

# **STUDENT HEALTH PLAN DOCUMENT**

**For Students and Dependents  
at**

**THE UNIVERSITY OF OKLAHOMA  
NORMAN, OKLAHOMA 73019**

**Plan Number:  
Domestic-MMH0000019  
International-MMH0000059  
Domestic GA/TA-MMH0000069**

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## **PLAN SUMMARY**

The Student Health Plan (the Plan) has been developed for the benefit of Students on the Norman Campus of the University of Oklahoma. The Plan is endorsed by the University of Oklahoma Student Association (UOSA). It is intended to provide protection to OU students 24 hours a day worldwide. Coverage can be obtained for Dependents of Students.

The Plan is operated under an Administrative Services Agreement between the University of Oklahoma Student Association (UOSA) and Maksin Management Corp. DBA Macori Administration (Macori). Under this agreement, Macori pays Benefits in accordance with the terms of the Plan and performs certain other services on behalf of the UOSA.

Macori Administration performs administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This document summarizes the important features of the Plan. Please read this document carefully so that you will be acquainted with the general benefits of the Plan should injury or illness occur. Questions regarding coverage or eligibility should be directed to the Student Health Plan Office at (405) 325-9196 or Macori (800) 285-8133.

## **IMPORTANT INFORMATION**

**Please read this section carefully!** It explains the roles the Goddard Health Center and the Provider Networks play in your health care coverage. It also explains important cost containment features in your program. Together, these features allow you to receive quality health care in cost-effective settings, while helping you experience lower out-of-pocket expenses by protecting you against unnecessary Hospital confinements and Hospital stays that may be longer than required.

By becoming familiar with these programs, you will be assured of receiving the maximum Benefits possible under the plan whenever you need to use your health care services.

## **GODDARD HEALTH CENTER**

The University of Oklahoma Student Association has tailored this program in an effort to combine quality service with affordable rates. A major part of this program is the Goddard Health Center, which offers covered Students and their families valuable health care protection at minimal charge for many health care services. The services of the Goddard Health Center are a significant factor in reducing your insurance costs. Goddard Health Center is your Primary Care Provider.

As a result, Students and their families are required to use the Goddard Health Center as their first choice for health care services. The Goddard Health Center staff will provide treatment, or refer you to a PPO Provider. Please follow these guidelines to receive the full Benefits outlined in this Plan Document.

Goddard Health Center is located at:

620 Elm Avenue  
Norman, Oklahoma 73019  
(405) 325-4611 or (405) 325-4441  
Hours of Operation: 8:00 a.m. - 6:00 p.m. Monday – Friday

## **GODDARD HEALTH CENTER REFERRAL REQUIRED**

You are required to use the resources of the Goddard Health Center first, where treatment will be administered or a valid referral will be issued. Expenses incurred for medical treatment rendered outside the Goddard Health Center for which no valid **prior** referral was obtained will be paid as shown in the Schedule of Benefits for out-of-network providers.

**If you require Emergency or Urgent Care outside of Goddard when the center is closed, or if you require medical care while you are temporarily away from the OU Campus (more than 50 miles away), you must contact Goddard Health Center within 48 hours for a valid referral and/or follow up care.**

IF YOU DO NOT GET A REFERRAL AS STATED ABOVE FOR COVERED SERVICES RECEIVED OUTSIDE OF GODDARD HEALTH CENTER, YOU WILL RECEIVE OUT-OF-NETWORK BENEFITS.

After hours urgent care (see definition on Page 13) is provided by Norman Regional Minor Emergency located at:

800 24<sup>th</sup> Avenue NW  
Norman, Oklahoma 73072  
(405) 321-7100  
Hours of Operation:  
8:00 a.m. - 8:00 p.m. 7 days a week

Covered Persons receiving health services from the minor emergency facility should pay the Copayment and their Coinsurance amount at the time of service, if applicable.

If you need Emergency Care, seek care at the Norman Regional Hospital emergency room located at:

901 N. Porter Ave.  
Norman, Oklahoma 73071  
(405) 307-1500

If you are away from the University on vacation or business and need Emergency Care, seek medical attention at the nearest appropriate facility, such as a Hospital emergency room or clinic.

## PPO PROVIDER NETWORK

A network of quality Health care Providers has been developed for the students and dependents of OU. This network of quality health care Providers works with Macori to help keep down the cost of health care. Covered Persons can take advantage of a higher level of Benefits by using PPO Providers whenever possible. When you use PPO Providers, and obtain a valid referral from Goddard, you will have less out-of-pocket expense. In contrast, when care is received from an Out-of-Network Provider, a higher Deductible and Coinsurance will apply, Covered Services will be limited and Benefits will be limited as shown in the Schedule of Benefits.

If Goddard Health Center cannot provide the services or treatment you require, they will refer you to a PPO Provider. You must obtain this referral before receiving services outside Goddard Health Center. Remember, a referral from Goddard Health Center is not a guarantee that Benefits will be provided. The services you receive must be covered under this Plan in order for Benefits to be provided.

## PPO PROGRAM

### ▪ Finding a PPO Doctor or Hospital

- 1. Medical Treatment (other than Rx):** Goddard Referral Required (see above)  
**Within Norman area:** Norman Physician Hospital Organization (NPHO)  
Toll-free: 1-800-944-2740 extension 2155  
Website: [www.normanpho.com](http://www.normanpho.com)  
  
**Outside the Norman area:** First Health (Coventry)  
Toll-free: 1-800-226-5116  
Website: [www.firsthealth.com](http://www.firsthealth.com)
- 2. Prescription Drug Program**  
Prescription Drugs (Rx only): Catalyst Rx  
In or outside Oklahoma Toll-free: 1-888-869-4600

Remember you are responsible for receiving precertification for hospital admissions and a referral from the Goddard Health Center referral nurse is also required within 48 hours. As always, in the case of an emergency, you should seek immediate care from the closest health care provider.

## MEDICAL NECESSITY LIMITATION

THE FACT THAT A DOCTOR OR OTHER PROVIDER PRESCRIBES OR ORDERS A SERVICE DOES NOT AUTOMATICALLY MAKE IT MEDICALLY NECESSARY OR A COVERED SERVICE.

This Plan provides Benefits for Covered Services that are Medically Necessary (see definition of "Medically Necessary" on page 10).

PRECERTIFICATION - Call Utilization Management Corp. at 1-866-352-4404.

For an Inpatient Hospital stay, you must request Precertification from Utilization Management Corp. 5 days prior to the scheduled admission. Utilization Management Corp. will consult with your Doctor or Hospital to determine if Inpatient care is required for your illness or injury. Utilization Management Corp. and your doctor may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Doctor's office). If Utilization Management Corp. determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision. If you are admitted to a Hospital that is not a PPO Hospital without Utilization Management Corp.'s approval, or if you fail to request Precertification or obtain a valid referral from Goddard, Benefits will be reduced as shown in the Schedule of Benefits.

If you are admitted to a Hospital for Emergency Care and there is not time to obtain Precertification, *you or your Provider Must notify* Utilization Management Corp. *and Goddard Health Center within two working days following the emergency admission.*

Please keep in mind that any treatment provided to a Covered Person which is not a Covered Service under the Plan, or which is not Medically Necessary, will be excluded. This applies even if Precertification approval is requested or received. Precertification is not a guarantee that benefits will be provided. The service you receive must be covered under this plan in order for benefits to be provided.

