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GeoBlue Trekker Choice

Individual Certificate Number:	**See Identification Card Issued to Individual**
Individual Effective Date:	**See Identification Card Issued to Individual**
Issued Under Group Certificate Number:	**4ELI–1002–17**
Held By	**Global Citizens Association**
Group Policy Effective Date:	**April 1, 2017**

This Individual Certificate of Coverage 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 Global Citizens Association. 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 Eligible Participant and any Eligible Dependents are a member.

SATISFACTION GUARANTEE
Within 10 days of purchasing the plan, You may request a full refund of premium from Us provided You have not already departed on Your Trip or filed a claim. No refunds shall be paid to You after 10 days of purchasing the plan.

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.

SECRETARY

HF Buchanan, III
PRESIDENT

Table of Contents

I.	Introduction	Page 2
II.	Who is eligible for coverage?	Page 4
III.	Definitions	Page 6
IV.	How the Plan Works	Page 10
V.	Benefits: What the Plan Pays	Page 11
VI.	Exclusions and Limitations: What the Plan does not pay for	Page 15
VII.	Prescription Drug Benefits	Page 17
VIII.	General Provisions	Page 18

I. Introduction

About This Plan

This Individual Certificate of Coverage, and any attached riders, is issued by 4 Ever Life International Limited ("Insurer") through a Group Certificate issued to the Global Citizens Association (GCA). The Insurer will use a third party Administrator to perform certain duties on its behalf. The Global Citizens Association and the Eligible Participant are hereby notified of the use of Worldwide Insurance Services, LLC as its Administrator.

4 Ever Life International Limited and Worldwide Insurance Services, LLC are Independent Licensees of the Blue Cross Blue Shield Association

In this Plan, the "Insurer" means 4 Ever Life International Limited. The "Eligible Participant" is the person who meets the eligibility criteria of this Certificate. The term "Covered Person, "You", or "Your", means the Eligible Participant and any Eligible Dependents.

The benefits of this Plan are provided only for those services that the Insurer determines are Medically Necessary and for which the Covered Person has benefits. The fact that a Physician prescribes or orders a service does not, by itself, mean that the service is Medically Necessary or that the service is a Covered Expense. The benefits and services listed in this Certificate of Coverage will be provided for Covered Persons for a covered Illness, Injury, or condition, subject to all of the terms and conditions of the Certificate of Coverage. The Eligible Participant may consult this Certificate of Coverage or telephone the Insurer at the number shown on his/her identification card if he/she has any questions about whether services are covered.

This Certificate of Coverage contains many important terms (such as "Medically Necessary" and "Covered Expense") that are defined in Part III and capitalized throughout this Certificate of Coverage. Before reading through this Certificate of Coverage, consult Part III for the meanings of these words as they pertain to this Certificate of Coverage.

Any payments under this Certificate will only be made in full compliance with all United States of America economic or trade sanction laws or regulations, including, but not limited to, sanctions, laws and regulations administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"). Therefore, any expenses incurred or claims made involving travel that is in violation of such sanctions, laws and regulations will not be covered under the policy. For more information, you may consult the OFAC internet website at www.treas.gov/resource-center/sanctions or a GeoBlue representative.

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

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.

International/Foreign Country Providers

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, Covered Expenses for these Foreign Country Providers are based on the Usual & Customary Fee, if applicable, which may be less than actual billed Charges. Foreign Country Providers can bill the Covered Person for amounts exceeding Covered Expenses. GeoBlue provides a list to Covered Persons of Foreign Country Providers with whom GeoBlue has contracted to accept assignment of claims and direct payments from Us or Our Administrator for Covered Expenses incurred by Covered Persons, thus alleviating the necessity of the Covered Person paying the Foreign Country Provider and submitting a claim for reimbursement. This particular group of Foreign Country Providers are a group of Foreign Country Providers for whom GeoBlue is able to provide background information and to arrange access for Covered Persons.

Benefit Overview Matrix

Following is a very brief description of the benefit schedule of the Plan. This should be used only as a quick reference tool. The entire Certificate of Coverage sets forth, in detail, the rights and obligations of both the Covered Person and the Insurer. It is, therefore, important that **THE ENTIRE CERTIFICATE OF COVERAGE BE READ CAREFULLY!**

The benefits outlined in the following table show the payment percentages for Covered Expenses AFTER the Covered Person has satisfied any Deductibles. **Covered Expenses are based on Reasonable Charges which may be less than actual billed charges. Providers can bill the Covered Person for amounts exceeding Covered Expenses.**

After the Deductible is satisfied, benefits are paid for Covered Expenses as follows:

BENEFIT OVERVIEW MATRIX

Policy Maximums	Insurer pays Per Covered Person
Period of Insurance Maximum Medical Benefits	$250,000 if the Covered Person is under age 70; and $100,000 if the Covered Person is age 70 through age 84
Trip Period Maximum Medical Benefits	$250,000 if the Covered Person is under age 70; and $100,000 if the Covered Person is age 70 through age 84
Deductible Deductible is waived if services are provided by a GeoBlue contracted provider	$50 per Covered Person per Period of Insurance
First Level Payment	The Insurer will pay 100% of the Reasonable Charges up to a maximum benefit as shown above per Period of Insurance
Emergency Medical Transportation	Deductible is not applicable. Maximum Benefit per Trip Period for all Evacuations up to $500,000
Emergency Family Travel Arrangements	Deductible is not applicable. Maximum Benefit per Trip Period up to $2,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person
Repatriation Of Mortal Remains	Deductible is not applicable. Maximum Benefit up to $25,000
Accidental Death & Dismemberment	Deductible is not applicable. Maximum Benefit: Principal Sum up to $25,000

