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Medical Coverage for Living Abroad: Worldwide Premier

Individual Certificate Number: **See Identification Card**

Individual Effective Date: **See Identification Card**

Issued Under Group Certificate Number: **4ELI-1015-26**

Held By: **Global Citizens Association**

Group Policy Effective Date: **July 1, 2026**

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.

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

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

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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, d/b/a Blue Cross Blue Shield Global Solutions℠ (BCBS Global Solutions℠) as its Administrator.

Important Trademark and Licensure Disclosures: Blue Cross Blue Shield Global Solutions is the trade name of Worldwide Insurance Services, LLC (Blue Cross Blue Shield Global Solutions Insurance Services in California and BCBS Global Solutions Insurance Services in New York), an independent licensee of Blue Cross and Blue Shield Association (BCBSA). Blue Cross Blue Shield Global Solutions is a Brand owned by the BCBSA. 4 Ever Life International Limited and BCBS Global Solutions are Independent Licensees of the BCBSA. The license allows the Licensee to use certain BCBSA trademarks in the geographic area of the Policyholder. The Licensees are not contracting as an agent of BCBSA, and no person, entity or organization other than the Licensees shall be held accountable or liable for any of the Licensee's obligations under this agreement.

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 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 BCBS Global Solutions 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, including the eligible Participant's Home Country; and
- Inside 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 Allowed Amount, if applicable, which may be less than actual billed Charges. Foreign Country Providers can bill the Covered Person for amounts exceeding Covered Expenses. BCBS Global Solutions provides a list to Covered Persons of Foreign Country Providers with whom BCBS Global Solutions 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 BCBS Global Solutions is able to provide background information and to arrange access for Covered Persons.

Services inside the U.S., Puerto Rico, and the U.S. Virgin Islands

BlueCard® Program and Other Inter-Plan Arrangements

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

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

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

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

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

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

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

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

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

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

- **Non-Participating Health Care Providers.**
  Please refer to the "Allowed Amount" definition in the Definitions section of this Contract.

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

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

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

Special Plan Provisions – only applicable to services provided inside the United States

Services Available in Conjunction with Your Medical Plan

The following pages describe helpful services available in conjunction with Your medical plan. You can access these services by calling the toll-free number shown on the back of Your ID card.

Pre-certification, Continued Stay Review, and Case Management services are performed through a utilization review program by a Review Organization with which 4 Ever Life International Limited and its Administrator have contracted.

Pre-certification/Pre-certify

Certain services require Pre-certification by Us. The term Pre-certification means the approval that a Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this Certificate. Pre-certification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Us to help Your Provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to Pre-certify services provided by a network provider. Network providers will be responsible for obtaining necessary pre-certification for you. Since pre-certification is the provider's responsibility, there is no additional out-of-pocket cost to you because of a network provider's failure to pre-certify services.

When You go to an out-of-network provider, it is Your responsibility to obtain pre-certification from Us for any services or supplies on the pre-certification listed in this section.

The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies there are certain Pre-certification procedures that must be followed.

You do not need to Pre-certify services provided by a network provider. Network providers will be responsible for obtaining necessary Pre-certification for you. Since pre-certification is the provider's responsibility, there is no additional out-of-pocket cost to you because of a network provider's failure to pre-certify services.

When You go to an out-of-network provider, it is Your responsibility to obtain pre-certification from Us for any services or supplies on the pre-certification services listed in this section. You or a member of your family, a hospital staff member, or the attending physician, must notify Us to Pre-certify the admission or medical services and expenses prior to receiving any of the services or supplies that require pre-certification pursuant to this Booklet-Certificate in accordance with the following timelines:

Pre-certification should be secured within the timeframes specified below. To obtain Pre-certification, call Us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your physician or the facility will need to call and request Pre-certification at least 14 days before the date You are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For outpatient non-emergency medical services, equipment or supplies, or for all other medical services requiring Pre-certification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Services and Supplies that Require Pre-certification

Some services or supplies in this list may not be covered by the Plan. Please check the benefits as listed in the Schedule of Benefits and the Exclusions and Limitations listed.

Pre-certification is required for the following types of medical expenses:

- All Inpatient Hospital services, including: acute habilitation admissions; elective surgical and nonsurgical inpatient admissions; inpatient hospice admissions; long term acute care facility admissions; skilled nursing facility admissions.
- Stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment.
- Home Health Care Services.
- Maternity Services.
- Outpatient facility services.

- Chemotherapy.
- Outpatient private duty nursing.
- intensive Outpatient programs including those for mental health or substance abuse treatments.
- Advanced radiological imaging, including CT and CTA scans, MRAs and MRIs, PET and PETT scans.
- Elective/non-emergency ground, air and sea ambulance transportation.
- Obesity surgery, including bariatric surgery.
- Reconstructive procedures that might be considered cosmetic procedures: examples include, but are not limited to: blepharoplasty, bone grafts, breast reconstruction, gender reassignment surgery, rhinoplasty, surgery for varicose veins.
- Any procedure, device or service that may be conserved experimental or investigational including: new emergent technology/procedures, as well as existing technology and procedures applied for new used and treatments.
- Any durable medical equipment more than $500, including, but not limited to: insulin pumps; CPAP or Bi-PAP devices; electric, power and motorized wheelchairs; external defibrillators; speech generating devices.
- Custom prosthetics/orthoses.
- Specialty Drugs.
- Transplant services.

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an Outpatient, or an Inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, Mental Health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to You or Your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, Your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on Your ID card. In addition, a claim office or a utilization review program (see the Pre-authorization section of Your Certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or Your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if You do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with You, Your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between Us, the patient, his or her family and Physician as needed (for example, by helping You to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Pre-certification and Continued Stay Review are performed through a utilization review program by a Review Organization with which 4 Ever Life International and its Administrator have contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for any other part of this Plan, except for the "Coordination of Benefits" section.

Retrospective Review

If neither pre-service review, admission review nor continued stay review were performed, We will use retrospective review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a Hospital stay or any other service is not Medically Necessary, the Covered Person is responsible for payment of the Charges for those services.

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 and prior to satisfaction of his/her Out-of-Pocket Limit. **Covered Expenses are based on the Allowed Amount which may be less than actual billed charges. Providers can bill the Covered Person for amounts exceeding Covered Expenses.**

After the Deductible is satisfied and/or Copayment paid by Covered Person, benefits are paid for Covered Expenses as follows:

BENEFIT OVERVIEW MATRIX

	International	U.S. Participating Provider	U.S. Non-Participating Provider
MEDICAL EXPENSES			
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	100% of the Allowed Amount	80% of the Allowed Amount	60% of the Allowed Amount
Calendar Year Medical Deductible			
Individual	The amount shown in the Confirmation of Coverage Page as selected by the Eligible Participant	The amount shown in the Confirmation of Coverage Page as selected by the Eligible Participant	The amount shown in the Confirmation of Coverage Page as selected by the Eligible Participant
Family Maximum	2.5 times the individual Deductible	2.5 times the individual Deductible	2.5 times the individual Deductible
Family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance. Deductibles will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate. Deductible amounts incurred in the last three months of the Calendar year (Oct, Nov, Dec) will apply towards the next year's Calendar Year Deductible.			
Coinsurance Maximum			
Individual	The amount shown in the Confirmation of Coverage Page as selected by the Eligible Participant	The amount shown in the Confirmation of Coverage Page as selected by the Eligible Participant	The amount shown in the Confirmation of Coverage Page as selected by the Eligible Participant
Family Maximum	2.5 times the individual Coinsurance Maximum	2.5 times the individual Coinsurance Maximum	2.5 times the individual Coinsurance Maximum
Family members meet only their individual Coinsurance Maximum and then their claims will be covered at 100%; if the family Coinsurance Maximum has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%. Coinsurance Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International.			
OTHER COVERAGES			
Accidental Death & Dismemberment	Deductible is not applicable. Maximum Benefit: Principal Sum up to $50,000		
Emergency Medical Transportation Includes Emergency Medical Evacuation, Repatriation, and Repatriation of Mortal Remains	Deductible is not applicable. Maximum Lifetime Benefit for all Evacuations up to $250,000		
Emergency Family Travel Arrangements	Deductible is not applicable. Up to a maximum benefit of $2,500 per Calendar Year 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		

SCHEDULE OF BENEFITS

(Subject to Maximums, Coinsurance, and Deductibles in Overview Matrix)

Benefits	International	U.S. Participating Provider	U.S. Non-Participating Provider
Preventive and Primary Care			
Preventive Care for Babies/Children: Birth through Age 18 a. Office Visits/examination b. Immunizations, Lab work & X-rays done in conjunction with an office visit	100%, no deductible	80%, no deductible	60%, no deductible
Preventive Care For Adults: Age 19 and Older a. Office Visits/examination b. Immunizations as recommended on the published Center for Disease Control (CDC) immunization schedule for adults c. Routine Pap Smears, annual mammogram d. PSA For Men e. Diagnostic Lab work & X-rays done in conjunction with an office visit	100%, no deductible	80%, no deductible	60%, no deductible
Travel Vaccinations Calendar Year Maximum of $500	100%, no deductible	80%, no deductible	60%, no deductible
Annual Physical Examination/Health Screening Calendar Year Maximum of $1,000 and limited to one per Calendar Year	100%, no deductible	80%, no deductible	60%, no deductible
Primary Care Physician or Specialist Office Visits	100%, no deductible $10 Copayment *	100%, no deductible $30 Copayment	60%, no deductible
Urgent Care Facility	100%, no deductible	100% no deductible, $75 Copayment	60%, no deductible
* Copayment waived when visiting a BCBS Global Solutions contracted provider			
Services and Supplies Provided by a Hospital **(Pre-Certification, where noted, is only applicable to services provided inside the United States)**			
Outpatient Hospital Care Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Ambulatory Surgical Center Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Hospital Emergency Room	100%, after deductible Additional $50 Copayment per visit – waived if admitted	80%, after deductible Additional $50 Copayment per visit – waived if admitted	60%, after deductible Additional $50 Copayment per visit – waived if admitted
Inpatient Hospital Care Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible

Benefits	International	U.S. Participating Provider	U.S. Non-Participating Provider
Surgery, X-rays, In-hospital doctor visits, Organ/Tissue Transplant Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab work. Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Maternity Care/Obstetrical Services Pre-Certification Required			
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	Not Covered	Not Covered	Not Covered
Laboratory, Radiology Services and or Advance Radiological Imaging	Not Covered	Not Covered	Not Covered
Delivery Charges – Facility (Hospital, Birthing Center)	Not Covered	Not Covered	Not Covered
Other Services **(Pre-Certification, where noted, is only applicable to services provided inside the United States)**			
Infusion Therapy	100%, after deductible	80%, after deductible	60%, after deductible
Ambulance Service Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Durable Medical Equipment Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Newborn Care	100%, after deductible	80%, after deductible	60%, after deductible
Short-Term Rehabilitative Therapy Limited to 20 visits per Calendar Year	100%, no deductible	100%, no deductible	100%, no deductible
Treatment of specified therapies, including Acupuncture and Chiropractic Care $2,000 Maximum per Calendar Year if under the care of a licensed Physician	100%, after deductible	80%, after deductible	60%, after deductible
Mental, Emotional or Functional Nervous Disorders – Inpatient Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Mental, Emotional or Functional Nervous Disorders – Outpatient	100%, no deductible, $10 Copayment *	100%, no deductible, $30 Copayment	60%, no deductible
Substance Abuse – Inpatient in a Hospital, Non-hospital Residential Treatment Center or Day Care Center Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible

Benefits	International	U.S. Participating Provider	U.S. Non-Participating Provider
Substance Abuse – Outpatient Treatment	100%, no deductible, $10 Copayment *	100%, no deductible, $30 Copayment	60%, no deductible
Home Health Care Maximum of 30 visits per Calendar Year Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Hospice Maximum of $5,000 per lifetime Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Skilled Nursing Facilities Maximum of $250 per day for a maximum of 50 days per Calendar Year. Pre-Certification Required	100%, after deductible	80%, after deductible	60%, after deductible
Dental Care required due to an Injury Maximum of $1,000 per Calendar Year maximum/$200 per tooth	100%, after deductible	100%, after deductible	100%, after deductible
Prescription Drugs	Deductible is not applicable. 100% of the actual charge up to a Calendar Year maximum of $3,500		
* Copayment waived when visiting a BCBS Global Solutions contracted provider			

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; and
2. Has submitted an enrollment form, if applicable, and the GCA membership fees to the GCA; and
3. Is under age 75 at the time of application and under age 84 at time of renewal; and
4. Is a U.S. citizen or permanent resident of the U.S. (as defined by the immigration code of the U.S.) residing or scheduled to reside outside of the United States for a period greater than three (3) months; or
5. Is either i) a foreign national affiliated with a U.S. based entity; ii) a foreign national temporarily residing in the U.S. who is affiliated with a U.S. entity; or iii) is a foreign national temporarily in the U.S. on a valid visa other than a tourist visa; and
6. Meets the underwriting criteria otherwise established by the Insurer.