## CONCURRENT REVIEW

As part of the Precertification process described above, Utilization Management Corp. will determine an "expected" or "typical" length of stay based upon the medical information given to them at the time of or just before your admission. These length of stay estimates are used for a concurrent review during the course of your Hospital confinement in order to determine if Benefits are eligible in accordance with the Medical Necessity rules of the Plan.

Whenever it is determined that Inpatient care may no longer be Medically Necessary, Utilization Management Corp.'s Medical staff will advise you, your Doctor, and/or the Hospital of this decision.

## IDENTIFICATION CARD

You will get an Identification Card to show the Hospital, Ambulatory Surgical Facility, Doctor, or other Providers when you need to use your coverage.

Your Identification Card also helps in other ways. The Plan Number shows the Plan through which you are enrolled. Additional cards for your Dependents, or replacements for lost cards, may be requested from: [macori@macori.com](mailto:macori@macori.com)

Carry your card at all times. In case of loss, you can still use your coverage. You can replace your card faster if you know your identification number. Your identification number is your Social Security Number or your Student Identification Number.

## WHEN YOU HAVE QUESTIONS

You usually will be able to answer your health care Benefit questions by referring to this document or your Plan Summary Document. If you need more help, call Macori at 1-800-285-8133.

## DEFINITIONS

### ACCIDENT

An occurrence which (a) is unforeseen; (b) is not due to or contributed to by Illness or disease of any kind; and (c) causes Injury.

### ALLOWABLE CHARGE

The charge that Macori will use as the basis for Benefit determination for Covered Services Incurred by a Covered Person under the Plan. Macori will use the following criteria to establish the Allowable Charge, not to exceed any allocation stated in the Schedule of Benefits:

- Goddard Health Center - Goddard established charges whether or not insurance is involved.
- PPO Providers - the Provider's charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a PPO agreement.
- Out-of-Network Providers - The Provider's charge not to exceed usual and customary charges, or the amount shown in the Schedule of Benefits.

### AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Doctors which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- provides treatment by or under the supervision of Doctors and nursing services whenever the patient is in the facility;
- does not provide Inpatient accommodations; and
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a Doctor.

## BENEFIT PERIOD

The period of time following the date of an Injury or the start of the first treatment of Illness during which Covered Services must be incurred. Following the individual's Effective Date, the Benefit Period begins on the date of Injury or the first treatment of Illness and ends on the earliest of the individual's Termination Date except as specifically provided under the Extension of Benefits or on the Termination Date of the Plan. Your claim form or other Proof of Loss should be furnished to Macori within 30 days from the date of treatment. In no event will any payments be issued after February 24, 2010 whether or not expenses were incurred during the term of this Plan.

## BENEFITS

The payment, reimbursement and/or indemnification of any kind which you will receive under this Plan.

## COINSURANCE

The *percentage* of Allowable Charges for Covered Services for which the Covered Person is responsible.

## COPAYMENT

A fixed dollar amount required to be paid by a Covered Person in connection with the delivery of certain Covered Services under the Plan.

## COVERED PERSON

A person meeting all eligibility requirements and paying the appropriate contributions.

## COVERED SERVICE/MEDICAL CARE

A treatment, service or supply shown in the Plan and performed or given by a Provider for which the Plan will provide Benefits.

## CUSTODIAL CARE

Aid to patients who need help with daily tasks like eating, dressing and walking. Custodial Care does not directly treat an Injury or Illness.

## DEDUCTIBLE

A specified amount of Covered Services that you must incur before the Plan will start to pay.

## DEPENDENT

A Covered Person other than the Student as shown in the Eligibility section.

## DIAGNOSTIC SERVICES

A test or procedure performed when you have specific symptoms to detect or monitor your disease or condition (except as specifically provided for routine mammography screening or when in connection with routine examinations provided only at Goddard Health Center). It must be ordered by a Doctor.

- Radiology, ultrasound and nuclear medicine
- Laboratory and pathology
- EGG, EEG, and other electronic diagnostic medical procedures and physiological medical testing.

Diagnostic Services does not include screening exams, including x-ray examinations without film.

## DOCTOR

A person who is a professional practitioner of a healing art defined and recognized by law, and who holds a Doctor license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or Surgery or other procedures and provide services within the scope of such license.

## EFFECTIVE DATE OF PLAN

12:01 AM on August 14, 2008\*

\*See specific Coverage Period effective and termination dates on page 17.

## ELIGIBLE PERSON

A person entitled to apply to be a Covered Person as shown in the Eligibility section.

## EMERGENCY CARE

Treatment for the sudden onset of a medical condition manifesting itself by acute symptoms which are so severe that the absence of immediate medical attention could reasonably result in:

- permanently placing your health in jeopardy;
- causing other serious medical consequences;
- causing serious impairment to bodily functions; or
- causing serious and permanent dysfunction of any body organ or part.

## EXPERIMENTAL/INVESTIGATIVE

A drug, device or medical treatment or procedure which meets any of the following criteria:

- The drug or device cannot be lawfully marketed without approval of the US Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- Reliable Evidence shows that:
  - The drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
  - the prevailing opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trails are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

*"Reliable Evidence"* shall mean only:

- published reports and articles in the authoritative medical and scientific literature;
- the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.
- communications provided by Catalyst Rx.

## EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled or pregnant on the date coverage terminates, We will extend that Covered Person's benefits for any hospitalization for the Covered Injury or Sickness. Benefits will be paid as if coverage had remained in effect.

Extension of benefits will end at the earlier of:

- the end of Total Disability;
- the end of a 90\* day period following the date coverage terminates; or
- the date the Lifetime Aggregate Maximum Amount is reached;
- the Plan Sponsor terminates the Plan with the Third Party Administrator.

\*30 days for Center for English Language (CESL) or any programs less than a full academic semester.

If the Plan terminates on either January 20, 2009 or August 24, 2009 and the Covered Person is no longer a Student but will be a new University of Oklahoma employee whose employee benefits are not effective until the first of the month following termination of the Plan, the Person's coverage will be extended until the earlier of:

- the date the Person's employee benefits become effective;
- the date the Person is no longer a University of Oklahoma employee;
- the date the Lifetime Aggregate Maximum Amount is reached;
- the Plan Sponsor terminates the Plan with the Third Party Administrator.

This Extension of Benefits is applicable only to the extent the Covered Person will not be covered under the UOSA Plan or any health insurance policy in the ensuing term of coverage.

## GODDARD - GODDARD HEALTH CENTER

### HOSPITAL

A Provider that is a short-term, acute care, general Hospital which:

- is licensed;
- mainly provides Inpatient diagnostic and therapeutic services under the supervision of Doctors;
- has organized departments of medicine and major Surgery;
- provides 24-hour nursing service; and
- is not, other than incidentally, a:
  - skilled nursing facility;
  - nursing home;
  - custodial care home;
  - health resort;
  - spa or sanitarium;
  - place for rest;
  - place for the aged;
  - place for the treatment of Mental Illness;
  - place for the treatment of alcoholism or drug abuse;
  - place for the provision of hospice care;
  - place for the provision of rehabilitation care;
  - place for the treatment of pulmonary tuberculosis.

