AcademicBlue℠

ORU ORAL ROBERTS UNIVERSITY

Oral Roberts University Student Health Insurance Plan 2016-2017

Underwritten by:
Blue Cross and Blue Shield of Oklahoma (BCBSOK)

Please read the brochure to understand your coverage.
Please see "Important Notice" on the final page of this document.

Account Number:
Medical: 188776

Table of Contents

Introduction

Oral Roberts University is pleased to offer the AcademicBlue Student Health Insurance Plan, underwritten by Blue Cross and Blue Shield of Oklahoma and administered by Academic HealthPlans. This brochure explains your health care benefits, including what health care services are covered and how to use the benefits. This insurance Plan protects Insured students and their covered Dependents on or off campus for weekends, holidays, summer vacations, at home or while traveling 24 hours per day for the Policy year. This Plan meets the requirements of the Affordable Care Act. The actuarial value of this plan is 70%, which would meet or exceed a silver metal level of coverage. This policy will always pay benefits in accordance with any applicable federal and Oklahoma state insurance law(s).

Keep these three fundamental Plan features in mind as you learn about this Policy:

- **This student health insurance plan is a Participating Provider Option (PPO) plan.** You should seek treatment from the BCBSOK BlueChoice® Participating Provider Option (PPO) Network, which consists of hospitals, doctors, ancillary, and other health care providers who have contracted with BCBSOK for the purpose of delivering covered health care services at negotiated prices, so you can maximize your benefits under this Plan. A list of network providers can be found online at **oru.myahpcare.com** by clicking on the "Find a Doctor or Hospital" link under "Benefits," or by calling (855) 267-0214. Using BCBSOK providers may save you money.
- **Participating in an insurance plan does not mean all of your health care costs are paid in full by the insurance company.** There are several areas for which you could be responsible for payment, including, but not limited to, a Deductible, a Copayment or Coinsurance (patient percentage of Covered Medical Expenses), and medical costs for services excluded by the Plan.
- **It is your responsibility to familiarize yourself with this plan. Exclusions and limitations are applied to the coverage as a means of cost containment (please see page 17 for more details).** To make this coverage work for you, it is helpful to be informed and proactive. Check the covered benefits in this brochure before your procedure whenever possible. Know the specifics and communicate them to your health care provider. Review the User Guide for a step-by-step overview of how to use your benefits.

We are here to help.
Representatives from Academic HealthPlans and BCBSOK are available to answer your questions. You may contact AHP at (855) 422-3833 for enrollment and eligibility questions and BCBSOK at (855) 267-0214 for benefit and claim questions.

Please Note: We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your Policy. Please review the meaning of the capitalized terms in the Definitions section on page 13.

Privacy Notice

We know that your privacy is important to you and we strive to protect the confidentiality of your personal health information. Under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the HIPAA Notice of Privacy Practices upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605, or call **(817) 809-4700**, or you may view and download a copy from the website at **oru.myahpcare.com**.

Eligibility/How to Enroll

The Policy issued to the University is a non-renewable, one-year term policy. However, if you still maintain the required eligibility, you may purchase the Plan the next year. It is the Covered Person's responsibility to enroll for coverage each year in order to maintain continuity of coverage, unless you are automatically enrolled. If you no longer meet the eligibility requirements, contact Academic HealthPlans at **(855) 422-3833** prior to your termination date.

Eligibility Requirements

All registered international and domestic degree-seeking students, including full and part-time students, are eligible and may enroll in this plan.

Eligible students who enroll may also insure their Dependents. Dependent enrollment must take place at the initial time of student enrollment (or within 30 days if the premium is billed with the student's tuition); exceptions to this rule are made for newborn or adopted children, or for Dependents who become eligible for coverage as the result of a qualifying event. (Please see "Qualifying Events," on page 3, for more details.) Dependent means an Insured's lawful spouse or an Insured's child, stepchild, foster child, dependent grandchild or spouse's dependent grandchild, or a child who is adopted by the Insured or placed for adoption with the Insured, or for which the Insured is a party in a suit for the adoption of the child; or a child whom the Insured is required to insure under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the Company within 31 days after the date the child ceases to qualify as a dependent for the reasons listed above. During the next two years, the Company may, from time to time, require proof of the continuation of such condition and dependence. After that, the Company may require proof no more than once a year. Dependent coverage is available only if the student is also insured. Dependent coverage must take place within the exact same coverage period as the Insured's; therefore, it will expire concurrently with that of the Insured's Policy.

