Student Health Insurance Plan

2012-2013

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

Please read the brochure to understand your coverage.

Account Number:
Medical: 000501-12
Dental: K00014-12

BlueCross BlueShield of Oklahoma

OKLAHOMA CHRISTIAN UNIVERSITY
Since 1950

Academic HealthPlans

Independent, Authorized Agent

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.

Eligibility

All degree seeking students taking nine (9) or more credit hours are eligible and must be enrolled in the Student Accident & Sickness Insurance Plan.

All registered international students are automatically enrolled in the insurance Plan and the premium for coverage is added to their tuition billing.

Students taking at least six (6) credit hours (three (3) hours in the summer) required to complete their degree are eligible to enroll in the Plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless he or she withdraws from classes due to an Injury or Sickness and the absence is an approved medical leave. Home study, correspondence, internet classes and television (TV) courses do not fulfill the eligibility requirements that the student must actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students who enroll may also insure their Dependents. Dependent enrollment must take place at the initial time of student enrollment or beginning with the next enrollment period, with the exception of newborn or adopted children. Dependent means an Covered Person's lawful spouse; or an Covered Person's child, stepchild, foster child, dependent grandchild or spouse's dependent grandchild, a child who is adopted by the Covered Person or placed for adoption with the Covered Person, or for which the Covered Person is a party in a suit for the adoption of the child; or a child which the Covered Person 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 Covered Person 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 BCBSOK within 31 days after the date the child ceases to qualify as a child 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 cannot exceed the coverage of the Covered Person and expires concurrently with that of the student.

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.

Qualifying Event: 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, within 31 days of the qualifying event; students send a copy of the Certificate of Creditable Coverage, the completed Qualifying Events Form and the letter of ineligibility to Academic HealthPlans. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment or legal separation. The premium will be the same as it would have been at the beginning of the semester or quarter, whichever applies.

However, the effective date will be the later of the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. You may download the forms from www.ahpcare.com/oc.

Effective and Termination Dates

The Policy on file at the school becomes effective at 12:01 a.m. standard time at the University's address on the later of the following dates:

1) The effective date of the Policy, August 12, 2012; or
2) The date premium is received by the Company or its authorized representative.

Coverage is effective as follows:

Semester	From	Through
Annual	08/12/12	08/11/13
Fall	08/12/12	01/09/13
Spring/Summer	01/10/13	08/11/13
Summer	05/01/13	08/11/13

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

1) The last day of the period through which the premium is paid;
2) August 11, 2013; or
3) The date the eligibility requirements are not met.

You must meet the Eligibility requirements listed herein each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage Expiration Date. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage. **Refunds of premium are allowed only upon entry into the Armed Forces, and the Company receives proof of active duty. Otherwise all premiums received by the Company will be considered fully earned and nonrefundable.**

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. If you no longer meet the eligibility requirements contact Academic HealthPlans at (855) 247-2273 prior to your termination date.

Extension of Benefits

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, Covered Expenses for such covered Injury or Sickness will continue to be paid provided the condition continues but not to exceed 90 days after termination date.

The total payments made in respect of 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.

Additional Covered Expenses

The Policy will always pay benefits in accordance with any applicable Oklahoma State Insurance Law(s).

Primary Excess Provision

We pay the first $100 of covered medical expenses without regard to any other Health Care Plan benefits payable for the covered person. We will then pay Covered Medical Expenses:

1. After the Covered Person satisfies any applicable Deductible and co-payment specified in the Schedule of Benefits; and
2. Only when they are in excess of any amounts paid by any other Health Care Plan.

We pay benefits without regard to any Coordination of Benefits provisions in any other Health Care Plan.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

Network Provider Information

Network Providers allow the Covered Person to maximize the benefits offered under this Plan. You should seek treatment from the Blue Cross and Blue Shield of Oklahoma (BCBSOK) Blue Choice® 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.

A list of network providers can be found online at *www.ahpcare.com/oc* **by clicking the *"Find a Doctor or Hospital" link under Benefits*** or by calling (800) 521-2227.

Outpatient Prescription Drug Benefit

AT PHARMACIES PARTICIPATING IN THE PRIME THERAPEUTICS NETWORK ONLY: Expenses are payable at 100% of the Allowable Charge after a $15 copay for each Generic, and a $25 copay for each Brand Name, and $45 copay for each non-formulary prescription drug dispensed by a pharmacy participating in the Prime Network. You must go to a pharmacy participating in the Prime 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 on-line at the pharmacy. You can locate a participating pharmacy by calling (800) 423-1973 or online at ***www.ahpcare.com/oc*** by clicking on the "Find a Pharmacy" link.