## IDENTIFICATION CARD

The card issued to you identifying you as an OU Student Health Plan Member and providing other helpful information for you and your medical providers.

## ILLNESS

Disease or illness including related conditions and recurrent symptoms of the Illness. Illness also includes pregnancy and Complications of Pregnancy. All Illnesses due to the same or a related cause will be considered one Illness.

## INCURRED

A charge is Incurred on the date you receive the service or supply for which the charge is made.

## INJURY

Bodily injury caused by an Accident, including related conditions and recurrent symptoms of this injury.

## INPATIENT

A Covered Person who is a registered bed patient in a Hospital and for whom a room and board charge is made.

## INTENSIVE CARE UNIT

A specially designated facility of the Hospital that provides the highest level of Medical Care, and which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. It must be permanently equipped with special life-saving equipment for the care of the critically ill or injured, and under constant and continuous observation by nursing staffs assigned on a full-time basis exclusively to the Intensive Care Unit. Intensive Care Unit shall include a Cardiac Care Unit of the Hospital, but does not include any of these step-down units:

- Progressive care;
- Sub-acute intensive care;
- Intermediate care units;
- Private monitored rooms;
- Observation units; or
- Other facilities which do not meet the standards for intensive care.

## ROUTINE MAMMOGRAPHY SCREENING

The x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

## MATERNITY SERVICES

Care required as a result of being pregnant, including prenatal care and postnatal care.

## MEDICAL CARE

Professional services given by a Doctor or other Medical Provider to treat illness or injury.

## MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

A service or supply given by a Hospital, Doctor, or other Medical Provider which we determine is:

- appropriate for the symptoms and diagnosis or treatment of your condition, illness or injury; and
- in line with standards of good medical practice; and
- not primarily for your or your Provider's convenience; and
- the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as a bed patient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care as an Outpatient.

## MEDICARE

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

## MENTAL ILLNESS

An emotional or mental disorder in which a person's thoughts, feelings or actions are abnormally disturbed.

## NEWBORN CHILD

A child less than 31 days old born to a covered Student or covered Dependent spouse.

## ORGAN PROCUREMENT SERVICES

The services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor and transport the organ to the location of the recipient within 24 hours after the match is made.

## ORTHOGNATHIC SURGERY

Services or supplies received for corrections of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

## OUT-OF-NETWORK PROVIDER

A Provider who has not entered into an agreement with Maksin Management Corp dba Macori Administration to be a part of its PPO network.

## OUTPATIENT

A Covered Person who receives services or supplies while not an Inpatient.

## PHARMACY

A person, firm or corporation duly authorized by state law to dispense Prescription Drugs and is a Catalyst Rx member.

## PLAN

This Plan of Benefits provided by and through the University of Oklahoma Student Association.

## PLAN YEAR

The 12-month period beginning on \*August 25, 2008 and ending on August 24, 2009.

\*8/14/08 Effective Date for Covered Persons maintaining continuous coverage from the 2007/08 Plan who 1) are enrolling in this Plan (without a break); and 2) who had an 8/13/08 Expiration Date.

## PPO PROVIDER

A Provider Organization who has entered into an agreement with NPHO (if treated within the Norman area), or First Health (Coventry) (if treated outside the Norman area) to bill students at a discounted fee.

## PRECERTIFICATION

Certification from Utilization Management Corp. that, based upon the information presented by you and/or your Provider at the time Precertification was requested, Inpatient level of care was necessary to treat your condition. Precertification does not guarantee that the care and services a Covered Person receives are eligible for Benefits under the Plan. At the time the Covered Person's claims are submitted, they will be reviewed in accordance with the terms of the Plan.

## PRE-EXISTING CONDITION

The following conditions are considered "pre-existing":

- a condition which would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 12 months immediately before the Effective Date; or
- a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately before the Effective Date;
- a pregnancy existing on the Effective Date (whether known or unknown).

## PRESCRIPTION DRUG

- Medicinal substance (including contraceptive medications, regardless of Medical Necessity) required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal Law prohibits dispensing without prescription."
- A medication compounded by a pharmacist which contains a Prescription Drug;
- Injectable insulin; and
- Catalyst Rx Formulary

## PROOF OF LOSS

A formal statement or claim regarding a loss which provides sufficient information to allow Macori to determine the Plan's liability for Covered Services. This includes: Goddard Health Center referral; a completed claim form; the Provider's itemized statement of services rendered and related charges; medical records; and other information needed by Macori in order to process claims including but not limited to accident details, other insurance information, subrogation agreements, and pre-existing condition investigation.

## PROVIDER

A Hospital, Ambulatory Surgical Facility, Doctor, or other practitioner or Provider of medical services or supplies licensed to render Covered Services and performing within the scope of such license.

## REFERRAL

A Goddard Health Center's referral constitutes a valid referral if issued prior to obtaining treatment that is covered under the plan. Exceptions are specifically stated on Page 2 for Emergency Care, Urgent Care when Goddard is closed or when you are temporarily away from campus (50 mile radius).

## STUDENT

An Eligible Person who meets the enrollment requirements shown in the Eligibility section.

## STUDENT AND SPOUSE COVERAGE

Coverage under this Plan for you and your spouse.

## STUDENT AND CHILD(REN) ONLY COVERAGE

Coverage under this Plan for you and your Dependent child(ren) only.

## STUDENT ONLY COVERAGE

Coverage under this Plan for you only.

## STUDENT, SPOUSE AND CHILD(REN) COVERAGE

Coverage under this Plan for you, your spouse, and your Dependent child(ren).

## SURGERY

- The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures;
- The correction of fractures and dislocations;
- Usual and related preoperative and postoperative care.

## TERMINATION DATE OF PLAN

12:00 midnight on August 24, 2009

## THERAPY SERVICE

The following services and supplies ordered by a Doctor or other approved Medical Provider when used to treat and promote your recovery from an illness or injury:

- Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.
- Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
- Respiratory Therapy - introduction of dry or moist gases into the lungs for treatment purposes.
- Dialysis Treatment - the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- Physical Therapy - the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- Speech Therapy - treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.
- Occupational Therapy - treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

## TOTAL DISABILITY/TOTALLY DISABLED

The complete inability of a Covered Person to perform all of the substantial and material duties and functions of his or her regular occupation. Does not include a temporary or short term Disability.

## URGENT CARE

Treatment for an unexpected illness or injury that is not life or limb threatening but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to, lacerations, high fever, severe vomiting and/or diarrhea, pulled muscles or other similar illnesses or injuries.

## USUAL AND CUSTOMARY CHARGES

The charge which is the smallest of: (a) the actual charge; (b) the charges usually made for a covered service by the provider who furnishes it; (c) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. The prevailing charge made for a covered service in a geographic area is based on the Ingenix schedule, 80<sup>th</sup> percentile; (d) the PPO allowable charge.