Medical Benefit Limitations	Insurer pays after the deductible, if applicable, subject to First Level Payment Percentage listed above
Professional Services a. Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab b. Office Visits: including X-rays and lab work billed by the attending physician.	The Insurer will pay 100% of the Reasonable Charges up to the Period of Insurance Medical Benefit
Inpatient Hospital Services a. Surgery, X-rays, In-hospital doctor visits b. In-patient medical emergency	The Insurer will pay 100% of the Reasonable Charges up to the Period of Insurance Maximum Medical Benefit
Ambulatory Surgical Center	The Insurer will pay 100% of the Reasonable Charges up to the Period of Insurance Maximum Medical Benefit
Ambulance Service (non-Medical Evacuation)	100% up to $1,000 Maximum per Trip Period
Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) or other recognized national/international governing body required or diving under the supervision of a certified instructor)	Reasonable Charges limited to the Trip Period Maximum or $10,000, whichever is less.
Outside the U.S. Outpatient prescription drugs	100% of Reasonable Charges up to a maximum benefit of $5,000 per Trip Period
Dental Care required due to an Injury	100% of Reasonable Charges with a maximum benefit of $200 per Trip Period
Dental Care for Relief of Pain	100% of Reasonable Charges with a maximum benefit of $100 per Trip Period
Physical and/or Occupational Therapy/Medicine, Including spinal manipulations and other specified therapies including acupuncture	Maximum payment of $100 per visit and maximum of 6 visits per Trip Period

II. Who is eligible for coverage?

Covered Persons are the only people qualified to be covered by this Certificate. The following section describes who qualifies as an Eligible Participant or Eligible Dependent, as well as information on when and who to enroll and when coverage begins and ends.

Who is Eligible to Enroll Under This Certificate?

Eligible Participant
An Eligible Participant means:
1. A member of the Global Citizens Association (GCA) covered under this Certificate;
2. Has submitted an enrollment form, if applicable, and the premium to the Insurer;
3. Meets the eligibility requirements as stated in this Certificate of Coverage;

Eligible Dependents
An Eligible Dependent means a person who is the Eligible Participant's:
1. spouse; civil union partner, or domestic partner**;**
2. natural child, stepchild or legally adopted child who has not yet reached age 26;
3. own or spouse's, civil union partner's or domestic partner's own child, of any age, enrolled prior to age 26, who is incapable of self-support due to continuing mental retardation or physical disability and who is chiefly dependent on the Eligible Participant. The Insurer requires written proof from a Physician of such disability and dependency within 31 days of the child's 26th birthday and annually thereafter;
4. For a person who becomes an Eligible Dependent (as described below) after the date the Eligible Participant's coverage begins, coverage for the Eligible Dependent will become effective in accordance with the following provisions:
   a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's Newborn Child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
   b. Adopted Children: An Insured Participant's adopted child is automatically covered for Illness or Injury for 31 days from either date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. To continue coverage beyond 31 days, an Insured Participant must enroll the adopted child within 31 days either from the date of placement or the final decree of adoption.
   c. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is spouse, civil union partner, domestic partner or minor child, coverage will be automatic for the first 31 days following the date which the court order is issued. To continue coverage beyond 31 days, an Insured Participant must enroll the Eligible Dependent within that 31 day period;
5. grandchild, niece or nephew who otherwise qualifies as a dependent child, if: (i) the child is under the primary care of the Insured Participant; and (ii) the legal guardian of the child, if other than the Insured Participant, is not covered by an accident or sickness policy.

   The term "primary care" means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis.

A person **may not** be an Insured Dependent for more than one Insured Participant.

Additional Requirements for an Eligible Participant and Eligible Dependents: An Eligible Participant or an Eligible Dependent must meet the following requirements:
1. Home Country is the U.S.; and
2. under Age 85; and
3. enrolled in a Primary Plan; and
4. For children under age 6, must be enrolled with a parent; and
5. Initial purchase must be made in Home Country prior to departing on trip.

Application and Effective Dates
The Coverage for an Eligible Participant and his or her Eligible Dependents will become effective if the Eligible Participant submits a properly completed application to the Insurer, is approved for coverage by the Insurer, and the Global Citizens Association and/or the Eligible Participant pays the Insurer the premium. The Effective Date of the Coverage under this Certificate is indicated as follows:

Period of Insurance: Each Eligible Participant's and his/her Eligible Dependent's Period of Insurance starts on the latest of the following:
1. The Effective date of this Individual Certificate of Coverage as shown on the Eligible Participant's identification card;
2. 12:00:01 am on the date the Insurer receives the enrollment or the postmark of the enrollment received by the Insurer;
3. 12:00:01 am on the date designated by the Eligible Participant in the enrollment form, if that date is after the Insurer receives the enrollment form.

Trip Coverage Start Date: The Covered Person's coverage under this Certificate for a trip starts on the latest of the following:
1. For a scheduled trip to a Foreign Country, when the Covered Person boards a conveyance at the start of the trip.