Eligible Dependents

An Eligible Dependent means a person who is the Eligible Participant's:

1. spouse; civil union partner, or domestic partner**;**
2. own or spouse's, civil union partner's or domestic partner's own unmarried 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 unmarried child, of any age, enrolled prior to age 26, who is incapable of self-support due to continuing cognitive impairment 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. Adopted Children or Children born to a Surrogate: Children who are born to a surrogate or have been adopted, can only be covered by the policy when they are 90 days old. Cover for the child will be subject to completion of a medical health questionnaire, whereby we may apply special restrictions or exclusions, or not accept them on the plan as a Covered Person.

As used above:

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

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

Application and Effective Dates

Coverage for an Eligible Participant and his or her Eligible Dependents will become effective if the eligible person submits a properly completed application to the Insurer, is approved for coverage by the Insurer, and the Group and or the Eligible Participant pays the Insurer the premium.

Disclosure of Medical Information
The Covered Person must provide complete and accurate information in the enrollment application and any renewal. The Covered Person must disclose all known medical conditions for which medical advice, diagnosis, care, or treatment was received prior to the Effective Date, including any such conditions disclosed or arising under any prior policy issued by the Company or its affiliates. Failure to disclose material medical information may result in denial of claims, retroactive adjustment of benefits, or rescission of coverage.

The Effective Date of Coverage under the Plan is indicated below:
1. The Effective Date for a participant who becomes eligible after the Effective Date of the Policy will be the first of the month following the Waiting Period (the Initial Eligibility Date), provided the Insurer receives a fully completed application prior to the Initial Eligibility Date. The Effective Date will be the first or the fifteenth, as chosen by the Eligible Participant, of the month following the date the Insurer approves the application.
2. If a person meets the above definition of an Eligible Dependent on the date the Eligible Participant is qualified to apply for the Plan, then the Eligible Dependent qualifies to apply at the same time that the Eligible Participant applies, and should be included on the Eligible Participant's application.
3. For a person who becomes an Eligible Dependent after the date the Eligible Participant's coverage begins, the Eligible Dependent is qualified to apply for the Plan within 31 days following the date he/she meets the above definition of an Eligible Dependent. Coverage for the Eligible Dependent will become effective in accordance with the following provisions subject to approval by the Insurer:
   a. Newborn Children: Coverage will be automatic for the first 31 days following the birth of an Insured Participant's child. To continue coverage beyond 31 days, the Newborn child must be enrolled within 31 days of birth.
   b. Court Ordered Coverage for a Dependent: If a court has ordered an Insured Participant to provide coverage for an Eligible Dependent who is a spouse or minor child, coverage will be automatic for the first 31 days following the date on 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.
   c. Adopted Children or Children born to a Surrogate: Children who are born to a surrogate or have been adopted, can only be covered by the policy when they are 90 days old. Cover for the child will be subject to completion of a medical health questionnaire/full medical underwriting, whereby we may apply special restrictions or exclusions, or not accept them on the plan as a Covered Person.
   d. Other Dependents: A written application **must be received within 31 days of the date that a person first qualifies** as an Eligible Dependent. Coverage will become effective on the first day of the month following date of approval.
4. If the application is not received within the time frames outlined above, the Eligible Participant/Dependent will become a Late Enrollee. The Late Enrollee may become covered for Participant and/or Dependent coverage only at the start of the next Period of Coverage and after the Insurer receives and approves the application.

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 Eligible Participant's Effective Date of Coverage.

Notification of Eligibility Change
1. Any person who does not satisfy the eligibility requirements is not covered by the Plan and has no right to any of the benefits provided under the Plan.
2. The Group and/or the Insured Participant must notify the Insurer within 31 days of any change that affects an individual's eligibility under the Plan, including the additional requirements for an Eligible Participant and Eligible Dependents.

How Coverage Ends

The benefits provided by this Certificate terminate at the end of the current Period of Coverage. At the beginning of the next Period of Coverage you may re-apply for coverage. Any re-application is subject to submission of a properly completed application to the Insurer, the Insurer's approval of that application, and payment of the applicable premium to the Insurer by the Eligible Participant. Premiums will be based upon the attained age of the Covered Person at the beginning of the Period of Coverage.

If it becomes unlawful for Us to offer coverage in a jurisdiction, we will terminate coverage with a 60-day notice. Any unearned premium will be returned, but returned premium will only be for the number of full months of unexpired term of coverage. A Covered Person's coverage will end without prejudice to any claim existing at the time or termination.

Insured Participants
The Insured Participant's coverage ends without notice from the Insurer on the earlier of:
1. the last day of the month after the date the Insured Participant no longer meets the definition of an Eligible Participant;
2. the end of the last period for which premium payment has been made to the Insurer;
3. the date the Policy terminates;
4. the end of any Period of Coverage;
5. 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.

Insured Dependents
The Eligible Participant's insured Dependent's coverage will end on the earlier of:
1. the end of the month after the date the Eligible Participant's insured Dependent no longer meets the definition of an Eligible Dependent as defined in the Plan;
2. the end of the period for which premium payment has been made to the Insurer;
3. the date the Certificate of Coverage terminates;
4. the date the Insured Participant's coverage terminates;
5. the end of any Period of Insurance
6. the date of fraud or misrepresentation of material fact by the Insured Dependent, except as indicated in the Time Limit on Certain Defenses provision.

Note: In the event the Participant dies while covered under this plan, any currently enrolled Spouse and any currently enrolled Dependent Children are allowed to stay covered with the existing plan benefits for up to 24 months without paying any additional premium. The continuation of benefits terminates at the earlier of 24 months or when the dependents return to their Home Country.

Medical Benefits Extension during Hospital Confinement Upon Certificate Cancellation
If the Medical Benefits under this Certificate cease for You or Your Dependent due to cancellation of the Policy (except if the Policy is canceled for nonpayment of premiums) and You or Your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:
1. the date You exceed the Maximum Benefit, if any, shown in the Schedule of Benefits;
2. the date You are covered for medical benefits under another group plan;
3. the date You or Your Dependent is no longer Hospital Confined; or
4. 10 days from the date the Certificate of Coverage is canceled.

Premium Provisions

Premium
We provide insurance in return for premium payments. Premiums are due prior to the Effective Date of Coverage to Our Plan Administrator. Failure to pay premiums when due or within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

Cancellation of this Policy
Any date prior to Your Effective Date of Coverage, You may request a full refund of premium from Us. Additionally, each member has a "Money Back Guarantee" for up to 10 days after your effective date of coverage where You may request a full refund of premium from Us (See Conditions Below).

Cancellation of coverage must be in writing or received telephonically or electronically to Us from the Eligible Participant.

Once Your Effective Date of Coverage starts, You may request cancellation of coverage, but the following conditions apply:
- Only full month premiums will be considered refundable.
- Cancellation of coverage must be in writing or received telephonically or electronically to Us from the Eligible Participant and are subject to review of all plan provisions.
- If this request is received within the 10-day "Money Back Guarantee" period, a full refund of premium will be provided. If this request is received on the 11th day of coverage or after, only full month premiums will be eligible for a refund, on a pro rata basis. Refund requests take effect 31 days after We receive the request from the Eligible Participant.
- If a confirmation of coverage letter is generated for the purposes of obtaining a visa, the "Money Back Guarantee" is no longer applicable, and any cancellation request will become effective only after the first 31 days of coverage.

Cancellation of Coverage by Us:
Unless otherwise prohibited by law, the Insurer may cancel coverage if, at any time, it is determined that the Eligible Participant:
1. Provided false, misleading, or fraudulent information on the enrollment form or in any material submission related to the Policy;
2. Engaged in intentional misrepresentation of a material fact; or
3. Otherwise communicated fraud in connection with obtaining or maintaining coverage;
4. Is identified as a sanctioned or restricted person or entity, to any applicable economic or trade sanctions, laws, or regulations.

If coverage is cancelled, it will be treated as if coverage under the Certificate has expired. No claim incurred after the effective date of cancellation will be accepted. Any claims incurred prior to the effective date of cancellation will be reviewed against the provisions of the Certificate as normal. The Eligible Participant will receive a pro-rated refund of any unearned premium from the Insurer. The Insurer will provide notice to the Eligible Participant in accordance with applicable laws and regulations.

Rescission of Coverage:
Unless otherwise prohibited by law, the Insurer may rescind coverage if, at any time, it is determined that the Eligible Participant:
1. Provided false, misleading, or fraudulent information on the enrollment form or in any material submission related to the Policy;
2. Engaged in intentional misrepresentation of a material fact; or
3. Otherwise communicated fraud in connection with obtaining or maintaining coverage;
4. Is identified as a sanctioned or restricted person or entity, to any applicable economic or trade sanctions, laws, or regulations.

If coverage is rescinded, it will be treated as if it never took effect, premium will be refunded, and any claims paid may be subject to recovery by the Insurer. The Insurer will provide notice to the Eligible Participant in accordance with applicable laws and regulations.

Cancellation or Rescission shall not impact the Insurer's rights to recover benefits paid under fraudulent or misrepresented claims nor does it limit the Insured's rights under any applicable appeal or dispute resolution processes provided under this Policy or applicable law.

Grace Period

A grace period of 1 month is granted for each premium due after the premium due date. Coverage will stay in force during this period provided the Eligible Participant pays all the premiums due by the last day of the grace period, unless notice has been sent to the Plan Administrator to terminate the coverage. If the premium is not paid by the end of the grace period, coverage will be cancelled back to the end of the period for which premium was paid. Any claims with incurred dates after the period for which premium was paid will not be covered.

Reinstatement

A Plan may be reinstated within 2 months of lapse if it is lapsed for nonpayment of premium, if the Eligible Participant pays all premium due in full and the Plan Administrator accepts on Our behalf the past due premium. If the Plan Administrator does not accept the premium, or if the Eligible Participant requests to have their Plan reinstated outside of the grace period, the Eligible Participant will have to reapply for coverage by completing a new application. The Eligible Participant will be underwritten and is subject to reconsideration for 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.

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

Age means the Covered Person's attained age.