## ELIGIBILITY

### WHO IS AN ELIGIBLE PERSON

You are eligible for Student Health Plan coverage if you are: 1) an undergraduate student enrolled in at least nine credit hours during the Fall and Spring semesters (or at least three credit hours if purchasing for Summer Only coverage), undergraduate students are eligible to continue coverage under the Plan with less than the required hours if they are in their last semester before graduation and do not need the full nine credit hours to graduate (this option is available only one time during attendance at OU); 2) a graduate student enrolled in at least six credit hours during the Fall and Spring semesters (or at least three credit hours if purchasing Summer Only coverage), graduate students are eligible to continue coverage under the Plan with less than the required hours if they are in their last semester before taking their thesis or dissertation credit hours and do not need the full six hours before taking their thesis or dissertation (this option is available only one time during attendance at OU); 3) a graduate student enrolled in at least two thesis or dissertation credit hours; or 4) students not enrolled in full-time credit hours, but who have petitioned OU with documentation of a disability (as defined in this Plan) and have received approval from OU for full time status might be allowed to participate on the plan; or 5)\* Non-immigrant international J scholars; 6) Non-immigrant international students and scholars taking credit hours are automatically enrolled unless a waiver is granted; or 7)\* other groups as specifically designated by OU; 8) in order to retain coverage under the Plan, a student must attend classes or other required coursework for at least 31 days following the first day of his/her effective coverage date of coverage under the Plan; 9) home study, correspondence, television and online courses do not fulfill eligibility requirements. Students who withdraw or graduate from school are required to notify the OU Student Health Plan Office within 48 hours of their change in status. If you are not considered a student anymore, you are not allowed to be seen at Goddard except as follows: (1) You are not enrolled in the summer semester but did complete the spring semester; and (2) If you are withdrawing after the 31st day of the semester, you will be treated until the end of the semester for which contribution has been paid. **Graduate student, international student and dependent information is located on the next page of this document.**

\*Excluding non-immigrant international visitors and/or non-student scholar programs.

*International Students on an F or J visa* - When you are enrolled as a University of Oklahoma student, premium for Plan II (The Basic Plan) is automatically billed to your account by the Office of the Bursar. International students may upgrade to Plan I (The Alternate Plan) and/or add dependents to their policy, but the additional cost must be paid. This added coverage cannot be billed. No benefits will be available until complete payment of the cost of your elected coverage is received.

International students and scholars on an F or J visa may waive the OU Student health plan by providing proof of other coverage under another qualified health insurance plan. Proof of continuing coverage must be presented to the Student Health Plan Office by the end of the open enrollment period of each semester. A brochure explaining the required guidelines can be picked up at the OU Student Health Plan Office or at the Office for International Student Services. **NOTE: No waivers will be accepted after the deadline for each semester except as shown in "Coverage Deadlines and Qualifying Events" below.**

*Graduate Teaching and Research Assistants* - The University pays the cost of "Plan II" for qualified Graduate Teaching Assistants and Graduate Research Assistants. To qualify, a student must 1) be enrolled in 6 credit hours per semester (3 credit hours for summer semester), 2) be appointed to a .50 FTE or greater position, and 3) the appointment must be approved by the Graduate College. If the appointment is only for the fall semester, the student has the option to enroll in annual coverage and pay the portion not paid by the University.

Graduate Assistants may upgrade to "Plan I" or add dependents to either Plan at initial enrollment by paying the additional costs by payroll deductions. To continue coverage from academic year to academic year, a new student health plan enrollment form will need to be completed each plan year during the Open Enrollment Period. If a qualified Graduate Assistant does not complete the enrollment form by the deadline, then he/she will be defaulted to "Plan II".

Loss of Appointment, applicable only if annual coverage was not selected: A qualified Graduate Assistant who loses their appointment may continue coverage under the student health plan provided he/she is enrolled in 6 credit hours per semester (2 credit hours if student is in their final semester before graduation). The Graduate Assistant will be required to pay the cost of the student health plan for the remainder of the Coverage Period for which they enrolled if electing to continue coverage.

International Graduate Assistants who lose their appointment will be required to pay the cost of the student health plan for the remainder of the Coverage Period or provide documentation of other comparable coverage prior to the end of the student health plan enrollment period for the term in which they lose their appointment.

Graduate Assistant who lose their appointments are encouraged to contact the Student Health Plan Office to discuss their options for continuing coverage.

*Payroll Deduction for Graduate Assistants* - A Payroll Deduction will automatically be deducted for Graduate Assistants who add dependents or buy up to plan I. This option is only available during the Fall Annual Enrollment Period and the deductions are scheduled in eight equal installments (September through April). These payroll deductions cannot be cancelled during the Plan year, unless the participant's graduate appointment ends or if the Covered Person becomes ineligible for coverage. **Note: In any event, you will remain personally liable for any remaining payments due.**

**In Order to Retain Coverage:** The student must actively attend classes at University of Oklahoma for at least 31 days after his/her effective date of coverage. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 31 days of the period for which coverage is purchased will not be covered under the Plan and a full refund of contribution will be made upon receipt of written notification of such withdrawal. Students withdrawing after such 31 days will remain covered under the Plan until the end of the Coverage Period of the semester for which a contribution was paid and no refund will be allowed; however, in no event will coverage extend beyond one Plan Year when withdrawal is due to Sickness or Injury. Eligibility requirements must be met each time a contribution is paid to continue coverage.

We reserve the right to investigate student status and attendance records to verify that Plan eligibility requirements have been and continue to be met. Upon discovery that the Plan eligibility requirements have not or are not being met, The Plan's only obligation is refund of contribution less any claims paid.

## WHO IS AN ELIGIBLE DEPENDENT

The following individuals may also be covered under the OU Student Health Plan: 1) Student's spouse; 2) Unmarried children under age 19 for whom the covered student is legally responsible. Dependents will have coverage under the same Plan and have the same payment method as the enrolled student. A registered Student who is covered under the OU Student Health Plan as a Dependent will be limited to the Dependent level of benefits. After the published enrollment deadlines have passed, dependents may only be added to the plan **within 31 days of a Qualifying Event**.

The Plan reserves the right to request verification of a Dependent child's age, dependency, and/or disability upon initial enrollment and from time to time thereafter as the Plan may require.

	<u>Coverage Periods</u>	<u>Deadline for Enrolling**</u>
Annual	*8/25/08 - 8/24/09	9/12/08
Fall Semester	*8/25/08- 1/19/09	9/12/08
Spring Semester Only	1/20/09 – 6/08/09	2/02/09
Spring and Summer	1/20/09 - 8/24/09	2/02/09
Summer Semester	6/09/09 - 8/24/09	6/19/09

**\*8/14/08 Effective Date for Covered Persons maintaining continuous coverage from the 2007/08 Plan who 1) are enrolling in this Plan (without a break); and 2) who had an 8/13/08 Expiration Date.**

**\*\*A grace period of thirty-one days will be granted for each renewal after the initial contribution. See page 42 for more information.**

**Coverage Deadlines and Qualifying Events:** No applications for enrollment or changes to current enrollments will be accepted after the published enrollment deadline dates except as described when a student experiences a "Qualifying Event" and completes the appropriate form for Notification of a Qualifying Event. For administrative purposes, "Notification of Qualifying Event" shall be the date the Student Health Plan Office receives the Change in Coverage form and all supporting documentation. The enrollment form and documentation of the Qualifying Event must be submitted to the OU Student Health Plan Office **within 31 days of the Qualifying Event**. The 31 day notification period cannot be extended. Qualifying Events are defined as follows: birth, adoption, death, marriage, divorce, gain/loss of other insurance coverage (other than coverage under the UOSA Student Health Plan), change of status (such as graduation or withdrawal) or International student/dependent's arrival in the U.S. The effective coverage date for loss of insurance will be the date of the actual loss of insurance, or the date the enrollment form, payment (or authorization to charge student's Bursar account) and documentation are received, whichever is later. The effective drop date for gaining new insurance coverage will be the next available Open Enrollment Period following receipt of all the required documentation.

