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Ball State University
CERTIFICATE OF COVERAGE

BLANKET SHORT TERM STUDENT ACCIDENT AND SICKNESS INSURANCE

POLICY NO. 4EL-1111-16 ("the Policy")

Organization or Institution: Ball State University ("the Policyholder")

Organization's or Institution's Effective Date: August 15, 2016

Eligible Participant: See Identification Card Issued to Participant

Eligible Dependents: See Identification Card Issued to Participant

Coverage Start Date: See Identification Card Issued to Participant

This Certificate refers to an Eligible Participant and an Eligible Dependent as a "Covered Person," and to **4 Ever Life Insurance Company** as "Insurer." The Policy will be administered on behalf of the Insurer by the Administrator: "Worldwide Insurance Services, LLC".

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.

The benefits provided by this Certificate are not subject to the guaranteed renewability and portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Insured Person may not purchase insurance for a period longer than the current Period of Coverage.


 SECRETARY

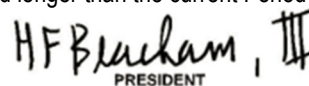

 PRESIDENT

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**SECTION 1
SCHEDULE OF BENEFITS
ELIGIBLE CLASSES**

The Classes eligible for coverage available under the Plan are shown below. The coverages applicable to a Participating Organization or Institution are as shown in the Schedule of Benefits in the copy of the sample Certificate provided to that Participating Organization or Institution.

X Class I: Regular, full-time Eligible International Participants of the educational organization or institution and their Eligible Dependents.

All benefits and limits are stated per Covered Person

**SCHEDULE OF BENEFITS
TABLE 1**

	Limits Eligible Participant	Limits Spouse	Limits Child
COVERAGE A – MEDICAL EXPENSES			
Period of Coverage Maximum Benefits	\$1,000,000	\$1,000,000	\$1,000,000
Maximum Benefit per Injury or Sicknesses	\$250,000	\$250,000	\$250,000
Period of Coverage Deductible	\$0 per Injury or Sickness	\$0 per Injury or Sickness	\$0 per Injury or Sickness
Period of Coverage Out-of-Pocket Limit Out-of-pocket Limit means the amount of Reasonable Expenses for which the Covered Person is responsible after which the Insurer pays 100% of the Reasonable Expenses, subject to the limits and provisions of the Policy.	After the Covered Person reaches a \$2,500 Out-of-pocket Limit per Period of Coverage, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a \$2,500 Out-of-pocket Limit per Period of Coverage, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-pocket Limit.	After the Covered Person reaches a \$2,500 Out-of-pocket Limit per Period of Coverage, the Insurer pays the Reasonable Expenses at 100% and up to the applicable maximums in the Tables 2 and 3. Deductibles, Copayments, and amounts above the maximums do not apply toward the Out-of-pocket Limit.
COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT	Maximum Benefit: Principal Sum up to \$10,000	Maximum Benefit: Principal Sum up to \$5,000	Maximum Benefit: Principal Sum up to \$1,000
COVERAGE C – REPATRIATION OF REMAINS	Maximum Benefit up to \$25,000	Maximum Benefit up to \$25,000	Maximum Benefit up to \$25,000
COVERAGE D – MEDICAL EVACUATION	Maximum Lifetime Benefit for all Evacuations up to \$100,000	Maximum Lifetime Benefit for all Evacuations up to \$100,000	Maximum Lifetime Benefit for all Evacuations up to \$100,000
COVERAGE E – BEDSIDE VISIT	Up to a maximum benefit of \$1,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person	Up to a maximum benefit of \$1,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person	Up to a maximum benefit of \$1,500 for the cost of one economy round-trip air fare ticket to, and the hotel accommodations in, the place of the Hospital Confinement for one (1) person

**SCHEDULE OF BENEFITS
TABLE 2**

COVERAGE A – MEDICAL EXPENSES	PPO Plan In PPO Limits+	PPO Plan Outside PPO Limits
Physician Office Visits*	100% of Reasonable Expenses after \$20 Copayment per visit	80% of Reasonable Expenses
Inpatient Hospital Services not including Emergency Hospital Services	100% of Reasonable Expenses after \$50 Copayment per visit	80% of Reasonable Expenses
Hospital and Physician Outpatient Services	100% of Reasonable Expenses after \$50 Copayment per visit	80% of Reasonable Expenses
Emergency Hospital Services	100% of Reasonable Expenses after \$50 Copayment per visit. If admitted to Hospital, then 100% of Copayment Waived	80% of Reasonable Expenses

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

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

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

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

**SCHEDULE OF BENEFITS
TABLE 3
COVERAGE A – MEDICAL EXPENSE BENEFITS**

BENEFITS LISTED BELOW ARE SUBJECT TO

- 1. TABLE 1, PERIOD OF COVERAGE MAXIMUMS, MAXIMUMS PER INJURY AND SICKNESS, DEDUCTIBLES, COINSURANCE, OUT-OF-POCKET MAXIMUMS;**
- 2. TABLE 2 PLAN TYPE LIMITS (PPO)**

