

**CHRISTIAN SCHOOLS INSURANCE  
MANDATORY COVERAGE  
SCHEDULE OF BENEFITS FOR THE PLANS LISTED BELOW**

**Schooltime with Sports Option**

**Cost Effective  
Plans**

**Economy Plan 1  
Medical  
Maximum  
\$10,000**

**Economy Plan 2  
Medical  
Maximum  
\$25,000**

|   |   |
|---|---|
| Injuries Involving Motor Vehicles   | \$ 5,000  |
| Accidental Death Benefit  | \$10,000  |
| Single Dismemberment  | \$ 5,000  |
| Double Dismemberment  | \$10,000  |
| Loss Period   | Treatment must begin within 60 days after the date of Injury      |
| Benefit Period  | One Year  |
| Coverage  | Full Excess   |
| <b>Hospital/Facility Services</b>   |   |
| <b>Inpatient</b>  |   |
| Hospital Room and Board   | 100% RE* for hospital semi-private room rate                      |
| Hospital Intensive Care   | \$100% RE*  |
| Inpatient Hospital Miscellaneous  | \$400 1 <sup>st</sup> day/ \$350 ea. thereafter / \$5,000 Maximum |
| <b>Outpatient</b>   |   |
| Outpatient Hospital Miscellaneous-<br>(Except physician services and x-rays paid as below)                                | \$150 Maximum   |
| Free-standing Ambulatory Surgical Facility  | \$1,500 Maximum   |
| Hospital Emergency Room Physician   | \$60 Maximum  |
| <b>Physician's Services</b>   |   |
| Surgical  | 80% RE* to \$2,000 Maximum  |
| Assistant Surgeon   | 25% of Surgical Benefits  |
| Anesthesiologist  | 25% of Surgical Benefits  |
| Physician's Non-surgical Treatment (Except as below)  | \$25/Visit  |
| Physician's Outpatient Treatment in connection with Physical Therapy<br>and/or Spinal Manipulation                        | \$25/Visit; \$350 Maximum   |
| <b>Other Services</b>   |   |
| Registered Nurses' Services   | 100% RE*  |
| Prescriptions - outpatient  | 100% RE*  |
| X-rays, includes interpretation - outpatient  | \$250 Maximum   |
| Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation - outpatient  | \$500 Maximum   |
| Ground Ambulance  | \$300 Maximum   |
| Durable Medical Equipment (includes Orthopedic Braces & Appliances)   | \$250 Maximum   |
| Replacement of eyeglasses, hearing aids, contact lenses,<br>if medical treatment is also received for the covered injury. | \$200 Maximum   |
| Dental Treatment to sound, natural teeth due to covered injury  | \$200/Tooth   |

**\*RE means Reasonable Expense**