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

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

B. The Allowed Amount for Non-Participating Providers will be determined as follows:

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

C. The Allowed Amount for Prescription Drugs provided by Pharmacies, Covered Expenses means the following:

- For Prescription Drugs provided by a Preferred Pharmacy, Covered Expenses means the amount that We have negotiated with our Pharmacy Benefits Manager as total reimbursement for the covered Prescription Drugs.
- For Prescription Drugs provided by a Non-Preferred Pharmacy, Covered Expense means the Pharmacy's charges for the covered Prescription Drugs.

D. The Allowed Amount for Covered Services incurred outside of the United States will be determined as follows:

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

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

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

We reserve the right to negotiate a lower rate with Non-Participating Providers or to pay a Host Blue plan's rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, and the Provider has agreed to extend the rate to this Certificate, the rate the Provider has agreed to accept from the other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

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.

Authorized Administrator (Administrator) – refers to Worldwide Insurance Services, LLC.

Benefit Period means the valid dates as shown in the Schedule of Benefits.

A **Calendar Year** is a 12-month period beginning each January 1 at 12:01 a.m. Eastern Time.

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

Certificate of Credible Coverage means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program.

Certified Nurse Midwife means a nurse-midwife who (a) practices according to the standards of the appropriate local licensing authority; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

1. is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
2. is a graduate of a program of nurse-midwives accredited by the appropriate local licensing authority.

Chemotherapy means the treatment of malignant conditions by pharmaceutical and/or biological antineoplastic drugs.

Chiropractor means a duly licensed chiropractor.

Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Claim means notification in a form acceptable to the Insurer that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which THE INSURER may request in connection with services rendered to you.

Claim Charge means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.")

Claim Payment means the benefit payment calculated by the Insurer, after submission of a Claim, in accordance with the benefits described in this Certificate. All Claim Payments will be calculated on the basis of the Allowed Amount for Covered Services rendered to you, regardless of any separate financial arrangement between a Plan or our Authorized Administrator and a particular Provider. (See provisions of this Certificate regarding "Separate Financial Arrangements with Providers.")

Clinical Laboratory means a clinical laboratory that complies with the licensing and certification requirements under the applicable federal, state and local laws.

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.**

Coinsurance Maximum is the amount of Coinsurance each Covered Person incurs for Covered Expenses in a Calendar Year. The Coinsurance **does not** include any amounts in excess of Covered Expenses, the Deductible and/or any Copayments, Prescription Drug Deductible and Copayments, any penalties, or any amounts in excess of other benefit limits of this Plan.

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, 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.

Coordinated Home Care means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of, a registered professional nurse, and the services of physical therapists, hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service.

Copayment is the dollar amount of Covered Expenses the Covered Person is responsible for paying. **Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expenses.**

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.**

Country of Assignment means the country for which the Eligible Participant has a valid visa, is required, and in which he/she is working and/or residing.

Course of Treatment is a planned, structured, and organized sequence of treatment procedures based on an individualized evaluation to restore or improve health function, or to promote chemical free status. A Course of Treatment is complete when the patient has finished a series of treatments without a lapse in treatment or has been medically discharged. If the Covered Person begins a series of treatments, it will count as one course of treatment, reducing the available benefits, even if the patient fails to comply with the treatment program for a period of 30 days.

Coverage Date means the date on which your coverage under this Certificate begins.

Covered Expenses are the expenses incurred for Covered Services. **Covered Expenses** for Covered Services will not exceed the Allowed Amount. In addition, Covered Expenses may be limited by other specific maximums described in this Certificate. 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.

Creditable Coverage means coverage you had under any of the following:
1. A group health plan;
2. Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health insurance issuer;
3. Medicare (Part A or B of Title XVIII of the Social Security Act);
4. Medicaid (Title XIX of the Social Security Act);
5. CHAMPUS (Title 10 U. S. C. Chapter 55);
6. The Indian Health Service or a tribal organization;
7. A State health benefits risk pool;
8. The Federal Employees Health Benefits Program;
9. A public health plan maintained by a State, county or other political subdivision of a State;
10. Section 5(e) of the Peace Corps Act.

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.

Custodial Care Service means those services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the health care facility involved.

Deductible means the amount of Covered Expenses the Covered Person must pay for Covered Services before benefits are available to him/her under this Plan. The **Annual Deductible** is the amount of Covered Expenses the Eligible Participant must pay for each Covered Person before any benefits are available regardless of provider type.

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

Diagnostic Service means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

Dialysis Facility means a facility (other than a Hospital) whose primary function is the treatment and/ or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

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.

Early Intervention Services means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three who are certified by the by the Department of Human Services as eligible for services under Part C of the Individuals with Disabilities Education Act.

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 (See Emergency Medical Care)

Emergency Accident Care means the initial Outpatient treatment of accidental injuries including related Diagnostic Service.

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.

Facility means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Family Coverage means coverage for you and your eligible dependent(s) under this Certificate.

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. BCBS Global Solutions provides Covered Persons with access to a database of Foreign Country Providers.

Group refers to the Global Citizens Association to which the Insurer has issued this Certificate.

Group health insurance coverage means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

Group health plan means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

1. "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
2. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
3. "Health benefit plan" does not include:
   a. Coverage only for accident, or disability income insurance, or any combination thereof;
   b. Coverage issued as a supplement to liability insurance;
   c. Liability insurance, including general liability insurance and automobile liability insurance;
   d. Workers' compensation or similar insurance;
   e. Automobile medical payment insurance;
   f. Credit-only insurance;
   g. Coverage for on-site medical clinics; and
   h. Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
4. "Health benefit plan" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
   a. Limited scope dental or vision benefits;
   b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
   c. Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
5. "Health benefit plan" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
   a. Coverage only for a specified disease or illness; or
   b. Hospital indemnity or other fixed indemnity insurance.
6. "Health benefit plan" shall not include the following if offered as a separate policy, certificate or contract of insurance:
   a. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
   b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
   c. Similar supplemental coverage provided to coverage under a group health plan.

Group Policy or Policy means the agreement between the Insurer and the Group, any riders, this Certificate, the Schedule of Benefits, the Benefit Program Application and any employee application form of the persons covered under the Policy.

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.

Hearing Aids means any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.

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.

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy and must be either certified as a home health care provider by Medicare or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Home Health Care Services

Home Health Care Services means those services and supplies from a Provider, approved by Us that is engaged in providing, either directly or through an arrangement, health care or skilled nursing services on an intermittent basis in the patient's home in accordance with an approved Home Health Care treatment Plan.

Hospice Care Program

The term Hospice Care Program means:

1. a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
2. a program that provides palliative and supportive medical, nursing and other health services through home or Inpatient care during the Sickness;
3. a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

Hospice Facility means an institution or part of it which:

1. primarily provides care for Terminally Ill patients;
2. is accredited by the National Hospice Organization;
3. meets standards established by Us; and
4. fulfills any licensing requirements of the state or locality in which it operates

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.

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

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.

Inpatient or Inpatient Admission means a Covered Persons actual entry into a Hospital, extended care facility, or facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility, or facility Provider and for whom a Bed and Board charge is made; the Inpatient stay shall continue until such time as the Covered Person is actually discharged from the facility.

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.

International means any country or territory other than the United States of America, the District of Columbia, the U.S. Virgin Islands or Puerto Rico.

Investigative Procedures (See Experimental/Investigational).

Maternity, Maternity Care, Maternity Service means the constellation of health services provided by a physician, nurse, midwife, hospital, or birthing center to a pregnant woman during pregnancy (prenatal), delver and after delivery (post-natal).

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.

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

Negotiated Rate is the rate of payment that the Insurer has negotiated with a Participating Provider for Covered Services.

Network means the group of participating providers providing services to a managed care plan**.**

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

Non-Participating Hospital (out-of-network) is a Hospital that has not entered into a Participating Hospital agreement with the Insurer at the time services are rendered.

A **Non-Participating Physician** (out-of-network) is a Physician who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

Non-Participating Provider (out-of-network) is a provider who does not have a Participating Provider agreement in effect with the Insurer at the time services are rendered.

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.

Optometrist means a duly licensed optometrist.

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.

Other Health Care Facility/Other Participating Health Professional

A person who is in a Provider category licensed to practice health care related services consistent with the laws in jurisdiction in which the services are performed. Such persons are considered health care Providers only to the extent services are covered by the provisions of this Plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain Health Care Facilities and other Providers of health care services and supplies, as specifically indicated in the Provider category listing below.

Covered licensed or certified categories of Providers, will include the following, provided that the services they furnish are consistent with state law, and the conditions of coverage described elsewhere in this Plan are met:

- Acupuncturists (L.Ac.), also called East Asian Medicine Practitioners (E.A.M.P.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (under the supervision of an M.D.)
- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following Health Care Facilities and other Providers of health care services and supplies will be considered health care Providers for the purposes of this Plan, as long as they are licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this Plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

Note: Outside of the United States, a Provider is a medical professional service Provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

Outpatient means medical, nursing, counseling or therapeutic treatment provided to a Participant who does not require an overnight stay in a Hospital or other Inpatient facility.

A **Participating Hospital** (in-network) is a Hospital that has a Participating Hospital agreement in effect with the Insurer at the time services are rendered. Participating Hospitals agree to accept the Allowed Amount as payment in full for Covered Expenses.

Participating Physician (in-network) is a Physician who has a Participating Physician agreement in effect with the Insurer at the time services are rendered. Participating Physicians agree to accept the Allowed Amount as payment in full for Covered Services.

A **Participating Provider** (in-network) is a Participating Physician, hospital, or other health care provider that has a Participating Provider agreement in effect with the Insurer at the time services are rendered. Participating Providers agree to accept the Allowed Amount as payment in full for Covered Expenses.

Pediatric Preventive Care means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a physician and rendered to a child.

A **Period of Coverage** is a period for which the Covered Person is insured.

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.

Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the Policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this Plan when performed by a Physician.

In addition, professional services provided by one of the following types of Providers will be covered under this Plan, but only when the Provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this Plan; and providing a service for which benefits would be payable if the service were provided by a Physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.)

Note: Outside of the United States, a Physician is a medical professional service Provider providing services within the scope of their license as determined by the local jurisdiction in which they are practicing.

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.

Plan Administrator is Blue Cross Blue Shield Global Solutions.

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

Post-partum Recovery Lodging is maternity confinement centers, maternity recovery suites/hotels, or similar facilities that primarily provide lodging, rest, meal services, newborn care instruction, or non-medical supportive services.

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.

Primary Care Physician is a Physician who supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician.

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. Medicare, Medicaid, state run Medicaid programs, and Veterans Administration health benefit plans are **not** considered a primary plan under this Certificate of Coverage.

Provider is any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, certified midwife, Hospital, Skilled Nursing Facility, rehabilitation Hospital, birthing facility, or home health Provider.

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)

The Insurer's **Service Area** is any place that is within twenty-five (25) miles of a Participating Provider.

Self-Administered Prescription Drug – a Prescription Drug that can be administered safely and effectively by either the Covered Person or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self- Administered Prescription Drugs include, but are not limited to:

- Oral drugs;
- Self-Injectable Drugs;
- Inhaled drugs; and
- Topical drugs.

Self-Injectable Prescription Drug (Self-Injectable Drug) – A Prescription Drug that:

- Is introduced into a muscle or under the skin with a syringe and needle; and
- Can be administered safely and effectively by either the Covered Person or a caregiver without medical supervision, regardless of whether initial medical supervision and/or instruction is required.

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.

Specialist is a Physician who practices in any generally accepted medical or surgical sub-specialty. Examples include Ob/Gyn, surgeons, cardiologists, urologists, dermatologists.

