Pain to the teeth that occurs while the Covered Person is covered under this Certificate. Services must be received while covered during the period the Covered Person is enrolled under the Certificate. The Insurer pays as stated in the Benefit Overview Matrix.

SECTION 4
EMERGENCY MEDICAL EVACUATION BENEFIT

If a Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services during the Period of Coverage, while traveling outside of his/her home country, and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the nearest appropriate medical facility. This medically-supervised evacuation will be to the nearest medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services. Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Covered Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

We will pay Reasonable Charges for escort services if the Covered Person is a minor or if the Covered Person is disabled during a trip and an escort is recommended in writing by the attending Physician and approved by the Insurer.

As part of a medical evacuation, Our Administrator shall also make all necessary arrangements for ground transportation to and from the hospital, as well as pre-admission arrangements, where possible, at the receiving hospital.

If following stabilization, when medically necessary and subject to the Administrator's prior approval, the Insurer will pay for a medically supervised return to the Covered Person's permanent residence or, if appropriate, to a health care facility nearer to their permanent residence or for one-way economy airfare to the Covered Person's point of origin, if necessary.

- You are the victim of a Felonious Assault during Your Period of Coverage and You no longer can complete Your trip or program, subject to verification by the Administrator, We will pay for You to return home from Your current location outside of the United States. Felonious Assault is an act of violence against You. Your return home will be via the most direct and economical means possible, less any refundable return ticket fees available to You.

- If, due to a covered Illness or Injury, which is so disabling as to cause a reasonable person to determine that they cannot continue their trip or if an academic program, cannot continue Your program, We will pay for Your return home from Your current location outside of the United States. Your return home will be via the most direct and economical means possible, less any refundable return ticket fees available to You.

- If the Covered Person has minor children who are left unattended as a result of your injury, illness or medical evacuation, We or Our designee will arrange and pay for the cost of economy class one-way airfares for the transportation of such minor children to Your Home Country or Country of Assignment.

The combined benefit for all necessary Emergency Medical Evacuation services is listed in the Schedule of Benefits.

No more than one Emergency Medical Evacuation and/or repatriation is allowed for any single medical condition of a Covered Member during the Period of Coverage.

All services under this benefit must be approved and coordinated by Administrator designated physicians.

With respect to this provision only, the following is in lieu of the Certificate's Extension of Benefits provision: No benefits are payable for Covered Expenses incurred after the date the Covered Person's insurance under the Certificate terminates. However, if on the date of termination the Covered Person is Hospital Confined, then coverage under this benefit provision continues until the earlier of the date the Hospital Confinement ends or the end of the 31st day after the date of termination.

SECTION 5
EMERGENCY FAMILY TRAVEL ARRANGEMENTS

If We determine that You are expected to require hospitalization in excess of 3 days due to an Injury or Sickness or are in critical condition while traveling outside of Your Home country, the Insurer will pay up to the maximum benefit as listed above for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the location of Your hospital confinement for one person designated by You. Payment for meals, ground transportation and other incidentals are the responsibility of the family member or friend.

With respect to any one trip, this benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip. The determination of whether the Covered Member will be hospitalized in excess of 3 days or is in critical condition shall be made by the Administrator after consultation with the attending physician. No more than one (1) visit may be made during any Period of Coverage. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

SECTION 6
EMERGENCY REUNION BENEFIT

In the event of the death, or a serious/life-threatening illness, of an Immediate Family member, the Administrator will pay up to the amount shown in the Schedule of Benefits for the cost of one economy round trip air fare ticket for the Covered Person to return home. Immediate Family means the spouse, children, brothers, sisters or parents, or grandparents of a Covered Person.

All transportation arrangement must be made by the most direct and economical route and conveyance possible and many not exceed the Usual and Customary Charges for similar transportation I the locality where the expense is incurred. Benefits will not be payable unless We (or Our authorized assistance provider) authorized in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider.

SECTION 7
REPATRIATION OF MORTAL REMAINS BENEFIT

If a Covered Person dies while covered under this Plan, We will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to the Covered Person's residence or place of burial. This benefit covers:

- Expenses for embalming or cremating of the remains.
- The minimally necessary casket or air tray required by the transporting airline.
- Domestic and International paperwork fees, including up to 3 copies of a death certificate.
- Transportation of the remains to Your place of residence or place of burial.

