

## Benefit Summary Kingston Advantage Plan

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### ACCIDENT MEDICAL EXPENSE BENEFIT

<b>Annual Maximum for all Accident Medical</b>	\$5,000 - \$10,000
<b>Loss Period</b>	First covered expenses must be incurred within 90 days from the date of the Covered Accident
<b>Benefit Period:</b>	12 months from the date of the Covered Accident provided the Injury occurs prior to the Expiration Date and care is Medically Necessary
<b>Terms of Payment</b>	Primary

### ACCIDENT MEDICAL EXPENSE BENEFITS

<b>Hospital Admission Benefit</b>	\$1,000 to \$2,500
<b>Hospital Room &amp; Board Daily Maximum Benefit Amount:</b>	\$50 to \$150 per day
<b>Intensive Care Room &amp; Board Daily Maximum Benefit:</b>	\$100 to \$500 per day
<b>Hospital Miscellaneous Maximum Benefit Amount:</b>	\$100 to \$200 per day
<b>Outpatient Hospital Emergency Room Treatment</b>	\$100 to \$300 per visit
<b>Physician's Visits</b>	
Maximum Benefit:	\$100 to \$200 per visit
Maximum Visits per year:	3 to 10
<b>X-Ray</b>	\$150 to \$350 per procedure
<b>Laboratory Benefit</b>	\$200 to \$500 per procedure
<b>Nursing Maximum Benefit Amount:</b>	\$75 to \$300 per injury
<b>Physiotherapy Benefit Maximum Benefit Amount</b>	\$50 to \$200 per visit
<b>Ambulance Maximum Benefit Amount:</b>	\$1,000
<b>Medical Equipment Maximum Benefit Amount:</b>	\$250 per injury
<b>Medical Services and Supplies Maximum Benefit Amount</b>	\$600 per injury

**Dental Treatment for Injury Only Maximum Benefit Amount:** \$250 per injury

**Mental or Nervous Disorders/Psychotherapy Benefit**

Maximum Benefit: \$500 per visit

Maximum Visits per year: 1 to 2

**ADDITIONAL ACCIDENT BENEFITS**

**Outpatient Surgery Benefit**

\$1,000 to \$2,500 per procedure

**Family Transportation Benefit**

Maximum Benefit: \$500

Maximum payments per year: 2 to 3

**Outpatient Prescription Drug Benefit**

Maximum Benefit: \$75 to \$200

Copay \$5

# Accident Coverage

GRP ACC + HMB HEALTH EFFICIENCY PLAN							HMB
BENEFIT CATEGORY	PLAN 1	PLAN 2	PLAN 3	PLAN 4	PLAN 5	PLAN 6	
<b>PREMIUM</b>	<b>\$600</b>	<b>\$750</b>	<b>\$900</b>	<b>\$1,050</b>	<b>\$1,200</b>	<b>\$1,500</b>	
HEALTH MAINTENANCE BENEFIT <i>Benefit Amount</i>	\$500	\$625	\$750	\$875	\$1,010	\$1,200	
AME <i>Annual Limit</i>	\$5,000	\$7,500	\$7,500	\$7,500	\$10,000	\$10,000	
AMBULANCE	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	
OUTPATIENT ER	\$100	\$100	\$100	\$150	\$200	\$300	
PHYSICIAN'S OFFICE VISIT	\$100	\$100	\$150	\$150	\$150	\$200	
<i>Visits</i>	3	5	5	7	7	10	
HOSPITAL ADMISSION	\$1,000	\$1,000	\$1,000	\$1,500	\$2,000	\$2,500	
HOSPITAL CONFINEMENT	\$50	\$50	\$50	\$100	\$100	\$150	
HOSPITAL MISCELLANEOUS	\$100	\$100	\$100	\$150	\$150	\$200	
ICU	\$100	\$100	\$100	\$150	\$250	\$500	
PHYSIOTHERAPY	\$50	\$50	\$75	\$100	\$100	\$200	
LAB	\$200	\$200	\$200	\$250	\$250	\$500	
X-RAY	\$150	\$150	\$150	\$200	\$200	\$350	
NURSING	\$75	\$75	\$100	\$100	\$200	\$300	
MEDICAL SERVICES & SUPPLIES	\$600	\$600	\$600	\$600	\$600	\$600	
DME	\$250	\$250	\$250	\$250	\$250	\$250	
MENTAL OR NERVOUS DISORDERS/PSYCHOTHERAPY	\$500	\$500	\$500	\$500	\$500	\$500	
<i>Visits</i>	1	1	1	1	2	2	
DENTAL TREATMENT FOR INJURY ONLY	\$350	\$350	\$500	\$500	\$500	\$500	
OUTPATIENT SURGERY BENEFIT	\$1,000	\$1,500	\$1,500	\$2,000	\$2,500	\$2,500	
FAMILY TRANSPORTATION BENEFIT	\$500	\$500	\$500	\$500	\$500	\$500	
<i>Payments</i>	2	2	2	3	3	3	
OUTPATIENT PRESCRIPTION DRUG BENEFIT	\$75	\$75	\$100	\$125	\$185	\$200	

## NOTES

1. Includes Initial / Follow-up Office Visit and Urgent Care
2. Paid in addition to ICU
3. Includes Step-Down Unit and Observation Unit
4. Miscellaneous services include supplies such as the cost of the operating room, lab tests, X-rays, anesthesia, medication, and other charges.
5. Paid in lieu of hospital confinement. Includes Traumatic Brain Injury
6. Includes Physical Therapy and Chiropractic Visit
7. Includes PTSD, Max filed is \$500 per occurrence
8. Includes Blood, Blood Transfusions, and Oxygen
9. Includes Crown and Extraction if resulting from an injury; Max field is \$500 per occurrence
10. Includes Closed/Partial/Open Dislocation, Closed/Partial/Open Fracture, Chip Fractures, Puncture Wound, Gunshot Wound
11. Subject to \$5 Copay

## Excludes:

Home Health Care, Pain Management, Prosthesis, Family Lodging, Occupational Hepatitis, HIV, Organized Sports, Telemedicine, Concussion, Eye Injury, Laceration and other exclusions listed in policy.