ALL OTHER PHARMACIES: Expenses are payable at 60% of the Allowable Charge after a $15 copay for each Generic, and a $25 copay for each Brand Name, and $45 copay for each non-formulary prescription drug. After your prescription is filled, you will be required to pay for the prescription in full, and file your claim with Blue Cross and Blue Shield of Oklahoma, for reimbursement.

Covered Expenses for all prescription drugs are limited to a 30 day supply.

Notice of Creditable Coverage

Your coverage under this health plan is "creditable coverage". You may need such a certificate if you become covered under a group health plan or other health plan within 63 days after your coverage under this health plan terminates. Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan from Academic HealthPlans.

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 five (5) working days 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 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling (800) 441-9188. **IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy; however, Pre-Authorization Notification is not a guarantee that benefits will be paid.

Schedule of Medical Expense Benefits
Injury and Sickness

$100,000 Maximum Benefit Per Covered Person Per Policy Year
$200 Deductible Per Covered Person Per Policy Year
$5,000 Out-of-Pocket Maximum Per Covered Person Per Policy Year

After the Deductible is satisfied, benefits will be paid based on the selected Provider. Benefits will be paid at 80% of the Allowable Charge for services rendered by Network Providers in the Blue Cross and Blue Shield of Oklahoma (BCBSOK) BlueChoice PPO Network, unless otherwise specified in the Policy. Services obtained from Out-of-Network providers (any provider outside the Blue Cross and Blue Shield of Oklahoma (BCBSOK) BlueChoice PPO Network) will be paid at 60% of 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, not to exceed the $100,000 Maximum Benefit. After the Deductible and Out-of-Pocket maximums have been satisfied, additional Covered Expenses will be paid at 100%.

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 limit has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Policy Year, up to any maximum that may apply. The Out-of-pocket limit does not include Deductible, copays or any charges exceeding the Allowable Amount.

Covered Expenses are:

Inpatient	Network Provider	Out-of-Network Provider
Hospital Expense, 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. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.	80% of Allowable Charge	60% 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 allowance for that procedure. The surgical procedure with the highest allowable should be priced at 100% of allowance and the remaining eligible procedures should be priced at 50% of the allowable.	80% of Allowable Charge	60% of Allowable Charge
Assistant Surgeon	80% of Allowable Charge	60% of Allowable Charge
Anesthetist	80% of Allowable Charge	60% of Allowable Charge
Registered Nurse	80% of Allowable Charge	60% of Allowable Charge
Doctor's Visits	80% of Allowable Charge	60% of Allowable Charge
Mental & Nervous Disorder / Alcoholism & Drug Abuse	80% of Allowable Charge	60% of Allowable Charge

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. The surgical procedure with the highest allowable should be priced at 100% of allowance and the remaining eligible procedures should be priced at 50% of the allowable.	80% of Allowable Charge	60% 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, including professional fees, anesthesia, drugs or medicines and supplies.	80% of Allowable Charge	60% of Allowable Charge
Assistant Surgeon	80% of Allowable Charge	60% of Allowable Charge
Anesthetist	80% of Allowable Charge	60% of Allowable Charge
Doctor's Visits	80% of Allowable Charge	60% of Allowable Charge
Physical Therapy, 10 visit maximum, benefits provided for one visit per day.	80% of Allowable Charge	60% of Allowable Charge
Radiation Therapy and Chemotherapy	80% of Allowable Charge	60% of Allowable Charge
Emergency Room Expenses, $150 Copay per visit, benefits are payable for the use of the Emergency Room & Supplies.	80% of Allowable Charge	60% of Allowable Charge
Diagnostic X-rays & Laboratory Procedures	80% of Allowable Charge	60% of Allowable Charge
Injections, when administered in the Doctor's office and charged on the Doctor's statement.	80% of Allowable Charge	60% of Allowable Charge
Tests & Procedures, diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy and X-rays and Lab procedures.	80% of Allowable Charge	60% of Allowable Charge
Prescription Drugs, limited to 30 day supply. (See Outpatient Prescription Drug Section for more details.)	***At pharmacies participating in the Prime Therapeutics Network:*** 100% of Allowable Amount after a $15 copay per Generic/ $25 copay per Brand Name $45 copay per Non-formulary	60% of Allowable Amount after a $15 copay per Generic/ $25 copay per Brand Name $45 copay per Non-formulary
Mental & Nervous Disorder / Alcoholism & Drug Abuse, 20 visit maximum, includes all related or ancillary charges incurred as a result of a Mental & Nervous Disorder. Benefits provided for one visit per day.	80% of Allowable Charge	60% of Allowable Charge
Other	**Network Provider**	**Out-of-Network Provider**
Ambulance Service	80% of Allowable Charge	80% of Allowable Charge
Durable Medical Equipment, when prescribed by a Doctor and a written prescription accompanies the claim when submitted. Replacement braces and appliances are not covered.	80% of Allowable Charge	60% of Allowable Charge
Dental, $1,000 maximum, made necessary by Injury to sound, natural teeth only.	80% of Allowable Charge	60% of Allowable Charge
Maternity/Complications of Pregnancy	80% of Allowable Charge	60% of Allowable Charge
Routine Well-Baby Care, limited to 3 days Hospital Confinement.	80% of Allowable Charge	60% of Allowable Charge