This benefit does not provided coverage for expenses not listed including expenses for urns, caskets, coffins (beyond the minimally necessary casket or air tray required for transportation), burial or funeral expenses.

We will not pay any claims under this provision unless the expense has been approved by Us or Our designee before the body is prepared for transportation.

All transportation arrangement must be made by the most direct and economical route and conveyance possible and many not exceed the Allowed Amount for similar transportation in the locality where the expense is incurred. Benefits will not be payable unless We (or Our authorized assistance provider or designee) authorized in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Our assistance provider or designee.

With respect to this provision only, the following is in lieu of the Plan's Extension of Benefits provision: No benefits are payable for Covered Expenses incurred after the date the Covered Person's insurance under the Plan terminates. However, if on the date of termination the Covered Person is deceased, then coverage under this benefit provision continues until the deceased Covered Person's remains are returned to their Home County.

SECTION 8
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit up the Principal Sum as stated in the Schedule of Benefits if a Covered Person sustains an Injury resulting in any of the losses stated below while covered under this Plan:

For Loss of:	Percentage of Maximum Amount
• Life	100%
• Both Hands or Both Feet	100%
• Sight of Both Eyes	100%
• One Hand and One Foot	100%
• One Hand and the Sight of One Eye	100%
• One Foot and the Sight of One Eye	100%
• Speech and Hearing in Both Ears	100%
• One Hand or One Foot	50%
• The Sight of One Eye	50%
• Speech or Hearing in Both Ears	50%
• Hearing in One Ear	25%
• Thumb and Index Finger of Same Hand	25%

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye. If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

Benefits payable are subject to the Exclusions and Limitations as listed in this document.

Exposure. If by reason of an Accident covered by the Certificate a Covered Person is unavoidably exposed to the elements and as a result of such exposure suffers a Loss for which the Principal Sum is otherwise payable hereunder such Loss will be covered under the terms of this Certificate.

Disappearance. If the body of a Covered Person has not been found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which such Eligible Participant was an occupant, then it shall be deemed, subject to all other terms and provisions of the Certificate, that such Covered Person shall have suffered Loss of life within the meaning of the Certificate.

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country or from loss of life or dismemberment due to a sickness, disease or infection.

SECTION 9
POST DEPARTURE TRIP INTERRUPTION

Post Departure Trip Interruption coverage provides a benefit up to the maximum shown in the Schedule of Benefits if Your trip is interrupted or must be discontinued for any of the following reasons:

- If, due to a covered Illness or Injury, which is so disabling as to cause a reasonable person to delay, cancel, or interrupt their Trip, We will pay for additional transportation expenses needed to reach the scheduled termination point of Your Trip or to travel from the place Your Trip was interrupted to the place where You can rejoin Your Trip.
- If You are diagnosed with or receive a positive test for an infectious disease that delays Your return to Your home destination due to restrictions placed on travel due to a possible exposure or Quarantine, and as a result, are unable to use Your previously booked return travel to Your home location, We will pay for Your return home from Your current location outside of the United States.

For all instances named above, We will pay up to the amount shown on the Schedule of Benefits for the cost of a one-way economy class air fare ticket to reach your destination. Amounts paid will not exceed the cost of economy airfare by the most direct route on the next available carrier, less any Refunds or credits paid to You for unused tickets.

- If You must Quarantine while covered under this Certificate because You are diagnosed with or receive a positive test for an infectious disease, coverage for the reasonable expenses of lodging and meals necessarily incurred as a result of a Quarantine, will be covered up to the amount shown on the Schedule of Benefits under the Post Departure Trip Interruption/Lodging & Incidentals Benefit.

Alcohol and Tobacco products are not reimbursable expenses.

For the purposes of this benefit, Quarantine means Your strict isolation imposed by a Government authority or Physician to prevent the spread of an infectious disease. An embargo preventing You from entering a country is not a Quarantine.

