

***A College Student Health Insurance***

*for*

***Southwestern Adventist University  
2011-2012***

*by*

***Markel Insurance Company  
Accident & Health Division***



## Accident and Sickness Student Health Insurance Plan

General Information	
Eligibility	All Students taking a maximum of 6 credit hours
Type of enrollment	Hard Waiver
Type of coverage	Primary

Plan Features	
<b>ACCIDENT BENEFITS</b>	
Aggregate Maximum (per cause)	\$5,000
<ul style="list-style-type: none"> <li>Base Plan Maximum (per cause)</li> </ul>	\$1,000
<ul style="list-style-type: none"> <li>Supplemental Plan Maximum (per cause)</li> </ul>	80% to \$4,000
Base Plan Benefits	Unallocated
Supplemental Plan Benefits	Unallocated
Deductible	None
<b>SICKNESS BENEFITS</b>	
Aggregate Maximum (per cause)	\$5,000
<ul style="list-style-type: none"> <li>Base Plan Maximum (per cause)</li> </ul>	\$1,000
<ul style="list-style-type: none"> <li>Supplemental Plan Maximum (per cause)</li> </ul>	80% to \$4,000
Base Plan Benefits	Allocated as shown below
Supplemental Plan Benefits	Unallocated
<b>Inpatient Sickness Benefits</b>	
Hospital Room & Board Expense	\$100
Hospital Room & Board Maximum # of Days	30 days
Hospital Miscellaneous Expense	\$750
Surgical Expense (90 <sup>th</sup> MDR)	\$750
Anesthetist Expense	None
Assistant Surgeon Expense	None
Inpatient Physician Expense	80% to \$100
Inpatient Physician Maximum # of Days	N/A
Licensed Nurse Expense	None
Inpatient Psychiatric Expense	None
<b>Outpatient Sickness Benefits</b>	
Hospital Miscellaneous Expense	\$750
Surgical Expense (90 <sup>th</sup> MDR)	\$750
Anesthetist Expense	None
Assistant Surgeon Expense	None
Outpatient Physician	80% to \$100
Outpatient Expense – Includes: X-Ray and Lab, ER, Medicines, excluding take home drugs and miscellaneous tests and procedures under a Physician's care	80% to \$750
Outpatient Prescription Drug Expense	80% to \$750

Outpatient Psychiatric Expense	None
Sickness Dental Expense	None
<b>Additional Sickness Benefits</b>	
Ambulance Expense	\$75
Voluntary Termination of Pregnancy	None
Accidental Death & Dismemberment	\$1,000
Intercollegiate Sports Coverage	None

<b>Cost Summary</b>	
Student Annual Rate	\$211
Spouse Annual Rate	\$1,006.00
Dependent Annual Rate	\$317
Student Spring Rate	\$141
Spouse Spring Rate	\$674
Dependent Spring Rate	\$212

## MANDATED BENEFITS

The following benefits are mandated by state regulation. These benefits are provided: 1) to the extent that the type of Expense is covered under the basic policy; and 2) at the same payment level as any other Sickness or Injury, unless otherwise stated below.

**Maternity Expense:** We will pay the Expense for maternity inpatient care with respect to a mother covered under the plan and her newborn child as follows: a) for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery; and b) a minimum of 96 hours of inpatient length of stay following a cesarean section. If a decision is made to discharge the mother and newborn child from inpatient care before the expiration of the minimum hours of coverage, We will provide coverage for timely post delivery care. That care may be provided to the mother and newborn by a Physician, registered nurse, or other appropriate licensed health care provider and may be provided at: a) the mother's home; b) a health care provider's office; c) health care facility; or d) another location determined to be appropriate under rules adopted by the commissioner.

**Reconstructive Breast Surgery Expense:** We will pay the Expense for reconstructive surgery incidental to a mastectomy for surgery on the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas and at least two external postoperative prostheses.

**Prostate Cancer Examinations Expense:** We will pay the Expense for annual prostate cancer examinations. The minimum benefits must include: a) physical examination for detection of prostate cancer; b) prostate-specific antigen test used for the detection of prostate cancer for each male: 1) who is at least 50 years of age or asymptomatic; or 2) at least 40 years of age with a family history or prostate cancer or another prostate cancer risk factor.

**Diabetes Expense:** We will pay the Expense incurred in connection with the treatment for diabetes as follows: a) Medically Necessary equipment and supplies; b) pharmacologic agents; c) outpatient self-management training and education. Outpatient self-management training and education shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

**In Vitro Fertilization Expense:** We will provide coverage for services incurred for outpatient Expenses in connection with in vitro fertilization. The following conditions apply to the in vitro fertilization: a) the patient for the in vitro fertilization is an Insured under the policy; b) the fertilization or attempt at fertilization of the patient's oocytes is made only with the patient's spouse's sperm; c) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy; d) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization; and e) the patient and the patient's spouse have a history of infertility of at least five continuous years duration or the infertility is associated with one or more of the following conditions: i) endometriosis; ii) exposure in utero to diethylstilbestrol (DES); iii) blockage of or surgical removal of one or both fallopian tubes; or iv) oligospermia.

**Mammography Expense:** We will pay the Expense for annual screening by low-dose mammography for the presence of occult breast cancer for insured females who are 35 years of age or older.

**Temporomandibular Joint Expense:** We will pay the Expense for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is Medically Necessary as a result of: 1) an Accident; 2) a trauma; 3) a congenital defect; 4) a developmental defect; or 5) a pathology.

