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4 EVER LIFE INSURANCE COMPANY

Schedule of Benefits

Benefit Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	
Policy Period Limit	Unlimited	
The Percentage of Covered Expenses the Plan Pays	90%	75% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	150% of Medicare Rates
Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentage of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.		
Policy Year Deductible Individual	$150	$150
Combined Medical/Pharmacy Policy Year Deductible	Yes	Yes
Out-of-Pocket Maximum Individual	$6,150	$6,150
Physician's Services		
Physician's Office Visit - Primary Care Physician	100%, No Deductible, $20 copay	75% after plan deductible
Student Health Center	90% after plan deductible	N/A
Office Visit – Specialist	100%, No Deductible, $20 copay	75% after plan deductible
Surgery Performed In the Physician's Office	90% after plan deductible	75% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	100%, No Deductible, $20 copay	75% after plan deductible
Allergy Treatment/Injections	100%, No Deductible, $20 copay	75% after plan deductible
Preventive Care Routine Preventive Care – all ages	100% not subject to plan deductible or copayments	75% after plan deductible
Immunizations – all ages	100% not subject to plan deductible or copayments	75% after plan deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to plan deductible or copayments	75% after plan deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to plan deductible or copayments	75% after plan deductible
Inpatient Hospital – Facility/Professional Charges		
Room and Board Charges	90% after plan deductible	75% after plan deductible
Physician's Visits/Consultations	90% after plan deductible	75% after plan deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90% after plan deductible	75% after plan deductible

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Benefit Highlights	In-Network	Out-of-Network
Inpatient Services at Other Heath Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Policy Year Maximum of 120 day limit.	90% after plan deductible	75% after plan deductible
Ambulatory Surgical Services		
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	90% after plan deductible	75% after plan deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90% after plan deductible	75% after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Hospital Emergency Room	90% after plan deductible Additional $150 copay per visit – waived if admitted	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate. Additional $150 copay per visit – waived if admitted
Outpatient Professional Services (radiology, pathology and ER Physician)	90% after plan deductible	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Urgent Care Facility	100% after plan deductible, $20 Copay	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	90% after plan deductible	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	90% after plan deductible	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.
Ambulance	90% after plan deductible	75% after plan deductible If true emergency, the benefit will be paid at the In-Network Rate.

Benefit Highlights	In-Network	Out-of-Network
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Independent X-ray and/or Lab Facility	90% after plan deductible	75% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Independent Facility	90% after plan deductible	75% after plan deductible
Maternity Care/Obstetrical Services		
Physician's Office visit to confirm pregnancy	100%, No Deductible, $20 copay	75% after plan deductible
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	90% after plan deductible	75% after plan deductible
Physician's Office visits in addition to the global maternity fee	100%, No Deductible, $20 copay	75% after plan deductible
Laboratory, Radiology Services and or Advance Radiological Imaging	90% after plan deductible	75% after plan deductible
Delivery Charges – Facility (Hospital, Birthing Center)	90% after plan deductible	75% after plan deductible
Termination of Pregnancy		
Medically Necessary	90% after plan deductible	75% after plan deductible
Elective	90% after plan deductible	75% after plan deductible
Infertility Expenses – Basic Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible

Benefit Highlights	In-Network	Out-of-Network
Family Planning/Contraception Management		
See benefit description for specific coverages		
For Women		
Physician's Office Visit	100% not subject to plan deductible or copayments	75% after plan deductible
Inpatient Facility	100% not subject to plan deductible or copayments	75% after plan deductible
Outpatient Facility	100% not subject to plan deductible or copayments	75% after plan deductible
Physician's Services	100% not subject to plan deductible or copayments	75% after plan deductible
For Men		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
Obesity/Bariatric Surgery		
Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese.		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
Organ Transplant Services		
Includes all medically appropriate, non-experimental transplants.		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	90% after plan deductible	Not Covered

Benefit Highlights	In-Network	Out-of-Network
Transgender Services See benefit description for covered services.		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
Nutritional Evaluation Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
Nutritional Formulas	90% after plan deductible	75% after plan deductible
Acupuncture Physician's office visit	100%, No Deductible, $20 copay	75% after plan deductible
Chiropractic Care/Spinal Manipulations Physician's office visit	100%, No Deductible, $20 copay	75% after plan deductible
Telehealth	100%, No Deductible, $20 copay	75% after plan deductible
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an injury		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
TMJ Treatment	90% after plan deductible	75% after plan deductible
Diabetic Equipment	90% after plan deductible	75% after plan deductible
Durable Medical Equipment	90% after plan deductible	75% after plan deductible
External Prosthetic Appliances	90% after plan deductible	75% after plan deductible

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Benefit Highlights	In-Network	Out-of-Network
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	90% after plan deductible	75% after plan deductible
Mental Health		
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Substance Abuse Health		
Inpatient Facility	90% after plan deductible	75% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Outpatient Facility	90% after plan deductible	75% after plan deductible
Hearing Benefit One Examination per 24 month period	100%, No Deductible, $20 copay	75% after plan deductible
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 24 months	90% after plan deductible	75% after plan deductible
Home Health Care Services Policy Year Maximum of 120 visit limit	90% after plan deductible	75% after plan deductible
Private Duty Nursing Policy Year Maximum of 120 visit limit	90% after plan deductible	75% after plan deductible
Hospice Care Services	90% after plan deductible	75% after plan deductible
Infusion Therapy		
Outpatient Facility	90% after plan deductible	75% after plan deductible
Physician's Services	90% after plan deductible	75% after plan deductible
Short Term Rehabilitative Therapy		
Physician's Office Visit	100%, No Deductible, $20 copay	75% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	75% after plan deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.		