Second Surgical Opinion	80% of Allowable Amount	60% of Allowable Amount
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 (800) 521-2227.	100% of Allowable Charge	70% of Allowable Charge

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 BCBSOK 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 BCBSOK 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 that 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 BCBSOK 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 the number on the back of the identification card.

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 Charge plus a determined percentage of the Allowable Charge 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.

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").

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 the Accident or Sickness occurs 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 BCBSOK.

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.

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, and are considered a single Injury.

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 which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, 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 Participant, 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 Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participants condition, and the Participant 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.

Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs 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.

Pre-Existing Condition Limitation
(Students & Dependents 19 years of age or over)

The Policy does not provide coverage for a Pre-existing Condition until the Covered Person's coverage has been in force for a period of not less than **12 months**. This limitation will not apply to pregnancy or coverage provided to newborn and adopted children, including a child for whom the Insured is a party to a suit for the purpose of adoption.

The Pre-existing Conditions Limitation will not apply if: the Covered Person did not receive any treatment, take any prescription medications, receive any advice or consult a Doctor for the pre-existing condition for a period of **6 consecutive months** ending after the effective date of coverage; or the Covered Person was insured under Prior Qualifying Coverage for a period of at least **6 months**; such coverage was continuous to a date not more than 63 days prior to the effective date of coverage under this Policy; and the Covered Person previously met the pre-existing conditions limitation of such coverage.

Pre-existing Condition means any condition, Injury or Sickness for which the Covered Person incurred expenses, received medical treatment, consulted a health care professional or took prescription drugs within the **6 months** immediately preceding the effective date of coverage.

Exclusions and Limitations

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

- charges that are not Medically Necessary or in excess of the Allowable Charge;
- services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
- acne;
- acupuncture procedures;
- bio-feedback procedures;
- breast augmentation or reduction;
- non-malignant warts;
- moles;
- lesions;
- testing or treatment for sleep disorders;
- any charges for surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are experimental or investigational;
- expenses incurred for Injury or Sickness, regardless if benefits are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- treatment, services or supplies in a Veteran's Administration 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;

- expenses in connection with services and prescriptions for 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;

- sinus or other nasal surgery, including correction of a deviated septum by submucous resection and/or other surgical correction, except for a covered injury

- 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;

- Injuries arising from Interscholastic Activities;

- 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;

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

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

- elective abortion;

- any expenses incurred in connection with sterilization reversal, vasectomy or vasectomy reversal and sexual reassignment;

- 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;

- organ transplants. Neither donor or recipient expenses will be covered;

- 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;

- foot care including: flat foot conditions, supportive devices for the foot, sublaxations, 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;

- hirsutism;

- alopecia;

- gynecomastia;

- patient controlled anesthesia (PCA);

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

- surgery for the removal of excess skin or fat;

- 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;
  - 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.

Academic Emergency Services

Students enrolled in the Student Health Insurance Plan can call the multilingual call center 24 hours a day, 365 days a year to confirm coverage and access available services. Services are available to students traveling more than 100 miles from their home or outside of their home country.

In addition to the insurance protection provided by your insurance plan, Academic HealthPlans has arranged to provide you with a $10,000 Accidental Death and Dismemberment benefit and access to travel assistance services anywhere in the world. These services include:

- **Medical Assistance** including referral to a doctor or medical specialist, medical monitoring when you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation, and return of mortal remains.
- **Personal Assistance** including pre-trip medical referral information and while you are on a trip: emergency medication, embassy and consular information, lost document assistance, emergency message transmission, emergency cash advance, emergency referral to a lawyer, translator or interpreter access, medical benefits verification and medical claims assistance.
- **Travel Assistance** including emergency travel arrangements and arrangements for the return of your traveling companion or dependents.
- **Security Assistance** including access to a secure, web-based system for tracking global threats and health or location based risk intelligence, and at an additional cost, a crisis hotline and on the ground security assistance to help address safety concerns or to secure immediate assistance while traveling outside of the country.