MEDICAL EXPENSES	Limits per Covered Person
Maternity Care for a Covered Pregnancy	Reasonable Expenses
Inpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to \$10,000 Maximum per Period of Coverage for a maximum period of 30 days per Period of Coverage
Outpatient treatment of mental and nervous disorders including drug or alcohol abuse	Reasonable Expenses up to a \$1,000 Maximum per Period of Coverage for a maximum period of 30 visits per Period of Coverage
Outpatient back and spine treatment (including modalities)	Reasonable Expenses up to a Maximum of 20 visits on an Outpatient basis
Treatment of specified therapies, including acupuncture and Physiotherapy	Reasonable Expenses up to a Maximum of 20 visits on an Outpatient basis
Annual cervical cytology screening for women 18 and older	Reasonable Expenses
Low dose mammography screening, one baseline mammogram and one mammogram per year.	Reasonable Expenses
Medical treatment arising from participation in intercollegiate, interscholastic or club sports	Reasonable Expenses up to \$10,000 Maximum per Period of Coverage. Injuries from participation in intramural sports are covered as any other Injury
Repairs to sound, natural teeth required due to an Injury	100% of Reasonable Expenses up to \$500 Maximum Period of Coverage
Outpatient prescription drugs including oral contraceptives and devices	Prescription Drug Program with the Copayment stated below. Limited to a 31 day supply for initial fill or refill.
1. Generic Drugs	All except a \$10 Copayment per prescription
2. Brand Name Drugs	All except a \$20 Copayment per prescription
3. Injectables	All except a \$10 Copayment per prescription

MEDICAL EXPENSES	Limits per Covered Person
Medical treatment received in the Home Country, if NOT covered by Other Plan	100% of Reasonable Expenses up to \$1,000 Period of Coverage maximum
Hearing Services	Reasonable Expenses up to \$1,000 per individual hearing aid per ear every 3 years for covered Dependent Children under age 24.
Scalp Prosthesis	Reasonable Expenses for scalp hair prosthesis for up to \$500 per Period of Coverage
Lead Screening	Reasonable Expenses
Low Protein Food Products	Reasonable Expenses

**SECTION 2
DESCRIPTION OF COVERAGES
COVERAGE A – MEDICAL EXPENSES**

- A. What the Insurer Pays for Covered Medical Expenses:** If a Covered Person incurs expenses while insured under the Plan due to an Injury or a Sickness, the Insurer will pay the Reasonable Expenses for the Covered Medical Expenses listed below. All Covered Medical Expenses incurred as a result of the same or related cause, including any Complications, shall be considered as resulting from one Sickness or Injury. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit for the Eligible Participant or the Maximum Benefit for an Eligible Dependent stated in Coverage A - Medical Expenses of Table 1 of the Schedule of Benefits. Benefits are subject to the Deductible Amount, Coinsurance, Copayments, and Maximum Benefits stated in the Schedule of Benefits, specified benefits and limitations set forth under Covered Medical Expenses, the General Policy Exclusions, the Pre-existing Condition Limitation, the Recognized Student Health Center provision and to all other limitations and provisions of the Policy.
- B. Covered General Medical Expenses and Limitations:** Covered Medical Expenses are limited to the Reasonable Expenses incurred for services, treatments and supplies listed below. All benefits are per Injury or Sickness unless stated otherwise.

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

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

1. Physician office visits.

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

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

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

- 3. Emergency Hospital Services:** Emergency Hospital Services are Emergency Medical Care delivered in a Hospital emergency room as defined in this Policy. If there is no admission to the Hospital, there will be a Copayment as stated in the Schedule of Benefits.
- 4. Recognized Student Health Centers:** The Policy does not cover the cost of treatment or services that are provided normally without charge by Policyholder' Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Policyholder, including team Doctor and trainers or any other service performed at no cost. No premium charged is charged for any such treatment.

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

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

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

1. Pregnancy: The Insurer will pay the actual expenses incurred as a result of pregnancy, childbirth, miscarriage, or any Complications resulting from any of these, except to the extent shown in the Schedule of Benefits. Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:

- a. A minimum of 48 hours of inpatient care following a vaginal delivery; or
- b. A minimum of 96 hours of inpatient care following delivery by cesarean section.

If the physician, in consultation with the mother, determine that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the physician in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- a. Parental education;
- b. Assistance and training in breast or bottle feeding; and
- c. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

2. Annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older: The cervical cytology screening includes an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services in connection with examining and evaluating the Pap smear.

3. Mammography screening, when screening for occult breast cancer is recommended by a Physician: Coverage is as follows:

- a. female Covered Persons are allowed one baseline mammogram;
- b. female Covered Persons are allowed a screening mammogram annually; (Mammograms are not subject to the deductible provision.);

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

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

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

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

8. Breast Reconstruction due to Mastectomy: If breast reconstruction is required in connection with a covered mastectomy, benefits will also be provided for Covered Expenses for the following:

- a. Reconstruction of the breast on which the mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- c. Prosthesis; and
- d. Treatment for physical complications of all stages of mastectomy, including lymphedemas.

9. Repairs to sound, natural teeth required due to an Injury: Benefits are payable for dental care for an Accidental Injury to natural teeth that occurs while the Insured Person is covered under this Plan, subject to the following:

- a. services must be received during the six months following the date of Injury;
- b. no benefits are available to replace or repair existing dental prostheses even if damaged in an eligible Accidental Injury; and
- c. damage to natural teeth due to chewing or biting is not considered an Accidental Injury under this Plan.

In addition, the Plan 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.

