PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. Medical withdrawal from school due to a covered Injury which originates after the Insured's Effective Date will not void an Insured's coverage.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish proof and that such proof was furnished as soon as was reasonably possible.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for services rendered by New Hampshire health care providers will be paid within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim. If the claim is denied or pended for further information, the Company will notify the health care provider or the Insured within 15 calendar days from receipt of the claim the reason for denying or pending the claim and what, if any, additional information is required to process the claim. The Company's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III
DEFINITIONS

CLEAN CLAIM means a claim for payment of Covered Medical Expenses that is submitted to the Company on the Company's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the Company's published filing requirements.

ELECTRONIC CLAIM means the transmission of data for purposes of payment of Covered Medical Expenses in an electronic data format specified by the Company.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence (for each Injury) as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not treat an Injury. Elective Surgery or Elective Treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental based on current medical criteria established by the appropriate medical peer review organization; or 2) are not recognized and generally accepted medical practices in the United States or countries with similar medical standards.

HOSPITAL means a general hospital operated pursuant to law or legally operated which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) maintains permanent medical history records; 6) provides organized facilities for diagnosis on the premises or in facilities available to the hospital or a prearranged basis; and 7) is not primarily a clinic, nursing, rest or convalescent home.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

INJURY for which benefits are provided, means accidental bodily injuries sustained by the Insured which are the direct cause, independent of disease or bodily infirmity or any other cause and which occur while the insurance is in force.

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means health care services that are provided to an Insured in a licensed Hospital emergency facility by a provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could be expected to result in any of the following: a) serious jeopardy to the patient's health, b) serious impairment to bodily functions, c) serious dysfunction of any bodily organ or part.

Expenses incurred for "Medical Emergency" will be paid only for Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

1) Essential for the symptoms and diagnosis or treatment of the Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

NAMED INSURED means an eligible, participant of the Policyholder, if: 1) the participant is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED GRADUATE NURSE means a professional nurse (R.N.) or a licensed nurse practitioner who is not a member of the Insured Person's immediate family.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

PART IV
COVERED LOSS - TIME LIMITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 60 days after the date of Injury; and b) is received within 12 months after date of Injury.

PART V-1
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS FOR INJURY

Maximum Benefit	**$100,000**
Deductible	**$0**
Coinsurance	**None**

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	100% Usual and Customary Charges
Intensive Care:	100% Usual and Customary Charges
Hospital Miscellaneous:	$10,000 maximum
Surgery:	80% Usual and Customary Charges / $3,000 maximum
Assistant Surgeon:	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance
Registered Nurse:	100% Usual and Customary Charges
Physician's Visits:	$60 per day
Pre-admission Testing:	Paid under Hospital Miscellaneous

Outpatient

Surgery:	80% Usual and Customary Charges / $3,000 maximum
Day Surgery Miscellaneous:	$750 maximum

(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

Assistant Surgeon:	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance
Physician's Visits:	$60 per day
Physiotherapy:	$75/visit / 5 visit maximum
Medical Emergency:	$575 Maximum
X-Rays:	$300 maximum
Laboratory:	$0 maximum
Tests & Procedures:	Paid under Laboratory
Prescription Drugs:	100% Usual and Customary Charges

Other

Ambulance:	
Ground:	$500 maximum
Air:	$1,500 maximum
Durable Medical Equipment:	$500 maximum
Dental:	$2,000 maximum

(Benefits paid on Injury to Sound, Natural Teeth only.)

*AD&D:	$10,000
Replacement of eyeglasses, hearing aids or contact lenses damaged during a covered Injury, if medical treatment is also received for the covered Injury	$700 maximum

MAXIMUM BENEFIT

(x) **52 week Benefit Period**

Other Insurance: **(x) Excess Insurance Injury Only Policy**

*If benefit is designated, see endorsement attached.