A Covered Person is eligible for benefits ONLY during his/her Trip Coverage Period.

All applications, if applicable, must be approved by the Insurer for coverage to go into effect.

In no event will an Eligible Dependent's coverage become effective prior to the Insured Participant's Effective Date of Coverage.

Period of Insurance Coverage Ends: The Covered Person's coverage ends without notice from the Insurer on the earlier of:

1. the end of the last period for which premium payment has been made to the Insurer;
2. the date the Certificate terminates;
3. the date the Maximum Period of Insurance/ Benefit of the Plan has been exhausted;
4. the date of fraud or misrepresentation of a material fact by the Insured Participant, except as indicated in the Time Limit on Certain Defenses provision.

Trip Coverage End Date: The Covered Person's coverage under this Certificate of Coverage ends on the earliest of:

1. For a scheduled trip to a Foreign Country, when the Covered Person alights from a conveyance at the completion of the trip;
2. 11:59:59 pm on the date the Maximum Trip Coverage Period has been achieved;
3. The date of fraud or misrepresentation of a material fact by Eligible Participant, except as indicated in the Time Limit on Certain Defense provision.

Maximum Trip Coverage Period: Coverage starts on the first day of any trip and continues for a maximum of the first 70 consecutive days of such trip.

In no event will coverage for a trip extend past the Extension of Coverage period stated below or as stated in the benefit provisions.

Extension of Coverage

If the Covered Person has not cancelled his/her coverage, then coverage for a trip will extend past the Trip Coverage End Date if the Insured Person's return is delayed by unforeseeable circumstances beyond his/her control. In this event, coverage will be extended, if:

1. The Covered Person's entire original itinerary was covered under this Certificate;
2. The Covered Person requests an extension of coverage through the Insurer's Administrator

The extension of coverage will end on the earlier of:

1. The date the Covered Person reaches his/her Home Country.
2. 7 days after the original coverage period requested and paid for by the Eligible Participant.

There is no charge for the Extension of Coverage.

III. Definitions

The following definitions contain the meanings of key terms used in this Certificate. Throughout this Certificate, the terms defined appear with the first letter of each word in capital letters.

Accidental Injury means an accidental bodily Injury sustained by a Covered Person which is the direct cause of a loss independent of disease, bodily infirmity, or any other cause.

Age means the Covered Person's attained age.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It also must meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Certificate of Coverage is the document issued to each Eligible Participant outlining the benefits under the Group Certificate.

Coinsurance is the percentage of Covered Expenses the Covered Person is responsible for paying (after the applicable Deductible is satisfied and/or Copayment paid). **Coinsurance does not include charges for services that are not Covered Services or charges in excess of Covered Expenses. These charges are the Covered Person's responsibility and are not included in the Coinsurance calculation.**

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.

A **Continuing Hospital Confinement** means consecutive days of in-hospital service received as an inpatient, or successive confinements for the same diagnosis, when discharge from and readmission to the Hospital occurs within 24 hours.

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Reconstructive Surgery** is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

Covered Expenses are the expenses incurred for Covered Services. **Covered Expenses** for Covered Services will not exceed Reasonable Charges. In addition, Covered Expenses may be limited by other specific maximums described in this Plan under section IV, How the Plan Works and section V, Benefits: What the Plan Pays. Covered Expenses are subject to applicable Deductibles, penalties and other benefit limits. **An expense is incurred on the date the Covered Person <u>receives</u> the service or supply.**

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

Covered Services are Medically Necessary services or supplies that are listed in the benefit sections of this Certificate, and for which the Covered Person is entitled to receive benefits.

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.

Deductible means the amount of Covered Expenses the Covered Person must pay for Covered Services before benefits are available to him/her under this Certificate.

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Domestic Partner means an unmarried same or opposite sex adult who resides with the Insured Participant and has registered in a state or local domestic partner registry with the Insured Participant.

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.

The **Effective Date of Coverage** is the date on which coverage under this Certificate begins for the Eligible Participant and any other Covered Person.

Eligible Dependent (See 'Eligibility Rules' in Section II of this Certificate)

Eligible Participant (See 'Eligibility Rules' in Section II of this Certificate)

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 Procedure is 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.

Foreign Country is a country other than the United States of America.

Foreign Country Provider is any institutional or professional provider of medical or psychiatric treatment or care who practices in a country outside the United States of America. A Foreign Country Provider may also be a supplier of medical equipment, drugs, or medications. GeoBlue provides Covered Persons with access to a database of Foreign Country Providers.

A **Full Time Student** is a student enrolled at an accredited college, university, or trade school. The student must be currently attending classes, carrying at least 12 units per term.

GeoBlue. This is the entity that provides the Covered Person with access to online databases of travel, health, and security information and online information about physicians and other medical providers. GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Insurance Services Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association.

GeoBlue International Healthcare Community consists of physicians, dentists, mental health professionals, other allied health professionals, hospitals, health systems and medical practices countries throughout the world, all dedicated to providing high quality medical care to international travelers, employees and students. The providers are accessed through the GeoBlue online database or through the GeoBlue customer services.

Group Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provided by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota share, or similar basis.

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.