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

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

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

- E. Hearing Aids for Covered Dependent Children:** The Insurer will pay the provider the Reasonable Expense for covered Dependent Children who are less than 24 years of age for Medically Necessary Hearing Aids.
- F. Scalp Prosthesis:** The Insurer will pay the provider the Reasonable Expense for scalp prosthesis that is Medically Necessary for hair loss suffered as a result of alopecia areata, resulting from autoimmune disease.
- G. Lead Screening:** The Insurer will pay the provider the Reasonable Expense for lead poison screening for Covered Persons at 12 months of age and benefits for screening and diagnostic evaluations for Covered Persons under age 6 who are at risk for lead poisoning in accordance with guidelines set forth by the Division of Public Health.
- H. Low Protein Food Products:** The Insurer will pay the provider the Reasonable Expense for low protein food products for the treatment of inherited metabolic diseases, if the low protein food products are Medically Necessary. Inherited Diseases shall mean a disease caused by the inherited abnormality of body chemistry.

SECTION 3 COVERAGE B – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Insurer will pay the benefit stated below if a Covered Person sustains an Injury in the Country of Assignment resulting in any of the losses stated below within 364 days after the date the Injury is sustained:

Loss	Benefit
Loss of life	100% of the Principal Sum
Loss of one hand	50% of the Principal Sum
Loss of one foot	50% of the Principal Sum
Loss of sight in one eye	50% of the Principal Sum

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

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

The Principal Sum is stated in Table 1 of the Schedule of Benefits.

There is no coverage for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.

SECTION 4 COVERAGE C – REPATRIATION OF REMAINS BENEFIT

If a Covered Person dies, while traveling outside of his/her home country during the School Year, 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 the Plan. However, if the Covered Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Covered Person's Confinement ends or 31 days after the Termination Date. The Insurer will not pay any claims under this provision unless the expense has been approved by the Plan Administrator before the body is prepared for transportation.

This benefit is available only to Covered Persons who are living outside of their Home Country while engaged in educational activities.

SECTION 5 COVERAGE D – MEDICAL EVACUATION BENEFIT

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

attending physician on the Covered Person's medical conditions. The decision of these designated physicians shall be conclusive in determining the need for medical evacuation services.

Transportation shall not be considered medically necessary if the physician designated by the Administrator determines that the Covered Person can continue his/her trip or can use the original transportation arrangements that he/she purchased.

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

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

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

For persons in the U.S., transportation home will be paid for only as a result of a Covered Injury or Sickness that prevents the Covered Person from continuing his/her scholastic program or covered trip. For Covered Dependents not enrolled in an educational program, transportation home will be covered only as a result of a Covered Injury or Sickness which prevents the Covered Dependent from remaining in the U.S. with the Eligible Participant.

All evacuations must be approved and coordinated by Administrator designated physicians. Transportation must be by the most direct and economical route.

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

The combined benefit for all necessary evacuation services is listed in Table 1 of the Schedule of Benefits.

SECTION 6 COVERAGE E – BEDSIDE VISIT 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 Table 1 of the Schedule of Benefits for the cost of one economy round-trip air fare ticket to, and the and 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 Member 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 more than one (1) visit may be made during any Period of Coverage. No benefits are payable unless the trip is approved in advance by the Plan Administrator.

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

SECTION 7 LIMITATIONS

A. Pre-existing Condition Limitation

The Insurer does not pay benefits for loss due to a Pre-existing Condition during the first 6 months of coverage. Pre-existing Conditions will be covered after the Covered Person's coverage has been in force for 6 months; however, a Pre-Existing Injury or Sickness covered after the Pre-Existing waiting period, will be subject to the same limitations and exclusions as an Injury or Sickness incurred during Coverage under this Plan. The origin, cause, or nature of the Pre-Existing Injury or Sickness will be used to determine the applicable Coverage, limitations, and exclusions.

This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.

SECTION 8 GENERAL POLICY EXCLUSIONS

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

1. Expenses incurred in excess of Reasonable Expenses.
2. Services or supplies that the Insurer considers to be Experimental or Investigative.

3. Expenses incurred prior to the beginning of the current Period of Coverage or after the end of the current Period of Coverage except as described in Covered General Medical Expenses and Limitations and Extension of Benefits.
4. Preventative medicines, routine physical examinations, or any other examination where there are no objective indications of impairment in normal health, unless otherwise noted.
5. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or Injury, unless otherwise noted.
6. Surgery for the correction of refractive error and services and prescriptions for eye examinations, eye glasses or contact lenses or hearing aids, except when Medically Necessary for the Treatment of an Injury or as specifically covered under the Plan.
7. Plastic or cosmetic surgery, unless they result directly from an Injury which necessitated medical treatment within 24 hours of the Accident.
8. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided for in the Plan.
9. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and performed while the Plan is in effect.
10. For diagnostic investigation or medical treatment for infertility, fertility, or birth control.
11. Reproductive and infertility services.
12. Expenses incurred for, or related to sex change surgery or to any treatment of gender identity disorders.
13. Organ or tissue transplant.
14. While traveling against the advice of a Physician, while on a waiting list for a specific treatment, or when traveling for the purpose of obtaining medical treatment.
15. The diagnosis or treatment of Congenital Conditions, except for a newborn child insured under the Policy.
16. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction's of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia, unless otherwise noted.
17. Expenses incurred in connection with weak, strained or flat feet, corns or calluses.
18. Diagnosis and treatment of acne.
19. Expenses incurred as a result of immunizations, vaccinations or vitamins.
20. Diagnosis and treatment of sleep disorders.
21. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays.
22. Expenses incurred for the repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices.
23. Deviated nasal septum, including submucous resection and/or surgical correction, unless treatment is due to or arises from an Injury.
24. Expenses incurred for any services rendered by a family member or a Covered Person's immediate family or a person who lives in the Covered Person's home.
25. Unless specifically provided for elsewhere under the Policy, the cost of treatment or services that are provided normally without charge by the Policyholder's Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Policyholder, including team Doctor and trainers or any other service performed at no cost.
26. Loss due to war, declared or undeclared; service in the armed forces of any country or international authority and participation in a riot or civil commotion.
27. Riding in any aircraft, except as a passenger on a regularly scheduled airline or charter flight.
28. Loss arising from
 - a. participating in any professional sport, contest or competition;
 - b. Racing or speed contests;
 - c. skin/scuba diving, sky diving, mountaineering (where ropes are customarily used), ultra light aircraft, parasailing, sail planning, hang gliding, parachuting, or bungee jumping.
29. Medical Treatment Benefits provision for loss due to or arising from a motor vehicle Accident if the Covered Person operated the vehicle without a proper license in the jurisdiction where the Accident occurred.
30. Under the Accidental Death and Dismemberment provision, for loss of life or dismemberment for or arising from an Accident in the Covered Person's Home Country.
31. Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
32. Hearing aids. Except as specifically covered under the Plan.
33. Routine hearing tests except as provided under Preventive and Primary Care.
34. Expenses covered under any Other Plan

