

Plan Summary for:

12379000 - JPS Health Network



# Summary of Benefits

## Scheduled Benefit Accident

EMERGENCY CARE & DIAGNOSTICS	Plan 1
<b>Ambulance - Ground</b> 1 trip(s) per covered accident	\$400 pp/pa
<b>Ambulance - Air</b> 1 trip(s) per covered accident	\$2,000 pp/pa
<b>Emergency Room</b> 1 trip(s) per covered accident	\$300 pp/pa
<b>Major Diagnostic Testing</b> (MRI, CT Scan, EEG) 1 exam(s) per covered accident	\$300 pp/pa
<b>X-Ray</b> 1 test(s) per covered accident	\$60 pp/pa
<b>Pain Management/Epidural</b> 1 visit(s) per covered accident	\$100 pp/pa
<b>Initial Doctor's Visit</b>	\$100 pp/pa
ACCIDENT HOSPITALIZATION & SURGICAL BENEFITS	
<b>Hospital Admission</b>	\$1,500 pp/pa
<b>ICU Admission</b>	\$3,000 pp/pa
<b>Hospital Confinement</b> Up to 365 day(s) per accident	\$300 per day
<b>ICU</b> Up to 30 day(s) per accident	\$600 per day
<b>Rehabilitation/Skilled Nursing Facility</b> Up to 90 day(s) per accident	\$150 per day
<b>Blood/Plasma/Platelets</b>	\$500 pp/pa
<b>Surgery - Open Abdominal, Thoracic</b>	\$3,000 per surgery
<b>Surgery - Cranial</b>	\$3,000 per surgery
<b>Surgery - Hernia</b>	\$1,500 per surgery
<b>Surgery - Exploratory or Without Repair</b>	\$400 per surgery
<b>Outpatient/Miscellaneous Surgery</b>	\$400 per surgery
<b>Transportation</b> Up to 3 trip(s) per accident	\$500 per trip
<b>Family Lodging</b> Up to 30 nights	\$125 per night

<b>Coma</b> After 7 day duration	\$8,000 pp/pa
<b>FOLLOW UP CARE</b>	
<b>Follow Up Doctor's Visit</b> 1 visit(s) per covered accident	\$100 pp/pa
<b>Physical Therapy</b> Up to 10 visits per accident	\$75 per visit
<b>Chiropractic Visit</b> Up to 10 visits per accident	\$75 per visit
<b>Medical Equipment</b> 1 appliance(s) per covered accident	\$400 pp/pa
<b>Prosthetic Device</b> 1 device per covered accident	\$2,500 pp/pa
<b>COMMON INJURIES</b>	
<b>Burns</b> Second Degree: 20 - 100 square centimeters Second Degree: 101 - 225 square centimeters Second Degree: More than 225 square centimeters	\$100 pp/pa \$200 pp/pa \$800 pp/pa
<b>Burns - Third Degree</b> Third Degree: 20 - 100 square centimeters Third Degree: 101 - 225 square centimeters Third Degree: More than 225 square centimeters Skin Grafts	\$800 pp/pa \$6,000 pp/pa \$20,000 pp/pa 25% of burn benefit
<b>Paralysis</b> Quadriplegia Paraplegia Hemiplegia Uniplegia	\$20,000 pp/pa \$10,000 pp/pa \$10,000 pp/pa \$5,000 pp/pa
<b>Lacerations</b> Not requiring sutures Under 3 inches, required sutures 3 to 6 inches, requires sutures Over 6 inches, requires sutures	\$50 pp/pa \$80 pp/pa \$150 pp/pa \$400 pp/pa
<b>Emergency Dental Work</b> Crown Repair Extraction	\$200 pp/pa \$100 pp/pa
<b>Eye Injuries</b> Removal of Foreign Object Surgical Repair	\$60 pp/pa \$300 pp/pa
<b>Specific Injuries</b> Ruptured Disc Tendons/Ligaments 1 tear with surgical repair Tendons/Ligaments 2 or more tears with surgical repair Tendons/Ligaments Arthroscopic surgery with no repair Torn Knee Cartilage Exploratory surgery with no repair	\$600 pp/pa \$800 pp/pa \$1,200 pp/pa \$300 pp/pa \$300 pp/pa