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of Physicians. It must:

1. be licensed as a hospital and operated pursuant to law; and

2. be primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians) medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. provide 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
4. be an institution which maintains and operates a minimum of five beds; and
5. have X-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. maintain permanent medical history records.

This definition **excludes** convalescent homes, convalescent facilities, rest facilities, nursing facilities, or homes or facilities primarily for the aged, those primarily affording custodial care or educational care.

An **Illness** is a sickness, disease, or condition of a Covered Person which first manifests itself after the Covered Person's Effective Date.

Injury (See Accidental Injury)

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.

Insurance Coverage Area is the primary geographical region in which coverage is provided to the Covered Person.

Insured Dependents are members of the Eligible Participant's family who are eligible and have been accepted by the Insurer under this Certificate.

Insured Participant is the Eligible Participant whose application has been accepted by the Insurer for coverage under this Certificate.

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

Investigative Procedures (See Experimental/Investigational).

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 Policy.

Mental Illness and **Mental and Nervous Disorder** 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. Mental Illness and Mental and Nervous Disorder does not mean or include developmental disorders, learning disabilities, attitudinal disorders or disciplinary problems.

A **Newborn** is a recently born infant within 31 days of birth.

Office Visit means a visit by the Covered Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:
1. History (gathering of information on an Illness or Injury).
2. Examination.
3. Medical Decision Making (the Physician's diagnosis and Plan of treatment).

This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

Other Plan is an insurance plan other than this plan that provides medical and/or repatriation of remains, and/or medical evacuation benefits for the Covered Person.

The **Period of Insurance Maximum Benefit** is the maximum amount of benefits available to each Covered Person during the person's Period of Coverage. All benefits furnished are subject to this maximum amount.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

A **Physician** means a physician licensed to practice medicine or any other practitioner who is licensed and recognized as a provider of health care services in the state and/or country the Covered Person resides or is treated; and provides services covered by this Certificate of Coverage that are within the scope of his/her licensure.

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.

Policy is the Group Certificate the Insurer has issued to the Global Citizens Association.

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 certain governmental health plan (including Medicare Supplements and Medicare Advantage plans) designed to be the first payor of claims for a Covered Person prior to the responsibility of this Plan. Medicaid, state run Medicaid programs, and Veterans Administration health benefit plans are **not** considered a primary plan under this Certificate of Coverage.

A **Reasonable Charge**, as determined by the Insurer, is the amount the Insurer will consider a Covered Expense with respect to charges made by a Physician, facility or other supplier for Covered Services. In determining whether a charge is Reasonable, the Insurer will consider all of the following factors:

1. The actual charge.
2. Specialty training, work value factors, practice costs, regional geographic factors and inflation factors.
3. The amount charged for the same or comparable services or supplies in the same region or in other parts of the country.
4. Consideration of new procedures, services or supplies in comparison to commonly used procedures, services or supplies.
5. The Average Wholesale Price for Pharmaceuticals.

Reconstructive Surgery (See Cosmetic and Reconstructive Surgery)

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.

Special Care Units are special areas of a Hospital that have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse means the Eligible Participant's lawful spouse as defined in the state or jurisdiction where the marriage occurred. This term includes a common law spouse if recognized by the state in which the Eligible Participant resides.

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.

Terrorism or **Terrorist Activity** shall mean an act or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorism can include, but not be limited to, the actual use of force or violence and/or the treat of such use. Furthermore, the perpetrators of terrorism can either be acting alone, or on behalf of, or in connection with any organization(s) or government(s).

Totally Disabled or Total Disability means:

1. As applied to an Insured Participant, any period of time during the Insured Participant's lifetime in which he/she is unable to perform substantially all the duties required by his/her usual occupation, provided the disability commences within twelve (12) months from the date the disabling condition occurred;
2. As applied to a Dependent, not being able to perform the normal activities of a like person of the same age and sex.

The patient must be under the care of a Physician.

Trip Coverage Period the period in which the Eligible Participant is covered under this Certificate of Coverage

The **Trip Coverage Period Maximum Benefit** is the maximum amount of benefits available to each Covered Person during the person's Trip Coverage Period. All benefits furnished are subject to this maximum amount.

United States (U.S.) of America 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.

You, Your means an Eligible Participant or Eligible Dependent.

IV. How the Plan Works

The Covered Person's Plan pays a portion of his/her Covered Expenses after he/she meets his/her Deductible for each Trip Coverage Period. This section describes the Deductible and discusses steps to take to ensure that he/she receives the highest level of benefits available under this Certificate of Coverage. See Definitions (Section III) for a definition of Covered Expenses and Covered Services.

The benefits described in the following sections are provided for Covered Expenses incurred by the Covered Person while covered under this Certificate of Coverage. An expense is incurred on the date the Covered Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this Certificate of Coverage, which may limit benefits or result in benefits not being payable.

Either the Covered Person or the provider of service must claim benefits by sending the Insurer properly completed claim forms itemizing the services or supplies received and the charges.

Benefits
This Benefits section shows the maximum Covered Expense for each type of provider.

No benefits are payable unless the Covered Person's coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms, conditions, limitations and exclusions of this Certificate of Coverage.

Hospitals, Physicians, and Other Providers
The amount that will be treated as a Covered Expense for services provided by a Provider will not exceed the lesser of actual billed charges or a Reasonable Charge as determined by the Insurer.