A newborn child will automatically be covered for the first 31 days following the child's birth. To extend coverage for a newborn child past the 31-day period, the covered student must:

1) Enroll the child within 31 days of birth, and

2) Pay any required additional premium

If you're not eligible for the Student Health Insurance Plan and would like coverage, please visit **ahpcare.com**.

If you're enrolled in Medicare due to age or disability, you are not eligible for the Student Health Insurance Plan.

Qualifying Events

Eligible students who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under the Policy provided that, within 31 days of the qualifying event, such students send to Academic HealthPlans:

- A copy of the Certificate of Creditable Coverage, or a letter of ineligibility (lost coverage), from their previous health insurer
- A Qualifying Events form, which they can download from **oru.myahpcare.com**

A change in status due to a qualifying event includes but is not limited to:

- Birth or adoption of a child
- Loss of a spouse, whether by death, divorce, annulment or legal separation
- If you are no longer covered on a family member's policy because you turned 26

The premium will be prorated as it would have been at the beginning of the semester. However, the effective date will be the later of the following: the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. To apply for coverage that is needed because of a qualifying event, you may download the "Qualifying Events Form" from **oru.myahpcare.com.**

Effective Dates and Termination

The Policy on file at the school becomes effective at 12 a.m. Central time at the University's address on the later of the following dates:

1) The effective date of the Policy**,** August 10, 2016; or

2) The date after the premium is received by the Company or its authorized representative.

Effective and Termination Dates

Domestic and International Students	From	Through
Annual	08/10/2016	08/09/2017
Fall	08/10/2016	12/31/2016
Spring/Summer	01/01/2017	08/09/2017

Open Enrollment Periods

The open enrollment periods during which students may apply for coverage for themselves, and/or their eligible spouse and/or Dependents, is as follows:

Annual/Fall July 22, 2016– August 31, 2016
Spring/Summer December 01, 2016 – January 31, 2017

The coverage provided with respect to the Covered Person shall terminate at 11:59 p.m. Central time on the earliest of the following dates:

1. The last day of the period through which the premium is paid;
2. August 9, 2017; or
3. The date the eligibility requirements are not met.

Renewal Notice

It is the student's responsibility to make a timely renewal payment to avoid a lapse in coverage. Please refer to your enrollment form to review the payment options you selected as a reminder of the enrollment periods and effective dates for your campus. Mark your calendar now to avoid any lapse in coverage. All Insureds who enroll for periods of less than one year will be mailed a renewal notice, to the Insured's last known address, to submit their next premium payment; however, it is the Insured's responsibility to make a timely renewal payment.

PLEASE NOTE: Renewal notices will not be mailed from one policy year to the next. If you maintain your student status, you will be eligible to enroll in the following year's policy.

Coverage period notice: Coverage periods are established by the University and subject to change from one Policy year to the next. In the event that a coverage period overlaps another coverage period, the prior coverage period will terminate as of the effective date of the new coverage period. In no case will an eligible member be covered under two coverage periods within the same group.

Extension of Benefits after Termination

The coverage provided under the Plan ceases on the termination date. However, if a Covered Person is hospital- confined on the termination date for a covered Injury or Sickness for which benefits were paid before the termination date, the Covered Expenses for such covered Injury or Sickness will continue to be paid provided the condition continues. However, payments will not continue after the earlier of the following dates: 90 days after the termination date of coverage, or the date of the Insured's discharge date from the hospital. The total payments made for the Covered Person for such condition, both before and after the termination date, will never exceed the maximum benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Coordination of Benefits

Under a Coordination of Benefits (COB) provision, the plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the Covered Expenses. When one plan does not have a COB provision, that plan is always considered Primary, and always pays first. You may still be responsible for applicable Deductible amounts, Copayments and Coinsurance.