PART V-2
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS FOR INJURY

Maximum Benefit	**$75,000**
Deductible	**$0**
Coinsurance	**None**

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	100% Usual and Customary Charges
Intensive Care:	100% Usual and Customary Charges
Hospital Miscellaneous:	$7,500 maximum
Surgery:	80% Usual and Customary Charges / $2,000 maximum
Assistant Surgeon:	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance
Registered Nurse:	100% Usual and Customary Charges
Physician's Visits:	$500 maximum
Pre-admission Testing:	Paid under Hospital Miscellaneous

Outpatient

Surgery:	80% Usual and Customary Charges / $2,000 maximum
Day Surgery Miscellaneous:	80% Usual and Customary Charges / $500 maximum

(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

Assistant Surgeon:	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance
Physician's Visits:	$500 maximum
Physiotherapy:	$40/visit / 5 visit maximum
Medical Emergency:	80% Usual and Customary/$400 maximum
X-Rays:	$250 maximum
Laboratory:	$0 maximum
Tests & Procedures:	Paid under Laboratory
Prescription Drugs:	100% Usual and Customary Charges

Other

Ambulance:	
Ground:	$400 maximum
Air:	$1,000 maximum
Durable Medical Equipment:	$300 maximum
Dental:	$1,500 maximum

(Benefits paid on Injury to Sound, Natural Teeth only.)

*AD&D:	$10,000
Replacement of eyeglasses, hearing aids or contact lenses damaged during a covered Injury, if medical treatment is also received for the covered Injury	$500 maximum

MAXIMUM BENEFIT

(x) **52 week Benefit Period**

Other Insurance: **(x) Excess Insurance Injury Only Policy**

*If benefit is designated, see endorsement attached.

PART V-3
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS FOR INJURY

Maximum Benefit	**$50,000**
Deductible	**$0**
Coinsurance	**None**

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	80% Usual and Customary Charges / $200 maximum per day
Intensive Care:	80% Usual and Customary Charges / $200 maximum per day
Hospital Miscellaneous:	$5,000 maximum
Surgery:	80% Usual and Customary Charges / $1,000 maximum
Assistant Surgeon:	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance
Registered Nurse:	80% Usual and Customary Charges
Physician's Visits:	$25 per day
Pre-admission Testing:	Paid under Hospital Miscellaneous

Outpatient

Surgery:	80% Usual and Customary Charges / $1,000 maximum
Day Surgery Miscellaneous:	$250 maximum

(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

Assistant Surgeon:	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance
Physician's Visits:	$25 per day
Physiotherapy:	$25/visit / 5 visit maximum
Medical Emergency:	80% Usual and Customary Charges / $200 maximum
X-Rays:	$200 maximum
Laboratory:	$0 maximum
Tests & Procedures:	Paid under Laboratory
Prescription Drugs:	80% Usual and Customary Charges

Other

Ambulance:	
Ground:	$200 maximum
Air:	$400 maximum
Durable Medical Equipment:	$150 maximum
Dental:	$1,000 maximum

(Benefits paid on Injury to Sound, Natural Teeth only.)

*AD&D:	$10,000
Replacement of eyeglasses, hearing aids or contact lenses damaged during a covered Injury, if medical treatment is also received for the covered Injury	$150 maximum

MAXIMUM BENEFIT

(x) **52 week Benefit Period**

Other Insurance: **(x) Excess Insurance Injury Only Policy**

*If benefit is designated, see endorsement attached.

SCHEDULE OF BENEFITS
OPTIONAL 24-HR DENTAL MEDICAL EXPENSE BENEFITS
INJURY ONLY BENEFITS

Optional 24-Hr. Dental Maximum Benefit	**$25,000**
Deductible	**-0-**
Coinsurance	**None**

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	No Benefits
Hospital Miscellaneous:	No Benefits
Surgery:	No Benefits
Anesthetist:	No Benefits
Registered Nurse:	No Benefits
Physician's Visits:	No Benefits
Pre-admission Testing:	No Benefits

Outpatient

Surgery:	No Benefits
Day Surgery Miscellaneous:	No Benefits

(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

Physician's Visits:	No Benefits
Medical Emergency:	No Benefits
X-Rays:	No Benefits
Laboratory:	No Benefits
Tests & Procedures:	No Benefits

Other

Dental: Injury must be treated within 60 days after the Injury occurs. Benefits are payable within 12 months after the date of Injury. When the dentist certifies that treatment must be deferred until after the 12 months in which treatment must occur, deferred benefits will be paid to a maximum of $1,000. (Benefits paid on Injury to Sound, Natural Teeth only.)

