



# HANNIBAL-LAGRANGE UNIVERSITY

## 2011-2012

US-037349



P.O. Box 979 • Valley Forge, PA 19482

Toll Free: 800-634-8628

Phone: 610-933-0800 • Fax: 610-933-4122

Email: info@agadm.com • www.agadministrators.com

## EXCLUSIONS AND LIMITATIONS

No benefits will be paid for loss or expense caused by or resulting from:

- Injury of the primary insured covered under any student accident insurance policy underwritten by us;
  - Any Sickness, as defined, that was initially diagnosed, treated or recommended for treatment prior to the Term of Coverage for a Covered Person, unless continuous coverage is applied;
  - Services and supplies furnished normally without charge by the participating institution's infirmary, its employees, or doctors who work for the participating institution;
  - Services covered or provided by the student health fee;
  - Normal health checkups, preventive testing or treatment, screening exams or testing in the absence of injury or sickness. This exclusion does not apply to medically necessary mammograms and pap smears;
  - Eye examinations, prescriptions or fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, unless payable as a covered expense associated with a sickness or injury covered by the policy;
  - Hearing examinations or hearing aids, or other treatment for hearing defects and problems, unless payable as a covered expense associated with an injury covered by the policy;
  - Dental treatment, except as specifically provided for in the Schedule;
  - War or any act of war, declared or undeclared, or while in the armed forces of any country;
  - Participation in a riot or civil disorder, commission of or attempt to commit a felony, or fighting, except in self-defense;
  - Intentionally self-inflicted injury, suicide or any attempt thereat.
  - Injury of any covered person sustained while:
    - a. Participating in any school, professional or organized sports contest or competition, unless specifically listed in the Schedule;
    - b. Traveling to or from such sport, contest or competition as a participant; or
    - c. During participation in any practice or conditioning program for such sport, contest or competition;
  - Skydiving; parachuting or bungi-cord jumping, hang gliding, glider flying, parasailing, sail planing, or flight in any kind of aircraft, except while riding as passenger on a regularly scheduled flight of a commercial airline;
  - Treatment in a military or Veterans Hospital or a hospital contracted for or operated by a national government or its agency unless:
    - a. The services are rendered on a medical emergency basis; and
    - b. A legal liability exists for the charges made on behalf of a covered person for the services given in the absence of insurance;
  - Injury caused by, or resulting from, the use of alcohol, controlled substance, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the person's doctor;
  - Any treatment for mental and nervous disorders, unless provided by Rider attached to the policy;
  - Psychotherapy, except as specifically provided for in the Schedule;
  - Elective surgery and elective treatment, except as required to correct an injury for which benefits are otherwise payable under the policy;
  - Prescription drugs dispensed or purchased unless during a hospital stay, or if specifically covered under the policy when dispensed at the student health center;
  - Any loss covered by state or federal worker's compensation law, employers liability law, occupational disease law, or similar laws
- or act;
  - Physiotherapy, except as specifically provided for in the Schedule;
  - Braces and appliances, except as specifically provided for in the Schedule;
  - Replacement braces and appliances;
  - Assistant surgeon services, except as specifically provided for in the Schedule;
  - Expense incurred within your home country or country of regular domicile;
  - Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;
  - Accidental bodily injuries arising out of a motor vehicle accident to the extent these benefits are payable under any medical expense payment provision (by whatever terminology used – including such benefits mandated by law) of any automobile policy;
  - Nuclear reaction or the release of nuclear energy. However, this exclusion will not apply if the loss is sustained within 180 days of the initial incident and:
    - (i) The loss was caused by fire, heat, explosion or other physical trauma which was a result of the release of nuclear energy; and
    - (ii) The covered person is within a 25-mile radius of the site of the release either:
      - At the time of the release; or
      - Within 24 hours of the start of the release;
  - Travel in or upon:
    - a. A snowmobile;
    - b. Any two-or three-wheeled motor vehicle; or
    - c. Any off-road motorized vehicle not requiring licensing as a motor vehicle;
  - Any accident where the covered person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license, except while in a Driver's Education Program;
  - Preventive medicines, serums, vaccines;
  - Blood or blood plasma, except for charges by a hospital for the processing or administration of blood;
  - Rest cures or custodial care;
  - Personal services such as television and telephone or transportation;
  - A hernia of any kind

### EXTENSION OF BENEFITS

If you are under the care and treatment of a doctor for a injury, benefits will continue to be paid for that condition for a period of up to 3 months following your term of coverage, or until there has been paid the maximum benefit, whichever occurs first.

### CONTINUOUS COVERAGE

If you are continuously covered under the policy offered through your participating institution you will be covered for an injury sustained while so covered. If you enroll for coverage offered through your participating institution within 30 days of the end of any preceding company's policy you will be considered to have maintained continuous coverage, except for expenses that are the liability of the previous policy. Coverage cannot be considered continuous if a break in enrollment of more than 30 days occurs.

Premiums are not prorated beyond this schedule.