The Covered Person will always be responsible for any expense incurred which is not covered under this Certificate of Coverage.

Deductibles
Deductibles are prescribed amounts of Covered Expenses the Covered Person must pay before benefits are available. The Deductible applies to all Covered Expenses, unless otherwise stated. Only Covered Expenses are applied to the Deductible. Any expenses the Covered Person incurs in addition to Covered Expenses are never applied to any Deductible.

Deductibles will be credited on the Insurer's files in the order in which the Covered Person's claims are processed, not necessarily in the order in which he/she receives the service or supply.

If the Covered Person submits a claim for services which have a maximum payment limit and his/her Period of Insurance Deductible is not satisfied, the Insurer will only apply the allowed per visit, per day, or per event amount (whichever applies) toward any applicable Deductible.

Payment
After the Insured Participant satisfies any required Deductible, payment of Covered Expenses is provided as defined in the Benefit Overview Matrix in Section I of this document.

Please note any additional limits on the maximum amount of Covered Expenses in the discussions of each specific benefit.

V. Benefits: What the Plan Pays

Before this Plan pays for any benefits, the Covered Person must satisfy his/her Trip Coverage Period Deductible. After the Covered Person satisfies the Deductible, the Insurer will begin paying for Covered Services as described in this section.

The benefits described in this section will be paid for Covered Expenses incurred on the date the Covered Person receives the service or supply for which the charge is made. These benefits are subject to all terms, conditions, exclusions, and limitations of this Plan. All services are paid at percentages and amounts indicated below or in the Benefit Overview Matrix, and subject to limits outlined in Section IV, How the Plan Works.

Following is a general description of the supplies and services for which the Covered Person's Plan will pay benefits, if such supplies and services are Medically Necessary:

Services and Supplies Provided by a Hospital

For any eligible condition not excluded under this Certificate other than for Mental, Emotional or Functional Nervous Conditions or Disorders, and Substance Abuse, the Insurer will pay indicated benefits on Covered Expenses for:

1. Inpatient services and supplies provided by the Hospital except private room charges above the prevailing two-bed room rate of the facility.

   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.

2. Outpatient services and supplies including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.
3. Emergency Hospitalization and Emergency Medical Care provided in a Hospital emergency room, including professional air and ground ambulance services for transport to and from the Hospital for such Emergency Hospitalization and Emergency Medical Care.

Payment of Inpatient Covered Expenses are subject to these conditions:

1. Services must be those which are regularly provided and billed by the Hospital.
2. Services are provided only for the number of days required to treat the Covered Person's Illness or Injury

Note: No benefits will be provided for personal items, such as TV, radio, guest trays, etc.

Note: Injuries and Illnesses resulting from Terrorism and pandemics are covered as any other Injury or Illness provided all of the following conditions are met:

1. The Covered Person had no direct or indirect involvement in the Terrorist Activity;
2. The Terrorist Activity or pandemic is not in a country or location where the United States movement has issued a travel warning that has been in effect with the three (3) months prior to the Covered Person's date of arrival
3. The Covered Person has not unreasonably failed or refused to depart a country or location following the date a warning to leave that country or location is issued by the United State Government.

Professional and Other Services

The Insurer will pay Covered Expenses not excluded under this Certificate for:

1. Services of a Physician.
2. Services of an anesthesiologist or an anesthetist.
3. Outpatient diagnostic radiology and laboratory services.
4. Surgical implants.
5. The first pair of contact lenses or the first pair of eyeglasses when required as a result of a covered eye surgery.
6. Self-Administered injectable drugs.
7. Syringes when dispensed with self-administered injectable drugs (except insulin).
8. Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.
9. Rental or purchase of Durable Medical Equipment and/or supplies that are **all** of the following:
   a. ordered by a Physician;
   b. of no further use when medical need ends;
   c. usable only by the patient;
   d. not primarily for the Covered Person's comfort or hygiene;
   e. not for environmental control;
   f. not for exercise; and
   g. manufactured specifically for medical use.

   Note: Medical equipment and supplies must meet **all** of the above guidelines in order to be eligible for benefits under this Certificate of Coverage. The fact that a Physician prescribes or orders equipment or supplies does not necessarily qualify the equipment or supply for payment. The Insurer determines whether the item meets these conditions. Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Ambulance Services
The following ambulance services are covered under this Certificate of Coverage:
1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or air service for transportation to and from a Hospital.
2. Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriate licensed person must render the services.

The Insurer pays as stated in the Benefit Overview Matrix.

Complications of Pregnancy
Complications of Pregnancy are covered under this Certificate of Coverage as any other medical condition. Benefits for complications of pregnancy shall be provided for all Covered Persons.

Dental Care for an Accidental Injury
Benefits are payable for dental care for an Accidental Injury to natural teeth that occurs while the Covered Person is covered under this Plan, subject to the following:
1. services must be received during the six months following the date of Injury;
2. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury; and
3. damage to natural teeth due to chewing or biting is not considered an Accidental Injury under this Certificate of Coverage.

In addition, the Certificate of Coverage 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. The Insurer pays as stated in the Benefit Overview Matrix.

Dental Care for Relief of 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 of Coverage. Services must be received while covered during the Trip Coverage Period. The Insurer pays as stated in the Benefit Overview Matrix.