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.

Telehealth means the mode of delivering health care or other health service via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health.

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.

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 U.S. Virgin Islands.

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

Urgent Care Facility or Urgent Care Centers – a Facility Provider designed to offer immediate evaluation and treatment for acute health conditions that require medical attention in a non-emergency situation when your Professional Provider's office is unavailable. Urgent Care is not the same as emergency care (see definition of **Urgent Care** above).

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

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 Calendar Year or pays his/her Copayment. This section describes the Deductible and Copayments 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 the Allowed Amount as determined by the Insurer.

Exception: If Medicare is the primary payer, Covered Expense does not include any charge:
1. By a Hospital in excess of the approved amount as determined by Medicare; or
2. By a Physician or other provider, in excess of the lesser of the maximum Covered Expense stated above; or
   a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
   b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

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

Copayments/Deductibles
Copayments, or Copays, are expenses to be paid by You or Your Dependent for covered services. Deductibles are also expenses to be paid by You or Your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Schedule of Benefits has been reached, You and Your family need not satisfy any further medical Deductible for the rest of that year.

Covered Expenses that were incurred and applied toward any Comprehensive Medical or Family Deductible during the last 3 months of the calendar year, will be applied toward the next year's Deductible.

Coinsurance
The term Coinsurance means the percentage of Charges for Covered Expenses that a Covered Person is required to pay under the Plan.

Coinsurance Maximums
The Coinsurance Maximum is the amount of Coinsurance each Covered Person incurs for Covered Expenses in a Period of Insurance. The Coinsurance Maximum **does not** include any amounts in excess of Covered Expenses, Deductibles, Copayments, Prescription drug Copayments**,** amounts applied to any penalties, or any amounts in excess of other benefit limits of this Certificate of Coverage.

Once a Covered Person meets their Coinsurance Maximum, he/she will no longer have to pay any Coinsurance for the remainder of the Calendar Year**.**

Accumulation of Plan Deductibles and Coinsurance Maximums
Deductibles and Coinsurance Maximums will cross-accumulate between U.S. Participating Provider, U.S. Non-Participating Provider and International. All other Plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.

Payment
After the Insured Participant satisfies any required Deductible and/or Copayment, payment of Covered Expenses is provided as defined in the Schedule of Benefits 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.

This section of the Certificate explains the types of expenses You must pay for covered services before the benefits of this Plan are provided. To prevent unexpected Out-of-Pocket Expenses, it is important for You to understand what You are responsible for.

Multiple Surgical Reductions
Multiple and/or bilateral surgical services rendered by the same professional Provider, in the same setting, and on the same date of service will be reviewed subject to auditing criteria. Allowance for the primary procedure is 100%. Allowance for each secondary procedure will be 50%.

Procedures performed in conjunction with the primary surgical procedure considered by Us to be incidental to that primary procedure will not receive additional reimbursement. Incidental procedures are defined as procedures requiring little additional Provider resources and/or are clinically integral to the performance of the primary procedure.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon
The maximum amount payable will be limited to Charges made by an assistant surgeon as specified in 4 Ever Life or its Administrator's reimbursement policies.

Co-Surgeon
The maximum amount payable will be limited to Charges made by Co-Surgeons as specified in 4 Ever Life or its Administrator's reimbursement policies.

V. Benefits: What the Plan Pays

Before this Plan pays for any benefits, the Covered Person must satisfy his/her 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 Schedule of Benefits, 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:

This section of Your Certificate describes the specific benefits available for Covered Services. Benefits, subject to the Copayments, coinsurance, Deductibles and limitations as noted are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered Sickness, disease or Injury;
- It must be Medically Necessary (please see the "Definitions" section in this Certificate) and must be furnished in a Medically Necessary setting. Inpatient care is only covered when You require care that could not be provided in an Outpatient setting without adversely affecting Your condition or the quality of care You would receive;
- It must not be excluded from coverage under this Plan;
- The expense for it must be incurred while You are covered under this Plan and after any applicable waiting period required under this Plan is satisfied;
- It must be furnished by a Provider (please see the "Definitions" section in this Certificate) who is performing services within the scope of his or her license or certification;
- It must meet the standards set in Our medical and payment policies. Our medical and payment policies are used to administer the terms of the Plan. Medical policies are generally used to determine if a Covered Person has coverage for a specific procedure or service. Payment policies define billing and Provider payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA).

Benefits for some types of services and supplies may be limited or excluded under this Plan. Please refer to the actual benefit provisions throughout this section and the "Exclusions and Limitations: What the Plan does not pay for" section for a complete description of covered services and supplies, limitations and exclusions. **Any applicable Copayments, Deductibles or limits are shown in the Schedule of Benefits.**

Services and Supplies Provided by a Hospital

For any eligible condition not excluded under this Certificate, 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.
4. Charges made by a Hospital, on its own behalf, for medical care and treatment received as an Outpatient.
5. Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
6. Charges made for Emergency Services and Urgent 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.

Professional and Other Services

The Insurer will pay Covered Expenses for:

1. Services of a Physician.
2. Charges made by a Physician or a Psychologist for professional services.
3. Charges made by a Nurse, other than a member of Your family or Your Dependent's family, for professional nursing service.
4. Charges made for anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
5. Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
6. Services of an anesthesiologist or an anesthetist.
7. Outpatient diagnostic radiology and laboratory services. If these services are the result of a Physician Office Visit or of Hospital and Physician Outpatient Services, there is no additional Copayment for these service. A Deductible may apply. However, if there is neither a Physician Office Visit nor Hospital or Physician Outpatient Services delivered, the Hospital and Physician Outpatient Services Copayment applies.

8. Cervical cancer screening tests and the Office Visit associated with those tests when ordered by the Covered Person's Physician, nurse practitioner or certified nurse midwife.
9. Mammogram examinations, limited to one baseline mammogram and an annual mammography examination upon the recommendation of the Covered Person's physician.
10. Prostate Specific Antigen tests and the Office Visit associated with this test when ordered by the Covered Person's Physician or nurse practitioner.
11. Radiation therapy and hemodialysis treatment.
12. The first pair of contact lenses or the first pair of eyeglasses when required as a result of eye surgery.
13. Syringes when dispensed with self-administered injectable drugs (except insulin).
14. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
15. Services for the detection and prevention of osteoporosis for qualified individuals.
16. Colorectal cancer screenings: Colorectal screenings shall be in compliance with the American Cancer Society colorectal cancer screening guidelines and are subject to any coinsurance and deductible.

Ambulance Services
Benefits for the following services are subject to Your Deductible and Coinsurance as stated in the Schedule of Benefits

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat Your condition, when any other mode of transportation would endanger Your health or safety. Medically Necessary Services and Supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for Your condition. This benefit only covers the Covered Person that requires transportation.

Annual Physical Examination/Health Screening
Benefits are provided up to the limit as shown in the Schedule of Benefit for medical services provided by a medical professional practicing within the scope of their licenses for an annual physical/executive health screening to cover labs and medical diagnostic tests recommended by the medical professional that are not covered under the Preventive Care benefits available to all Covered Persons.

Travel Vaccinations
Recommended travel vaccinations not covered under the Preventive Care Services above are covered according to the limits stated in the Schedule of Benefits.

Breast Reconstruction and Breast Prostheses
Charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce a symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Clinical Trials
This Certificate covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:
(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
(b) either
- the referring health care professional is a participating health care Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements: The study or investigation must:
- Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- Involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this Certificate for an individual who is not enrolled in a clinical trial and, in addition:
- Services required solely for the provision of the investigational drug, item, device or service;
- Services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- Services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service;
- Reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications; and
- Routine patient care costs (as defined) for Covered Persons engaging in clinical trials for treatment of life threatening diseases.

Routine patient care costs do not include:

- The investigational drug, item, device, or service, itself; or
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If Your Plan includes Participating Providers, clinical trials conducted by Non-Participating Providers will be covered at the Participating Provider benefit level if:

- There are no Participating Providers participating in the clinical trial that are willing to accept the individual as a patient, or
- The clinical trial is conducted outside the individual's state of residence.

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 Schedule of Benefits.

Diabetic Supplies/Education

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

Durable Medical Equipment

Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Us for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Covered Person's misuse are the Covered Person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- Special or extra-cost convenience features;
- Structural modifications to Your home or personal vehicle;
- Air quality items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities;
- Penile prostheses;
- Other equipment: heat lamps, heating pads, cryo-units, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances and Devices

Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician. External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; splints; and medical vision hardware.

Prostheses/prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement and from foot disfigurement caused by accident or developmental disability

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Medical Vision Hardware
Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, Charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be Charges made for treatment of Mental Health.

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.

Benefit limits for all services are shown in the Schedule of Benefits

Inpatient Mental Health Services
Services that are provided by a Hospital while You or Your Dependent is confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services
Services of Providers who are qualified to treat Mental Health when treatment is provided on an Outpatient basis, while You or Your Dependent is not confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, Outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and Outpatient testing and assessment.
A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services
Services provided for rehabilitation, while You or Your Dependent is confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24- hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24- hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services
Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while You or Your Dependent is not confined in a Hospital, including Outpatient rehabilitation in an individual, a group, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Abuse Detoxification Services
Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. We will decide, based on the Medical Necessity of each situation, whether such services will be provided in an Inpatient or Outpatient setting.

Exclusions
The following are specifically excluded from Mental Health and Substance Abuse Services:

- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature; for borderline intellectual functioning; occupational problems; counseling related to consciousness raising; and for vocational or religious counseling.
- Any costs associated with voluntary support groups, such as Alanon or Alcoholics Anonymous.
- I.Q. testing.
- Custodial Care, including but not limited to geriatric day care, and halfway houses, quarter way houses, recovery houses, and other sober living residences.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- A person has symptoms or signs of a genetically-linked inheritable disease;
- It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 5 visits per calendar year for both pre- and post-genetic testing.

Home Health Care Services

Covered Expenses include Charges for Home Health Care Services when ordered by a Physician as part of a home health Plan and provided You are:

- Transitioning from a Hospital or other Inpatient facility, and the services are in lieu of a continued Inpatient stay; or
- Homebound.

Covered Expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled Nurses make to ensure Your proper care, which means they are not on site for more than four hours at a time. If You are discharged from a Hospital or Skilled Nursing Facility after an Inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when:
  - It is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
  - It is ordered by a Physician;
  - It is not delivered for the purpose of assisting with activities of daily living, including but not limited to, dressing, feeding, bathing or transferring from a bed to a chair; and
  - It requires clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened if You are not progressing in goal-directed rehabilitation services or discharge rehabilitation goals.

Four hours = one visit; the Plan allows up to three visits per date of service (the maximum number of hours per day is 12 hours).

Benefits for Home Health Care visits are payable up to the Home Health Care Maximum shown in the Schedule of Benefits. Each visit by a Nurse or therapist is one visit.

In figuring the maximum visits, each visit of up to four hours is one visit. This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time Inpatient; and
- Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are not met, Covered Expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care Services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the Covered Person is a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family Covered Person or caregiver present in the home to meet the person's non-skilled needs.

Home Health Care Limits

Unless specified above, not covered under this benefit are Charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with You, or who is a member of Your or Your spouse's or Your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

The Plan does not cover Custodial Care, even if care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.

Refer to Your the Schedule of Benefits for details about any applicable Home Health Care visit maximums.

Benefits for Home Health Care visits are payable up to the Home Health Care Maximum. Each visit by a Nurse or therapist is one visit.