The 31-day notification period deadline must be followed for all Qualifying Events.

## CHANGING PLANS

A person will neither be allowed to change choice of plans during any policy year, nor will he/she receive a "gain" in subsequent years by purchasing Plan I for a condition for which benefits or the pre-existing waiting period began or was in effect while covered under Plan II.

## DELAYED EFFECTIVE DATE

If any person (except a Newborn Child) is confined in a Hospital on the day that would otherwise be their Effective Date, the Effective Date will be delayed until the date of their final discharge from the Hospital. However, this provision does not apply to a person who was enrolled under the UOSA health plan in effect immediately before the Plan Effective Date and whose Effective Date coincides with the Plan Effective Date.

In no event will your Dependent's coverage become effective before your Effective Date.

## HOW TO ADD DEPENDENTS

You can change types of coverage to include Dependents, or add additional Dependents to your coverage. The Student Health Plan Office (SHPO) must receive your Change in Coverage form, enrollment form and required contribution payment within 31 days after you acquire an Eligible Dependent.

Coverage for a spouse will be effective on the date of marriage or the date SHPO receives the Change in Coverage form, enrollment form to add coverage for the spouse and required contribution payments, whichever is later.

A dependent child reaching the age of 19 while covered under the OU Student Health Plan will become ineligible on their 19th birthday. Exception: If the dependent child is also a registered student at OU, they may continue coverage until the end of the Coverage Period in SEMESTER in which attainment of age was met PROVIDED they have contacted the OU Student Health Plan Office in writing on or before their 19th birthday and requested and received permission to continue. They will not be eligible to re-enroll as a dependent child after the age of 19.

In the case of a Newborn Child born while you are enrolled in Student Only Coverage, coverage for the newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, SHPO must receive your Change in Coverage form and enrollment form to add coverage for the newborn within 31 days of the child's birth, along with the required contribution payments for such coverage from the date of birth. The full amount of premium is due for the Coverage Period in which the newborn is added.

In the case of a Newborn Child born while you are enrolled in Student and Spouse Only Coverage, coverage for the newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, SHPO must receive your Change in Coverage form and enrollment form to add coverage for the newborn within 31 days of the child's birth, along with the required contribution payments for such coverage from the date of birth. The full amount of premium is due for the Coverage Period in which the newborn is added.

In the case of a Newborn Child born while you are enrolled in Student and Child Only Coverage; Student and Children Only Coverage; Student, Spouse and Child Coverage; or Student, Spouse and Children Coverage, coverage for the newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, SHPO must receive your Change in Coverage form and enrollment form to add coverage for the newborn within 31 days of the child's birth, along with the required contribution payments for such coverage from the date of birth. The full amount of premium is due for the Coverage Period in which the newborn is added.

If you do not apply for coverage for yourself or an Eligible Dependent within 31 days of being first eligible to do so, you may apply during the next open enrollment period.

## THE END OF COVERAGE AND REFUND POLICY

Application for enrollment in the Student Health Plan constitutes a contract. Payments received are fully earned and nonrefundable. Refunds will be given only under the following circumstances: 1) If the Covered Person did not meet the eligibility requirements at the time of enrollment; 2) If the Covered Person enters the military service. In this case coverage is terminated on the date the individual enters the service. A pro-rated refund of payments will be made upon receipt of a written request; 3) When a participant is no longer enrolled as a student at the University of Oklahoma and is therefore no longer eligible for coverage. Coverage for the participant and covered dependents will end on the last day of the Coverage Period for which premium was paid except when the student declares a Qualifying Event (as explained below). The entire outstanding balance will be due for this period; 4) Qualifying events: a) Divorce of a student participant, making the covered spouse no longer eligible for coverage. Coverage will end on the last day of the Coverage Period in which the spouse is eligible; b) Gain of other verifiable coverage through employment of student participant or spouse of student participant; c) When a participant withdraws from school after a 31 day period following the his/her Effective Date. The effective drop date for Qualifying Events a) b) or c) will be the next available Open Enrollment Period following receipt of all the required documentation. The 31 day notification period deadline must be followed for all Qualifying Events. Note: Coverage for a Dependent child attaining the age of 19 years old will end as stated on the previous page.

## SCHEDULE OF BENEFITS

### *PLAN I (The Alternate Plan) - \$1,000,000 Lifetime Maximum*

BENEFIT PERIOD	Plan Year
COPAYMENT	
Goddard Health Center	Covered Students and Spouses Only - Outpatient Counseling Services - \$5 per visit for Students, \$10 per visit for Spouses
	Covered Students Only - Physical Therapy - \$5 per visit
	Dependents - Doctor's Office Visit - \$10 per visit
	Prescription Drugs - \$15 Generic/\$50 Brand Name
PPO Providers	Doctor's Office Visit (including minor emergency center) - \$10 per visit (does not apply to visits for Physical Therapy or Psychiatric Care Services)
	Emergency Room - \$35 <sup>1</sup> per visit (waived if admitted as an Inpatient) The Copayment applies in addition to the Deductible and Coinsurance.
	Prescription Drugs - \$15 Generic/\$50 Brand Name
Out-of-Network Providers	See Schedule of Benefits

<sup>1</sup>This additional charge is to discourage unnecessary use of Hospital emergency rooms. Facility charges in excess of the \$35 Copayment, including any ancillary services (such as diagnostic x-ray and laboratory services) are subject to the applicable Deductible and Coinsurance.

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DEDUCTIBLES	The following Deductible amounts apply to each Covered Person during each Benefit Period:
Goddard Health Center	None
Norman Regional Minor Emergency (for Urgent Care Only)	None <sup>2</sup>
PPO Providers	Prescription Drugs - \$50 (Other than Goddard) All Other Services - \$250
Out-of-Network Providers	Inpatient - \$350 Outpatient - \$350
	The Deductibles apply to all Covered Services except for Routine Mammography Screenings as specifically provided and Covered Services that are subject to the \$10 Copayment.