Additional Covered Expenses

The Policy will always pay benefits in accordance with any applicable federal and state insurance law(s).

Schedule of Benefits

The Network Provider for this Plan is Blue Cross and Blue Shield of Oklahoma (BCBSOK) BlueChoice® PPO Network. After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at **70%** of the Allowable Charge for services rendered by Network Providers in the BCBSOK BlueChoice® PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network Providers (any provider outside the BCBSOK BlueChoice® PPO Network) will be paid at **50%** of the Allowable Charge, unless otherwise specified in the Policy. Benefits will be paid up to the maximum for each service as specified below, regardless of the provider selected.

AT PHARMACIES CONTRACTING WITH THE PRIME THERAPEUTICS NETWORK: You must go to a pharmacy contracting with the Prime Therapeutics Network in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this Plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy by calling **(800) 423-1973**; you also can locate one online at **oru.myahpcare.com** by clicking on the "Find a Pharmacy" link under "Benefits."

Maximum Benefit	Unlimited	
	Network Provider	Out-of-Network Provider
Deductible (Per Covered Person, Per Policy year)	$3,500 Student $7,000 Family	$9,000 Student $27,000 Family
Out-Of-Pocket Maximum (Per Covered Person, Per Policy year)	$6,850 Student $12,700 Family	$12,500 Student $37,500 Family

OUT-OF-POCKET MAXIMUM means the maximum liability that may be incurred by a Covered Person in a benefit period for covered services, under the terms of a Coverage Plan. Once the Out-of-Pocket Maximum has been satisfied, Covered Expenses will be payable at **100%** for the remainder of the Policy year, up to any maximum that may apply. Coinsurance applies to the Out-of-Pocket Maximum.

The Network Out-of-Pocket Maximum may be reached by:

- The network Deductible
- Charges for outpatient prescription drugs
- The hospital emergency room Copayment
- The Copayment for Doctor office visits
- The Copayment for Specialist's office visits
- The payments for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the hospital's rate for a private room and a semi-private room, or any expenses incurred for Covered Services rendered by an Out-of-Network Provider other than Emergency Care and Inpatient treatment during the period of time when a Covered Person's condition is serious)

The relationship between Blue Cross and Blue Shield of Oklahoma (BCBSOK) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSOK, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

The Out-of-Network Out-of-Pocket Maximum may be reached by:

- The Out-of-Network Deductible
- The hospital emergency room Copayment
- The payments for Covered Services rendered by an Out-of-Network Provider for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the hospital's rate for a private room and a semi-private room)

Deductible applies unless otherwise noted

Inpatient	Network Provider	Out-of-Network Provider
Hospital Expenses: Includes daily semi-private room rate; intensive care; general nursing care provided by the hospital; hospital miscellaneous expenses such as the cost of the operating room, laboratory tests, X-ray examinations, pre-admission testing, anesthesia, drugs (excluding take-home drugs) or medicines, physical therapy, therapeutic services and supplies.	**70%** of Allowable Charge	**50%** of Allowable Charge
Surgical Expense: When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Charge for that procedure.	**70%** of Allowable Charge	**50%** of Allowable Charge
Assistant Surgeon	**70%** of Allowable Charge	**50%** of Allowable Charge
Anesthetist	**70%** of Allowable Charge	**50%** of Allowable Charge
Doctor's Visits	**70%** of Allowable Charge	**50%** of Allowable Charge
Routine Well-Baby Care	**70%** of Allowable Charge	**50%** of Allowable Charge
Mental Illness/Substance Abuse Disorder	Paid as any other covered Sickness	Paid as any other covered Sickness