Hormone Replacement Therapy

If prescription drugs are covered, such coverage will include expenses incurred for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause or as prescribed by Your physician for use within the approved package label for the drug and/or a recognized treatment for an indication in standard reference compendia or in the clinical literature.

Hospice Care Services

Charges made for a Covered Person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Bed and Board and Services and Supplies;
- by a Hospice Facility for services provided on an Outpatient basis;
- by a Physician for professional services;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such Charges would have been payable under this Certificate if the Covered Person had remained or been Confined in a Hospital or Hospice Facility.
- Up to three (3) bereavement sessions, including assessment of the needs of the bereaved family and development of a care Plan to meet those needs, both prior to and following the Covered Person's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means Your spouse, children, stepchildren, parents, and siblings.

The following Charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of Your family or Your Dependent's family or who normally resides in Your house or Your Dependent's house;
- for any period when You or Your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under this Certificate;
- for services or supplies that are primarily to aid You or Your Dependent in daily living.

Infertility Services

Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.

Infusion Therapy

Infusion Therapy is covered only when Medically Necessary for the treatment of a diagnosed Illness or Injury. Infusion Therapy does not include services primarily intended for wellness enhancement, anti-aging, immune support, detoxification, metabolic optimization, performance improvement, fatigue management, or general health maintenance.

Covered Expenses include Charges made on an Outpatient basis for Infusion Therapy if the rendering Provider's bill includes fees for both medication and administration and if the services are provided by:

- A free-standing facility;
- The Outpatient department of a Hospital; or
- A Physician in his/her office or in Your home.

Services provided by facilities primarily offering elective infusion or wellness services are not covered unless required for emergency stabilization of an acute medical condition.

When You obtain Infusion Therapy medications from a Pharmacy or if they are not billed by Your Provider along with the therapy administration fee, You should submit Your claims for medications under the Prescription Drug benefits, rather than the medical benefits.

Infusion Therapy is the intravenous or continuous administration of medications or solutions that are a part of Your course of treatment. Charges for the following Outpatient Infusion Therapy services and supplies are Covered Expenses:

- The pharmaceutical when administered in connection with Infusion Therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives). Hydration therapy is covered only when required for the treatment of an acute Illness or Injury and not when provided for elective, preventive, or comfort purposes.

Not included under this Infusion Therapy benefit are Charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for Inpatient Infusion Therapy is provided under the Plan's Inpatient Hospital and Skilled Nursing Facility benefits.

Benefits payable for Infusion Therapy will not count toward any applicable Home Health Care maximums.

Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Mastectomy and Related Procedures

Benefits are payable for hospital and professional services under this Plan for mastectomy for the treatment of breast cancer as described in the previous pages. If the Covered Person elects breast reconstruction in connection with such mastectomy, benefits will also be provided for Covered Expenses for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the policy definition of "Medically Necessary."

Benefits will be payable on the same basis as any other Illness or Injury under the Policy.

Newborn Care

For newborn enrollment information, please see the "Who Is Eligible For Coverage?" section.

Plan benefits and provisions will apply, subject to the child's own applicable Copayment, Calendar Year Deductible and coinsurance requirements, and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending Provider in consultation with the mother.

Hospital Care
Benefits for these services are subject to Your Certificate year Deductible and coinsurance when You use a facility.

The Newborn Care benefit covers Hospital nursery care as determined necessary by the attending Provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a Hospital and Outpatient or emergency room services for Medically Necessary treatment of a Sickness or Injury.

Group health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, this restriction does not apply in any case where the decision to discharge the mother or her newborn child before the expiration of the minimum length of stay is made by an attending Provider in consultation with the mother.

Professional Care
Benefits for services received in a Provider's office are subject to the terms of the Professional Visit benefit. Well-baby exams in the Provider's office are covered under the Preventive Care benefit. This benefit covers:

- Inpatient newborn care, including newborn exams
- Follow-up care consistent with accepted medical practice that is ordered by the attending Provider, in consultation with the mother. Follow-up care includes services of the attending Provider, a home health agency and/or a registered Nurse.
- Circumcision

Inpatient Professional Care
Benefits for these services are subject to Your Certificate year Deductible and coinsurance when services are provided by an attending Provider.

Outpatient Professional Visits
You pay the Copayment as stated in the Schedule of Benefits per visit in an office setting when You use a Provider.

When You see a Provider outside an office setting, benefits are subject to Your Certificate year Deductible and coinsurance.

Please Note: Attending Provider as used in this benefit means a Physician (M.D. or D.O.), a Physician's assistant, a certified Nurse midwife (C.N.M.), a licensed midwife or an advanced registered Nurse practitioner (A.R.N.P.).

This benefit does not cover immunizations and Outpatient well-baby exams. See the Preventive Care benefit for coverage of immunizations and Outpatient well-baby exams.

Obesity Treatment
Covered Expenses include Charges made by a Physician, licensed or certified dietician, nutritionist or Hospital for the non-surgical treatment of obesity for the following Outpatient weight management services:

- An initial medical history and physical exam; or
- Diagnostic tests given or ordered during the first exam

The Plan covers Inpatient or Outpatient Charges made by a Hospital or a Physician for the Medically Necessary surgical treatment of Morbid Obesity. Bariatric surgery must be approved in advance by claims Administrator.

Covered Expenses include one Morbid Obesity surgical procedure within a two-year period, beginning with the date of the first Morbid Obesity surgical procedure, unless a multi-stage procedure is planned.

The Plan does not cover

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of Obesity or clinically severe (Morbid) Obesity; and
- bariatric surgery when done for cosmetic reasons; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

Organ Transplant Services
The Transplants benefit is not subject to a separate benefit maximum other than the maximums for donor costs described below. This benefit covers medical services only if provided by Providers or "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about Approved Transplant Centers.

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered Experimental or Investigational for the treatment of Your condition. (Please see the "Definitions" section in this Certificate for the definition of "Experimental/Investigational" services.) We reserve the right to base coverage on all of the following:

Organ transplants and bone marrow/stem cell reinfusion procedures must meet Our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of organ transplants and bone marrow/stem cell reinfusion procedures that currently meet Our criteria for coverage are:

- Heart

- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

For the purposes of this Plan, the term "transplant" does not include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

- Your medical condition must meet Our written standards.
- The transplant or reinfusion must be furnished in an Approved Transplant Center, (an "Approved Transplant Center" is a Hospital or other Provider that has developed expertise in performing organ transplants, or bone marrow or stem cell reinfusion, and is approved by Us.) Whenever medically possible, We will direct You to an Approved Transplant Center that We have contracted with for transplant services.

If none of Our centers or the Approved Transplant Centers can provide the type of transplant You need, this benefit will cover a transplant center that meets written approval standards set by Us.

The following services are included in the Transplant Services benefits:

- **Inpatient Facility Services** – Benefits for services in a facility or an approved transplant center are subject to Your Certificate year Deductible and Coinsurance.

- **Inpatient Professional and Surgical Services** – Benefits for a Provider or an approved transplant Provider are subject to Your Certificate year Deductible and Coinsurance.

- **Outpatient Surgical Facility Services** – Benefits for a facility or an Approved Transplant Center are subject to Your Certificate year Deductible and Coinsurance.

- **Outpatient Professional Visits** – You pay the Copayment as stated in the Schedule of Benefits per visit in an office setting to a Provider or an approved transplant Provider. Please see the Schedule of Benefits section of this Certificate for details about the professional office visit Copayment.

  When a professional visit is not provided in an office setting, benefits are subject to Your Participating Provider Certificate year Deductible and Coinsurance.

- **Other Outpatient Professional Services** – Benefits for a Provider or an approved transplant Provider are subject to Your Deductible and Coinsurance.

- **Recipient Costs** – This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the Inpatient or Outpatient stay in which the transplant was performed.

- **Donor Costs –** Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

This benefit does not cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that is not covered under this benefit, or for a recipient who is not a Covered Person.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless We determine they are not Experimental/Investigational services (please see the "Definitions" section in this Certificate).
- Personal care items.
- Transportation and Lodging
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future.

Preventive and Primary Care for Children (Up To Age 18)

Payment will be provided for Covered Expense for the following services for a Covered Person under the age of 19 Years.

1. Childhood immunizations and routine physical examination associated with the immunization, including Physician services.
2. Medically appropriate laboratory tests, procedures and radiology services in connection with the examination.
3. Routine hearing and vision tests and Physician services in connection with those tests. (Hearing tests will include screening tests for newborns, including auditory brainstem response, otoacustic emissions or other appropriate nationally recognized screening test.)

Preventive and Primary Care for Children shall specifically provide coverage for:

1. measurements, sensory screening, neuro-psychiatric evaluation and developmental screening, including unlimited visits for minor children up to age 12 Years and 3 visits per Year for minor children ages 12 Years up to 18 Years of age; and
2. hereditary and metabolic screening at birth, urinalysis, tuberculin tests, hemacrit, hemoglobin and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy, as recommended by a physician.

Preventative Care For Adults: (Age 19 and Older)

Payment will be provided for services listed in the Schedule of Benefit for a Covered Person age 19 and older.

The Medical Necessity of the listed services, the frequency and age appropriateness of each listed service, will be based on the guidelines as set by the American Cancer Society.

The Medical Necessity of covered vaccinations will be based on guidelines listed in the most recent Adult Immunization Schedule published by the Centers for Disease Control (CDC).

Services and Supplies Provided by a Skilled Nursing Facility

Benefits for Skilled Nursing Facility services are limited as stated in the Schedule of Benefits.

For any eligible condition that is Insurer Authorized, the Insurer will pay Covered Expenses for Inpatient services and supplies provided by the Skilled Nursing Facility except private room charges above the prevailing two-bed room rate of the facility.

Payment of benefits for Skilled Nursing Facility services are subject to **all** of the following conditions:

1. The Covered Person must be referred to the Skilled Nursing Facility by a Physician.
2. Services must be those, which are regularly provided and billed by a Skilled Nursing Facility.
3. The services must be consistent with the Covered Person's Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury.
4. The Covered Person must remain under the active medical supervision of a Physician treating the Illness or Injury for which he/she is confined in the Skilled Nursing Facility.

Note: No benefits will be provided for:

1. Personal items, such as TV, radio, guest trays, etc.
2. Skilled Nursing Facility admissions in excess of 50 days per Calendar Year.

Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or Preventive Treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple Outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Sterilization

The Plan includes benefits for tubal ligation or vasectomy.

Telehealth

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

Equipment costs and transmission costs associated with Telehealth are not reimbursable.

Temporomandibular Joint (TMJ) Disorders

Benefits for medical and dental services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical or dental condition. Treatment of TMJ disorders is not covered under the Dental Rider, if included.

This benefit includes coverage for Inpatient and Outpatient facility and professional care, including professional visits.

Medical and dental services and supplies are those that meet all of the following requirements:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case.
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food.
- Recognized as effective, according to the professional standards of good medical or dental practice.
- Not Experimental or Investigational, as determined by Us according to the criteria stated under "Definitions," or primarily for cosmetic purposes.

Treatment of specified therapies, including acupuncture and chiropractic care

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: chelation, massage and hearing 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: 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.

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 while covered under this Policy:

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

Loss of one hand or loss of one foot means the actual severance through or above the wrist or ankle joints. Loss of the sight of one eye means the entire and irrecoverable loss of sight in that eye.

If more than one of the losses stated above is due to the same Accident, the Insurer will pay 100% of the Principal Sum. In no event will the Insurer pay more than the Principal Sum for loss to the Covered Person due to any one Accident.

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.

The Principal Sum is stated in Schedule of Benefits.