SECTION 9 DEFINITIONS

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

Accident (Accidental) means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury.

Age means the Covered Person's attained age.

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

Ambulatory Surgical Facility means an establishment which may or may not be part of a Hospital and which meets the following requirements:

1. Is in compliance with the licensing or other legal requirements in the jurisdiction where it is located;
2. Is primarily engaged in performing surgery on its premises;
3. Has a licensed medical staff, including Physicians and registered nurses;
4. Has permanent operating room(s), recovery room(s) and equipment for Emergency Medical Care; and
5. Has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

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

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

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

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

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

Copayment means the dollar amount of Reasonable Expenses for Medically Necessary services, treatments and supplies which the Insurer does not pay and which the Covered Person is responsible for paying. The dollar amount which the Covered Person must pay is stated in the Schedule of Benefits.

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

Covered Medical Expense means an expense actually incurred by or on behalf of a Covered Person for those services and supplies which are:

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

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

Deductible Amount means the dollar amount of Covered Medical Expenses which must be incurred as an out-of-pocket expense by each Covered Person on a per Injury or per Sickness basis before certain benefits are payable under the Plan. The Deductible Amounts are stated in the Schedule of Benefits.

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

Durable Medical Equipment means medical equipment which:

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

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

Eligible Dependent: An Eligible Dependent may be the Eligible Participant's lawful spouse partner and/or his/her children under age 26.

A dependent child shall include:

1. A son or daughter of the Eligible Participant less than age 26; or
2. A stepchild, child subject to legal guardianship, grandchild, or other blood relative less than age 26.

A child who becomes incapable of self-sustaining employment because of mental retardation or mental or physical disability and is chiefly dependent upon the Eligible Participant for support and maintenance before reaching the limiting age for dependent children may continue coverage after reaching the limiting age. The Company must receive proof of incapacity within 120 days after coverage would otherwise terminate. This insurance will continue for as long as the Eligible Participant's insurance stays in force and the child remains incapacitated.

An eligible dependent includes a child who is required to be provided coverage by the Eligible Participant or his spouse under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

The Eligible Dependent is one who

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

As used above:

1. The term "spouse" means the Eligible Participant's spouse as defined or allowed by the state where the Policy is issued. This term includes a common law spouse if allowed by the State where the Policy 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. as entered into a domestic partnership arrangement with the named Insured.
4. The term "domestic partnership arrangement" means the Eligible Participant and another person of the same or opposite sex has any three of the following in common:
 - a. joint lease, mortgage or deed;
 - b. joint ownership of a vehicle;
 - c. joint ownership of a checking account or credit account;
 - d. designation of the domestic partner as a beneficiary for the Eligible Participant's life insurance or retirement benefits;
 - e. designation of the domestic partner as a beneficiary of the employee's will;
 - f. designation of the domestic partner as holding power of attorney for health care; or
 - g. shared household expenses.

Eligible Participant means a person who:

1. Is engaged in international educational activities; and
2. Is temporarily located outside his/her Home Country as a non-resident alien; and
3. Has not obtained permanent residency status.

Emergency Hospitalization and Emergency Medical Care means hospitalization or medical care that is provided for an Injury or a Sickness condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain for which the absence of immediate medical attention could reasonably result in:

1. Permanently placing the Covered Person's health in jeopardy; or
2. Causing other serious medical consequences; or
3. Causing serious impairment to bodily functions; or
4. Causing serious and permanent dysfunction of any bodily organ or part.

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

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

Hearing Aid means any nonexperimental wearable instrument or device designed for the ear and offered for purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords and other assistive listening devices such as 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.

Hospital means a facility that:

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

Immediate Family means the spouse, children, brothers, sisters, parents or grandparents of a Covered Person.

Injury means bodily injury caused directly by an Accident. It must be independent of all other causes. A Sickness is not an Injury. A bacterial infection that occurs through an Accidental wound or from a medical or surgical treatment of a Sickness is an Injury.

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

The Insurer means 4 Ever Life Insurance Company which is a nationally licensed and regulated insurance company.