Physical and/or Occupational Therapy/Medicine, Including spinal manipulations and other specified therapies including acupuncture
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 Certificate of Coverage: physical, occupational, 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 Certificate of Coverage; Acupuncture that treats a covered illness or injury provided by Doctor of Acupuncture.

Therapies excluded under this coverage include, but are not limited to: speech therapy, 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.

These Covered Expenses are Limited as stated in the Benefit Overview Matrix.

Benefits for Claims resulting from downhill skiing and scuba diving
The Insurer will pay Covered Expenses for claims resulting from downhill (alpine) skiing. It will also pay Covered Expenses resulting from scuba diving provided that the diver is certified by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI), or equivalent governing body, or provided that he/she is diving under the supervision of a certified instructor. These Covered Expenses are Limited as stated in the Benefit Overview Matrix.

Emergency Medical Transportation Benefit

Emergency Medical Evacuation Benefit
If a Covered Person suffers a sudden accident or unforeseen illness, resulting in a life-threatening/limb-threatening medical condition, and We, or Our designee's medical director, determines that adequate medical facilities are not available locally, We, or Our designee, will arrange for an emergency evacuation to the nearest or most appropriate provider capable of providing adequate care, without which there would be a significant risk of death or serious impairment. You must contact Us at the phone number indicated on Your identification card to begin this process.

In making our determinations, We, and/or Our designee, will consider the nature of the emergency, Your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Repatriation after an Emergency Medical Evacuation
Following any covered emergency evacuation, We will pay for the following if it is deemed appropriate by Our or Our designee's medical director, in consultation with the attending physician:

- You will be transferred to your original location, the location from which you were evacuated from, or to Your permanent residence.
- If it is Medically Necessary that Your transportation needs to be medically supervised a qualified medical attendant will escort You. Additionally, if We and/or Our designee determine a mode of transport other than economy class seating on a commercial aircraft is required, We or Our designee will arrange accordingly and such will be covered by Us.

Return of Dependent Children: If the Covered Person has minor children who are left unattended as a result of their injury, illness or medical evacuation, We or Our designee will arrange and pay for the cost of economy class one-way airfares, and an escort as may be reasonably required, for the transportation of such minor children to their Home Country or Country of Assignment.

General Limitations/ Exclusions for Emergency Medical Evacuation and Repatriation after an Emergency Medical Evacuation Benefits
In addition to any of the general exclusions listed in Section VI. of this certificate, the following exclusions also apply to the Emergency Medical Transportation benefit:

1. Transportation shall not be considered Medically Necessary if We or Our designee's medical director determines that the Covered Person is receiving adequate care in their current location.
2. Transportation shall not be considered Medically Necessary if We or Our designee's medical director determines that the Covered Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.
3. No more than one Emergency Medical Evacuation and/or Repatriation is allowed for any single medical condition of a Covered Member while covered under this Certificate.
4. No payment will be made for charges for:
   a. services rendered without the authorization or intervention of Us or Our designee;
   b. non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to You;
   c. a condition which would allow for treatment at a future date convenient to You and which does not require emergency evacuation or repatriation;
   d. expenses incurred if the original or ancillary purpose of Your trip is to obtain medical treatment;
   e. Any expense for medical evacuation or repatriation if the Covered Member is not suffering from a Serious Medical Condition, and/or in the opinion of Our designee's medical director, the Covered Member can be adequately treated locally, or treatment can be reasonably delayed until the Covered Member returns to his/her Home Country or Country of Assignment.

Emergency Family Travel Arrangements

If a Covered Person is Hospital Confined due to an Injury or Sickness for more than 7 days, is likely to be hospitalized for more than 7 days or is in critical condition, while traveling outside of his/her home country, the Insurer will pay up to the maximum benefit as listed in Benefit Overview Matrix for the cost of one economy round trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one person designated by the Covered Person. 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 Person will be hospitalized for more than 7 days or is in critical condition shall be made by the Administrator after consultation with the attending physician. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

This benefit is available only to Covered Persons who are traveling outside of their Home Country while covered under this Certificate of Coverage.

The benefit for all Bedside Visits is listed in the Benefit Overview Matrix.

Repatriation of Mortal Remains Benefit

If a Covered Person dies, while traveling outside of his/her home country, the Insurer will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Benefit Overview Matrix, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to his/her Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body, urns, caskets, coffins, visitation, burial or funeral expenses. Any expense for repatriation of remains requires approval in advance by the Plan Administrator.

The Insurer will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

This benefit is available only to Covered Persons who are traveling outside of their Home Country

The benefit maximum for all necessary repatriation of mortal remains services is listed in the Benefit Overview Matrix.

No benefit is payable if the death occurs after the Termination Date of this Certificate of Coverage. However, if the Covered Person dies while coverage is in effect, eligibility for this benefit continues until the earlier of the Termination Date of this Certificate of Coverage or 7 days after the Termination Date.

Accidental Death and Dismemberment Benefit

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury resulting in any of the losses stated below within 365 days after the date the Injury is sustained:

For Loss of:	Percentage of Maximum Amount
• 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.

The Principal Sum is stated in Benefit Overview Matrix.

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 Covered Person 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.