Special Limitations/Expenses Not Covered

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.

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 Benefit

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

1. A return to the Covered Person's permanent residence, or if appropriate, to a health care facility nearer to their permanent residence. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case. Transportation must be by the most direct and economical route.
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 needs to be medically supervised 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 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.

Repatriation of Mortal Remains Benefit

If a Covered Person dies, while living or traveling outside of his/her home country, the Insurer 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 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.

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 31 days after the Termination Date.

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

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. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
4. A Covered Person on an organ transplant list prior to enrollment will not be eligible for transport for that transplant.
5. 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.
6. 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 Arrangement Benefit

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 Schedule of Benefits 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 living or traveling outside of their Home Country while covered under this Certificate of Coverage.

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

Excluded Services

The Plan does not provide benefits for:

1. Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage except as described in the Extension of Benefits
2. Hospitalization, services and supplies that are not Medically Necessary.
3. Services or supplies that are not specifically mentioned in this Certificate
4. Services related to pregnancy or maternity care other than for Complications of Pregnancy.
5. We will not pay for surrogacy or any related treatment. We will not pay for Maternity Care/Obstetrical Services or treatment for a beneficiary acting as a surrogate or anyone acting as a surrogate for a beneficiary.
6. Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits.
7. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government whether or not that payment or benefits are received.
8. Conditions caused by or contributed by: (a) An act of war; (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) A Covered Person participating in the military service of any country; (d) A Covered Person participating in an insurrection, rebellion, or riot; (e) 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.
9. Services or supplies that do not meet accepted standards of medical and/or dental practice.
10. Investigational Services and Supplies and all related services and supplies.
11. Routine physical examinations, unless otherwise specified in this Certificate.
12. Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of Mental Illness.
13. Cosmetic Surgery and related services and supplies, whether or not for psychological purposes, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases that occur after your Coverage Date.
14. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
15. Charges for failure to keep a scheduled visit or charges for completion of a claim form.
16. 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 (except when joined to braces) or shoe inserts, including orthotics; 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
17. Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Certificate.
18. Blood derivatives that are not classified as drugs in the official formularies.
19. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Certificate.
20. Treatment to change the refraction of one or both eyes (laser eye correction), including refractive keratectomy (RK) and photorefractive keratectomy (PRK).
21. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this Plan as shown in the Schedule of Benefits section. A hearing aid is any device that amplifies sound.
22. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
23. Routine foot care, except for persons diagnosed with diabetes, 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.
24. Immunizations, unless otherwise specified in this Certificate.
25. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
26. Non-medical counseling or ancillary services, including but not limited to Custodial Care services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, 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.
27. Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case-finding, research studies, screening, or similar procedures and studies, or tests which are Investigational unless otherwise specified in this Certificate.

28. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
29. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Certificate.
30. Investigational or experimental organ transplantation including animal to human organ transplants.
31. Consultations performed by you, your spouse, parents or children.
32. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this Plan.
33. Charges for the services of a standby Physician.
34. Medical and surgical services, initial and repeat, intended for the treatment or control of Obesity, except for treatment of clinically severe (Morbid) Obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of Obesity or clinically severe (Morbid) Obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
35. Treatment for hair loss.
36. Growth hormone treatment for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
37. Dental treatment, dental surgery, dental prostheses and orthodontic treatment unless otherwise specified in this Certificate.
38. 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.
39. Medical aids unless otherwise specified in this Certificate.
40. Services and treatment related to elective abortions.
41. Infertility, Assisted Reproduction And Sterilization Reversal
    a. Treatment of infertility, including procedures, supplies and drugs;
    b. Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof.

    Please Note: This exclusion does not apply to the diagnosis of infertility or the surgical correction or a condition causing infertility. This would be treated the same as any other medical condition.
42. Expenses incurred for, or related to gender reassignment surgery.
43. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
44. Non-prescription drugs.
45. Nutritional counseling or food supplements, except for treatment of Phenylketonuria (PKU) and other inherited metabolic diseases and diabetes.
46. Telephone, e-mail, and Internet consultations unless specifically approved by the Administrator due to limited resources while located in a country outside of the United States.
47. 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

Benefits are not available for any services received on or within 6 months after the Eligibility Date of a Covered Person if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to a Newborn that is enrolled within 31 days of birth, a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption.

Exception: The Insurer will credit time a Covered Person was covered by Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of Coverage under this Plan, excluding the Waiting Period.

This limitation does not apply to the Emergency Medical Transportation, the Repatriation of Mortal Remains and to the Emergency Family Travel Arrangements Benefits.

VII. Prescription Drug Benefits

Covered Expenses

If You or any one of Your Dependents, while insured for Prescription Drug Benefits, incurs expenses for Charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a practitioner licensed to prescribe, We will provide coverage for those expenses as shown in the Schedule of Benefits. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to You or Your Dependents by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

You may avoid higher out-of-pocket expenses by choosing a Participating Pharmacy. In addition, You may also reduce Your costs by asking Your practitioner licensed to prescribe, and Your pharmacist, for the more cost-effective generic form of Prescription Drugs. Refer to the Schedule of Benefits to determine Your Copayment, Coinsurance and Deductible (if any) amounts.

Note: Your Copayments and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Our designated Pharmacy benefits manager from Drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Us from Our designated Pharmacy benefits manager.

Administered by a Medical Provider

This Plan also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an Outpatient facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Participating Provider orders the Drug and administers it to You and is paid as a Medical Expense

Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self-Administered Injectable Drugs) are covered under the Prescription Drug Benefits.

Conditions of Service

To be a covered service, the Prescription Drug or medicine must be:

1. Prescribed in writing by a practitioner licensed to prescribe and dispensed within one Calendar Year of being prescribed, subject to federal, state laws or local jurisdictional rules;
2. To be a Covered Expense, the Prescription Drug or medicine must be prescribed for use within the approved package label for the drug and/or a recognized treatment for an indication in standard reference compendia or in the clinical literature. Any coverage for use outside of the approved package label shall also include Medically Necessary services associated with the administration of the drug;
3. To be a Covered Expense, the Prescription Drug or medicine must not be listed or used for any exclusions or limitations contained in this entire Plan;
4. If purchased outside of the United States, the purchase and distribution is subject to the local laws and local jurisdictional responsibilities;
5. For the direct care and treatment of the Covered Person's Sickness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included;
6. Purchased from a licensed retail or mail order Pharmacy;
7. Not prohibited by law.

What Is Covered

1. Prescription Drugs from either a retail Pharmacy or Our mail order Pharmacy;
2. Prescription Contraception and devices;
3. Smoking Cessation drugs;
4. Specialty Drugs;
5. Self-Administered Injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectable and infused Drugs that need Provider administration and/or supervision are covered under the medical portion of this Plan by Medical Provider benefit;
6. Self-injectable insulin and supplies and equipment used to administer insulin including syringes;
7. Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;
8. Appropriate pain management medications for terminally ill patients.

Definitions

To understand the Your Prescription Drug Benefits, it may be helpful to review these important terms:

Compound Drugs or Compound Medicines means a compounded prescription that is the result of mixing two or more drug ingredients into a final dosage form (tablet, capsule, liquid, suspension, cream, ointment, gel, etc.). The act of compounding is a practice in which a licensed pharmacist, a practitioner licensed to prescribe, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.

Drugs (Prescription Drugs) means: a drug which has been approved by the Food and Drug Administration (FDA) for safety and efficacy; certain drugs approved under the FDA's Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

For purposes of this benefit, insulin is considered a Prescription Drug.

Fixed Dose Combination Drugs means manufactured fixed dose combination medicines that because of unique formulation characteristics permits market exclusivity for these medicines and single source brand drug status.

Injectable Drug is a drug that can put into the body with a needle or syringe. The medicine is put under the skin, or into a vein.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with Us at the time services are rendered. The Covered Person will be responsible for a larger portion of the pharmaceutical bill when the Covered Person goes to a Non-Participating Pharmacy.

Participating Pharmacy is a retail Pharmacy with which We or Our designee have contracted to provide prescription services to Covered Persons, or a designated home delivery Pharmacy with which We or Our designee have contracted to provide home delivery prescription services to Covered Persons. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

Pharmacy means a licensed retail Pharmacy, or a home delivery (mail order) Pharmacy.

Prescription means a written order by a practitioner licensed to prescribe.

Specialty Drugs are "bioengineered" oral or injectable medicines that target and treat complex medical conditions including: blood disorders, cancers, Infertility, hormone or enzyme deficiencies, multiple sclerosis, rheumatoid arthritis, and a growing list of obscure or "orphan" diagnoses. Specialty drugs are complex compounds and some have unique "handling" requirements. The FDA in selected situations has required dispensing from a single Pharmacy or a limited set of "approved" pharmacies. Some Specialty Drugs are oral tablets or capsules while others require injection.

Limitations

Each Prescription Order or refill shall be limited as follows:

1. up to a consecutive 90-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
2. up to a consecutive 90-day supply at a mail order Pharmacy, unless limited by the drug manufacturer's packaging; or
3. to a dosage and/or dispensing limit as determined by the Pharmacy &Therapeutics (P&T) Committee.
4. the prescription cannot be for longer than the Covered Person is enrolled in the plan
5. The drug or medicine must **not** be used while the Covered Person is an inpatient in any facility.

Important Details about Prescription Drug Coverage

The Prescription Drug coverage under this benefit Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, the prescribing practitioner may be asked to provide more information before a decision regarding Medical Necessity can be determined. Quantity and or age limits may be set for specific Prescription Drugs or use recommendations made as part of the Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List or formulary, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when You fill a Prescription, and will also be told about any details We would need to decide benefits.

Drug Utilization Review

Prescription Drug benefits include utilization review of Prescription Drug usage for Your health and safety. Certain Drugs may require prior authorization. Also, a Participating Pharmacist can help arrange prior authorization or dispense an Emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify Your personal practitioner licensed to prescribe and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Step Therapy
Step therapy is a process in which You may need to use one type of drug before We will cover another. We or Our Administrator will check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a practitioner licensed to prescribe decides that a certain Prescription Drug is needed, the prior authorization will apply.

Day Supply and Refill Limits
Certain day supply limits apply to Prescription Drugs as listed in the Schedule of Benefits. In most cases, You must use a certain amount of Your Prescription (e.g., 85%) before it can be refilled.

Prior Authorization for Specialty Drugs, Compound Drugs and/or Fixed Dose Combination Drugs
Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We or the Administrator will contact Your Provider to get the details they need to decide if prior authorization should be given. We or the Administrator will give the results of our decision to both You and Your Provider. The prior authorization process is also used to approve requests from Your Provider for contraceptive methods that are Medically Necessary for You based on Your medical or personal history.

Prior authorization procedures and requirements for coverage are based on clinical need and therapeutic rationale. Administration of the prior authorization process considers the desired outcome for the patient, the design of the drug benefit, the value to Us, and all statutory and regulatory requirements. The process offers the prescriber an opportunity to justify the therapeutic basis for the prescribed medication and receive information concerning the acceptance and payment of claims for a particular drug.

You may need to try a Drug other than the one originally prescribed if We determine that it should be clinically effective for You. However, if We determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to You after You make the required Copayment. (If, when You first become enrolled, You are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for Your medical condition and You underwent a prior authorization process under a prior Plan which required You to take different Drugs, We will not require You to try a Drug other than the one You are currently taking.)