MEDICAL EXPENSE BENEFITS
MAXIMUM BENEFIT

The Maximum Benefit for all benefit coverage afforded under this policy is $25,000 for any one Injury. Covered Medical Expenses shall not include amounts paid by the Insured for coinsurance.

Other Insurance: (X) ***Excess Insurance Injury Only Policy**

PART VI
MEDICAL EXPENSE BENEFITS FOR INJURY

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

4. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this inpatient surgery benefit; or under the outpatient surgery benefit, but not both. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

5. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.

6. **Anesthetist Services:** professional services administered in connection with inpatient surgery.

7. **Registered Nurse's Services:** 1) while Hospital Confined; 2) ordered by a licensed Physician; and 3) a Medical Necessity.

8. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

9. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit.

10. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

11. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.

12. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

13. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

14. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.

15. **Physiotherapy (Outpatient):** See Schedule of Benefits.

16. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the attending Physician's charges, laboratory procedures, the use of the emergency room and supplies.

17. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays.

18. **Laboratory Procedures (Outpatient):** See Schedule of Benefits.

19. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.

20. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

21. **Ambulance Services:** See Schedule of Benefits.

22. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.

23. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

24. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

PART VII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

2. Elective Surgery or Elective Treatment;

3. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

4. Injury caused by, contributed to, or resulting from intoxication, the use of intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

5. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

6. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance in excess of $10,000;

7. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

8. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury;

9. Sickness or disease in any form;

10. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

11. Supplies, except as specifically provided in the policy;

12. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

13. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded for such period not covered when the Company is notified of the Insured's entry into the armed services of any country);

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 365 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the "Medical Benefits" provision (and under Supplemental Medical, if coverage is afforded under Supplemental Medical) provision.

For Loss Of:

Life	$10,000.00
Both Hands, Both Feet, or Sight of Both Eyes	$10,000.00
One Hand and One Foot	$10,000.00
Either One Hand or One Foot and Sight of One Eye	$10,000.00
One Hand or One Foot or Sight of One Eye	$ 5,000.00
Entire Thumb and Index Finger of Either Hand	$ 5,000.00

Loss shall mean with regard to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

EXCESS PROVISION
INJURY ONLY

No benefit of this policy is payable for any expense incurred for Injury which is paid or payable by: 1) other valid and collectible insurance; or, 2) under an automobile insurance policy.

This Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

COL-03-NH END (5A) (Rev 05-06)

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

RESOLUTION OF GRIEVANCES

The Company will notify the Insured in writing if an Insured's claim or any part of the Insured's claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent plan provision(s) on which the denial was based.

If the Insured has a complaint about a claim denial, the Insured may call our Member Services telephone number 1-800-767-0700 for further explanation to informally resolve the complaint. If the Insured is not satisfied with the explanation of why the claim was denied, the Insured, the Insured's authorized representative or provider may request an internal review of the claim denial. The Company's grievance review process is outlined below:

1) The Insured must request in writing a benefit review within 180 days after the date of receipt of the notice denying the Insured's claim. This will be an informal reconsideration review process of the claim by a Claims Supervisor. The Insured may not attend this review.

2) A decision will be made by the Claims Supervisor, within 30 days after the receipt of the Insured's request for review or the date all information required from the Insured is received.

3) If the Claims Supervisor denies the claim submitted for review and the Insured is not satisfied with the explanation for the decision, the Insured may request a first-level grievance review. The Insured is not required to attend the first level review.

FIRST LEVEL GRIEVANCE REVIEW

1) **The first level grievance material must be submitted in writing by the Insured or his/her provider for consideration by the first level reviewer.**

2) **Within 3 business days after the Company's receipt of the Insured's request for a first-level grievance review, the Company must provide the Insured with the name, address and telephone number of the grievance coordinator and information on how to submit written material.**

3) **The Insured may or may not attend this review but is not required to do so.**

4) A first level review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 20 days of the receipt of the grievance. If a decision cannot be made within 20 business days due to circumstances beyond the Company's control, the Company may take up to an additional 10 business days to issue a written decision. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review shall contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.
b. A statement of the reviewer's understanding of the grievance.
c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position.
d. A reference to the evidence or documentation used as the basis for the decision.
e. A statement advising the Insured of his or her right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance.