Outpatient	Network Provider	Out-of-Network Provider
Surgical Expense: When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure.	**70%** of Allowable Charge	**50%** of Allowable Charge
Day Surgery Miscellaneous: Related to scheduled surgery performed in a hospital, including the cost of the operating room, laboratory tests, X-ray examinations, professional fees, anesthesia, drugs or medicines and supplies.	**70%** of Allowable Charge	**50%** of Allowable Charge
Assistant Surgeon	**70%** of Allowable Charge	**50%** of Allowable Charge
Anesthetist	**70%** of Allowable Charge	**50%** of Allowable Charge
Doctor Office Visit/Consultation: **Doctor:** Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians **Specialist:** Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider refer to Medical/Surgical Expenses section for more information.	**100%** of Allowable Charge after **$25** Copayment per visit (Deductible waived) **$35** Copayment per visit (Deductible waived)	**50%** of Allowable Charge
Physical Medicine Services: Physical therapy or chiropractic care - office services. Physical medicine services include, but are not limited to, physical, occupational, and manipulative therapy.	**70%** of Allowable Charge	**50%** of Allowable Charge
Benefit Period Visit Maximum	Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and muscle manipulations/spinal subluxation will be limited to a combined maximum of 25 visits per Benefit Period.	

Outpatient	Network Provider	Out-of-Network Provider
Radiation Therapy and Chemotherapy: Includes dialysis and respiratory therapy	**70%** of Allowable Charge	**50%** of Allowable Charge
Emergency Care and Accidental Injury		
Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply)	**70%** of Allowable charge after **$100** Copayment. (Deductiblewaived)	
Physician services	**70%** of Allowable charge after Deductible	
Non-Emergency Care		
Facility Services: (Copayment is waived if the Insured is admitted; Inpatient hospital expenses will apply)	**70%** of Allowable Charge after **$100** Copayment (Deductible waived)	**50%** of Allowable Charge after Deductible
Physician Services:	**70%** of Allowable Charge after Deductible	**50**% of Allowable Charge after Deductible
Urgent Care Services	**70%** of Allowable Charge after Deductible	**50%** of Allowable Charge
Diagnostic X-rays and Laboratory Procedures	**70%** of Allowable Charge	**50%** of Allowable Charge
Tests and Procedures: Diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits	**70%** of Allowable Charge	**50%** of Allowable Charge
Mental Illness/Substance Abuse Disorder	Paid as any other covered Sickness	Paid as any other covered Sickness
Extended Care Expenses	**Network Provider**	**Out-of-Network Provider**
Extended Care Expenses: All services must be pre-authorized.	**70%** of Allowable Charge	**50%** of Allowable Charge
Home Health Care	Limited to 30 visit maximum each Benefit Period	
Skilled Nursing	Limited to 30 visit maximum each Benefit Period	
Hospice Care	No Benefit Period visit maximum	
Private Duty Nursing	Limited to 85 visit maximum each Benefit Period	

Other	Network Provider	Out-of-Network Provider
Ground and Air Ambulance Services	**70%** of Allowable Charge	**70%** of Allowable Charge
Durable Medical Equipment: When prescribed by a Doctor and a written prescription accompanies the claim when submitted.	**70%** of Allowable Charge	**50%** of Allowable Charge
Maternity/Complications of Pregnancy	**70%** of Allowable Charge	**50%** of Allowable Charge
Speech and Hearing Services: Services to restore loss of or correct an impaired speech or hearing function	**70%** of Allowable Charge	**50%** of Allowable Charge
Hearing Aids Hearing Aid Maximum	Hearing Aids Coverage includes: For children up to age 18: one hearing aid per ear every 48 months but coverage may provide up to four additional ear molds.	

