

**4 Ever Life International Limited**  
**Cumberland House**  
**1 Victoria Street, 6<sup>th</sup> Floor**  
**P.O. Box HM 3033**  
**Hamilton HM NX, Bermuda**

Administrative Office:  
 Worldwide Insurance Services, LLC  
 933 First Avenue  
 King of Prussia, PA 19406

## GeoBlue Emergency Medical Evacuation Coverage

**Individual Certificate Number:** See Individual Identification Card  
**Issued Under Group Certificate Number:** 4EL-2023-A-20  
**Held By:** Indiana University (“Member”)  
**Effective Date:** May 1, 2020  
**Coverage Year:** May 1, 2020 to April 30, 2021

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

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

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

  
 PRESIDENT

### TABLE OF CONTENTS

SECTION 1	<a href="#">SCHEDULE OF BENEFITS – Eligible Classes</a>	Page 2
	<a href="#">SCHEDULE OF BENEFITS – Table 1 SCHEDULE OF BENEFITS</a>	Page 2
SECTION 2	<a href="#">DESCRIPTION OF COVERAGES – Emergency Medical Evacuation Benefit</a>	Page 2
SECTION 3	<a href="#">DESCRIPTION OF COVERAGES – Emergency Family Travel Arrangements Benefit</a>	Page 3
SECTION 4	<a href="#">DESCRIPTION OF COVERAGES – Repatriation of Mortal Remains Benefit</a>	Page 3
SECTION 5	<a href="#">DEFINITIONS</a>	Page 3
SECTION 6	<a href="#">EXCESS COVERAGE</a>	Page 5
SECTION 7	<a href="#">ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE</a>	Page 5
SECTION 8	<a href="#">CLAIM PROVISIONS</a>	Page 7
SECTION 9	<a href="#">GENERAL PROVISIONS</a>	Page 7

**SECTION 1  
SCHEDULE OF BENEFITS  
ELIGIBLE CLASSES**

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

- Class I: Eligible Study Abroad Student Participants and their Eligible Dependents enrolled in the Member's sponsored or approved travel program who are temporarily traveling outside of the United States.
- Class II: Eligible Study Abroad Staff Participants and/or approved escort and their Eligible Dependents providing direct support to the Member's sponsored or approved travel program who are temporarily traveling outside of the United States.

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

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

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

**SCHEDULE OF BENEFITS  
TABLE 1**

	<b>Limits Individual Insured</b>	<b>Limits Spouse</b>	<b>Limits Dependent Child(ren)</b>
<b>EMERGENCY MEDICAL EVACUATION</b>	Maximum Benefit up to \$250,000 per Coverage Year	Maximum Benefit up to \$250,000 per Coverage Year	Maximum Benefit up to \$250,000 per Coverage Year
<b>EMERGENCY FAMILY TRAVEL ARRANGEMENTS</b>	Maximum Benefit up to \$2,500 per Coverage Year	Maximum Benefit up to \$2,500 per Coverage Year	Maximum Benefit up to \$2,500 per Coverage Year
<b>REPATRIATION OF MORTAL REMAINS</b>	Maximum Benefit up to \$50,000 per Coverage Year	Maximum Benefit up to \$50,000 per Coverage Year	Maximum Benefit up to \$50,000 per Coverage Year

**SECTION 2  
EMERGENCY MEDICAL EVACUATION BENEFIT**

If a Covered Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical services while traveling outside of the United States and adequate medical facilities are not available, the Administrator will coordinate and pay for a medically-supervised evacuation, up to the Maximum Limit shown in the Schedule of Benefits, to the nearest appropriate medical facility. This medically-supervised evacuation will be to the nearest medical facility only if the facility is capable of providing adequate care. The evacuation will only be performed if adequate care is not available locally and the Injury or Sickness requires immediate emergency medical treatment, without which there would be a significant risk of death or serious impairment. The determination of whether a medical condition constitutes an emergency and whether area facilities are capable of providing adequate medical care shall be made by physicians designated by the Administrator after consultation with the attending physician on the Covered Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services.

**Repatriation**

Following any covered emergency evacuation, or if deemed appropriate by Our or Our designee's medical director, We will pay for one of the following:

1. If it is deemed Medically Necessary and appropriate by Our or Our designee's medical director, You will be transferred to your permanent residence via a one-way economy airfare or;
2. You will be transferred back to your original location or the location from which you were evacuated via a one-way economy airfare.

If Your transportation is deemed to require medical supervision a qualified medical attendant will escort you. Additionally, if We and/or Our designee, determines 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. 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.