Torn Knee Cartilage	\$800 pp/pa
Surgical repair	
Concussion	\$300 pp/pa
<b>Dislocations (Closed Reduction)</b>	
3 dislocation benefits per person, per accident maximum	
Hip	\$5,000 per dislocation
Knee (except patella)	\$2,000 per dislocation
Shoulder	\$2,000 per dislocation
Foot/Ankle	\$2,000 per dislocation
Wrist	\$2,000 per dislocation
Lower Jaw	\$2,000 per dislocation
Elbow	\$2,000 per dislocation
Bones of the Hand (except fingers)	\$1,000 per dislocation
Collarbone	\$1,000 per dislocation
2 or more fingers	\$400 per dislocation
2 or more toes	\$400 per dislocation
1 finger or toe	\$150 per dislocation
Open Reduction	200% of dislocation benefit
Partial Dislocation	25% of dislocation benefit
<b>Fractures (Closed Reduction)</b>	
3 fracture benefits per person, per accident maximum	
Skull	\$5,000 per fracture
Hip/Thigh	\$5,000 per fracture
Vertebral Body (excluding vertebral processes)	\$5,000 per fracture
Pelvis	\$5,000 per fracture
Arm (upper)	\$3,000 per fracture
Shoulder Blade	\$3,000 per fracture
Leg	\$3,000 per fracture
Upper Jaw	\$2,000 per fracture
Vertebral Processes	\$2,000 per fracture
Knee Cap	\$2,000 per fracture
Collarbone	\$2,000 per fracture
Forearm	\$2,000 per fracture
Foot/Ankle	\$2,000 per fracture
Hand/Wrist	\$1,500 per fracture
Lower Jaw	\$1,500 per fracture
Ribs (2 or more)	\$1,000 per fracture
Facial Bones or Nose	\$1,000 per fracture
1 rib, finger, or toe	\$400 per fracture
Coccyx	\$400 per fracture
Open Reduction	200% of fracture benefit
Bone Chip	25% of fracture benefit
<b>CATASTROPHIC ACCIDENT BENEFITS</b>	
<b>Accidental Death<sup>1</sup></b>	\$50,000
<b>Common Carrier Accidental Death<sup>1</sup></b>	\$100,000

<b>AD&amp;D Benefits<sup>1</sup></b>	
Double Dismemberment	
Loss of both hands, both feet or sight in both eyes	\$50,000
Loss of Speech or Hearing in both ears	\$25,000
Loss of 1 hand and 1 foot	\$50,000
Loss of 1 eye	\$25,000
Loss of 1 hand or 1 foot	\$25,000
Loss of 2 or more fingers or toes	\$10,000
Loss of 1 finger or toe	\$2,500
<b>OPTIONAL BENEFITS</b>	
<b>Wellness Screening Benefit</b>	\$100 pp/pcy
<b>Occupational Coverage</b>	Not Included
<b>Portability</b>	Included
<b>Child Organized Sports</b>	Included
Additional 25% of accident benefits	
\$5,000 per person/per accident maximum	
<b>Monthly Premium</b>	<b>Plan 1</b>
Single	\$12.28
Employee + Spouse	\$21.34
Employee + Child(ren)	\$26.94
Family	\$38.12

<sup>1</sup>Benefit Amounts: Employee 100%, Spouse 50%, Child 25%

<sup>2</sup>pp/pa = per person/per accident

To Calculate: Weekly=Monthly cost x 12 ÷52; Bi-Weekly =Monthly cost x 12÷26; Semi-Monthly=Monthly cost x 12 ÷24

**Please refer to the Description of Benefits included in this packet for additional information on your benefits.**

**These benefits are designed to be offered to those covered under a High-Deductible Health Plan ("HDHP") without the effect of disqualifying a participant from electing an HSA. Please consult with your Benefits Advisor to assist with determination that electing this limited benefit coverage is in fact permitted coverage under the rules applicable to an HSA.**

Scheduled Benefit Accident insurance policies are for accident only insurance and do not provide coverage for sickness. Select Benefits insurance policies are not a replacement for a major medical policy or other comprehensive coverage and do not satisfy the minimum essential coverage requirements of the Affordable Care Act. They are designed to provide benefits at a preselected, fixed-dollar amount. Coverage may be subject to exclusions, limitations, reductions, and termination of benefit provisions. Select Benefits policies are insured by Symetra Life Insurance Company located at 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004, and are not available in all U.S. states or any U.S. territory.