Other	Network Provider	Out-of-Network Provider
Dental: Made necessary by Injury to sound, natural teeth only.	**80%** of Allowable Charge	**60%** of Allowable Charge
Pediatric Vision, up to age 19: See benefit flier for details	**100**% of Allowable charge	Refer to set Fee Schedule
Pediatric Routine Dental Care, up to age 19: See benefit flier for details.	**80%** of Allowable charge	**60%** of Allowable amount
Pediatric Basic and Major Dental, up to age 19: See benefit flier for details	**50%** of Allowable charge	**30%** of Allowable charge
Pediatric Medically Necessary Orthodontia, up to age 19: See benefit flier for details. (Deductible waived)	**50%** of Allowable charge	**30%** of Allowable charge
Organ and Tissue Transplant Services: The transplant must meet the criteria established by BCBSOK for assessing and performing organ or tissue transplants as set forth in BCBSOK's written medical policies.	**70%** of Allowable Charge	**50%** of Allowable Charge

Other	Network Provider	Out-of-Network Provider
Preventive Care Services: a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"); c. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and d. With respect to women, such additional preventive care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the HRSA. Preventive care services as mandated by state and federal law. Please refer to the Policy or call Blue Cross and Blue Shield of Oklahoma for more information at **(855) 267-0214.**	**100%** of Allowable Charge (Deductible waived)	**50%** of Allowable Charge

Pharmacy Benefits	Network Provider	Out-of-Network Provider
Retail Pharmacy: (Deductible waived) Benefits include diabetic supplies. Copayment amounts are based on a 30-day supply. With an appropriate prescription order, up to a 90-day supply is available at three (3) times the Copayment. Copayment amounts will apply to Out-of-Pocket Maximum.	*At pharmacies contracting with Prime Therapeutics Network:* **100%** of Allowable Charge after a	When a Covered Person obtains prescription drugs from an Out-of-Network pharmacy (other than a Network pharmacy): Benefits will be provided at **50%** of the allowable amount a Covered Person would have received had he/she obtained drugs from a Network pharmacy minus the Copayment amount or Coinsurance amount.
Generic Drug	**$25** Copayment	**$25** Copayment
Preferred Brand-name Drug	**$40** Copayment*	**$40** Copayment*
Non-Preferred Brand-name	**$60** Copayment*	**$60** Copayment*

*Copayment plus the cost difference between the Brand Name Drug or supplies per prescription for which there is generic drug or supply available.

Pre-Authorization Notification

BCBSOK should be notified of all hospital confinements prior to admission.

1. **Pre-authorization Notification of Medical Non-emergency Hospitalizations:** The patient, Doctor or hospital should telephone **(800) 441-9188** at least one (1) working day prior to the planned admission.

2. **Pre-authorization Notification of Medical Emergency Hospitalizations:** The patient, patient's representative, Doctor or hospital should telephone **(800) 441-9188** within two (2) working days of the admission or as soon as reasonably possible to provide the notification of any admission due to medical emergency.

BCBSOK is open for Pre-authorization Notification calls from 8 a.m. to 6 p.m. Central time, Monday through Friday.
IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; in addition, pre-authorization notification is not a guarantee that benefits will be paid.

The relationship between Blue Cross and Blue Shield of Oklahoma (BCBSOK) and Contracting Pharmacies is that of Independent Contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSOK, as well as several other independent Blue Cross Plans, has an ownership interest in Prime Therapeutics.

Definitions

Allowable Charge means the maximum amount determined by BCBSOK to be eligible for consideration of payment for a particular service, supply or procedure.

For hospitals, Doctors and other providers contracting with Us or any other Blue Cross and Blue Shield Plan - The Allowable Charge is based on the terms of the Network Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For hospitals, Doctors and other providers not contracting with Us or any other Blue Cross and Blue Shield Plan (non-contracting Allowable Charge) - The Allowable Charge will be the lesser of:

(i) The provider's billed charges, or

(ii) The non-contracting Allowable Charge.

The Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor shall be not less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for non-contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. We will utilize the same claim processing rules and/or edits that We utilize in processing participating provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Plan does not have any claim edits or rule, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Us within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

In the event the non-contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's the non-contracting Allowable Charge for a particular service, Covered Persons may call customer service at (855) 267-0214.