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Prescription Drugs
Schedule of Benefits

The below section describes the coverage for Prescriptions Drugs for all Eligible Subscribers. The plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in the schedule and as described in the Prescription Drug Coverage section of this certificate. To receive Prescription Drug Benefits, the Eligible Subscriber may be required to pay a portion of the Covered Expenses. That portion includes any applicable Deductible and/or Copayments as may be applicable. Benefits are limited as described in the Prescription Drug section of this certificate and are subject to the Medical "Exclusions" section of this certificate.

Benefit Highlights	Participating Pharmacy	Non-Participating Pharmacy
Retail Prescription Drugs	Cost per 30 day Supply	Cost per 30 day Supply
Certain medications as part of preventive care services are covered at 100% with no cost sharing either through a retail drug store. Detailed information is available at www.healthcare.gov		
Tier 1, Generic*	$10 copayment, deductible does not apply	$10 copayment, after plan deductible
Tier 2, Formulary Brand-Name*	$25 copayment, deductible does not apply	$25 copayment, after plan deductible
Tier 3, Non - Formulary	$50 copayment, deductible does not apply	$50 copayment, after plan deductible
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Other Coverages	
Accidental Death & Dismemberment Benefit	Maximum Benefit: Principal Sum up to $10,000 per Insured Participant. If dependents are covered, Maximum Benefit for Spouse is a Principal Sum of $5,000 and for dependent child(ren) maximum benefit is $1,000 per child
Emergency Medical Evacuation	Unlimited
Repatriation of Mortal Remains	Unlimited
Emergency Family Travel Arrangements	Maximum Benefit up to $2,500

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Charges for preventive care, injuries or sickness incurred in your Home Country.
5. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with Urgent Care or an Emergency.
6. For or in connection with an Injury or Sickness which is due to participation in a riot, civil commotion or police action.
7. For claim payments that are illegal under applicable law.
8. Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
9. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Care or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
10. Non-Treatment Facilities, Institutions or Programs - Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations

11. For or in connection with experimental, investigational or unproven services.

    Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

12. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
13. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty for cosmetic reasons; Redundant skin surgery; Removal of skin tags for cosmetic reasons; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
14. Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Services" provision under the section COVERED EXPENSES BENEFIT DESCRIPTION.
15. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of COVERED EXPENSES BENEFIT DESCRIPTION. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
16. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
17. Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
18. Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
19. Infertility, Assisted Reproduction And Sterilization Reversal
    a. Treatment of infertility, including procedures, supplies and drugs;
    b. Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof;

    Please Note: This exclusion does not apply to the diagnosis of infertility or the surgical correction or a condition causing infertility. This would be treated the same as any other medical condition.
20. Reversal of male or female voluntary sterilization procedures.
21. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
22. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
23. Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, gym or swim therapy, legal or financial counseling, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or intellectual disabilities.
24. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
25. Family and marital counseling except when medically necessary to treat the diagnosed mental or substance use disorder or disorders of an insured Subscriber.
26. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
27. Private duty nursing except as provided under the Home Health Services provision.

28. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
29. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata or due to cancer treatment.
30. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Schedule of Benefits section. A hearing aid is any device that amplifies sound.
31. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books except as shown in the Covered Expenses section for treatment of autism.
32. Vision Treatment, eye exercise, equipment or surgery to correct eyesight, such as laser treatment, refractive keratotomy (RK) and photorefractive Keratotomy (PRK). We will pay for eligible treatment or surgery of a detached retina, glaucoma, cataracts or keratoconus.
33. Vision Exams, Lenses and Hardware, including eyeglasses, contact lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye. This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.
34. All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, Non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
35. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
36. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs or voluntary support groups.
37. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
38. Dental services or supplies except as specifically stated.
39. Orthodontia services, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces and retainers.
40. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
41. Blood administration for the purpose of general improvement in physical condition.
42. Cosmetics, dietary supplements and health and beauty aids.
43. Drugs, supplies, equipment or procedures to replace hair, slow hair loss or stimulate hair growth.
44. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
45. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
46. Expenses incurred for treatment of sport-related accidental injury resulting from professional sports or participating in any practice or conditioning program for such sport, contest or completion.
47. Consultations provided using telephone, facsimile machine, or electronic mail.

General Limitations

No payment will be made for expenses incurred for an Eligible Subscriber:

1. For charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
2. To the extent that an Eligible Subscriber is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
3. To the extent that payment is unlawful where the person resides when the expenses are incurred.
4. For charges which would not have been made if the person had no insurance.
5. To the extent that they are more than Maximum Reimbursable Charges.
6. To the extent of the exclusions imposed by any certification requirement shown in this plan.
7. Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
8. Charges made by any covered provider who is a member of your family or your Dependent's Family.