Benefit Summary
Century Advantage Plan

ACCIDENT MEDICAL EXPENSE BENEFIT

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

ACCIDENT MEDICAL EXPENSE BENEFITS

Hospital Admission Benefit	$1,000 to $2,500
Hospital Room & Board Daily Maximum Benefit Amount:	$50 to $150 per day
Intensive Care Room & Board Daily Maximum Benefit:	$100 to $500 per day
Hospital Miscellaneous Maximum Benefit Amount:	$100 to $200 per day
Outpatient Hospital Emergency Room Treatment	$100 to $300 per visit
Physician's Visits	
Maximum Benefit:	$100 to $200 per visit
Maximum Visits per year:	3 to 10
X-Ray	$150 to $350 per procedure
Laboratory Benefit	$200 to $500 per procedure
Nursing Maximum Benefit Amount:	$75 to $300 per injury
Physiotherapy Benefit Maximum Benefit Amount	$50 to $200 per visit
Ambulance Maximum Benefit Amount:	$1,000
Medical Equipment Maximum Benefit Amount:	$250 per injury
Medical Services and Supplies Maximum Benefit Amount	$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							
BENEFIT CATEGORY	**PLAN 1**	**PLAN 2**	**PLAN 3**	**PLAN 4**	**PLAN 5**	**PLAN 6**	
PREMIUM	**$600**	**$750**	**$900**	**$1,050**	**$1,200**	**$1,500**	HMB
HEALTH MAINTENANCE BENEFIT *Benefit Amount*	$500	$625	$750	$875	$1,010	$1,200	
AME *Annual Limit*	$5,000	$7,500	$7,500	$7,500	$10,000	$10,000	ACCIDENT MEDICAL EXPENSE BENEFITS
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	
Visits	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	
Visits	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	ADDITIONAL ACCIDENT BENEFITS
FAMILY TRANSPORTATION BENEFIT	$500	$500	$500	$500	$500	$500	
Payments	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.