The prior authorization review process is outlined below:
1. A rejected Prescription Drug claim will initiate a request for prior authorization with a request for patient demographic and necessary clinical data of the practitioner licensed to prescribe.
2. Our Pharmacy Benefit Manager (PBM) reviews available data and determines:
   a. Information provided is sufficient to make a determination;
   b. Information provided is insufficient to make a determination and initiates fax request for necessary clinical data to prescribing practitioner within 24 hours following receipt of review request.
3. Review of historic medication claim data, standard clinical references and clinical data/information received from the practitioner licensed to prescribe.
4. Match of available data and information with labeled indication(s) for prescribed medication requiring authorization and against generally accepted clinical authorization criteria.
5. A recommendation to accept claims for payment will be made in writing and provided to Us and removal of Prior Authorization criteria in the Rx claim system will be completed.
6. A recommendation to not accept claims for payment will be made in writing and will be provided to Us, the practitioner licensed to prescribe, the Prescription Drug claims processor and the Covered Person.
7. Review and recommendation to be completed within 48 hours following receipt of clinical data from practitioner.

If prior authorization is denied You have the right to file a grievance as outlined in Section VIII.

For a list of Drugs that need prior authorization, please call the telephone number listed on Your ID Card or visit www.bcbsglobalsolutions.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which drugs are covered under the Prescription Drug 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. Dietary supplements, cosmetics, health or beauty aids.
4. 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.
5. Drugs taken while the Eligible Participant or Eligible Dependents are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility.
6. 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).
7. Durable medical equipment, devices, appliances and supplies.
8. Immunizing agents, biological sera, blood, blood products or blood plasma.
9. Anti-malarial drugs, unless the Covered Person has been diagnosed with malaria.
10. Oxygen.
11. Professional charges in connection with administering, injecting or dispensing of Drugs.
12. Drugs and medications dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctor's offices.
13. Drugs used for cosmetic purposes.
14. Drugs used for the primary purpose of treating infertility.
15. Drugs used for the purpose of treating hair loss.
16. Drugs to increase or enhance sexual performance or treat sexual dysfunction including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.
17. Anorexiants or Drugs associated with weight loss.
18. Allergy desensitization products, allergy serum.
19. 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.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
21. Drugs used to enhance athletic performance.
22. Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent.
23. Glucagon-like peptide-1 (GLP-1) agonists class of drugs except if prescribed for treatment of diabetes.
24. Antihistamines
25. The replacement of lost or stolen Prescription Drugs.

Reimbursement/Filing a Claim

For Prescription Drugs or Related Supplies purchased inside the United States, when You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, and you have purchased the optional Prescription Drug rider, You pay any applicable Copayment, or Coinsurance and/or Deductible shown in the Schedule of Benefits at the time of purchase. You do not need to file a claim form.

If you have not purchased the optional Prescription Drug rider, or If You or Your Dependents purchase Your Prescription Drugs or Related Supplies through a Non-Participating Pharmacy, You must pay the full cost at the time of purchase and then submit a claim form with a receipt showing the drug, quantity purchased and cost of the drug to be reimbursed.

For Prescription Drugs or Related Supplies purchased outside of the United States, You must pay the full cost at the time of purchase and then submit a claim form with a receipt showing the drug, quantity purchased and cost of the drug to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery (mail order) Participating Pharmacy, contact customer service for assistance.

VIII. General Provisions

Coordination of Benefits: This section applies if You or any one of Your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan. For claims incurred within the United States, You should file all claims under each plan. For claims incurred outside the United States, if You file claims with more than one plan, You must indicate, at the time of filing a claim under this Plan that You also have or will be filing Your claim under another plan.

Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits or services for medical, dental or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan
A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted Providers, and that limits or excludes benefits provided by Providers outside of the panel, except in the case of emergency or if referred by a Provider within the panel.

Primary Plan
The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan
A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to You.

Allowable Expense
A necessary, reasonable and customary service or expense, including Deductibles, coinsurance or Copayments that is covered in full or in part by any Plan covering You. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If You are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If You are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If You are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If Your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher coinsurance percentage, a Deductible and/or a penalty) because You did not comply with Plan provisions or because You did not use a preferred Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-certification of admissions or services.

Claim Determination Period
A calendar year, but does not include any part of a year during which You are not covered under this Certificate or any date before this section or any similar provision takes effect.

Reasonable Cash Value
An amount which a duly licensed Provider of health care services usually Charges patients and which is within the range of fees usually charged for the same service by other health care Providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules
A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers You as an enrollee or an employee shall be the Primary Plan and the Plan that covers You as a Dependent shall be the Secondary Plan;
- If You are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If You are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

- then, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with custody of the child;
- then, the Plan of the parent not having custody of the child, and
- finally, the Plan of the spouse of the parent not having custody of the child.

- The Plan that covers You as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers You as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers You is issued out of the state whose laws govern this Certificate, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination,
- The Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered You for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan
If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans for a Claim are not more than 100% of the total of all Allowable Expenses.

When the Allowable Expenses incurred for a Covered Person in any Claim are less than the sum of:
a. the benefits that would be payable under This Plan without applying the Coordination of Benefits provision; and
b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions benefit;

The benefits described in a. of this section will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

Recovery of Excess Benefits
If 4 Ever Life International Limited pays Charges for benefits that should have been paid by the Primary Plan, or if 4 Ever Life International Limited pays Charges in excess of those for which We are obligated to provide under the Certificate, 4 Ever Life International Limited will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

4 Ever Life International Limited will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If We request, You must execute and deliver to Us such instruments and documents as We determine are necessary to secure the right of recovery.

Right to Receive and Release Information
4 Ever Life International Limited, without consent or notice to You, may obtain information from and release information to any other Plan with respect to You in order to coordinate Your benefits pursuant to this section. You must provide Us with any information We request in order to coordinate Your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, You will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligible Insured Participants
Covered Persons eligible for Medicare receive the full benefits of this Plan, except for those Covered Persons listed below:
1. Covered Persons who are receiving treatment for end-stage renal disease following the first 30 months such Covered Persons are entitled to end-stage renal disease benefits under Medicare, regardless of group size.
2. Covered Persons who are entitled to Medicare benefits as disabled persons, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 100 or more Employees (subject to COBRA legislation).
3. Covered Persons who are entitled to Medicare for any other reason, unless the Covered Persons have a current employment status, as determined by Medicare rules, through a Group of 20 or more Employees (subject to COBRA legislation).

In cases where exceptions 1, 2 or 3 apply, We will determine Our payment and then subtract the amount of benefits available from Medicare. We will pay the amount that remains after subtracting Medicare's payment. Please note, We will not pay any benefit when Medicare's payment is equal to or more than the amount which We would have paid in the absence of Medicare.

For example: Assume exception 1, 2 or 3 applies to the Covered Person, and he/she is billed for $100 of Covered Expense. And assume in the absence of Medicare, We would have paid $80. If Medicare pays $50, We would subtract that amount from the $80 and pay $30. However, if in this example, Medicare's payment is $80 or more, We will not pay a benefit.

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 Covered Person subject to the following:

1. The Insured Participant agrees to advise the Insurer, in writing, within 60 days of any Covered 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 Covered 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 Covered 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:

Blue Cross Blue Shield Global Solutions
Attn: Appeals Department
933 First Avenue
King of Prussia, PA 19406
+1 610 470 2440 / Toll Free: 866 306 0169

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 provisions of the certificate will be governed by and construed under the laws of Pennsylvania without regard to conflict of law provisions of such jurisdiction.

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 Blue Cross Blue Shield Global Solutions
933 First Avenue
King of Prussia, PA 19406
+1 610 470 2440 / Toll Free: 866 306 0169

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.

4 Ever Life International Limited
Wessex House
45 Reid Street, 3rd & 4th Floor
P.O. Box HM 3352
Hamilton HM, Bermuda

Administrative Office:
Blue Cross Blue Shield Global Solutions℠
933 First Avenue
King of Prussia, Pennsylvania 19406

Prescription Drug Rider – Optional

The Covered Services under this Rider are covered if the Participant has selected and paid the premium for the benefits outlined in this Rider.

The Schedule of Benefits found in Section I Schedule of Benefits is hereby amended to remove the Prescription Drugs Benefits described and replaced with the following Prescription Drug Benefits:

Prescription Drug Benefits	Deductible is not applicable. The Copayment stated below up to a Calendar Year maximum of $25,000
Pharmacy – Outside the U.S. Maximum 90-day supply	Deductible is not applicable. 100% of the actual charge
Pharmacy – Inside the U.S. Maximum 90-day supply	Deductible is not applicable. The Copayment stated below
1. Generic Drugs	All except a $10 Copayment per prescription, per 30-day supply
2. Brand name Drugs	All except a $10 Copayment per prescription, per 30-day supply
3. Injectables	All except a 30% Copayment per Prescription, per 30-day supply

All other provisions found in Section VII, Prescription Drug Benefits, including the Conditions of Service, Definitions, Limitations and Prescription Drug Exclusions and Limitations apply

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life International Limited

PRESIDENT

4 Ever Life International Limited
Wessex House
45 Reid Street, 3rd & 4th Floor
P.O. Box HM 3352
Hamilton HM, Bermuda

Administrative Office:
Blue Cross Blue Shield Global Solutions℠
933 First Avenue
King of Prussia, Pennsylvania 19406

Dental & Vision Care Rider – Optional

The Covered Services under this Rider are covered if the Participant has selected and paid the premium for the benefits outlined in this Rider.

The benefits of this section are subject to all of the terms and conditions of this Rider and of the Certificate this Rider is attached to. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Dental Care	Deductible not applicable. Subject to a maximum Covered Expenses of $1,500 per Calendar Year
Preventive Dental Services	100% of Actual Cost
Primary Dental Services	80% of Actual Cost
Major Dental Services	50% of Actual Cost Major Dental Services are not covered during the first 3 months the Covered Person is insured.
Orthodontic Dental Care *Limited to Covered Persons under age* 19	No Deductible. 50% of Actual Cost up to a Lifetime Maximum of $1,000 Orthodontic expenses are not covered during the first 3 months the Covered Person is insured.
Vision Care	Deductible not applicable. 70% of Covered Expenses per Calendar Year up to a maximum of $250 for Vision Care that is not the result of an Injury or Illness.

Dental Care

Description of Covered Services

Covered Services

The following section lists covered dental services. We may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Us.

The Covered Services under this dental rider are classified as Diagnostic and Preventive, Basic, Major and Orthodontic services. The lists of services that relate to each type are outlined in the following pages under "Description of Covered Services". These services are covered once all of the following requirements are met. It is important to understand all of these requirements so You can make the most of Your dental benefits.

Benefits are available for the services described in this Plan that are furnished for a covered dental condition. Such services must meet all of the following requirements:

- They must be Dentally Necessary (see definition of "Dentally Necessary");
- They must be named in this Plan as covered;
- They must be furnished by a licensed Dentist (D.M.D. or D.D.S.) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law. (These providers are referred to as "Dental Care Providers."); and
- They must not be excluded from coverage under this benefit

At times We may need to review diagnostic materials such as dental X-rays to determine Your available benefits. These materials will be requested directly from Your Dental Care Provider. If We are unable to obtain necessary materials, the Plan will provide benefits only for those dental services We can verify as covered.

Alternative Benefits

To determine benefits available under this Plan, We consider alternative procedures or services with different fees that are consistent with acceptable standards of dental practice. In all cases where there is an alternative course of treatment that is less costly, the Plan will only provide benefits for the treatment with the lesser fee. If You and Your Dental Care Provider choose a costlier treatment, You are responsible for the additional charges beyond those for the less costly alternative treatment.