SECTION 10

PRE-EXISTING CONDITION LIMITATION

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

SECTION 11
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 amount 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, including routine care of a newborn infant, 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, eye glasses 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. Elective termination of pregnancy.
11. 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.
12. Expenses incurred for, or related to gender reassignment surgery.
13. Organ or tissue transplant.
14. Participating in an illegal occupation or committing or attempting to commit a felony.
15. 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.
16. Expenses incurred within the Covered Person's Home Country.
17. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Certificate.
18. 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.
19. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
20. Diagnosis and treatment of acne.
21. Diagnosis and treatment of sleep disorders.
22. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
23. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
24. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
25. 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.
26. For loss due to a Covered Person participating in the military service of any country or due a Covered Person participating in an Act of Terrorism or their Participation in Riot or Civil Commotion.
27. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
28. 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 and climbing equipment are customarily used), ultra-light aircraft, parasailing, sailplaning/gliders, hang gliding, parachuting, or bungee jumping.
29. 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.

30. 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.
31. 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.
32. Telephone, e-mail, and Internet consultations unless specifically approved by the Administrator due to limited resources while located in a country outside of the United States. This exclusion does not apply to services provided via GeoBlue's Telemedicine Services and the Global TeleMD™ smartphone app.
33. Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
34. To the extent that such payments would be prohibited by law.

SECTION 12
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.

Act of Terrorism means an act by any person, group or groups of people, including, but not limited to, the use of threat of force or violence, whether acting alone, on behalf of, or in conjunction with, any organization or government. This includes, but is not limited to, act intended to influence any government or cause fear to members of the public, whatever the reason.

Acupuncture means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body.

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 Covered Services incurred outside of the United States will be determined as follows:
   - For Providers or Facilities contracted with GeoBlue or contracted with their network partners, 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 the 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 services or supplies are received.

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

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 the 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.

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 care provided primarily to meet the Covered Person's personal needs. This includes help in walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administration of medicine that is usually self-administered, or any other care that does not require continuing services of a medical professional.

Doctor of Acupuncture means a person licensed to practice the art of healing known as acupuncture.

Domestic Partner means a person of the same or opposite sex who:
1. is not married or legally separated;
2. 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;
3. 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;
4. occupies the same residence as the Eligible Participant;
5. has not entered into a domestic partnership relationship that is temporary, social, political, commercial or economic in nature; and
6. has entered into a domestic partnership arrangement with the named Insured.

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:
1. joint lease, mortgage or deed;
2. joint ownership of a vehicle;
3. joint ownership of a checking account or credit account;
4. designation of the domestic partner as a beneficiary for the Insured Participant's life insurance or retirement benefits;
5. designation of the domestic partner as a beneficiary of the employee's will;
6. designation of the domestic partner as holding power of attorney for health care; or
7. shared household expenses.

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.

Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings

Eligible Dependent or Dependent means
1. Your lawful spouse or domestic partner; and
2. any child of Yours or your domestic partner who is:
   - less than 26 years old.
   - 26 or more years old, unmarried and primarily supported by You and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a Dependent under a prior plan with no break in coverage.
   - Proof of the child's condition and dependence must be submitted to the Plan within 60 days after the date the child ceases to qualify above. After two years from the initial determination, the Plan may require proof of the continuation of such condition and dependence and annually thereafter.

Eligible Participant or Participant means a person who:
1. Qualifies in one of the Classes of Eligible Participants listed in the Schedule of Benefits; and
2. Is temporarily traveling outside his/her Home Country as a non-resident alien; and/or
3. Has not obtained permanent residency status in the country that they are traveling to.

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.

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 a country from which the Eligible Participant holds a passport. If the Eligible Participant holds passports from more than one country, his or her Home Country will be that country which Eligible Participant has declared to Us in writing as his or her Home Country. The Home Country of a Covered Dependent 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.

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 group, an association, a preparatory or high school or an institution of higher learning offering a course of general studies leading to a high school diploma, associate's degree, bachelor's degree, master's degree or doctorate; a part of a university offering a specialized group of

courses; or an institution offering instruction in a professional, vocational, or technical field 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, and is a member of the Global Citizens Association.