**COST**  
**August 1, 2011 - August 1, 2012**

Student Only \_\_\_\_\_  \$660

Student and Spouse \_\_\_\_\_  \$2,462

Each Child \_\_\_\_\_  \$1,234



Plan administered by AG Administrators, Inc.

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# DESCRIPTION OF BENEFITS

## INJURY/SICKNESS SCHEDULE OF BENEFITS

**Maximum Benefit per Accident/Sickness: \$50,000 per policy**  
**Deductible: \$50 per policy year**

### BENEFITS

#### Inpatient Hospital Expense:

Room and Board Intensive Care	80% URC	Semi-private room rate up to \$1000 per day with a 30 day max
Hospital Miscellaneous	80% URC	Preadmission Testing to be included and must be done within 3 days of admission
Surgeon's Fees	80% URC	\$2000 max per policy period for inpatient and outpatient procedures

#### Surgical Expense (Inpatient and Outpatient):

Inpatient Surgery	80% URC	Semi-private room rate up to \$1000 per day with 30 day max
Outpatient Surgery	80% URC	\$1000 max per policy period

Anesthesia	25% of the Surgical Expense	
Assistant Surgeon	25% of the Surgeon Allowable	

#### Outpatient Miscellaneous Expense: Note: Outpatient miscellaneous expense has a \$700 max per policy year

Office Visit	80% URC	\$30 co-payment for office visits
Chiropractic Care	80% URC	
Physical Therapy	80% URC	
Medical Emergency Care	80% URC	
Speech Therapy	80% URC	
Medical Emergency Services	80% URC	
Nurse Benefits	80% URC	

#### Mental and Nervous:

Inpatient	80% URC	
Outpatient	80% URC	\$500 max per policy year

#### Alcohol and Substance Abuse:

Inpatient and Outpatient	80% URC	
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#### Additional Benefits

Prescription Drugs	80% URC	Caremark RX Card \$350 max per year
DME (Durable Medical Equipment)	80% URC	\$1000 max per year
Ambulance Expense	80% URC	\$500 max per year
Accident Dental Injury	80% URC	\$200 max per year
Maternity Expense	80% URC	Pre-natal Vitamins excluded

# DESCRIPTION OF PLAN

All Students enrolled (minimum of twelve credit hours) in the plan will be insured for those injuries covered by the plan for which the premium has been paid.

Spouses and children of students enrolled in the insurance plan will be covered by the plan for which the premium has been paid.

Deductible for those enrolled in the insurance plan will be \$50.00. Coinsurance for those enrolled in the insurance plan is 20%. Maximum benefit amount awarded will not exceed \$50,000.

### BENEFITS FOR IMMUNIZATIONS

Benefits will be paid the same as any other Sickness for immunizations of a child from birth to five years of age as provided by department of health regulations.

Benefits shall not be subject to any Deductible or copayment limits.

### BENEFITS FOR DENTAL GENERAL ANESTHESIA

Benefits will be paid the same as any other Sickness for administration of general anesthesia and Hospital charges for dental care to a Dependent child under the age of five, a Covered Person who is severely disabled, or a Covered Person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.

### BENEFITS FOR INITIAL PROSTHETIC DEVICE AND RECONSTRUCTIVE SURGERY

Benefits will be paid the same as any other Sickness for the initial prosthetic device or reconstructive surgery necessary to restore symmetry incident to Mastectomy when recommended by a Doctor. "Mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a Doctor. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.

### BENEFITS FOR CYTOLOGIC SCREENING

Benefits will be paid the same as any other Sickness for a pelvic examination and cytologic screening (pap smear) for an Covered Person in accordance with the current American Cancer Society guidelines.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.

### BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for a colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Covered Person in accordance with the current American Cancer Society guidelines.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.

### BENEFITS FOR PROSTATE SCREENING

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Covered Person in accordance with the current American Cancer Society guidelines.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy.

### DIABETES TREATMENT BENEFIT

Covered expenses include all medically appropriate and necessary equipment and supplies and diabetes outpatient self-management training and educational services used to treat diabetes when the treating doctor certifies that such treatment is medically necessary.

## HANNIBAL-LA GRANGE UNIVERSITY - 2011 STUDENT ACCIDENT & SICKNESS INSURANCE ENROLLMENT FORM

AG ADMINISTRATORS • P.O. Box 979 • Valley Forge, Pa 19482

Student's Name (Please Print) \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 (Last Name) (First Name) (M.I.)  
 (Street) (City) (State) (Zip) Email \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_

I wish to purchase the following coverage (Check box on the back side of this form). If purchasing dependent coverage, list dependents below on this form.  
 This charge will be put on to your student account after a completed form is turned into the Business Office.

**DEPENDENT INFORMATION**

Student Name _____	Birth Date _____
Spouse's Name _____	Birth Date _____
Child's Name _____	Birth Date _____
Student Signature _____	Date / / _____

Soc. Sec. # \_\_\_\_\_  
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