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

### **General Limitations/ Exclusions for Emergency Medical Evacuation and Repatriation Benefits**

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 during the Period of Coverage.
4. No payment will be made for charges for:
  - a. Services rendered without the authorization or intervention of Us or Our designee;
  - b. Hospital or medical expenses of any kind or nature.
  - 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 in the opinion of the GeoBlue physician, 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.
  - f. Any expense for medical evacuation or repatriation where the Covered Member, in the opinion of the GeoBlue physician, can travel as an ordinary passenger without a medical escort.
5. To the extent that such payments would be prohibited by law.

### **SECTION 3 EMERGENCY FAMILY TRAVEL ARRANGEMENTS**

If We determine that You are expected to require hospitalization in excess of 3 days at the location to which You are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by You. If Your Dependent Child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

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

Coverage is also provided immediately following a felonious assault (i.e. theft, rape) for victims needing the support of a family member or friend.

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

### **SECTION 4 REPATRIATION OF MORTAL REMAINS BENEFIT**

If a Covered Person dies while covered under this Certificate, We will pay the necessary expenses actually incurred, up to the Maximum Limit shown in the Schedule of Benefits, for the preparation of the body for burial, or the cremation, and for the transportation of the remains to the Covered Person's 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 Us or Our designee.

No benefit is payable if the death occurs after the Termination Date of the Certificate. We will not pay any claims under this provision unless the expense has been approved by the Administrator before the body is prepared for transportation.

### **SECTION 5 DEFINITIONS**

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

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

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

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

**Covered 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.

**Eligible Dependent:** An Eligible Dependent may be the Individual Insured's lawful spouse/partner and/or his/her unmarried children under age 26 who are chiefly dependent upon the Insured Person for support and maintenance. The term "child/children" includes a natural child, a legally adopted child, a stepchild, and a child who is dependent on the Insured Person during any waiting period prior to finalization of the child's adoption. The Eligible Dependent is one who:

1. With a similar visa or passport, accompanies the Insured Person while that person is engaged in international educational activities; and
2. Is temporarily located outside the Covered Person's Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

As used above:

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

**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 Insured Person.

**Hospital** means a facility that:

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

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

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

**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.

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

**Medically Necessary** services or supplies are those that the Insurer determines to be **all** of the following:

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

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

**Member** means group, an association, a preparatory or high school or an institution of higher learning offering a course of general studies leading to a high school diploma, associate's degree, bachelor's degree, master's degree or doctorate; a part of a university offering a specialized group of courses; or an institution offering instruction in a professional, vocational, or technical field which has elected that its Participants and, if applicable, the dependents of those Participants be covered under the Group Certificate which has been accepted by the Insurer for coverage under the Group Certificate, and is a member of the Global Citizens Association.

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

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

**Participant** means a person who:

1. Is engaged in international education or cultural activities; and
2. Is temporarily traveling outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status in the country that they are traveling to.

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

**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.

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

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

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

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

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

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

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

**You, Your** means a Covered Person.

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

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

## **SECTION 6 EXCESS COVERAGE**

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

## **SECTION 7 ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE**

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

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

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

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

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

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the premium is received by the Insurer.

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

**When an Insured Person's Coverage Ends:** Coverage for an Covered Person will automatically terminate on the earliest of the following dates:

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

Any unearned premium will be returned upon request, but returned premium will only be for the number of full months of the unexpired term of coverage. Premium will be refunded in full or pro-rated if it is later determined that the Covered Person is not eligible for coverage or if the enrollment form contained inaccurate or misleading information.

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

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

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

Thereafter, the insurance is effective 24 hours a day, worldwide except whenever the Covered Person is in his/her Home Country. In no event, however, will insurance start prior to the date the enrollment form, if any, with premium is received by the Insurer or one of its authorized agents.

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

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

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

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

## SECTION 8 CLAIM PROVISIONS

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

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

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

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

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

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

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

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

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

## SECTION 9 GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Grievances

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

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

### Start with Customer Services

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

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

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

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



## **Appeals Procedure**

The Insurer has a two-step appeals procedure for most coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask to register your appeal by telephone. Call or write to the Administrator at the toll-free number or address shown on your identification card, explanation of benefits or claim form.

### **Level One Appeal**

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

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

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

### **Level Two Appeal**

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

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

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

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

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

### **Dispute Resolution**

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

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

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

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

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

## **Privacy Statement**

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

### **Information We Collect**

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

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

### **Information We Disclose**

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

### **Confidentiality and Security**

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

### **Right to Access or Correct Your Personal Information**

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

### **Contacting Us**

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