Special Limitations/Expenses Not Covered

In addition to general exclusions listed in Section VI., “Exclusions and Limitations: What the Plan does not pay for”, of this Certificate of Coverage, benefits will not be provided for the following:

1. For loss of life or dismemberment due to a Sickness, disease or infection.
2. For any loss of life or dismemberment before the effective date of coverage or after coverage ends.
3. There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person’s Home Country.

VI. Exclusions and Limitations: What the Plan does not pay for

Excluded Services

The Plan does not provide benefits for:

1. Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Plan.
2. Services **not specifically listed** in this Plan as Covered Services.
3. Expenses incurred in the Home Country.
4. Services or supplies that are **not Medically Necessary** as defined by the Insurer.
5. Services or supplies that the Insurer considers to be **Experimental or Investigative.**
6. Expenses incurred for **elective treatment or elective surgery** which can safely be done after the Covered Person returns to their Home Country.
7. Services received **before the Effective Date** of Coverage or during an inpatient stay that began before that Effective Date of Coverage.
8. Services received **after coverage ends** unless an extension of benefits applies as specifically stated under Extension of Benefits in the 'Who is Eligible for Coverage' section of this Plan.
9. Services for which the Covered Person has **no legal obligation to pay** or for which no charge would be made if he/she did not have a health policy or insurance coverage.
10. Services for any condition **for which benefits are recovered or can be recovered**, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Covered Person does not claim those benefits.
11. Treatment or medical services required **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.
12. Services related to **pregnancy or maternity** care other than for complications of pregnancy that may arise during a Trip Coverage Period.
13. Conditions caused by or contributed by (a) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (b) A Covered Person participating in the **military service** of any country; (c) A Covered Person participating in an **insurrection, rebellion, or riot**; (d) Services received for any condition caused by a Covered Person's commission of, or attempt to commit a **felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation;** (e) A Covered Person **voluntarily using illegal drugs; intentionally taking over the counter medication not in accordance with recommended dosage and warning instructions**; and **intentionally misusing prescription drugs**.
14. Any services provided by a local, state or federal **government agency** except when payment under this Plan is expressly required by federal or state law.
15. Professional services received or supplies purchased from the Covered Person, a person who lives in the Covered Person's home or who is **related to the Covered Person** by blood, marriage or adoption, or the Covered Person's employer.
16. Inpatient or outpatient services of a **private duty nurse.**
17. Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
18. 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.
19. Treatment of **Mental, Emotional of Functional Nervous Conditions or Disorders.**
20. Treatment of **Substance Abuse including drug and alcohol abuse or addiction**.
21. **Dental services,** dentures, bridges, crowns, caps or other dental prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically stated under Dental Care for Relief of Pain and/or Dental Care for Accidental Injury in the Benefits section of this Plan.
22. Dental and orthodontic services for Temporomandibular Joint Dysfunction (**TMJ**).
23. **Orthodontic Services,** braces and other orthodontic appliances.
24. **Dental Implants:** Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
25. Routine **hearing tests or hearing aids.**
26. **Optometric services,** eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.
27. An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
28. Outpatient **speech therapy**.
29. Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.
30. Any intentionally **self-inflicted Injury or Illness**. This exclusion does not apply to the Emergency Medical Evacuation Benefit, to the Repatriation of Mortal Remains Benefit and to the Bedside Visit Benefit.
31. **Cosmetic surgery** or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or to Medically Necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.

32. Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**.
33. Treatment of **sexual dysfunction** or inadequacy.
34. All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization.
35. **Cryopreservation** of sperm or eggs.
36. All **contraceptive** services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures.
37. **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.
38. Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method of treatment.
39. **Routine physical exams** or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority.
40. Charges by a provider for **telephone consultations.**
41. Items which are furnished primarily for the Eligible Participant's **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc.).
42. **Educational services** except as specifically provided or arranged by the Insurer.
43. **Nutritional counseling** or food supplements.
44. **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Plan. 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.
45. All i**nfusion therapy, chemotherapy, radiation therapy, hemodialysis** together with any associated supplies, Drugs or professional services are excluded.
46. **Joint replacement or arthroplasty surgery** of any kind.
47. **Surgical treatment to the spine, back, or discs of the spine**, unless it is the result of an accident that occurred during the Trip Period.
48. **Growth Hormone Treatment.**
49. Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet.
50. **Charges for which the Insurer are unable to determine the Insurer's liability** because the Eligible Participant or a Covered Person failed, within 90 days, or as soon as reasonably possible to: (a) authorize the Insurer to receive all the medical records and information the Insurer requested; or (b) provide the Insurer with information the Insurer requested regarding the circumstances of the claim or other insurance coverage.
51. Charges for the services of a **standby Physician.**
52. Charges for **animal to human organ transplants.**
53. Under the medical treatment benefits, 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.
54. Loss arising from
    a. participating in any intercollegiate/interscholastic sport, contest or competition;
    b. participating in any intramural sport competition, contest or competition;
    c. participating in any club sport competition, contest or competition;
    d. participating in any professional sport, contest or competition;
    e. while participating in any practice or condition program for such sport, contest or competition;
    f. Racing or speed contests;
    g. sky diving, mountaineering (where ropes or climbing gear are customarily used), ultra-light aircraft, parasailing, sailplaning, hang gliding, bungee cord jumping, spelunking, or extreme skiing.
55. Claims arising from loss due to riding in any **aircraft** except one licensed for the transportation of passengers.
56. Treatment for or arising from **sexually transmittable diseases**. (This exclusion does not apply to HIV, AIDS, ARC or any derivative or variation.)
57. Under the **Repatriation of Remains Benefit and the Medical Evacuation Benefit provision**, for repatriation of remains or medical evacuation of the Covered Accident in the Covered Person's Home Country.
58. 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.
59. Treatment of **Congenital Conditions**.
60. Whenever coverage provided by this Certificate would be **in violation of any U.S. economic or trade sanctions**, such coverage shall be null and void.