For multiple surgeries - The Allowable Charge for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

For Prescription Drugs as applied to Network Provider and Out-of-Network Provider Pharmacies - The Allowable Charge for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSOK and the pharmacy in effect on the date of service. The Allowable Charge for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

Benefit Period means the period of time starting with the effective date of this Policy through the termination date as shown on the face page of the Policy. The Benefit Period is as agreed to by the Policyholder and the Insurer.

Coinsurance means a percentage of an eligible expense that the Covered Person is required to pay toward a Covered Expense.

Company means Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (also referred to herein as "BCBSOK").

Copayment means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Policy.

Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date of the accident or Sickness until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply that gave rise to the expense or the charge was rendered or obtained.

Covered Person means any eligible student or an eligible dependent who applies for coverage, and for whom the required premium is paid to the Company.

Deductible means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before benefits are payable under the Policy.

Dependent means an Insured's lawful spouse including or an Insured's child, stepchild, foster child, dependent grandchild or spouse's dependent grandchild; or a child who is adopted by the Insured or placed for adoption with the Insured, or for whom the Insured is a party in a suit for the adoption of the child; or a child whom the Insured is required to insure under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

Doctor means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's immediate family or household.

Emergency Care means health care services provided in a hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Sickness or Injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate such emergency medical condition and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

Injury means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a covered accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Inpatient means that a Covered Person is a registered bed patient and is treated as such in a health care facility.

Insured means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

Interscholastic Activities means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

Medically Necessary means those services or supplies covered under the Plan that are:

- Essential to, consistent with, and provided for in the diagnosis or the direct care and treatment of the condition, Sickness, disease, *I*njury, or bodily malfunction; and
- Provided in accordance with, and are consistent with, generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Insured, his physician, behavioral health practitioner, the hospital, or the other provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Insured. When applied to hospitalization, this further means that the Insured requires acute care as a bed patient due to the nature of the services provided or the Insured's condition, and the Insured cannot receive safe or adequate care as an outpatient.

The medical staff of BCBSOK shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities; the guidelines and practices of Medicare, Medicaid, or other government-financed programs; and peer-reviewed literature. Although a physician, behavioral health practitioner or professional other provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Network Provider means a Hospital, Doctor or other provider who has entered into an agreement with BCBSOK (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

Out-of-Network Provider means a Hospital, Doctor or other provider who has not entered into an agreement with BCBSOK (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

Outpatient means that a Covered Person is receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether a Covered Person is subsequently registered as an Inpatient in a health care facility**.**

Out-of-Pocket Maximum means the maximum liability that may be incurred by a Covered Person in a Benefit Period before benefits are payable at 100% of the Allowable Charge.

Pre-authorization means the process that determines in advance the Medical Necessity or experimental, Investigational and/or unproven nature of certain care and services under this Policy.

Qualifying Intercollegiate Sport means a sport: (a.) which has been accorded varsity status by the Institution as an NCAA sport; and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which the eligibility of the participating student athlete is reviewed and certified in accordance with NCAA legislation, rules, or regulations; and (d.) which entitles qualified participants to receive the Institution's official awards.

Sickness means an illness, disease or condition of the Covered Person causing the Covered Person to incur medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

We, Our, Us means Blue Cross and Blue Shield of Oklahoma or its authorized agent.

Exclusions and Limitations

Except as specified in this Policy, coverage is not provided for loss or charges incurred by or resulting from:

1. Services that are not Medically Necessary or in excess of the Allowable Charge;

2. Services that are provided, normally without charge, by the Student Health Center, infirmary or hospital, or by any person employed by the University;

3. Acne, including acne prescription drugs covered under Outpatient Prescription Drug Program;

4. Acupuncture procedures;

5. Biofeedback procedures;

6. Breast augmentation or reduction;

7. Routine circumcision, unless the procedure is Medically Necessary for treatment of a sickness, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an accident or except for covered infants within 28 days of birth;

8. Non-malignantwarts;

9. Moles;

10. Lesions;

11. Testing or treatment for sleep disorders;

12. Any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are experimental or investigational or unproven;

13. Any illness or Injury occurring in the course of employment if whole or partial compensation or Benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or Injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not a Covered Person claims the Benefits or compensation or recover the losses from a third party.

