4 Ever Life Insurance Company
2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois 60181
(800) 621-9215

This Plan provides medical benefits while a person is temporarily away from Home. This Plan is supplemental to health insurance under a group plan that does not provide coverage while the Insured Person is outside their Home Country. It is 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 under this Plan for a Period of Insurance longer than 364 days.

The Insurance Coverage Area is any place that is outside the United States.


PRESIDENT


SECRETARY

This Certificate of Coverage is issued by 4 Ever Life Insurance Company ("Insurer") through a policy issued to HTH International Group Insurance Trust.

In this Plan, the "Insurer" means . The "Eligible Participant" is the person who meets the eligibility criteria of this Certificate. The term "Insured Person," means the Eligible Participant and any Insured Dependents.

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

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

The Insurer has issued a Policy to the Group identified on the Eligible Participant's identification card. The benefits and services listed in this Certificate of Coverage will be provided for Insured Persons for a covered Illness, Injury, or condition, subject to all of the terms and conditions of the Group's Policy.

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

Worldwide Insurance Services 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 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 payment practices in both instances are described below.

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Worldwide Insurance Services will remain responsible for fulfilling Worldwide Insurance Services 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.

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 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.

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

Following is a very brief description of the benefit schedule of the Plan. This should be used only as a quick reference tool. The entire Certificate of Coverage sets forth, in detail, the rights and obligations of both the Insured Person and the Insurer. It is, therefore, important that

The benefits outlined in the following table show the payment percentages for Covered Expenses AFTER the Insured Person has satisfied any Deductibles and prior to satisfaction of his/her Out-of-Pocket.

: T

Eligible Participants and their Eligible Dependents are the only people qualified to be covered by the Group's Policy. The following section describes who qualifies as an Eligible Participant or Eligible Dependent, as well as information on when and who to enroll and when coverage begins and ends.

1. Is a member or employee of a Group covered under the Policy.
2.

The Coverage for an Insured Person will become effective if the individual qualifies as an Eligible Participant of the Group, and the Group and/or the Eligible Participant pays the Insurer the premium. The Effective Date of the Coverage under the Plan is indicated as follows:

(See ‘Eligibility Rules’ in Section II of this Plan)

(See ‘Eligibility Rules’ in Section II of this Plan)

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

is the Group Policy the Insurer has issued to the Group.

A is a Group Health Benefit Plan, an individual health benefit plan, or a governmental health plan (including Medicare) designed to be the first payor of claims for an Insured Person prior to the responsibility of this Plan.

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

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

(See Cosmetic and Reconstructive Surgery)

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

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

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

means the United States of America.

payment of Covered Expenses is provided as defined below:

Regardless of the Insured Person's Out-of-Pocket Maximum, the Insurer pays:

1. For Ambulance Service (non Medical Evacuation), 100% up to $1,000;
2. Benefits for claims resulting from downhill (alpine) skiing and scuba diving (certification by the Professional Association of Diving Instructors (PADI) or the National Association of Underwater Instructors (NAUI) required or diving under the supervision of a certified instructor) that are Limited to the Trip Period Maximum or $10,000 whichever is less;
3. Outside Home Country for Outpatient prescription drugs 100% of Reasonable Charges for Covered Expenses;
4. Dental Care required due to an Injury, 100% of Covered Expenses up to $200 wi2(un)8(d)1en-US

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

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

No benefit is payable if the death occurs after the Termination Date of the Policy. However, if the Insured Person is Hospital Confined on the Termination Date, eligibility for this benefit continues until the earlier of the date the Insured 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 Administrator before the body is prepared for transportation.

The benefit for all necessary repatriation services is listed in the Overview Matrix.

If an Insured Person is involved in an accident or suffers a sudden, unforeseen illness requiring emergency medical service, 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 physi

means a licensed retail pharmacy. 3.

means a written order issued by a Physician.

1. Outpatient Drugs and medications that federal and/or State law restrict to sale by Prescription only.
2. Insulin.
3. Insulin syringes, needles, alcohol swabs and Glucagon.

To be entitled to receive benefits, a managing conservator of a child must submit to the Insurer with the claim form, written notice that such person is the managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured Participant where the Insured Participant has paid any portion of a medical bill that would be covered under the terms of the Plan.

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.

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:

4 Ever Life Insurance Company
2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois 60181

State of Illinois

This Endorsement is made part of the policy/certificate to which it is attached as of the effective date of such policy/certificate.

By attachment of this Endorsement, it is understood and agreed that the insurance under the policy/certificate is amended, with respect to Covered Persons residing in the state of Illinois, as follows:

1. The benefits of this Plan are provided only for those services that are Medically Necessary and for which the Insured Person has benefits. The fact that a Physician prescribes or orders a service does not, by itself, mean that the service is Medically Necessary or that the service is a Covered Expense. The Eligible Participant may consult this Certificate of Coverage or telephone the Insurer at the number shown on his/her identification card if he/she has any questions about whether services are covered.

2.

As used above:

1. The term “primary care” means that the Insured Participant provides food, clothing and shelter on a regular and continuous basis during the time that the public schools are in regular session.
2. 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.
3. The term “partner” means an Eligible Participant’s spouse or domestic partner.
4. 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.

4.

Benefits for covered losses will be paid immediately upon receipt of due written proof of loss. Any benefits payable to the Insured Participant and remaining unpaid within 30 days following receipt by the insurer of due proof of loss shall entitle the insured to interest at the