In the event of a medical emergency call Academic Emergency Services immediately.

1-800-625-8833 toll free in the USA or Canada
1-240-330-1470 collect outside of the USA

This information provides you with a brief outline of the services available to you. Accident insurance is underwritten by ACE American Insurance Company on Form # AH-10324. Reimbursement for any service expenses is limited to the terms and conditions of the accident policy under which you are insured. You may be required to pay for services not covered under the policy. ***(Academic Emergency Services, Inc. is not affiliated with BCBSOK.)***

Optional Dental Benefits

Maximum Benefit (Per Plan Year): $750 per Participant
Deductible (Per Plan Year): $50 per Individual | $150 per Family

This benefit is subject to payment of an additional premium. Dental coverage is available to students and Dependents. Students are NOT required to be enrolled in the Student Health Insurance Plan to be eligible to enroll in the Dental coverage. If the student chooses to purchase dental coverage for the Dependent, it must be purchased at the same time as the student coverage. The Dependent must have the same coverage as the student. Students and Dependents may enroll online for dental coverage or download the dental enrollment form at ***www.ahpcare.com/oc*** and complete the form then mail it along with your premium payment to Academic HealthPlans.

Type of Service	Network Provider	Out-of-Network Provider
Diagnostic and Preventive Care Benefits *(Deductible Waived)* Oral Examinations (2 exams per plan year) Prophylaxis (2 cleanings per plan year) Fluoride Treatment Dental X-rays (Subject to booklet provision)	100%	100%
Miscellaneous Services Sealants Space Maintainers Labs and Tests Palliative Care	100%	100%
Restorative Services Amalgams and Composites Simple Extractions (Not Covered) Pin Retention	80%	80%
General Services Anesthesia Stainless Steel Crowns	Not Covered	Not Covered
Endodontic Services Root Canals Direct pulp caps Apicoectomy/Apexification Retrograde filling Root amputation/hemisection Therapeutic pulmotomy Gross pulpal debridement	Not Covered	Not Covered
Periodontal Services Periodontal scaling an root planning Full mouth debridement Gingivectomy/gingivoplasty Gingival flap procedure Osseous surgery and grafts Soft tissue grafts	Not Covered	Not Covered
Oral Surgery Services Simple tooth extractions Alveoloplasty Vestibuloplasty	Not Covered	Not Covered
Crowns, Inlays/Onlays Services Prefabricated post and cores Recementation of crowns, inlays/onlays Crown repair	Not Covered	Not Covered
Prosthodontic Services Refine/Rebase Bridges and dentures Recementation and repair of bridges	Not Covered	Not Covered
Orthodontic Benefits *(Deductible Waived)* Orthodontic Diagnostic Procedures and Treatment (available to Children only)	Not Covered	Not Covered

Claim Procedure

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

1) Report to the Student Health Services for treatment or when not in school, to your Doctor or Hospital. Covered Persons 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 Prime Therapeutics, medical and hospital bills along with patient's name and Insured student's name, address, social security 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.

Submit all Claims or Inquiries to:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

BCBSOK Customer Service	(800) 521-2227
Medical Providers Call	(800) 496-5774
All Other Calls	(855) AHP-CARE or (855) 247-2273

Academic HealthPlans

Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, Texas 76034-1605
(855) 247-2273
(817) 479-2100
Fax (817) 479-2101
www.AcademicHealthPlans.com

For more information about this Plan please visit:

www.AHPCare.com/oc

Important Notice

This information provides a brief description of the important features of the insurance plan. It is not a contract of insurance. 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.

Privacy Disclosure

Under HIPAA's Privacy Rule, 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 BCBSOK HIPAA Privacy Notice upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605 or call (817) 479-2100. You may also view and download a copy from the website at: *www.ahpcare.com/oc*.

Affordable Care Act Notice

The student health insurance coverage outlined in this brochure, offered by Blue Cross and Blue Shield of Oklahoma, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. This student health insurance coverage puts an annual limit of $100,000 on covered benefits. If a Covered Person has any questions or concerns about this notice, they can contact Blue Cross and Blue Shield of Oklahoma Customer Service at (800) 521-2227. Be advised that a Covered Person may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if the Covered Person is under the age of 26. Students can contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.