SCHEDULE OF BENEFITS – TABLE 2
MEDICAL EXPENSE BENEFITS

MEDICAL EXPENSES	Participating Provider+	Non-Participating Provider
Physician Office Visits*	100% of the Allowed Amount after a $20 Copayment per visit	80% of the Allowed Amount
Treatment at an Urgent Care Facility	100% of the Allowed Amount after a $35 Copayment per visit	80% of the Allowed Amount
Hospital and Physician Outpatient Services Pre-Certification May be Required	100% of the Allowed Amount after a $50 Copayment per visit	80% of the Allowed Amount
Inpatient Hospital Services Pre-Certification May be Required	100% of the Allowed Amount after a $50 Copayment per visit	80% of the Allowed Amount
Emergency Hospital Services	100% of the Allowed Amount after a $100 Copayment per visit. If admitted to Hospital, then 100% of Copayment Waived	80% of the Allowed Amount

+Payment of Covered Medical Expenses for Participating Providers is based on the Allowed Amount. Participating Providers have agreed to accept the Allowed Amount as payment in full.

*All Physician Visit Copayments and Deductibles for an Injury or Sickness are waived for treatment received at 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
MEDICAL EXPENSE BENEFITS

The benefits listed below are subject to coverage maximums, Deductible, Coinsurance, and Copayments listed in Tables 1 & 2 above.

MEDICAL EXPENSES	Covered Person
Maternity Care for a Covered Pregnancy Pre-Certification May be Required	Allowed Amount
Complications of Pregnancy	Allowed Amount
Inpatient treatment of mental and nervous disorders including substance abuse Pre-Certification May be Required	Allowed Amount up to $10,000 Maximum per Coverage Year for a maximum period of 30 days per Coverage Year
Outpatient treatment of mental and nervous disorders including substance abuse	Allowed Amount up to $1,000 Maximum per Coverage Year for a maximum period of 30 visits per Coverage Year.
Treatment of specified therapies, including acupuncture and Physiotherapy Pre-Certification May be Required	Allowed Amount up to 20 visits per Coverage Year on an Outpatient basis
Annual cervical cytology screening for women 18 and older	Allowed Amount
Low dose mammography screening, one baseline mammogram and one mammogram per year	Allowed Amount
Colorectal cancer screenings	Allowed Amount
Diabetic Supplies/Education	Allowed Amount
Prostate screening tests	Allowed Amount
Child Preventive and Primary Care Services	Allowed Amount
Breast Reconstruction due to Mastectomy	Allowed Amount
Repairs to sound, natural teeth required due to an Injury	Allowed Amount up to $500 per Coverage Year maximum

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MEDICAL EXPENSES	Covered Person
Outpatient prescription drugs including oral contraceptives and devices	50% of the Allowed Amount. Limited to a 31-day supply for initial fill or refill

SECTION 2
SPECIAL PLAN PROVISIONS

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

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

Pre-certification/Pre-certify

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

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

When You go to an out-of-network provider, it is Your responsibility to obtain pre-certification from Us for any services or supplies on the pre-certification services listed in this section. If you do not Pre-certify, your benefits may be reduced, or the plan may not pay any benefits.

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

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

When You go to an out-of-network provider, it is Your responsibility to obtain pre-certification from Us for any services or supplies on the pre-certification listed in this section. If you do not Pre-certify, your benefits may be reduced, You may incur a penalty, or the plan may not pay any benefits. You or a member of your family, a hospital staff member, or the attending physician, must notify Us to Pre-certify the admission or medical services and expenses prior to receiving any of the services or supplies that require pre-certification pursuant to this Booklet-Certificate in accordance with the following timelines:

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

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

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Services and Supplies that Require Pre-certification

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

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

- All Inpatient Hospital services, including: acute habilitation admissions; elective surgical and nonsurgical inpatient admissions; inpatient hospice admissions; long term acute care facility admissions; skilled nursing facility admissions.
- Stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment.
- Home Health Care Services.
- Maternity Services.
- Outpatient facility services.
- Chemotherapy.
- Outpatient private duty nursing.
- Intensive Outpatient programs including those for mental health or substance abuse treatments.
- Advanced radiological imaging, including CT and CTA scans, MRAs and MRIs, PET and PETT scans.
- Elective/non-emergency ground, air and sea ambulance transportation.
- Reconstructive procedures that might be considered cosmetic procedures: examples include, but are not limited to: blepharoplasty, bone grafts, breast reconstruction, gender reassignment surgery, rhinoplasty, surgery for varicose veins.
- Any procedure, device or service that may be conserved experimental or investigational including: new emergent technology/procedures, as well as existing technology and procedures applied for new used and treatments.
- Any durable medical equipment more than $500, including, but not limited to: insulin pumps; CPAP or Bi-PAP devices; electric, power and motorized wheelchairs; external defibrillators; speech generating devices.
- Custom prosthetics/orthoses
- Specialty Drugs – see addendum to this Certificate for a list of specialty drugs. That list is subject to change.
- Transplant services.

Case Management

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

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

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

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

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

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

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

SECTION 3
DESCRIPTION OF COVERAGES
MEDICAL EXPENSES

A. What the Insurer Pays for Covered Medical Expenses: If a Covered Person incurs expenses while insured under the Certificate due to an Injury or a Sickness, the Insurer will pay the Allowed Amount 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 Covered Person or the Maximum Benefit for an Eligible Dependent stated in the 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 Certificate Exclusions, the Pre-Existing Condition Limitation, the Recognized Student Health Center provision and to all other limitations and provisions of the Certificate.

B. Covered General Medical Expenses and Limitations: Covered Medical Expenses are limited to the Allowed Amount incurred for services, treatments and supplies listed below.

No Medical Treatment Benefit is payable for 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 plan administered by the Administrator immediately prior to the Coverage Start Date shown on the Identification Card issued to the Covered Person, 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.

   Note: When outside the United States, this benefit will provide coverage for private rooms if that is all that is available or if the choice is between a ward or a more than two person room and a private room.

3. **Emergency Hospital Services:** Emergency Hospital Services are Emergency Medical Care delivered in a Hospital Emergency room as defined in this Certificate.

4. **Urgent Care Center visits:** Care delivered at a facility or clinic that provides immediate, but not emergent, ambulatory medical care to patients. The facility should have "Urgent Care" used in its title or advertising words, that is physically separate from a hospital and is licensed in the state in which it is located.

5. **Recognized Student Health Centers:** The Certificate does not cover the cost of treatment or services that are provided normally without charge by Member's Student Health Center, covered or provided by the student health fee, rendered by a person employed by the Member, 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 the Allowed Amount with no Copayment or Deductible.

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