Intensive Care Facility means an intensive care unit, cardiac care unit or other unit or area of a Hospital:

1. Which is reserved for the critically ill requiring close observation; and
2. Which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

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

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

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

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

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

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

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

Out-of-Pocket Limit means the amount of Reasonable Expenses which the Covered Person must pay after which the Insurer pays 100% of the reasonable Expenses, subject to the limits and provisions of the Plan.

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

Participating Organization or Institution means a preparatory or high school; an institution of higher learning offering a course of general studies leading to a bachelor's degree, master's degree or doctorate; a part of a university offering a specialized group of courses; or an institution offering instruction in a professional, vocational, or technical field which has elected that its Eligible Participants and, if applicable, the dependents of those Eligible Participants be covered under the Plan and which has been accepted by the Insurer for coverage under the Plan.

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

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

Period of Coverage means the period beginning on the Covered Person's effective date. It ends on the earlier of:

1. The date the Covered Person's insurance under the Plan ends; or
2. The last day of the current School Year as defined by the Participating Organization or Institution; or
3. 364 days from the Covered Person's effective date at 11:59 PM.

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

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

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

Pre-Existing Condition means any Injury or Sickness for which a Physician was consulted or for which treatment or a medication was recommended or received up to 6 months prior to the Covered Person's effective date of coverage.

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

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

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

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

School Year means the period of time commencing on the first day of the fall semester and ending on the last day of the spring semester as defined date determined by the Organization or Institution.

Sickness means an illness, ailment, disease, or physical condition of a Covered Person that is not caused by an injury.

Total Disability or Totally Disabled

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

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

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

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

**SECTION 10
EXTENSION OF BENEFITS**

No benefits are payable for medical treatment benefits after a Covered Person's insurance terminates. However, if the Covered Person is in a Hospital on the date the insurance terminates, the Insurer will continue to pay the medical treatment benefits until the earlier of the date the Confinement ends or 31 days after the date the insurance terminates.

If the Insurer terminates the Policy, coverage will be extended for a Covered Person who:

1. Is Totally Disabled on the date coverage ends.

Coverage under this provision is provided only for Covered Medical Expenses with respect to:

1. A Totally Disabled Covered Person, for the condition causing the Total Disability.

Coverage so extended will end on the first of the following to occur:

1. The 90th day following termination of the Policy; or
2. The date the Total Disability ends.

Except as stated above, coverage is not provided for any expense incurred after the date the Covered Person's insurance terminates.

This coverage extension will not apply to termination initiated by any Covered Person, Participating Organization or Institution or the Policyholder.

SECTION 11
COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any policy year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance, accidental death and dismemberment, or disability benefits.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Definitions.

- A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **The order of benefit determination rules** determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.
- When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
- D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

- E. **Closed panel plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B. 1. Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 2. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
 - c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
 3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
 4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
 5. **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
 6. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of This Plan. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive And Release Needed Information. Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. The Insurer may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The Insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Insurer any facts it needs to apply those rules and determine benefits payable.

Facility of Payment. A payment made under another Plan may include an amount that should have been paid under This plan. If it does, the Insurer may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The Insurer will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Insurer is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 12 ELIGIBILITY REQUIREMENTS AND PERIOD OF COVERAGE

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

Enrollment for Coverage: An Eligible Participant and their Eligible Dependents will be eligible for coverage under the Plan subject to the particular types and amounts of insurance as specified in his/her enrollment form. If dependent coverage is offered by the Organization or Institution, an Eligible Participant may also enroll his/her Eligible Dependents for coverage on the later of:

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

When an Eligible Participant's Coverage Starts: Coverage for an Eligible Participant starts at 12:01 AM on the latest of the following:

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

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

For Transfers Only: If a Covered Person transfers from a Group which has coverage under a policy issued on the same form as this plan of insurance to another Organization or Institution which also has coverage under the same policy form, or transfers from one plan to another under the same policy that person must re-enroll in the newer plan. A Preexisting Condition will not be covered under the newer plan until the benefit period expires for such condition under the prior plan (the plan under which the Covered Person was insured prior to the date of transfer). At that time, the Preexisting Condition will be covered under the newer plan. Benefit payments for Preexisting Conditions shall be the lesser of:

1. The unused portion of the maximum benefit applicable to the covered medical condition under the prior plan; or
2. The maximum benefit applicable to the covered medical condition under this plan.

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

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

1. The date the Policy terminates;
2. The Organization's or Institution's Termination Date;
3. The date of which the Eligible Participant ceases to meet the Individual Eligibility Requirements
4. The end of the term of coverage specified in the Eligible Participant's enrollment form;

5. The date the Eligible Person permanently leaves the Country of Assignment for his/her or her Home Country;
6. The date the Eligible Participant requests cancellation of coverage (the request must be in writing); or
7. The premium due date for which the required premium has not been paid, subject to the Grace Period provision.
8. The end of any Period of Coverage.

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

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

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

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

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

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

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

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

Renewing Coverage: 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. There is a 31 day grace period in which to pay the premium due. Any Covered Person whose coverage under the Policy lapses may not re-apply until the next enrollment period and shall be subject to all Policy exclusions as of any subsequent effective date.