Coverage is provided under policy form number SBC-03510.

Description of Benefits for:

12379000 - JPS Health Network

## Scheduled Benefit Accident



### EMERGENCY CARE & DIAGNOSTICS

#### **Ambulance Transportation Benefit**

This benefit pays for ground or air ambulance transportation as shown in the Schedule of Benefits. It will be paid for transportation by a licensed ground or air ambulance transportation service from the place of injury to the nearest accredited hospital where adequate treatment facilities are available. Air ambulance transportation must be within 96 hours of the accident. Ground transportation must be within 90 days of the accident.

#### **Emergency Room Benefit**

The benefit amount shown in the Schedule of Benefits will be paid for treatment in an emergency room for an injury. Emergency room services must be incurred within 30 days from the Accident.

#### **Major Diagnostic Testing Benefit**

The benefit amount shown in the Schedule of Benefits will be paid if for any of the following major diagnostic tests as the result of the injury. Tests must be administered by a provider within 365 days of the accident. If multiple tests are performed, only one benefit will be paid. The following tests are covered: magnetic resonance imaging (MRI), computed tomography (CT, Cat Scan), electrocardiogram (EKG) and electroencephalogram.

#### **X-Ray Benefit**

The benefit amount shown in the Schedule of Benefits will be paid if an x-ray is performed as a result of the injury. The x-ray must be performed by a provider within 365 days of the accident.

#### **Pain Management/Epidural Benefit**

The benefit amount shown in the Schedule of Benefits will be paid if medical pain management services, including the application of epidural injections, are administered for treatment of injury. Services must be administered by a provider within 365 days of the accident. Services may be provided at the doctor's office, outpatient hospital clinic or urgent care facility.

#### **Initial Doctor Visit Benefit**

The benefit amount shown in the Schedule of Benefits will be paid for the first day of treatment from a doctor for an injury. The initial visit must occur within 365 days of the accident. Services must be provided at the doctor's office, an outpatient hospital clinic or urgent care facility. This benefit is payable once per person, per accident.

### ACCIDENT HOSPITALIZATION & SURGICAL BENEFITS

#### **Hospital Admission Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for the first calendar day of confinement and admission to a hospital as the result of an injury for a minimum of 24 consecutive hours or if a charge is made for room and board. Hospital admission must occur within 365 days from the date of the accident. The benefit is payable once per person, per accident. This benefit is payable regardless of other hospital benefits available.

**Intensive Care Unit (ICU) Admission Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for the first calendar day of confinement and admission to an ICU as the result of an injury for a minimum of 24 consecutive hours or a charge is made for room and board. ICU admission must occur within 365 days from the date of the accident. The benefit is payable once per person, per accident. This benefit is payable regardless of other ICU benefits available.

**Hospital Confinement Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for confinement to a hospital for treatment of injury. Hospital confinement must be for a minimum of 24 hours and begin within 365 days from the date of the accident.

**Intensive Care Unit (ICU) Confinement Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for confinement to an ICU for treatment of injury. ICU confinement must be for a minimum of 24 hours and begin within 365 days from the date of the accident.

**Rehabilitation/Skilled Nursing Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for confinement to a rehabilitation facility or skilled nursing facility for treatment of an injury. Confinement must be for a minimum of 24 hours and begin within 365 days from the date of the accident.

**Blood/Plasma/Platelets Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for transfusion of blood, plasma or platelets for a surgical procedure. This benefit is paid one time per person, per accident.

**Surgery Benefit**

This benefit will pay the amount shown in the Schedule of Benefits based on the type of surgical procedure performed. Surgery must be performed within 365 days of date of the accident. If more than one surgical procedure is performed on the same day, the benefit paid will be based on the surgery that provides the largest benefit amount.