SECOND LEVEL GRIEVANCE REVIEW

1) **A second level grievance review is available to the Insured dissatisfied with the first level grievance review decision.**

2) Within 10 days of the receipt of the request for the second level review, the Company will provide the following information to the Insured:

a. The name, address and telephone number of the grievance review coordinator.
b. A statement of the Insured's rights, including the right to:
   i. Request and receive all information relevant to the case;
   ii. Present his/her case to the review panel;
   iii. Submit supporting material prior to and at the review meeting;
   iv. Ask questions of any member of the panel;
   v. Be assisted or represented by a person of the Insured's choosing, including a family member, employer representative or attorney.

3) The Company will convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not the Company's employees, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if the Company used a clinical peer on an appeal on a first-level grievance review panel then the Company may use one of its employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.

4) **The second level grievance review meeting will be held within 45 days of receipt of the second level review request.**

5) The Insured will receive at least 15 days notice of the second level grievance review meeting date.

6) The Insured will have the right to full review without condition of his/her attendance at the meeting.

7) A written statement of the second level grievance review panel's decision shall be issued to the Insured within 5 business days after the review meeting. The decisions shall include:

a. The professional qualifications and licensure of the members of the review panel;
b. A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
c. The review panel's recommendation to the Company and the rationale behind that recommendation;
d. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
e. In the review of a clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation;
f. The rationale for the Company's decision if it differs from the review panel's recommendation;
g. A statement that the decision is the Company's final determination in the matter; and
h. Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED GRIEVANCE REVIEW

1) **An expedited grievance review shall be provided in a situation where the time frame of the standard grievance procedures would seriously jeopardize the life or health of an Insured or would jeopardize the Insured's ability to regain maximum function. Expedited reviews shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers shall not have been involved in the initial adverse determination.**

RESOLUTION OF GRIEVANCES (Continued)

2) The Company will provide an expedited review to all requests concerning an admission, availability of care, continued stay or health care service for an Insured who has received emergency services but has not been discharged from a facility. Adverse determinations made on a retrospective basis may only be appealed through the standard grievance process. All necessary information, including the Company's decision, shall be transmitted between the Company and the Insured or the provider acting on behalf of the Insured by telephone, facsimile or the most expeditious method available.

3) In an expedited review, the Company will make a decision and notify the Insured as expeditiously as the Insured's medical condition requires, but in no event more than 72 hours after the review is commenced. If the expedited review is a concurrent review determination, the service shall be continued without liability to the Insured until the Insured has been notified of the determination. The Company will provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.

4) The Company will provide reasonable access, not to exceed one business day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

5) In any case where the expedited review process does not resolve a difference of opinion between the Company and the Insured or the provider acting on behalf of the Insured, the Insured or the provider acting on behalf of the Insured may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. The Company will review it as a second level grievance. In conducting the review, the Company will make a decision and notify the Insured as expeditiously as the Insured's medical condition requires, but in no event more than 72 hours after the grievance is submitted.

The State of New Hampshire Insurance Department is available to assist insurance consumers with insurance related problems and questions.
Inquiries may be made to the Department at:
56 Old Suncook Road, Concord, NH 03301-7317,
603-271-2261, or toll-free at (800) 852-3416.

This endorsement takes effect and expires concurrently with the policy to which it is attached and is subject to all of the terms and conditions of the policy not inconsistent therewith.

SUMMARY OF THE 1996 NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (RSA 408-B)
AND
NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

IMPORTANT DISCLAIMER

The New Hampshire Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Hampshire. Other conditions may preclude coverage.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contact sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
P.O. Box 515
Concord, NH 03302
(603) 226-9114

New Hampshire Department of Insurance
56 Old Suncook Road
Concord, NH 03301
(603) 271-2261

2023 – 2024 VOLUNTARY STUDENT ACCIDENT INSURANCE COVERAGE

(If the school purchases Mandatory Coverage to cover students participating in Recess, Physical Education, One Day Field Trips and Overnight Field Trips, the below Optional Coverages will exclude coverage for these activities.)