SECTION 13 COVERAGE OF NEWBORN INFANTS AND ADOPTED CHILDREN

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

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

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

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

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

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

SECTION 14 CLAIM PROVISIONS

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

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

Proofs of Loss: Written proof of loss must be furnished to the Insurer or to its Administrator within 90 days after the date of loss. However, in case of claim for loss for which the Plan 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 Plan will be paid immediately upon receipt of satisfactory written proof of loss. In no event will this be more than 30 days for a claim filed electronically or 45 days for a written claim measured from the date all information needed to process the claim is received, unless the Plan provides for periodic payment. Where the Plan provides for periodic payments, the benefits will accrue and be paid monthly, subject to satisfactory written proof of loss. If the Insurer fails to pay or deny a clean claim within the specified time period and the Insurer subsequently pays the claim, the Insurer will pay interest on the claim as required by law.

Payment of Claims: Benefits for accidental loss of life under Coverage B will be payable in accordance with the beneficiary designation and the provisions of the Plan 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 Coverages A, C, D, and E shall be payable to the provider of the service. Benefits payable under Coverage B, other than for loss of life, will be paid to the Covered Person.

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

Notice to non-custodial parents: Whenever a child has coverage through a non-custodial parent, the Insurer shall: (1) provide any information to the custodial parent that is necessary for the child to obtain benefits through this coverage; (2) permit the custodial parent, or the provider of medical assistance services with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and (3) make payments on insurance claims submitted under subdivision (2) directly to the: (a) custodial parent; (b) provider of the medical assistance services; or (c) office of Medicaid policy and planning.

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

Worldwide Insurance Services, LLC/4 Ever Life Insurance Company has 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 inside the United States, Puerto Rico, or the United States Virgin Islands, 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 Worldwide Insurance Services, LLC/4 Ever Life Insurance Company and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care inside the United States, Puerto Rico, and the United States Virgin Islands, you will 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 geographic area ("Host Blue"). In some instances, you may obtain care from providers that do not contract with the Host Blue (non-participating healthcare providers). Worldwide Insurance Services, LLC/4 Ever Life Insurance Company payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Worldwide Insurance Services, LLC/4 Ever Life Insurance Company will remain responsible for fulfilling Worldwide Insurance Services, LLC/4 Ever Life Insurance Company 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 inside the United States, Puerto Rico, and the United States Virgin Islands, 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 Worldwide Insurance Services/4 Ever Life Insurance Company.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. 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/or 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 of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Worldwide Insurance Services, LLC/4 Ever Life Insurance Company uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of U.S. States may require the Host Blue to add a surcharge to your calculation. If any of these state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Non-Participating Healthcare Providers inside the U.S., Puerto Rico, and the U.S. Virgin Islands

1. Member Liability Calculation

When covered healthcare services are provided inside the United States, Puerto Rico, or the United States Virgin Islands by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue’s non-participating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment Worldwide Insurance Services, LLC/4 Ever Life Insurance Company will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, Worldwide Insurance Services, LLC/4 Ever Life Insurance Company may use other payment bases, such as billed covered charges, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-participating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the Worldwide Insurance Services, LLC/4 Ever Life Insurance Company will make for the covered services as set forth in this paragraph.

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 Plan and, in the event of death, make an autopsy in case of death, where it is not forbidden by law.

SECTION 15 GENERAL PROVISIONS

Entire Contract: The entire contract between the Insurer and the Policyholder consists of the Policy, this Certificate, the application of the Policyholder and the application of the Organization or Institution, copies of which are attached to and made a part of the Master Policy. All statements contained in the applications 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 Policy, or to extend the time for payment of premiums, or to waive any of the Insurer’s rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer’s officers and delivered to the Policyholder.

Incontestability: The validity of a Covered Person’s insurance will not be contested except for nonpayment of premium, after his/her insurance under the Plan has been continuously in force for two years during his/her lifetime. No statement made by a Covered Person relating to his/her insurability will be used in defense of a claim under the Plan unless: 1. it is contained in the enrollment form or renewal form signed by the Covered Person; and 2. a copy of the enrollment form or renewal form has been furnished to the Covered Person, or to his/her beneficiary.

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 on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of the Plan which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

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 Plan.

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 Plan 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 Plan does not satisfy any requirement for Workers' Compensation.

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

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

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

Right of Recovery: Whenever the Insurer have made payments with respect to benefits payable under the Plan 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 Policy to the extent of the overpayment.

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

Grievance Procedures: If the Covered Person's claim is denied in whole or in part, he/she will receive written notification of the denial. The notification will explain the reason for the denial.

The Covered Person has the right to appeal any denial of a claim for benefits by submitting an oral or written request for reconsideration with the Insurer. Requests for reconsideration must be filed within 60 days after receipt of the written notification of denial. The insurer will acknowledge the grievance within five business days of receipt. When the Insurer receives the Covered Person's oral or written request, the Insurer will review the claim and arrive at a determination.

There will be made available to the Covered Person, a member services representative to assist the Covered Person throughout the grievance process. The Covered Person also has a right to designate an outside independent representative to assist the covered person or the Covered Person's member services representative through the grievance process.

The insurer will respond to grievances it receives within 20 business days after the insurer receives all information reasonably necessary to complete the review. If an insurer is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the insurer's control, the insurer shall: (1) before the twentieth business day, notify the covered individual in writing of the reason for the delay; and (2) issue a written decision regarding the grievance within an additional ten (10) business days. The insurer will inform the Covered Person in writing of the decision regarding the covered person's grievance, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

All communications regarding the grievance/appeals process will be recorded, documented and maintained for at least 3 years.