Pre-existing Condition Limitation

Pre-existing conditions are covered under this plan as any other condition, subject to the terms and exclusions listed in the policy**.**

VII. Prescription Drug Benefits

Pharmacy means a licensed retail pharmacy.

Prescription means a written order issued by a Physician.

What Is Covered

1. Outpatient Drugs and medications that federal and/or State law restrict to sale by Prescription only.
2. Insulin.
3. Insulin syringes prescribed and dispensed for use with insulin.
4. All non-infused compound Prescriptions that contain at least one covered Prescription ingredient.

Conditions of Service

The Drug or medicine must be:

1. Prescribed in writing by a Physician and dispensed within one Period of Insurance of being prescribed, subject to federal or state laws.
2. Approved for use by the Food and Drug Administration.
3. For the direct care and treatment of the Covered Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included.
4. Purchased from a licensed retail Pharmacy or other authorized entity in the country in which purchased.
5. Not excluded under the Prescription Drug Exclusions and Limitations below.

The drug or medicine must **not** be used while the Covered Person is an inpatient in any facility.

The Prescription must not exceed a 30-day supply or for longer than the Period of Coverage.

Prescription Drug Exclusions and Limitations

Prescription Drug reimbursement is subject to and treated as part of any benefit maximums, limitations on Pre-existing Conditions or any other exclusions or limitations contained in this entire Plan. In addition, reimbursement will not be provided for:

1. Drugs and medications not requiring a Prescription, except insulin.
2. Non-medical substances or items.
3. Contraceptive Drugs and devices prescribed for birth control, even if prescribed for other than contraceptive purposes, Drugs and medications used to induce non-spontaneous abortions.
4. Dietary supplements, cosmetics, health or beauty aids.
5. Any vitamin, mineral, herb or botanical product which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition.
6. Drugs taken while the Eligible Participant or Eligible Dependents are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
7. Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs, any Drug or medication prescribed for experimental indications (such as progesterone suppositories).
8. Syringes and/or needles, except those dispensed for use with insulin.
9. Durable medical equipment, devices, appliances and supplies.
10. Immunizing agents, biological sera, blood, blood products or blood plasma.
11. Anti-malarial drugs, unless the Covered Person has been diagnosed with malaria.
12. Oxygen.
13. Professional charges in connection with administering, injecting or dispensing of Drugs.
14. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
15. Drugs used for cosmetic purposes.
16. Drugs used for the primary purpose of treating infertility.
17. Drugs used for the purpose of treating hair loss.
18. Drugs used for sexual stimulation.
19. Anorexiants or Drugs associated with weight loss.
20. Allergy desensitization products, allergy serum.
21. Drugs for treatment of a condition, Illness, or Injury for which benefits are excluded or limited by a Pre-existing Condition, or other contract limitation.
22. Growth Hormone Treatment.
23. Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.

VIII. General Provisions

Excess Coverage: The Insurer will reduce the amount payable under the Policy 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 Insured Person is entitled, whether or not a claim is made for the benefits. This Policy is secondary coverage to all other policies. During the claims settlement process, if the Insurer pays a provider directly, the Insurer does not relinquish their right to coordinate benefits or subrogate against any and all collectable insurance available to the Covered Person.

Third Party Liability: No benefits are payable for any Illness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Insurer will advance the benefits of this Plan to the Insured Person subject to the following:

1. The Insured Participant agrees to advise the Insurer, in writing, within 60 days of any Insured Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as the Insurer may require to facilitate enforcement of the claim. The Insured Participant and Insured Person also agree to take no action that may prejudice the Insurer's rights or interests under this Plan. Failure to provide notice of a claim or to cooperate with the Insurer, or actions that prejudice the Insurer's rights or interests, will be material breach of this Plan and will result in the Insured Participant being personally responsible for reimbursing the Insurer.
2. The Insurer will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Insured Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by the Insurer under this Plan for the treatment of the Illness, disease, Injury or condition for which the third party is liable.

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.

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 Global Citizens Association'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 Global Citizens Association.

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.

Provision in Event of Partial Invalidity: If any provision or any word, term, clause, or part of any provision of this Plan shall be invalid for any reason, the same shall be ineffective, but the remainder of this Plan and of the provision shall not be affected and shall remain in full force and effect.

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.

The Claims Process

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 60 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.

Proof 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.

Payment of Claims: Benefits for Accidental Death & Dismemberment 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 any of the other benefits may be payable to the provider of the service.

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.

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.

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.

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:

GeoBlue
c/o Worldwide Insurance Services, LLC
Attn: Appeals Department
100 Matsonford Road
Building One, Suite 100
Radnor, PA 19087

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 Insured Person and his/her Insured Dependents or the Member because the Insured 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,
100 Matsonford Road, Building One, Suite 100
Radnor, PA 19087
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.