**Well Child Benefits Expense:** We will pay the Expense for a screening test for hearing impairment, hearing loss from birth through the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. We will pay the Expense for childhood immunizations from birth through the date the child is six years of age for: a) diphtheria; b) haemophilus influenza type b; c) hepatitis B; d) measles; e) mumps; f) pertussis; g) polio; h) rubella; i) tetanus; j) varicella; and k) any other immunization that is required by law for the child.



**Rehabilitative and Habilitative Services Expense for Children with Developmental Delays:** We will pay the Expense for rehabilitative and habilitative therapies for children with developmental delays including: a) occupational therapy evaluations and services; b) physical therapy evaluations and services; c) speech therapy evaluations and services; and d) dietary or nutritional evaluations.

**Prosthetic and Orthotic Devices Expense:** We will pay the Expense for Medically Necessary Prosthetic Devices, Orthotic Devices, and professional services related to the fitting and use of those devices. Prosthetic and Orthotic Device coverage is limited to the most appropriate model of Prosthetic Device or Orthotic Device that adequately meets the medical needs of the Insured as determined by the Insured's treating Physician or podiatrist and prosthetist or orthotist, as applicable. Prosthetic and Orthotic Device coverage does not include repair and replacement due to misuse or loss by the Insured. "Prosthetic Device" means an artificial device to replace, wholly or partly, an arm or leg. "Orthotic Device" means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

**Cardiovascular Disease Screening Expense:** We will pay the Expense up to \$200 every five years for cardiovascular disease screening for an Insured covered under the plan: (a) who is: (1) a male older than 45 years of age and younger than 76 years of age; or (2) a female older than 55 years of age and younger than 76 years of age; and (b) who: (1) is diabetic; or (2) has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher. Coverage includes one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner by rule: (a) computed tomography (CT) scanning measuring coronary artery calcification; or (b) ultrasonography measuring carotid intima-media thickness and plaque.

**Acquired Brain Injury Expense:** We will pay the Expense for Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, and Psychophysiological Testing and Treatment, Neurofeedback Therapy, and Remediation required for and related to treatment of an Acquired Brain Injury. Coverage is included for Post-Acute Transition Services, Community Reintegration Services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an Acquired Brain Injury. Coverage is included for Reasonable Expenses related to periodic reevaluation of the care of an individual covered under the plan who: 1. has incurred an Acquired Brain Injury; 2. has been unresponsive to treatment; and 3. becomes responsive to treatment at a later date. "Acquired Brain Injury" means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. "Cognitive Communication Therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information. "Cognitive Rehabilitation Therapy" means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits. "Community Reintegration Services" means services that facilitate the continuum of care as an affected individual transitions into the community. "Neurobehavioral Testing" means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others. "Neurobehavioral Treatment" means interventions that focus on behavior and the variables that control behavior. "Neurocognitive Rehabilitation" means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques. "Neurocognitive Therapy" means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities. "Neurofeedback Therapy" means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood. "Neurophysiological Testing" means an evaluation of the functions of the nervous system. "Neurophysiological Treatment" means interventions that focus on the functions of the nervous system. "Neuropsychological Testing" means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning. "Neuropsychological Treatment" means interventions designed to improve or minimize deficits in behavioral and cognitive processes. "Post-Acute Transition

Services” means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration. “Psychophysiological Testing” means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior. “Psychophysiological Treatment” means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors. “Reasonable Expenses” are determined by consideration of factors including: 1) cost; 2) the time that has expired since the previous evaluation; 3) any difference in the expertise of the Physician or practitioner performing the evaluation; 4) changes in technology; and 5) advances in medicine. “Remediation” means the process(es) of restoring or improving a specific function.

## EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

- Expenses for dental treatment, except for treatment resulting from Injury to natural teeth; or as specifically provided by a Sickness Dental Expense Benefit, if included in the policy;
- Services normally provided without charge by the Policyholder's health service, infirmary, Hospital or employees;
- Routine eye exams and contacts; replacing eyeglasses or prescription therefore; routine examinations and services related to hearing examinations or hearing aids; or treatment for hearing defects not related to an Injury or Sickness;
- Routine physical examinations; preventive care; elective surgery and elective treatment; services solely to improve appearance; for personal hygiene; services specifically for dietary control; custodial, sanitarial or rest care; or fertility testing;
- Cosmetic surgery. Cosmetic surgery does not include reconstructive surgery which results from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or deformity of a dependent child. Cosmetic surgery due to congenital defects will be covered for newborn children;
- False labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy;
- Treatment or supplies for the newborn infant except that required for the treatment of a covered Accident or Sickness;
- Voluntary termination of pregnancy;
- Skydiving; recreational parachuting; hang gliding; glider flying; parasailing; sail planing; bungee jumping; or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
- Injury or Sickness resulting from any declared or undeclared war;
- Injury due to participation in a riot; commission of or attempt to commit a felony;
- Suicide, attempted suicide or intentionally self-inflicted Injury;
- Injury or Sickness while in the armed forces of any country. When an Insured enters such armed forces, We will refund the unearned pro rata premium to the Insured;
- Injury or Sickness covered by any workers' compensation or occupational disease law;
- Injury or Sickness resulting from being under the influence of alcohol or drugs unless taken on a Physician's advice;
- Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
- Injury resulting from the practice or play of intercollegiate sports; or
- Pre-Existing Conditions.