If the matter is still not resolved to the Covered Person's satisfaction, he/she may appeal any grievance decision resulting in a denial, termination, or other limitation of covered health care services by requesting a second review of the claim by sending the Insurer a written request for a second reconsideration. This written request must be filed within 60 days of the Eligible Participant's receipt of the Insurer's written notification of the result of the first review. If the issue involves a dispute over the coverage of medical services, or the extent of that coverage, the second review will be completed by physician consultants who did not take part in the initial reconsideration. The Covered Person will be informed, in writing, of the Insurer's final decision.

There shall be three levels of appeal of a grievance decision.

Informal Internal Review: An Informal Internal Review shall consist of the Covered Person's right to discuss and appeal the insurer's grievance decision with the insurer's medical director or with the physician or health care provider designee who rendered the decision.

If an appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the covered person or his/her member service's representative. All other concurrent or prospective appeals conducted pursuant to this section shall be conducted by the insurer within 14 business days, unless the medical circumstances surrounding the case require the insurer to respond sooner.

If the Informal Internal Review is not concluded to the Covered Person's satisfaction, the insurer shall provide the Covered Person with a written explanation of the decision within five business days after completing the investigation, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

If still dissatisfied, the covered person or his/her member representative has a right to engage in a second level appeal.

Formal Internal Review: If dissatisfied with the Informal Internal Review decision, the Covered Person shall have a right to appeal before a reviewer or panel of physicians, or advanced practice registered nurses, or other health care professionals selected by the insurer.

The panel of reviewers selected by the insurer shall not have been involved in the initial grievance decision under review.

For all reviews which require medical expertise, the medical reviewer or in the case of a panel of reviewers, the panel shall consist of at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

A medical reviewer shall be a physician, or an advanced practice registered nurse or other appropriate health care provider possessing a non-restricted license to practice or provide care anywhere in the United States and have no history of disciplinary action or sanctions pending or taken against them by any governmental agency or professional regulatory body.

A medical reviewer shall be certified by a recognized specialty board in the areas appropriate to review.

All Formal Internal Reviews will be acknowledged by the insurer within 5 business days of receipt.

If the Formal Internal Appeal is from a determination regarding urgent or emergency care, the insurer shall conclude the appeal within 24 hours of receiving notification of appeal from the covered person or his/her member representative. All other concurrent or prospective appeals conducted pursuant to this section shall be conducted by the insurer within 30 business days, unless the medical circumstances surrounding the case require the insurer to respond sooner. The time may be extended at the request of the Covered Person or his/her member services representative.

If the Formal Internal Review is not concluded to the Covered Person's satisfaction, the insurer shall provide the Covered Person with a written explanation of the decision within five business days after completing the investigation but not later than forty-five (45) days after the appeal is filed, which shall, at a minimum, consist of:

1. The reviewer's understanding of the grievance;
2. The reviewer's decision in clear terms;
3. The contract basis or medical rationale in enough detail for the member or member representative to understand and to respond to the insurer's position; and
4. All applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal, including the right to external grievance review by an independent review organization.

If the covered person or his/her member representative is dissatisfied with the Formal Internal Review decision, he/she may pursue an external grievance.

If the insurer fails to comply with any of the deadlines for completion of a formal internal appeal, the covered person or his/her member representative shall be relieved of his/her obligations under the Formal Internal Review Process and may proceed directly to the external appeal process.

External Grievance Process: If dissatisfied with the decision rendered in a Formal Internal Review, the Covered Person may pursue an External Review before an independent review organization.

Within 45 business days from receipt of a written decision of the formal internal appeal panel, the Covered Person shall file a written request with the director for an external review along with a signed release, allowing the insurer to release medical records pertinent to the appeal.

Upon receipt of the request for an external appeal, together with the executed release form, the Director shall determine whether:

1. The individual was or is a member of the health benefits plan;
2. The health care service which is the subject of the appeal reasonably appears to be a service covered by the health benefits plan;
3. The member or member representative has fully complied with the informal and formal internal appeals processes; and

4. The member or member representative has provided all information required by the independent review organization and the

Director to make the preliminary determination, including the appeal form, and a copy of any information provided by the insurer regarding its decision to deny, reduce, or terminate a covered service, and the release form required pursuant to subsection (b) of this section.

Upon completion of the preliminary review, the Director shall notify the member or member representative and insurer in writing as to whether the appeal has been accepted for processing. If the appeal is accepted by the Director, the Director shall assign the appeal to an independent review organization for full review. If the appeal is not accepted by the Director, the Director shall provide a statement of the reasons for the non-acceptance to the member or member representative and the insurer.

The staff of the independent review organization that is assigned to the appeal shall have meaningful prior experience in performing utilization review, peer review, quality of care assessment or assurance, or the hearing of appeals. Any independent review organization, its staff, and its professional and medical reviewers, shall not have any material, professional, familial, or financial affiliation with the insurer that is a party to the appeal.

The Director may waive exhaustion of the informal and formal appeals process as a prerequisite for proceeding to the external appeals process in cases of emergency or urgent care.

The insurer shall provide timely access to all its records relating to the matter under review and to all provisions of the health benefits plan or health insurance coverage, including any evidence of coverage, "member handbook", certificate of insurance or contract and health benefits plan relating to the matter.

Upon acceptance of the appeal for processing, the independent review organization shall conduct a full review to determine whether, as a result of the insurer's decision, the member was deprived of any service covered by the health benefits plan.