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<sup>2</sup> \$10 copayment for doctor's visits



GODDARD HEALTH CENTER SERVICES

The following services are covered by the Plan at Goddard Health Center:

COVERED SERVICES:	AMOUNT:	
	<i>Students</i>	<i>Dependents</i>
▪ Doctor's Office Visit	100%	100% <sup>3</sup>
▪ In-Office Minor Surgery	100%	80%
▪ Women's Center Office Visit	100%	100% <sup>3</sup>
▪ Outpatient Diagnostic Services	100%	80%
▪ Medical Supplies	100%	80%
▪ Required Immunizations through Age 18	100%	100%
▪ HPV Vaccine Series (three injections) (limited to Students and spouses only)	100% <sup>6</sup>	100% <sup>6</sup>
• Routine examinations (One per plan year, except 4 visits are allowed for well baby/ child exams up to 6 months of age scheduled at 2-4 weeks, 2 months, 4 months and 6 months) Includes Gynecological visits, not to exceed \$100 per plan year. (These benefits only available at Goddard)	100%	100% <sup>3</sup>
• Prescription Drugs (limited to \$1,250 aggregate maximum benefit (subject to the Catalyst Formulary ) per Benefit Period per Covered Person from Catalyst Rx Providers including Goddard Health Center)	100% <sup>4</sup>	100% <sup>4</sup>
• Physical Therapy	100% <sup>5</sup>	80%
• Outpatient Psychiatric Counseling Services (limited to Students and spouses only)	100% <sup>5</sup>	100% <sup>3</sup>

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<sup>3</sup> \$10 Office Visit Copayment

<sup>4</sup> \$15 generic/\$50 brand name copayment per prescription

<sup>5</sup> \$5 per visit Copayment

<sup>6</sup> \$10 per injection Copayment

PPO PROVIDER AND OUT-OF-NETWORK PROVIDER SERVICES

Services received from PPO Providers are covered by the Plan at the in-network benefit level only if a valid referral has been obtained from Goddard Health Center prior to treatment except as listed on Page 2 for emergency and urgent care. If a referral is not obtained, Benefits will be provided at the Out-of-Network Benefit level. Benefits are subject to the applicable Copayment and Deductible amounts.

*Plan I - Continued*

COVERED SERVICES:

AMOUNT:

	<i>PPO Providers</i>	<i>Out-of-Network Providers</i>
<ul style="list-style-type: none"> <li>• Inpatient Hospital Miscellaneous Benefits (when Room &amp; Board is charged) Psychiatric Inpatient care is limited to a maximum of 30 days or \$25,000, whichever comes first, per covered person, per lifetime.</li> </ul>	80%	50%
<ul style="list-style-type: none"> <li>• Outpatient Hospital Miscellaneous and Ambulatory Surgical Center Benefits</li> </ul>	80%	50%
<ul style="list-style-type: none"> <li>• Minor Emergency Center for urgent care doctor's visits</li> </ul>	100% <sup>7</sup>	No Benefit
<ul style="list-style-type: none"> <li>• Minor Emergency Center for other covered services</li> </ul>	80%	No Benefit
<ul style="list-style-type: none"> <li>• Emergency Room (facility charges only)</li> </ul>	100% <sup>8</sup>	50%
<ul style="list-style-type: none"> <li>• Surgical/Medical Services                             <ul style="list-style-type: none"> <li>- Doctors' Office Visits</li> <li>- All Other Surgical/Medical Services</li> </ul> </li> </ul>	100% <sup>9</sup> 80%	50% <sup>9</sup> 50%
<ul style="list-style-type: none"> <li>• Outpatient Diagnostic Services                             <ul style="list-style-type: none"> <li>- Routine Mammography Screening (limited to \$115) age restrictions apply (see page 30)</li> <li>- All Other Outpatient Lab &amp; Xray Diagnostic Services</li> </ul> </li> </ul>	100% <sup>10</sup> 80%	No Benefit 50%
<ul style="list-style-type: none"> <li>• Outpatient Therapy Services                             <ul style="list-style-type: none"> <li>- Radiation Therapy</li> <li>- Chemotherapy</li> <li>- Respiratory Therapy</li> <li>- Dialysis Treatment</li> <li>- *Physical Therapy (payable only when an evaluation and a valid referral has been made by the Goddard Health Center Physical Therapy Department)</li> <li>- *Dependent Children only, (up to 5 visits, not to exceed \$120 per visit. Evaluation by Goddard Health Center Physical Therapy Department is not required; however, a valid referral is required)</li> <li>- Speech Therapy (limited to 20 visits per Covered Person per Benefit Period)</li> <li>- Occupational Therapy (limited to 20 visits per Covered Person per Benefit Period)</li> </ul> </li> </ul>	80% 80%	50% No Benefit No Benefits
<ul style="list-style-type: none"> <li>• Maternity Services - Payable as any other illness</li> </ul>		

<sup>7</sup> Only the actual charge for the office visit is subject to the \$10 Copayment. The Deductible does not apply.

<sup>8</sup> \$35 Emergency Room Copayment in addition to the applicable Deductible.

<sup>9</sup> \$10 Office Visit Copayment.

<sup>10</sup> No deductible applied

*Plan I - Continued*

• Human Organ and Tissue Transplant	80%	50%
• Ambulatory Surgical Facility Services	80%	50%
• Psychiatric Care Services (limited to 20 visits per Benefit Period per Covered Person)	80%	No Benefit
• Private Duty Nursing Services	80%	50%
• Ambulance Services	80%	50% (limited to \$500 per trip)
• Dental Services Related to Accidental Injury	80%	50%
• Prescription Drugs (limited to \$1,250 per Benefit Period per Covered Person through Catalyst Rx Providers including Goddard Health Center)	80% <sup>11</sup>	No Benefit
• Durable Medical Equipment (limited to \$5,000 per Benefit Period per Covered Person) Includes Diabetic Supplies	80%	50%
• Chiropractic Services (limited to \$100 per Benefit Period per Covered Person-including diagnosis and treatment)	80%	No Benefit

<sup>11</sup> \$15 generic/\$50 brand name copayment after a \$50 deductible.

**OTHER BENEFITS**

Medical Evacuation Benefit of up to \$10,000 for evacuation of the Covered Person to his/her natural country.

Repatriation Benefit of up to \$7,500 for preparing and transporting the remains of the deceased Covered Person's body to his/her natural country.

***PLAN II (The Basic Plan)- \$50,000 Per Condition Lifetime Medical Maximum***

<b>BENEFIT PERIOD</b>	Plan Year
<b>COPAYMENT</b>	
Goddard Health Center	Physical Therapy available for students only - \$5 per visit copayment
	Prescription Drugs - \$15 Generic/\$50 Brand Name per prescription
<b>DEDUCTIBLE</b>	The following Deductible amounts apply to each Covered Person during each Benefit Period.
Goddard Health Center	None
PPO Providers	Inpatient - \$250 Outpatient - \$250 Prescription Drugs - \$100 (No deductible at Goddard)
Out-of-Network Providers	Inpatient - \$450 Outpatient - \$450 The deductibles apply to all Covered Services except as noted.
<b>OUT-OF-POCKET LIMIT</b>	None
<b>MAXIMUMS</b>	\$50,000 Lifetime per Covered Person per condition.