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity. **Annual Premium: Plan 1: $31.00 Plan 2: $20.00 Plan 3: $10.00**

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).
Annual Premium: Plan 1: $125.00 Plan 2: $81.00 Plan 3: $41.00

OPTIONAL FOOTBALL COVERAGE - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9th graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.
Annual Premium: Plan 1: $163.00 Plan 2: $106.00 Plan 3: $53.00
Spring/Summer Weight and Conditioning Training Only Rates Plan 1: $57.00 Plan 2: $44.00 Plan 3: $27.00
(for new players who participate in spring training and not already insured under Optional Football Coverage)

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24-Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.
Annual Premium: $7.00

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending academic classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available).**

EXCESS PROVISION If an Injury to the Insured Person results in incurring Covered Medical Expenses for any of the services specified in the Schedule of Benefits, the Company will pay the Covered Medical Expenses incurred subject to the Deductible Amount and Coinsurance Percentage (if any), that are in excess of Covered Medical Expenses payable by any other valid and collectible insurance. The Excess Provision will not be applied to the first $100 of medical expenses incurred. Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

MEDICAL EXPENSE BENEFITS – INJURY ONLY Benefits are payable under the Policy for Covered Medical Expenses less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement to the policy thereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT If such Injury shall independently of all other causes and within 365 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the "Medical Expense Benefits" provision. Loss of Life - $10,000.00; Loss of Both Hands, Both Feet or Sight of Both Eyes - $10,000.00; Loss of One Hand and One Foot - $10,000; Loss of Either One Hand or One Foot and Sight of One Eye - $10,000.00; Loss of One Hand or One Foot or Sight of One Eye - $5,000.00; Loss of Entire Thumb and Index Finger of Either Hand - $5,000.00
Loss shall mean with regards to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

DEFINITIONS Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any. **Injury** for which benefits are provided, means accidental bodily injuries sustained by the Insured which are the direct cause, independent of disease or bodily infirmity or any other cause and which occur while the insurance is in force. **Usual and Customary Charges** means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under the Policy for any expenses incurred which in the judgement of the Company are in excess of Usual and Customary Charges.

EXCLUSIONS No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to: 1) Dental treatment, except for accidental Injury to Sound, Natural Teeth; 2) Elective Surgery or Elective Treatment; 3) Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet; 4) Injury caused by, contributed to, or resulting from intoxication, the use of intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician; 5) Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation; 6) Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance in excess of $10,000; 7) Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting; 8) Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury; 9) Sickness or disease in any form; 10) Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury; 11) Supplies, except as specifically provided in the Policy; 12) Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and 16) War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded for such period not covered when the Company is notified of the Insured's entry in the armed services of any county.

RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. **IMPORTANT NOTICE – THE POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This brochure has been designed to illustrate the highlights of this insurance. All information in this brochure is subject to the provisions of Policy Form COL-03-NH, underwritten by Gerber Life Insurance Company. If there is any conflict between this brochure and the Policy, the Policy will prevail. Please see the Master Policy for individual state details.**

HOW TO FILE A CLAIM

Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company. Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss.

In the event of an Accident, students should: 1) Secure treatment at the nearest medical facility of their choice. (Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with is policy provisions or requirements.); 2) Obtain a receipt (if payment of any bills were made) and itemized copy of charges from the provider of medical services and send copies of their itemized bills, primary insurance explanation of benefits and the fully completed and **signed** accident claim form to the claims office – mail all correspondence to WEB-TPA, P.O. Box 2415, Grapevine, TX 76099-2415; and 3) **Call 1-866-975-9468** with any Claims questions.

Medical withdrawal from school due to a covered Injury which originates after the Insured's Effective Date will not void an Insured's coverage.

UNDERWRITTEN BY:
Gerber Life Insurance Company
1311 Mamaroneck Avenue, Suite 350
White Plains, NY 10605

MARKETING AGENT: Lefebvre Insurance, LLC
901 Pleasant Street, #1413
Attleboro, MA 02703
(800) 451-9668

To apply for coverage, please enroll on-line with a credit card at www.k12specialmarkets.com or cut along the dotted line, complete the form and mail it, along with your check or money order, to the Please Return To: address shown below.