    -The Covered Person agrees to:
    - Pursue their rights under the worker's compensation laws;
    - Take no action prejudicing the rights and interests of the Plan; and
    - Cooperate and furnish information and assistance the Plan requires to help enforce its rights.

    -If a Covered Person receives any money in settlement of their employer's liability, regardless of whether the settlement includes a provision for payment of their medical bills, the Covered Person agrees to:
    - Hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - To repay the Plan any money recovered from their employer or insurance carrier.

14. Treatment, services or supplies in a Veteran's Administration facility or hospital owned or operated by a national government or its agencies, unless there is a legal obligation for the Covered Person to pay for the treatment;

15. Testing for or treatment of allergies;

16. Expenses in connection with services and prescriptions for eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses; radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems, except for pediatric vision;

17. Sinus or other nasal surgery, including correction of a deviated septum by sub mucous resection and/or other surgical correction, except for a covered Injury;

18. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
    - A covered Injury that occurred while the Covered Person was insured;
    - An infection or other diseases of the involved part; or
    - A covered child's congenital defect or anomaly;

19. Injuries arising from Interscholastic Activities and Qualifying Intercollegiate Sports;

20. Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;

21. Injury resulting from racing or speed contests, skin diving, sky diving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;

22. War or acts of war, whether declared or undeclared, when serving in the military or an auxiliary until thereto;

23. Elective abortion, unless the life of the mother is endangered. (No longer bracketed)

24. Any expenses incurred in connection with sexual dysfunction, or sterilization reversal, vasectomy reversal and sexual reassignment;

25. Reproductive/Infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction; in vitro fertilization; embryo transplant; or similar procedures that augment or enhance the Covered Person's reproductive ability;

26. For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "Human Organ, Tissue and Bone Marrow Transplant Services;"

27. Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury;

28. Foot care, including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;

29. Hearing examinations: hearing aids; or other treatment for hearing defects or problems, except as specified under *"Audiological Services"* for Covered Persons up to age 18. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

30. Hirsutism;

31. Alopecia;

32. Gynecomastia;

33. Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;

34. Treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; bariatric Surgery or other surgical procedures for weight reduction; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.

35. Surgery for the removal of excess skin or fat;

36. Nutrition programs, except as related to treatment for diabetes;

37. Weight loss programs, except as related to treatment for diabetes;

38. Custodial care;

39. Long-term care service;

40. Treatment of temocclusion, alteration of teeth or jaws, Physical Therapy and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis;]smoking cessation programs, not including counseling as specified under "Preventive Care Services".

41. Prescription drug coverage is not provided for:
    - Refills in excess of the number specified or dispensed after one (1) year from the date of the Prescription;
    - Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs;
    - Immunizing agents, biological sera, blood or blood products administered on an outpatient basis; except as specifically provided in this Policy;

- Any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use;
- Drugs used for cosmetic purposes, including, but not limited to, Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc.;
- Fertility agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra;
- Lost or stolen prescriptions;
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control;
- Non-sedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant;
- Brand name proton pump inhibitors;
- Compound medications. For purposes of this exclusion. “compound medications” are substances made my mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product’s manufacturer and other FDA-approved manufacturer directions consistent with that labeling;
- Drugs determined by the Plan to have inferior efficacy or significant safety issues;
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.

Academic Emergency Services*

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans (AHP) has included Academic Emergency Services benefits in your student health plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small.

The following services and benefits are available to you 24 hours a day, 7 days a week:

Medical Assistance: Pre-travel information; physician referrals; medical monitoring to ensure adequate care; 24/7 Nurse Help Line; prescription assistance or medicine dispatch.

Emergency Medical Evacuation and Repatriation: Unlimited benefit for evacuation from inadequate facility to higher level of care facility, repatriation home for continued care if medically necessary, or recovery and repatriation of deceased remains.

