

## SCHEDULE OF MEDICAL BENEFITS

### PLAN AAA

#### POLICY MAXIMUM BENEFIT (per person, per incident)

Compulsory Student and Athletic Coverage

\$1,000,000.00

Voluntary Student Accident Coverage

\$1,000,000.00

#### HOSPITAL SERVICES

#### MAXIMUM BENEFIT

(per person, per incident)

1. Daily Room and Board: Semi-private while Hospital Confined. Usual & Reasonable
2. Intensive Care Room and Board. Usual & Reasonable
3. Miscellaneous Services: During Hospital Confinement or when surgery is performed. Usual & Reasonable
4. Emergency Room Out-patient: When Hospital Confinement is not required. Usual & Reasonable

#### PHYSICIAN SERVICES

1. Surgery, including pre- and post-operative Usual & Reasonable expenses in accordance with the 1974 Revised California Relative Value Studies, 5th Edition having a conversion factor of: Usual & Reasonable
2. Anesthesia, including administration. Usual & Reasonable  
(% of surgical allowance)
3. Assistant surgeon (% of surgical allowance). Usual & Reasonable
4. Physician Visits other than for physiotherapy or similar treatment, when no surgery benefit is paid. Usual & Reasonable
5. Consultants (when requested by attending Physician for confirmation or determining a diagnosis, but not for treatment) and second opinion. Usual & Reasonable

#### LABORATORY & X-RAY SERVICES

Other than dental and including fee for interpretation and/or reading of x-ray when not Hospital Confined.

Usual & Reasonable

Usual & Reasonable

#### ADDITIONAL SERVICES

1. Physiotherapy or similar treatment (With a Dr. Prescription)  
In-Hospital Usual & Reasonable  
Out-of-Hospital Usual & Reasonable

## SCHEDULE OF MEDICAL BENEFITS

### PLAN AAA (Continued)

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| 2. | Registered or licensed Nurse,<br>(in or out of Hospital).   | Usual & Reasonable                       |
| 3. | Ambulance to initial treatment facility.  | Usual & Reasonable                       |
| 4. | Orthopedic Appliances<br>In-Hospital<br>Out of Hospital   | Usual & Reasonable<br>Usual & Reasonable |
| 5. | Out-Patient Drugs and Medication:<br>administered in a Physician's office or by prescription.   | Usual & Reasonable                       |
| 6. | Eyeglasses, Contact Lenses and Hearing Aids:<br>Replacement of broken eyeglasses and/or<br>frames, contact lenses and hearing aids, resulting<br>from a covered Injury. | Usual & Reasonable                       |

### DENTAL SERVICES

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|--|--------------------|
| Treatment, repair or replacement of injured natural teeth. Includes initial braces when required for treatment of a covered injury as well as examination, x-rays, restorative treatment, endodontics, oral surgery, and treatment for gingivitis resulting from trauma. | Usual & Reasonable |
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### \*ADDITIONAL EXTENDED DENTAL SERVICES

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| 1. | Replacement of caps, crown, dentures, orthodontic appliances (including braces), fillings, inlays crozat appliances, endodontics, oral surgery, examinations and x-ray services required as a result of Injury. | Usual & Reasonable |
| 2. | When a Dentist certifies, in writing to the Claim Administrator that treatment will continue beyond a two year benefit period, an ADDITIONAL \$1,500.00 will be paid.   |                    |

\*NOT INCLUDED IN VOLUNTARY PLAN