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.

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.

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.

Period of Coverage means the period between the date the Covered Person's coverage under the certificates starts and the date the Covered Person's coverage ends.

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.

Plan is the set of benefits described in the Certificate of Coverage booklet and in the amendments to this booklet (if any). This Plan is subject to the terms and conditions of the Group Certificate the Insurer has issued to the Global Citizens Association. If changes are made to the Policy or Plan, an amendment or revised booklet will be issued to the Group for distribution to each Insured Participant affected by the change.

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.

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 an Eligible Participant prior to the responsibility of this Plan.

Reasonable Expense means the normal charge of the provider, incurred by the Covered Person, in the absence of insurance,

1. for a medical service or supply, but not more than the prevailing charge in the area for a like service by a provider with similar training or experience, or
2. for a supply which is identical or substantially equivalent. The final determination of a reasonable and customary charge rests solely with the Insurer.

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.

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.

Trip means Member sponsored travel by air, land or sea from the Covered Person's Home Country. It includes the period of time from when the Covered Person leaves their Home Country to the time they return to their Home Country coinciding with the effective date and end date while covered under this Plan.

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

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 13
EXTENSION OF BENEFITS

During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this Certificate cease for You due to cancellation or termination of this Certificate (except if the Certificate is canceled for nonpayment of premiums) and You are 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; or
2. the date You are covered for medical benefits under another group plan; or
3. the date You is no longer Hospital Confined; or
4. 31 days after Your coverage originally was set to terminate; or
5. 31 days from the date the Group Certificate is canceled.

SECTION 14
EXCESS COVERAGE

The Insurer will reduce the amount payable under this Certificate to the extent expenses are covered under any Other Plan. The Insurer will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from Other Plans includes any amount to which the Covered Person is entitled, whether or not a claim is made for the benefits. This Certificate is secondary coverage to all Other Plans.

SECTION 15
EFFECTIVE DATE OF INSURANCE

An Eligible Participant and their covered Dependent will be insured on the latest of the following dates if not required to contribute to the cost of this insurance:

1. the Plan Effective Date:
2. the date he or she is eligible;
3. the date of the scheduled Trip departure date;
4. the date of his or her departure from the United States; or
5. the date the required premium is paid.

Maximum Length of any one Trip: 365 days

SECTION 16
TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earlier of the date:
1. the Plan terminates;
2. the Covered Person is no longer eligible;
3. the period ends for which premium is paid;
4. the scheduled Trip return date;
5. The date the Maximum Trip length is exceeded;
6. the Insured returns to the United States; or
7. the date the Member's participation under the Plan ends.

SECTION 17
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, if included in this Plan, will be payable in accordance with the beneficiary designation and the provisions of the Certificate which are effective at the time of payment. Any benefit amount payable due to the loss of life of a Dependent Child will be paid to the Primary Insured Person.

If the Covered Person has not chosen a beneficiary or if there is no beneficiary alive when the Covered Person dies, the We will pay the benefit amount for loss of life to the first surviving party in the following order:
1. The Covered Person's Spouse or Domestic Partner;
2. In equal shares to the Covered Person's surviving children;
3. In equal shares to the Covered Person's surviving parents;
4. In equal shares to the Covered Person's surviving brothers and sisters;
5. The Covered Person's estate.

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 $1,500 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.

If any other benefits are payable for coverages under this Plan, the Insurer or its Administrator may pay and individual or entity who is deemed by the Insurer to be equitably entitled to payment, whether or not such benefits have been assigned by Covered Person due to the Covered Person's death, disability or unavailability.

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.

SECTION 18
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.

Alternate Cost Containment Provision: If it will result in less expensive treatment, the Insurer may approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the Plan. It must be mutually agreed to by the Insurer, the Covered Person, and the Covered Person's Physician, Provider, or other healthcare practitioner. The Insurer's offering an alternate treatment plan in a particular case in no way commits the Insurer to do so in another case, nor does it prevent the Insurer from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time or for any other Covered Person.

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, PA 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 Eligible Participant or the Member because the Eligible Participant'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, PA 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.