Please Return To: K12Special Markets Plan Administrators
1055 Main Street, Suite 101
Stevens Point, WI 54481

2023 – 2024 ENROLLMENT APPLICATION (please print or type)

Student's Last Name _____ Student's First Name _____ Student's Middle Initial _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Birthdate _____ Grade _____

School System _____ Name of School _____

Check your selection:					
	Plan 1	❑ School-Time $31.00	❑ 24-Hour Accident $125.00	❑ Football $163.00	❑ 24-Hour Dental $7.00
	Plan 2	❑ School-Time $20.00	❑ 24-Hour Accident $ 81.00	❑ Football $106.00	❑ 24-Hour Dental $7.00
	Plan 3	❑ School-Time $10.00	❑ 24-Hour Accident $ 41.00	❑ Football $ 53.00	❑ 24-Hour Dental $7.00
	Spring/Summer Weight and Conditioning Training Only Rates		❑ **Plan 1** $57.00	❑ **Plan 2** $44.00	❑ **Plan 3** $27.00

Please make check payable to Special Markets Insurance Consultants, Inc.

Total Enclosed: _____

Signature of Parent or Guardian _____ Date _____ #1541

SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENETIS
INJURY ONLY BENEFITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 60 days after the date of Injury; and, b) is received within one year after date of Injury.

Maximum Benefit:	**Plan 1**	**Plan 2**	**Plan 3**
School-Time Option	$100,000	$75,000	$50,000
24-Hour Option	$100,000	$75,000	$50,000
Football Option	$100,000	$75,000	$50,000
Injuries Involving Motor Vehicles	$10,000	$10,000	$10,000
Excess Provision	$100 Primary Excess	$100 Primary Excess	$100 Primary Excess
Inpatient			
Room & Board:	100% Usual and Customary Charges	100% Usual and Customary Charges	80% Usual &Customary / $200 maximum per day
Intensive Care:	100% Usual and Customary Charges	100% Usual and Customary Charges	80% Usual &Customary / $200 maximum per day
Hospital Miscellaneous:	$10,000 maximum	$7,500 maximum	$5,000 maximum
Surgery:	80% Usual and Customary Charges / $3,000 maximum	80% Usual and Customary Charges / $2,000 maximum	80% Usual &Customary / $1,000 maximum
Assistant Surgeon:	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Registered Nurse:	100% Usual and Customary Charges	100% Usual and Customary Charges	80% Usual and Customary Charges
Physician's Visits:	$60 per day	$500 maximum	$25 per day
Pre-admission Testing:	Paid under Inpatient Hospital Miscellaneous	Paid under Inpatient Hospital Miscellaneous	Paid under Inpatient Hospital Miscellaneous
Outpatient			
Surgery:	80% Usual and Customary Charges / $3,000 maximum	80% Usual and Customary Charges / $2,000 maximum	80% Usual &Customary / $1,000 maximum
Day Surgery Miscellaneous:	$750 maximum	80% Usual and Customary Charges / $500 maximum	$250 maximum
	(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)		
Assistant Surgeon:	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist:	25% of Surgery Allowance	25% of Surgery Allowance	25% of Surgery Allowance
Physician's Visits:	$60 per day	$500 maximum	$25 per day
Physiotherapy:	$75/visit / 5 visit maximum	$40/visit / 5 visit maximum	$25/visit / 5 visit maximum
Medical Emergency:	$575 maximum	80% Usual and Customary/$400 maximum	80% Usual and Customary/$200 maximum
X-Rays:	$300 maximum	$250 maximum	$200 maximum
Laboratory:	$0 maximum	$0 maximum	$0 maximum
Tests & Procedures:	Paid under Laboratory	Paid under Laboratory	Paid under Laboratory
Prescription Drugs:	100% Usual and Customary Charges	100% Usual and Customary Charges	80% Usual and Customary Charges
Other			
Ambulance:			
Ground:	$500 maximum	$400 maximum	$200 maximum
Air:	$1,500 maximum	$1,000 maximum	$400 maximum
Durable Medical Equipment:	$500 maximum	$300 maximum	$150 maximum
Dental:	$2,000 maximum	$1,500 maximum	$1,000 maximum
(Benefits paid on Injury to Sound, Natural Teeth only.)			
Replacement of eyeglasses, hearing aids, contact lenses, damaged during a covered injury if medical treatment is also received for the covered injury	$700 maximum	$500 maximum	$150 maximum

Accidental Death, Dismemberment and Loss of Sight Benefits – Described on the 1st page.

GER 0723 EFTB(NH 1,2,3)