**Outpatient/Miscellaneous Surgery Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for an outpatient surgical procedure or an inpatient surgical procedure not otherwise covered. Surgery must be required due to injury and performed within 365 days of the accident. This benefit is payable once per person, per accident.

**Transportation Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for each day an insured must travel to or from a health care facility more than 50 miles away from the primary residence for treatment of injury. Travel must occur within 365 days after the accident.

**Family Lodging Benefit**

This benefit will pay the amount shown in the Schedule of Benefits each day an expense is incurred for lodging by an adult family member or companion accompanying the insured who is confined as the result of an injury more than 50 miles away from the primary residence. This benefit is payable up to 30 nights per accident.

**Coma Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if an insured lapses into a coma as the result of an injury. The coma must occur within 365 days of injury and last for a minimum of 7 days.

**FOLLOW UP CARE****Follow Up Doctor's Visit Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for a follow up visit with a doctor for the treatment of an injury. Treatment must be provided at a doctor's office, an outpatient hospital facility or urgent care facility and occur after initial treatment in a doctor's office or emergency room.

**Physical Therapy Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for any day the insured receives physical therapy in a health care facility as the result of an injury. Physical therapy must begin within 365 days after the accident. This benefit is payable for up to 10 visits per accident.

**Chiropractic Visit Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for each day the insured receives chiropractic care as the result of an injury. Chiropractic care must begin within 365 days after the date of the accident. This benefit is payable for up to 10 visits per accident.

**Medical Equipment Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if the insured rents or buys durable medical equipment as the result of an injury. The medical equipment must be prescribed by a doctor within 365 days after the injury occurs.

**Prosthetic Device Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if the insured purchases a prosthetic device as the result of an injury. The prosthetic device must be prescribed by a doctor within 365 days after the injury occurs.

**COMMON INJURIES****Burn Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for second or third degree burns sustained due to an accident. Benefits are based on the severity of the burn. Only one benefit is payable per person, per accident. If multiple burns are sustained as the result of the same accident, the highest eligible benefit will be paid.

**Paralysis Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for paralysis due to an accident. The benefit amount is based on the type of paralysis. Paralysis must be diagnosed by a doctor within 365 days of the accident. This benefit is payable only once per person, per accident.

**Laceration Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for lacerations sustained as the result of an accident. The benefit amount is based on the type of laceration. Lacerations must be repaired within 96 hours after an accident. Only one laceration benefit will be paid per person, per accident. If multiple lacerations are sustained, the benefit amount applicable to the total length of all lacerations will be paid.

**Emergency Dental Work Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if emergency dental treatment is required as the result of an accident. This includes the repair of a broken sound, natural tooth or crown and the extraction of a broken sound, natural tooth. The benefit amount is based on the type of procedure. Dental work must occur within 365 days after the accident. This benefit will be paid once per person, per accident regardless of the number of teeth involved.

**Eye Injury Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if an eye injury is sustained as the result of an accident. The injury must require surgery or removal of a foreign object by a doctor within 365 days after the accident. One eye injury benefit is payable per person per accident.

**Specific Injury Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if one of the specific injuries listed is sustained as the result of an accident. Benefit amounts are based on the type of injury sustained. The injury must require surgery or medical treatment within 365 days after the accident. Only one benefit is payable per person per accident.

**Dislocations Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if a dislocation is sustained as the result of an accident. Benefit amounts are based on the type of dislocation sustained and must be treated by a doctor within 365 days after the accident. This benefit will be paid for up to 3 dislocations per person per accident.

**Fractures Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if a fracture is sustained as the result of an accident. Benefit amounts are based on the type of fracture sustained and must be treated by a doctor within 365 days after the accident. This benefit will be paid for up to 3 fractures per person per accident.

**CATASTROPHIC ACCIDENT BENEFITS****Accidental Death Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if the injury sustained results in loss of life. The loss must be a direct result of the accident, independent of all other causes and occur within 365 days of the accident.

**Common Carrier Accidental Death Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if the injury sustained results in loss of life while on or occupying a common carrier. The loss must be a direct result of an accident, independent of all other causes and occur within 365 days of the accident. This benefit is payable in lieu of the Accidental Death benefit.