The full review of an appeal of a health benefits decision shall be initially conducted by at least 2 physicians licensed to practice medicine in the District of Columbia, Maryland, or Virginia. On an exceptions basis, when necessary based on the medical, surgical, or mental condition under review, the independent review organization may select medical reviewers licensed anywhere in the United States who have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties, any applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.

The member or member representative and one insurer representative may request to appear in person before the independent review organization. The independent review organization shall conduct the hearing in the District of Columbia. The independent review organization's procedures for conducting a review, when the member or member representative or the insurer has requested to appear in person, shall include the following:

1. The independent review organization shall schedule and hold a hearing as soon as possible after receiving a request from a member or member representative or from an insurer representative to appear before the independent review organization. The independent review organization shall notify the member or member representative and insurer representative, either orally or in writing, of the hearing date and location. The independent review organization shall not unreasonably deny a request for postponement of the hearing made by the member or member representative or insurer representative.
2. A member or member representative and an insurer representative shall have the right to the following:
 - a. To attend the independent review organization hearing;
 - b. To present his or her case to the independent review organization;
 - c. To submit supporting material both before and during the hearing;
 - d. To ask questions of any representative of the independent review organization; and
 - e. To be assisted or represented by a person of his or her choice.

When necessary, the independent review organization shall consult with a physician or advance practice registered nurse trained in the same specialty or area of practice as the type of treatment that is the subject of the grievance and appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

The independent review organization shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, the independent review organization shall complete its review within 15 business days, or 72 hours in the case of an expedited appeal, from the time the Director assigns the appeal to the independent review organization. An insurer shall provide all documentation to the independent review organization within 5 days of receipt of the notice of approval of the appeal by the Director, or within 24 hours of receipt of the notice of approval of the grievance, for an expedited review. If an insurer does not provide the independent review organization all documentation required by this subsection within the time frames, or obtain the necessary extensions, the independent review organization may decide the appeal without receiving the information. The independent review organization shall extend its review for a reasonable period of time as may be necessary due to circumstances beyond its or the insurer's control, but only when the delay will not result in increased medical risk to the member. In such an event, the independent review organization shall, prior to the conclusion of the initial review period, provide written notice to the member or member representative and to the insurer setting forth the status of its review and the specific reasons for the delay.

The independent review organization shall notify the insurer and the member of their determination within 72 hours after making the determination, or 24 hours in the case of an expedited appeal.

If the independent review organization determines that the member was deprived of medically necessary covered services, the independent review organization shall recommend to the Director the appropriate covered health care services the member should receive. The Director shall forward copies of the recommendation to the member or member representative and the insurer.

When necessary, the independent review organization shall refer a case for review to a consultant physician or other health care provider in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the independent review organization shall be approved by the medical director of the independent review organization.

The decision of the independent review organization shall be binding on the insurer and shall not affect any other legal causes of action.

Upon the request of a member or member representative who is notified that the independent review organization has made a determination, the independent review organization shall provide to the member or member representative all information reasonably necessary to enable the member to understand the:

1. effect of the determination on member; and
2. manner in which the insurer may be expected to respond to the determination.

If, at any time during an external review, the member submits new information to the insurer that is relevant to the insurer's resolution of the member's appeal of a grievance decision and that was not considered by the insurer:

1. the insurer may reconsider the resolution; and
2. if the insurer chooses to reconsider, the independent review organization shall cease the external review process until the is completed.

An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of new information shall reconsider the resolution based on the information and notify the member or member representative of the insurer's decision:

1. within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the members:
 - a. life or health; or
 - b. ability to reach and maintain maximum function; or
2. within fifteen (15) days after the information is submitted, for a reconsideration not described in item 1.

If the decision reached is adverse to the member, the member or member representative may request that the independent review organization resume the external review. If an insurer to which new information is submitted (a) chooses not to reconsider the insurer's resolution, the insurer shall forward the submitted information to the independent review organization not more than two (2) business days after the insurer's receipt of the information.

This section shall not apply in cases directly involving Medicaid benefits.

Any appeal brought pursuant to this section by a member involving coverage provided pursuant to the Medicaid program shall be resolved in accordance with federal and District of Columbia laws, regulations, and procedures established for fair hearings and appeals for the Medicaid program.

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Eligible Participant or the Group because the Eligible Participant, the Group, or any person acting on the Eligible Participant's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

In the case of a reduction or a termination of services that is contrary to the recommendations of the treating physician or advance practice registered nurse, an insurer shall provide a member or member representative with 24 hours prior verbal notification, followed by a written decision as soon as practical.

The Insurer will meet any Notice requirements by mailing the Notice to the Group at the billing address listed on our records. The Group will meet any Notice requirements by mailing the Notice to the below address. **The insured may call the below toll free number to obtain information and to file a grievance:**

**4 Ever Life Insurance Company
c/o Worldwide Insurance Services, LLC
100 Matsonford Road, Building One, Suite 100
Radnor, PA 19087
Toll free: 1.844.268.2686**

Dispute Resolution

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

The Insurer shall not take any retaliatory action, such as refusing to renew or canceling coverage, against the Insured Participant and his/her Insured

Dependents or the Group because the Insured Participant's, the Group's, or any person's action on the Covered Person's or the Group's behalf, has filed a complaint against the Insurer or has appealed a decision made by the Insurer.

Important Notice

Questions regarding your policy or coverage should be directed to:

Worldwide Insurance Services, LLC

1.844.268.2686

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/doi