Accidental Death and Dismemberment: $25,000 benefit

Emergency Family Assistance: Benefits for visit of a family member or friend if hospitalized for 3 or more days, return of children if left unattended, bereavement reunion, emergency return home in the event a participant's family member suffers life threatening illness or death and return of participant's personal belongings in the event of evacuation or death.

Travel, Legal and Security Assistance: Pre-travel destination information or security advice; assistance locating lost luggage; passport replacement assistance; emergency travel arrangements; translation assistance; interpreter referral; legal consultation and referral; emergency message forwarding.

Preparing for your time away from home is easy, simply visit the Academic Emergency Services portal:

aes.myahpcare.com

To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis, call Academic Emergency Services immediately.

(855) 873-3555 call toll free from the US
+ 1 (410) 453-6354 call collect from anywhere
Email: assistance@ahpcare.com

This provides you with a brief outline of the services available to you. Terms, conditions, limitations and exclusions apply. All services must be arranged and paid for through AES service provider. There is no claim process for reimbursement of self-paid expenses unless specifically described in the service plan.

*Academic Emergency Services (AES) is a global emergency services product. These services are provided by a separate and independent company from AES or Academic HealthPlans. AES provides medical, security and natural disaster evacuation services, repatriation of remains, emergency medical and travel assistance, travel information and other services for Academic HealthPlans.

BlueCard®

Like all Blue Cross and Blue Shield Licensees, We participate in a program called "BlueCard." Whenever the Covered Person accesses health care services outside Our service area, the Claims for those services may be processed through BlueCard and presented to Us for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Covered Persons incur Covered Expenses within the geographic area served by an onsite Blue Cross and/or Blue Shield Licensee ("Host Blue"), We will remain responsible to the Covered Person for fulfilling the Policy's contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interactions with its participating providers.

Summary of Benefits and Coverage

The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your insurance Policy. To obtain an SBC for your Policy, please go to **oru.myahpcare.com.**

BCBSOK Online Resources

BCBSOK members have online access to claims status, EOBs, ID cards, network providers, correspondence and coverage information by logging in to **Blue Access for Members**[SM] (BAM). Visit **BCBSOK.com** and click on the "Log in" tab. Follow the simple, onscreen directions to establish an online account in minutes.

BAM has been enhanced to include BAM Mobile, a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.

Please go to **oru.myahpcare.com** for additional premium and benefit information.

Claims Processing and Appeals

In the event of Injury or Sickness, the student should:

1. Report to the Student Health Center for treatment, or, when not in school, to his/her Doctor or hospital. Insureds should go to a participating Doctor or hospital for treatment if possible.

IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.

2. Mail to the address below all prescription drug receipts (for providers outside of those contracting with Prime Therapeutics), medical and hospital bills, along with patient's name and Insured student's name, address, Social Security Number, BCBSOK member ID Number and name of the University under which the student is Insured.

3. File claims within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is underwritten by:
BCBSOK

Submit all claims or inquiries to:
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

BCBSOK Customer Service **(855) 267-0214**
Medical providers call **(800) 496-5774**
All Others: Call AHP **(855) 422-3833**

Plan is administered by:
Academic HealthPlans, Inc.
P. O. Box 1605
Colleyville, TX 76034-1605
Fax **(855) 858-1964**

For more information
oru.myahpcare.com

Service Representative
Wilcox & McGrath Insurance.
5591 South Lewis Ave.
Tulsa, OK 74105
Phone (918)949-6709
Fax (918)949-6750
khinkle@bfins.com

Important Notice

The information in this brochure provided a brief description of the important features of the insurance plan. It is not a contract of insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. The Master Policy is the contract and will govern and control the payment of benefits. The terms and conditions of coverage are set forth in the Policy issued in the state in which the Policy was delivered. Complete details may be found in the Policy on file at your school's office. The Policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

See the Policy on file with your school for more information.