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<b>PERCENTAGE AMOUNT PAYABLE BY THE PLAN</b>	The amount of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Providers is specified below. These amounts are applicable only after the Covered Person's Deductible Copayment, and/or Coinsurance has been satisfied. The "Goddard Health Center Services" percentage shown is applicable to Covered Services received from Goddard Health Center. The "PPO Provider Services" percentage shown is applicable to Covered Services received from a PPO Provider when a valid referral is obtained from Goddard Health Center. Benefits provided without a valid referral or outside the PPO are limited as shown.
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*Plan II - Continued*

**GODDARD HEALTH CENTER SERVICES**

The following services are covered by the Plan at Goddard Health Center:

COVERED SERVICES:	AMOUNT:	
	<i>Students</i>	<i>Dependents</i>
• Doctor's Office Visit	100%	80%
• In-Office Minor Surgery	100%	80%
• Women's Center Office Visit	100%	80%
• Lab & Xray Services	100%	80%
• Required Immunizations through Age 18 (Does not include office visit. This benefit is not available outside Goddard)	100%	100%
• Routine Examinations One per plan year. Includes gynecological visits not to exceed \$100 per plan year. (These benefits are available only at Goddard)	100%	80%
• Physical Therapy	100% <sup>1</sup>	No Benefit
• Prescription Drugs (limited to \$500 aggregate per year per Covered Person at Catalyst Rx Providers including Goddard Health Center. Includes diabetic supplies.)	100% <sup>2</sup>	100% <sup>2</sup>

**PPO PROVIDER SERVICES**

The following services are covered by the Plan outside Goddard but within the PPO network provided a valid referral has been obtained from Goddard Health Center:

COVERED SERVICES:	AMOUNT:
• Room and Board	80%
• Intensive Care	80%
• Maternity	Paid as any other illness
• Hospital Miscellaneous Services-Inpatient only (when room & board is charged)	80%
• Surgical Benefits includes Surgeon, Assistant Surgeon, and Anesthesiologist	80% up to \$1,500 per Benefit Period per Covered Person.
Surgeon	80% (considered part of the \$1,500 maximum stated above)
Assistant Surgeon	20% of surgeon's allowable benefit (considered part of the \$1,500 maximum stated above)
Anesthesiologist	25% of surgeon's allowable benefit (considered part of the \$1,500 maximum stated above)
• Inpatient Doctor's Visits	Allowable Charges up to \$25/day
• Private Duty Nursing	80%
• Day Surgery Miscellaneous (facility charges only)	80% to a maximum of \$800 per Benefit Period
• Minor Emergency Center for Urgent Care	80% <sup>3</sup>
• Ambulance (when room & board is paid)	80%
• Routine Mammography Screening	100% to a maximum of \$115 (not subject to the Deductible) age restrictions apply (see page 30)
• Chiropractic Services	80% up to \$100 maximum per plan year per covered person. Includes diagnosis and treatment.
• Prescription Drugs - Payable at 80% after \$15 generic or \$50 brand name Copayment per prescription. In any 30-day period, dispensing is limited to 34-day supply. \$500 aggregate maximum benefit (subject to the Catalyst Formulary) per Benefit Period per Covered Person whether dispensed at Goddard or another Catalyst RX Provider. Includes diabetic supplies.	

<sup>1</sup> \$5 Copayment per visit

<sup>2</sup> \$15 generic/\$50 brand name copayment per prescription

<sup>3</sup> \$25 copayment for office visit in addition to the applicable Deductible

**OUTPATIENT MISCELLANEOUS BENEFITS**

- Outpatient Miscellaneous Benefits for the following services are payable at 80% not to exceed an aggregate maximum of \$750 per plan year per Covered Person for all Conditions:
- Doctor's Office Visit-excluding Physical Therapy except as shown above at Goddard.
- Outpatient Diagnostic Services
- Injections - excluding immunizations except as shown above at Goddard.
- Medical Emergency
- Outpatient Hospital Care
- Radiation and Chemotherapy
- Ambulance (when room and board is not paid)

**OTHER BENEFITS**

Medical Evacuation Benefit of up to \$10,000 for evacuation of the Covered Person to his/her natural country.

Repatriation Benefit of up to \$7,500 for preparing and transporting the remains of the deceased Covered Person's body to his/her natural country.

**OUT-OF-NETWORK PROVIDER SERVICES OR SERVICES RECEIVED WITHOUT A VALID GODDARD HEALTH CENTER REFERRAL**

Inpatient Hospitalization (facility only)	30%
Outpatient Emergency Room (facility only)	30%

**EXPLANATION OF COVERED SERVICES FOR PLANS I AND II**

Subject to the Exclusions, conditions, and limitations of the Plan, you are entitled to the Benefits of this section for Covered Services rendered by a Hospital, Ambulatory Surgical Facility, Doctor or other approved Medical Provider in the amounts specified in the Schedule of Benefits.

**HOSPITAL SERVICES:**

We pay the scheduled amounts for the following Covered Services you receive from a Hospital or other approved medical Provider, provided all plan provisions have been met.

- Room and Board
  - Room, board and general nursing service in:
    - A room with two or more beds;
    - A private room (private room allowance is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;
    - A bed in a Special Care Unit which give intensive care to the critically ill.

- Hospital Miscellaneous Services
  - Operating, delivery and treatment rooms;
  - Prescribed drugs;
  - Whole blood, blood processing and administration;
  - Anesthesia, anesthesia supplies and services rendered by an employee of the Hospital or other Provider;
  - Medical and surgical dressings, supplies, casts and splints;
  - Oxygen;
  - Subdermally implanted devices or appliances necessary for the improvement of physiological function;
  - Diagnostic Services;
  - Therapy Services
- Emergency Accident Care  
Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.
- Emergency Medical Care
- Outpatient emergency Hospital services and supplies to treat a sudden and acute medical condition that requires prompt Medical Care.
- Surgery  
Hospital services and supplies for Outpatient Surgery furnished by an employee of the Hospital or other Provider other than the surgeon, anesthesiologist or assistant surgeon.
- Routine Nursery Care  
Inpatient Hospital Services for Routine Nursery Care of a covered newborn child.

Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement except as mandated. In the event the newborn requires such treatment or evaluation while covered under this Plan:

- the infant will be considered a Covered Person in its own right and will be entitled to the same Benefits as any other Covered Person under this Plan; and
- a separate Deductible will apply to the newborn's Hospital confinement.

Benefits are not provided for Routine Nursery Care for an infant born to a Dependent child.

## SURGICAL/MEDICAL SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Doctor or other approved medical Provider.

- Surgery  
Payment includes visits before and after Surgery.
  - If an incidental procedure<sup>12</sup> is carried out at the same time as a more complex primary procedure, then Benefits will be payable for only the primary procedure. Separate Benefits will not be payable for any incidental procedures performed at the same time.
  - When more than one primary surgical procedure is performed during one operation, you are covered for:
    - the primary procedure; plus
    - 50% of the amount payable for each of the additional procedures had those procedures been performed alone.
  - Sterilization, regardless of Medical Necessity-**This benefit is excluded under Plan II.**

- **Assistant Surgeon**  
Services of a Doctor who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant surgeon only if determined Medically Necessary.
- **Anesthesia**  
Administration of anesthesia by a Doctor or other approved medical Provider who is not the surgeon or the assistant surgeon.
- **Inpatient Medical Services**  
Medical Care when you are an Inpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specified.
  - **Inpatient Medical Care Visits**  
Inpatient Medical Care visits are limited to one visit or other service per day by the attending Doctor.
  - **Intensive Medical Care**  
Constant Doctor attendance and treatment when your condition requires it for a prolonged time.
  - **Concurrent Care**
    - Care for a medical condition by a Doctor who is not your surgeon while you are in the Hospital for Surgery.
    - If the nature of the illness or injury requires, care by two or more Doctors during one Hospital stay.
  - **Consultation**  
Consultation by another Doctor when requested by your attending Doctor, limited to one visit or other service per day for each consulting Doctor. Staff consultations required by Hospital rules are excluded.
  - **Newborn Well Baby Care**  
The initial Inpatient visit to examine a covered newborn.
- **Outpatient Medical Services**  
Outpatient Medical Care that is not related to Surgery, Pregnancy, or Mental Illness, except as specified.
  - **Emergency Accident Care**  
Treatment of accidental bodily injuries.
  - **Emergency Medical Care**  
Treatment of a sudden and acute medical condition that requires prompt Medical Care.