Diagnostic and Preventive Services

- Routine oral examinations are limited to 2 per 12 consecutive months. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations;
- Emergency oral examinations. (Please see the "Definitions" section for the definition of a Dental Emergency.) Services that are determined to be routine will be limited to 2 per 12 consecutive months;
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per 12 consecutive months;
- Topical application of fluoride is covered for Covered Persons under the age of 20. They are limited to 2 treatments per 12 consecutive months;
- X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months;
- Bitewing X-rays – Only 2 charges per person per 12 consecutive months;
- Space maintainers, for Covered Persons under the age of 20;
- Sealants, for Covered Persons under the age of 19, are limited to use on permanent teeth; and
- Oral pathology laboratory services, not including the removal of tissue sample, is covered when directly related to teeth and gums.

Basic Services

- Simple extractions;
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, and diagnosis and treatment of cysts and abscesses;
- Dentally Necessary injectable drugs administered in a dental office;
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance;
- Stainless steel crowns are limited to one per tooth every 2 calendar years;
- Non-surgical treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Periodontal scaling and root planing and sub-gingival curettage is limited to a total of 2 full-mouth treatments in any 12 consecutive months;
- Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, polishing, periodontal evaluation and review of oral hygiene, is limited to 4 visits per calendar year;
- Repair and re-cementing of crowns, inlays, bridgework and dentures;
- Emergency palliative treatment. We require a written description and/or office records of services provided;
- General anesthesia in a Dental Care Provider's office, when Dentally Necessary. This includes Covered Persons who are under the age of 7 or are disabled physically or developmentally;
- Osseous surgery, which includes gingivectomy, gingivoplasty, and gingival flap procedures;
- Endodontic (root canal) treatment;
- Benefits for root canals performed in conjunction with over-dentures are limited to 2 per arch;
- Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on Our review of the services rendered; and
- X-rays done in conjunction with a root canal. The primary periapical x-ray for diagnostic purposes is covered. Additional X-rays are limited to the allowance for the root canal therapy.

Major Services

Major Dental Services/expenses are not covered during the initial period the Covered Person is insured as stated in the Schedule of Benefits.

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings would not adequately restore the teeth;
- Replacement inlays, onlays, laboratory-processed labial veneers and crowns, but only when:
  - The existing restoration was seated at least 5 years before replacement; or
  - The service is a result of an Injury as described under "Dental Care Services For Injuries";
- Occlusal guards, for bruxism (grinding) only. Limited to 1 every 3 rolling years;
- Initial placement of dentures;
- Initial placement of fixed bridgework (including inlays, onlays and crowns to form abutments);

- Replacement dentures and fixed bridgework, but only when:
  - The existing denture or bridgework was installed at least 5 years before replacement;
  - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement; or
  - Re-preparation of the natural tooth structure under the existing fixed bridgework is required as a result of an Injury to that structure, and such repair is performed within 12 months of the injury as described under "Dental Care Services For Injuries";
- Relining and rebasing of dentures when performed 6 or more months after denture installation. Charges for relines, rebases and adjustments performed during the first 6 months following denture installation are limited to the allowance for the denture;
- Tooth build-ups for covered onlays and crowns, including bridge abutments;
- Precision attachments.

Orthodontic Services - *Limited to Covered Persons under age 19*
Orthodontic expenses are not covered during the initial period the Covered Person is insured as stated in the Schedule of Benefits.

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Dentally Necessary orthodontic care can be beneficial to generally prevent disease and promote oral health. To be considered Dentally Necessary orthodontic care, at least one of the following must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items (a) through (d) above, there is an overall orthodontic problem that interferes with the biting function.

You or Your orthodontist should send Your treatment plan to Us to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited treatment. Treatments which are not full treatment cases and are usually done for minor tooth movement;
- Interceptive treatment. A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment;
- Comprehensive (complete) treatment. Full treatment includes all radiographs, diagnostic casts or models, appliances and visits;
- Removable appliance therapy. An appliance that is removable and not cemented or bonded to the teeth;
- Fixed appliance therapy. A component that is cemented or bonded to the teeth; and
- Other complex surgical procedures. Surgical exposure of impacted or un-erupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before You were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or Outpatient Hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for Your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six-month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating Orthodontist should send a pre-treatment estimate to Us. An Estimate of Benefits form will be sent to You and Your Orthodontist indicating the estimated maximum allowed amount, including any amount You may owe. This form serves as a claim form when treatment begins.

When treatment begins, the Orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After We have verified Your Plan benefit and Your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to You and Your Orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Expenses Not Covered

This section of Your booklet explains circumstances in which benefits of this Plan are limited or not available. Benefits can also be affected by Your eligibility. Some benefits may also have their own specific limitations.

Limited and Non-Covered Services

In addition to the specific limitations stated elsewhere in this Plan, this Plan does not cover:

1. **Benefits From Other Sources -** Benefits are not available under this Plan when coverage is available through:
   a. Motor vehicle medical/dental or motor vehicle no-fault;
   b. Personal injury protection (PIP) coverage;
   c. Commercial liability coverage;
   d. Homeowner policy;
   e. Other types of liability insurance; or
   f. Worker's Compensation or similar coverage.
2. **Benefits That Have Been Exhausted -** Amounts that exceed the maximum benefit for a covered service.
3. **Broken Appointment Charges -** Amounts that are billed for broken or late appointments.
4. **Charges For Records Or Reports -** Separate charges from Providers for supplying records or reports, except those We request for utilization review.
5. **Cosmetic Services**
   a. Treatment of congenital malformations, except when the Covered Person is an eligible Dependent child; or
   b. Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and after effects thereof. This exclusion does not apply to services and supplies covered under the Orthodontia benefit, if this Plan includes that benefit.
6. **Dental Services Received From a:**
   a. Dental or medical department maintained for employees by or on behalf of an Employer; or
   b. Mutual benefit association, labor union, trustee, or similar person or group.
7. **Dietary Services -** Dietary planning for the control of dental caries, oral hygiene instruction and training in preventive dental care.
8. **Experimental Or Investigational Services -** Any service or supply that We determine is Experimental or Investigational on the date it's furnished, and any direct or indirect complications and after effects thereof. Our determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Definitions" section in this booklet).

   If We determine that a service is Experimental or Investigational, and therefore not covered, You may appeal Our decision. Please see the "What If I Have A Question Or An Appeal?" section in this booklet for an explanation of the appeals process.
9. **Extra Or Replacement Items -** Extra dentures or other appliances, including replacements due to loss or theft.
10. **Facility Charges -** Hospital and ambulatory surgical center care for dental procedures.
11. **Family Members Or Volunteers**
    a. Services or supplies that You furnish to yourself or that are furnished to You by a Provider who lives in Your home or is related to You by blood, marriage, or adoption. Examples of such providers are Your spouse, parent or child.
    b. Services or supplies provided by volunteers.
12. **Home-Use Products -** Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.
13. **Increase Of Vertical Dimension -** Any service to increase or alter the vertical dimension.
14. **Military And War-Related Conditions, Including Illegal Acts -** This includes:
    a. Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto;
    b. A Covered Person's commission of an act of riot or insurrection; or
    c. A Covered Person's commission of a felony or act of terrorism
15. **Multiple Providers -** Services provided by more than one Dental Care Provider for the same dental procedure.
16. **No Charge Or You Do Not Legally Have To Pay**
    a. Services for which no charge is made, or for which none would have been made if this Plan were not in effect; or
    b. Services for which You do not legally have to pay, unless benefits must be provided by law.
17. **Non-Standard Techniques -** Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

18. **Not Covered Under This Plan**
    a. Services that are not listed in this booklet as covered or that are directly related to any condition, service or supply that is not covered under this Plan;
    b. Services received or ordered when this Plan is not in effect, or when You are not covered under this Plan (including services and supplies started before Your Effective Date or after the date coverage ends), except for major services and root canals that:
        - Were started after Your Effective Date and before the date Your coverage ended under this Plan; and
        - Were completed within 30 days after the date Your coverage ended under this Plan.

    The following are deemed service start dates:
    - For root canals, it's the date the canal is opened;
    - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the preparation date;
    - For partial and complete dentures, it's the impression date.

    The following are deemed service completion dates:
    - For root canals, it's the date the canal is filled;
    - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it's the seat date;
    - For partial and complete dentures, it's the seat or delivery date.

19. **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.

20. **Not Dentally Necessary -** Services that are not Dentally Necessary (see definition of "Dentally Necessary").

21. **Orthodontia Services -** Orthodontia, including casts, models, X-rays, photographs, examinations, appliances, braces and retainers are only covered under the Orthodontia benefit, if this Plan includes that benefit. This exclusion does not apply to extractions incidental to orthodontic services.

22. **Oral Surgery** for the following procedures:
    a. Surgical services related to a congenital malformation;
    b. Surgical removal of complete bony impacted teeth;
    c. Excision of tumors or cyst of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of, the temporomandibular joints.

23. **Orthognathic Surgery (Jaw Augmentation or Reduction) -** Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.

24. **Outside The Scope Of A Provider's License Or Certification -** Services or supplies that are outside the scope of the Provider's license or certification, or that are furnished by a Provider that is not licensed or certified by the state in which the services or supplies were received.

25. **Prescription Drugs -** Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.

26. **Temporomandibular Joint (TMJ) Disorders -** Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and after effects thereof.

27. **Testing And Treatment Services -** Testing and treatment for mercury sensitivity or that are allergy-related.

28. **Work-Related Conditions -** Any Sickness, condition or Injury arising out of or in the course of employment, for which the Covered Person is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
    a. Occupational coverage required or voluntarily obtained by the Employer;
    b. State or federal workers' compensation acts; or
    c. Any legislative act providing compensation for work-related Sickness or Injury.

    This exclusion does not apply to owners, partners or executive officers who are full-time Employees of the Group if they are exempt from the above laws and if the Group does not furnish them with workers' compensation coverage. They will be covered under this Plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this Plan.

Vision Care

The Insurer will pay for Covered Expenses per Calendar Year as stated in the Schedule of Benefits for routine Vision Care that is not the result of an Injury or Illness. The Deductible is not applicable.

Your coverage includes benefits for vision care when You receive such care from a Physician, Optometrist or Optician. The benefits of this section are subject to all of the terms and conditions of the Certificate. For vision care benefits to be available such care must be Medically Necessary and rendered and billed for by a Physician, Optometrist or Optician, and You must receive such care on or after Your Effective Date. In addition to the definitions of this Certificate, the following definitions are applicable to this Benefit Section:

- **Contact Lenses** means ophthalmic corrective lenses, either glass or plastic, ground or molded to be fitted directly on your eye.
- **Frame** means a standard eyeglass frame adequate to hold Lenses.
- **Lenses** means ophthalmic corrective lenses, either glass or plastic, ground or molded to improve visual acuity and to be fitted to a Frame.

Covered Services

Benefits may be provided under this Benefit Section for the following:

- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses;
- Prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms) covered up to Plan allowance;
- Frames – One frame – choice of frame covered up to Plan allowance;
- Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Special Limitations

Benefits will not be provided for the following:

1. Prescription sunglasses;
2. Medical or surgical treatment of the eyes;
3. Orthoptic or vision training and any associated supplemental testing;
4. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
5. Magnification or low vision aids;
6. Any non-prescription eyeglasses, lenses, or contact lenses;
7. Safety glasses or lenses required for employment;
8. Charges in excess of the Usual & Customary Fee for the Service or Materials;
9. Charges incurred after the Policy ends or the Covered Person's coverage under the Policy ends; and
10. Experimental or non-conventional treatment or device.

There are no other changes to the form to which this Rider is attached.

Signed for 4 Ever Life International Limited

PRESIDENT