**Accidental Dismemberment Benefit**

This benefit will pay the amount shown in the Schedule of Benefits if the injury sustained results in a loss as described in the Schedule of Benefits. The loss must be a direct result of the accident, independent of all other causes and occur within 365 days of the accident.



## **OPTIONAL RIDERS**

### **Wellness Screening Benefit**

This benefit will pay the amount shown in the Schedule of Benefits for any of the wellness screening tests listed. The benefit will be paid once per person during a calendar year regardless of the number of screening tests administered during that year.

### **Child Organized Sports Benefit**

Provides an additional 25% benefit (up to a specified cap), for benefits payable under the Policy, if the Accident occurred while an Insured Dependent child is participating in an organized sport. The child must be insured by the Policy on the date the Accident occurred.

### **Screening Tests**

Abdominal aortic aneurysm ultrasonography  
Baseline testing for Concussion  
Blood test for lipids, including total cholesterol, LDL, HDL and triglycerides  
Bone density screening  
Bone marrow testing  
Breast MRI  
Breast ultrasound  
CA 15-3 blood test for breast cancer  
CA 125 blood test for ovarian cancer  
Carotid Doppler  
CEA blood test for colon cancer  
Chest X-ray  
Child sports physicals  
Colonoscopy or virtual colonoscopy  
CT angiography  
Electrocardiogram  
Fasting blood glucose test  
Flexible sigmoidoscopies  
Mammograms  
Pap smears  
Prostate-specific antigen (PSA) test  
Serum cholesterol test to determine level of HDL and LDL  
Stress test on a bicycle or treadmill  
Testicular ultrasound  
Thermography  
Thin Prep Pap Test

### **Portability/Extension of Coverage**

Allows coverage to continue following termination of employment or loss of eligibility. Review the certificate of coverage to understand the full details of this provision.

If there is any conflict between this information and the policy issued, the terms of the policy will prevail.

Scheduled Benefit Accident insurance policies are for accident only insurance and do not provide coverage for sickness. Select Benefits insurance policies are not a replacement for a major medical policy or other comprehensive coverage and do not satisfy the minimum essential coverage requirements of the Affordable Care Act. They are designed to provide benefits at a preselected, fixed-dollar amount. Coverage may be subject to exclusions, limitations, reductions, and termination of benefit provisions. Select Benefits policies are insured by Symetra Life Insurance Company located at 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004, and are not available in all U.S. states or any U.S. territory.

Coverage is provided under policy form number SBC-03510.

**Policyholder: JPS Health Network**  
**Policy Issue State: TX**  
**Scheduled Benefit Accident Plan**  
**Insured by Symetra Life Insurance Company**

**Exclusions**

**We will not pay benefits for any loss treated outside the United States, Canada or Mexico; dental treatment except as a result of accident; or for any Injury that results from or is caused by:**

- a. War or act of war;
- b. Aviation or aerial navigation, except as a paying passenger on a regularly scheduled commercial passenger flight;
- c. Motor vehicle acrobatic stunts, acrobatic/stunt flying on aircraft, endurance tests, or racing;
- d. Professional or semi-professional organized sports;
- e. Cosmetic or other elective surgery, other than reconstructive surgery required due to accidental injury;
- f. Active duty service or training in the military for more than 31 days;
- g. Disease, bodily/mental illness or degenerative process;
- h. Suicide, attempted suicide, or intentionally self-inflicted Injury (N/A for policies issued in MI);
- i. Participation in base jumping, bungee jumping, cliff jumping, hang gliding, kite surfing, kiteboarding, mountain climbing, parachuting, paragliding, parakiting, parasailing, rock climbing, sail gliding, scuba diving, skydiving, wingsuit flying or other similar extreme sports or high-risk activities;
- j. Voluntary intoxication or being under the influence of any narcotic, drug or controlled substance (N/A for policies issued in MD, SD, VT or WA, or for residents of MD<sup>1</sup>, SD<sup>1</sup>, VT<sup>1</sup> or WA<sup>1</sup>.);
- k. Voluntary intoxication through use of poison, gas, or fumes (N/A for policies issued in MD, NJ, SD or WA, or for residents of MD<sup>1</sup>, SD<sup>1</sup> or WA<sup>1</sup>. Also, N/A for CT residents covered under any policy where the majority of the group resides in CT\*); or
- l. Committing assault or a felony, or voluntary participation in a riot or insurrection (N/A for policies issued in MD, CT, IL, MI, NE, NJ, or UT, or for residents of MD<sup>1</sup>. Also, N/A for CT residents covered under any policy where the majority of the group resides in CT\*).

**If the benefits below are included in your plan, some variation of the following exclusions & limitations may apply; please see your plan's enrollment material for details.**

**Hospital Confinement, ICU and Rehabilitation or Skilled Nursing Facility Benefits** will not be paid for care in an emergency room, an outpatient hospital facility or clinic, an urgent care facility or in any other portion of a hospital which provides services that do not require confinement; or inpatient or outpatient surgical procedures.

**Follow up Doctor's Visit Benefits** will not be paid for care in an emergency room, physical therapy, chiropractic care, inpatient or outpatient surgical procedures or diagnostic X-ray and laboratory tests.

**Prosthetic Device Benefits** will not be paid for hearing aids, wigs, dental aids, including false teeth; or the repair or replacement of prosthetic devices unless the prosthetic device is damaged during an Accident.

**State-Specific Benefit Disclosures**

**If the benefits below are included in your plan, the following state requirements may apply, depending on the state where you live or the policy issue state (as shown above). Apart from any state requirements, please see your plan's enrollment material to determine if these benefits are available.**

**Wellness Screening Rider**

- N/A for policies issued in CA, CO, ID, IN, MD, MI, MN, NH, NM, or NY.

**Portability**

- N/A for policies issued in CO, KY, LA, MN, NH, NV, OR, UT, VT, WA, or WV, or for residents of LA<sup>1</sup>, MN<sup>1</sup>, NH<sup>1</sup>, VT<sup>1</sup> or WV<sup>1</sup>.

<sup>1</sup> Regardless of where the policy is issued.

\*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.

**Policyholder: JPS Health Network**

**Policy Issue State: TX**

**Scheduled Benefit Accident Plan**

**Insured by Symetra Life Insurance Company**

**Home Health Care Benefit**

Included for policies issued in CT and for CT residents under any policy where the majority of the group resides in CT\*.

**Congenital Anomaly Benefit - \$1,000 per dependent child**

Included if dependent coverage is selected, for policies issued in ID and for ID<sup>1</sup> residents. Benefit only pays for reconstructive or cosmetic surgery required to repair a functional defect and prescribed within 90 days of birth or placement for adoption.

**Second Opinion Benefit**

Included for policies issued in MD and for MD<sup>1</sup> residents.

**Surgical, Burn, Suture/Laceration, Dental, Eye Injury, and Blood/Plasma/Platelet Benefits**

Included for policies issued in NH and for NH<sup>1</sup> residents.

**Accidental Death and Double Dismemberment minimum benefit of \$10,000, Single Dismemberment of Limb benefit of \$50,000, and Dismemberment of Digit benefit of \$1,000 per person**

Included for policies issued in NH and for NH<sup>1</sup> residents.

**THE POLICY IS AN ACCIDENT INSURANCE POLICY. IT DOES NOT PAY BENEFITS FOR LOSSES CAUSED BY SICKNESS. YOUR COVERAGE UNDER THE POLICY IS NOT COMPREHENSIVE MEDICAL COVERAGE AND IS NOT INTENDED TO COVER THE COST OF ALL HOSPITAL OR OTHER MEDICAL SERVICES. THE POLICY DOES NOT SATISFY THE MINIMUM ESSENTIAL COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT.**

<sup>1</sup> Regardless of where the policy is issued.

\*Check with your employer if you want more information about the number of employees in certain states.

This document is intended as a summary of information on exclusions and state-required plan variations. For complete details, please see the certificate of coverage that will be provided for those who enroll. If there is a discrepancy between this summary and the terms of the policy, the policy will govern.