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<sup>12</sup> A procedure carried out at the same time as a primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and therefore, should not be reimbursed separately.

- Minor Emergency Center for Urgent Care  
Visits and consultation for the examination, diagnosis, and treatment of an injury or illness
- Doctor's Office Visits  
Visits and consultation for the examination, diagnosis, and treatment of an injury or illness.
- Chiropractic Services  
Chiropractic services limited to \$100 per Benefit Period.
- Well-Baby Care - **This Benefit is excluded under Plan II.**  
Well-baby care, including physical examinations, up to six months of age.
- Immunizations, available at Goddard only, limited to:
  - ❑ Diphtheria, whooping cough, and tetanus inoculation (DPT);
  - ❑ Tetanus toxoid, tetanus immune globulin (human) and tetanus antitoxin (horse serum);
  - ❑ Poliomyelitis vaccine and oral poliovirus vaccine (Sabin vaccine);
  - ❑ Measles virus vaccine;
  - ❑ Mumps virus vaccine;
  - ❑ German measles (rubella) vaccine;
  - ❑ Measles, mumps, and rubella vaccine (MMR);
  - ❑ Varicella (chicken pox) vaccine;
  - ❑ Pneumonia vaccine;
  - ❑ Hemophilus Influenza Type B (HIB);
  - ❑ Hepatitis A and Hepatitis B vaccine.

#### OUTPATIENT DIAGNOSTIC SERVICES

- Radiology, Ultrasound and Nuclear Medicine  
Radiological services include Routine Mammography Screening for the presence of occult breast cancer, regardless of Medical Necessity, payable not to exceed \$115. Frequency of visits is as specifically shown for the following age groups:
  1. Any female 35-39 years of age shall be entitled to screening once every 5 years; or
  2. Any female 40 years of age or older shall be entitled to annual screening.

All other medically necessary mammograms are subject to the Deductible and Coinsurance.

- Laboratory and Pathology  
ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as classified by Macori.

#### OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy
- Respiratory Therapy
- Dialysis Treatment  
Home dialysis and home dialysis training are excluded.

- Physical Therapy (Outpatient Physical Therapy is covered outside of Goddard Health Center for Plan I only when an evaluation and referral has been made by the Goddard Health Center Physical Therapy Department. For dependent children only, evaluation by the Goddard Health Center Physical Therapy Department is not required; however, a valid referral is required. Benefits for dependent children are limited to 5 visits, not to exceed \$120 per visit.) **Under Plan II, benefits are not available to dependents or outside Goddard for students.**
- Speech Therapy (limited to 20 visits per Covered Person per Benefit Period) Benefit only available under Plan I.
- Occupational Therapy (limited to 20 visits per Covered Person per Benefit Period) Benefit only available under Plan I.

## MATERNITY SERVICES

Hospital Services and Surgical/Medical Services from a Medical Provider to a covered Student or covered spouse for:

- Normal Pregnancy
- Complications of Pregnancy
- Interruptions of Pregnancy
  - Miscarriage
  - Therapeutic Abortion

Covered Maternity Services shall include:

- A minimum of 48 hours of Inpatient care at a Hospital or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under this Plan after childbirth, except as otherwise provided in this section; or
- A minimum of 96 hours of Inpatient care at a Hospital or a birthing center licensed as a Hospital, following a cesarean section for the mother and newborn infant who are covered under this Plan after childbirth, except as otherwise provided in this section; and
- Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:
  - physical assessment of the mother and newborn infant;
  - parent education regarding childhood immunizations;
  - training or assistance with breast or bottle feeding; and
  - performance of any Medically Necessary and appropriate clinical tests.

At the mother's discretion, visits may occur at the facility of the Medical Provider instead of the home.

- Inpatient care shall include, at a minimum:
  - physical assessment of the mother and newborn infant;
  - parent education regarding childhood immunizations;
  - training or assistance with breast or bottle feeding; and
  - performance of any Medically Necessary and appropriate clinical tests.

- This Plan may provide coverage for a shorter length of Hospital Inpatient stay for services related to maternity and newborn infant care provided:
  - The licensed health care Providers determine that the mother and newborn infant meet medical criteria contained within guidelines, developed by or in cooperation with licensed health care Providers, which recognize treatment standards, including, but not limited to, the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon:
    - evaluation of the antepartum, intrapartum, and postpartum course of the mother and newborn infant;
    - the gestational age, birth weight and clinical condition of the newborn infant;
    - the demonstrated ability of the mother to care for the newborn infant postdischarge; and
    - the availability of postdischarge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery.

Benefits are not provided for Maternity Services for Dependent children.

#### HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES - BENEFITS AVAILABLE ONLY UNDER PLAN I

Hospital and Surgical/Medical Services from a Provider for:

- Musculoskeletal transplants;
- Parathyroid transplants;
- Cornea transplants;
- Heart-valve transplants;
- Kidney transplants.

Hospital Services and Surgical/Medical Services rendered by a Hospital, Doctor or other approved Medical Provider for bone marrow transplants, liver transplants, heart transplants, lung transplants subject to the following special provisions:

- *The Covered Person must receive Precertification from Utilization Management Corp. in order for Benefits to be provided under this Plan.* Utilization Management Corp. has the sole and final authority for approving or declining requests for Precertification. This decision is based upon a review by Utilization Management Corp. of supporting documents submitted by the attending Doctor, stating the diagnosis, the recommended course of treatment, and the name of the facility in which the transplant will be performed.
- Precertification will be considered for a heart transplant, provided the Covered Person:
  - has terminal heart disease with an estimated life expectancy of less than six months; and
  - has normal liver and kidney function; and
  - has no serious concurrent systemic diseases, including but not limited to: sepsis, neoplasm, insulin dependent diabetes, collagen vascular or auto-immune disease, major neurologic disorders, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; and
  - is psychosocially stable and has a supportive social milieu.

Precertification will be considered for a single-lung transplant, double-lung transplant, or heart/lung transplant, provided the Covered Person:

- has end-stage cardiopulmonary or pulmonary disease with a life expectancy of 18 months or less; and
  - is not currently on mechanical ventilation; and
  - has no serious concurrent systemic diseases, including but not limited to: sepsis, neoplasm, insulin dependent diabetes, collagen vascular or auto-immune disease, major neurologic disorders, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; and
  - has no concurrent use of systemic steroids; and
  - has normal liver and kidney function; and
  - has no previous major cardio-thoracic Surgery; and
  - is psychosocially stable and has a supportive social milieu.
- Precertification will be considered for a liver transplant, provided the Covered Person:
- has end-stage liver disease with a life expectancy of less than six months due to any of the following conditions:
    - Extra hepatic biliary atresia;
    - Primary biliary cirrhosis;
    - Primary sclerosing cholangitis;
    - Hepatitis B antigen-negative hepatitis;
    - Hepatic vein thrombosis (Budd Chiari syndrome);
    - Certain inborn errors of metabolism (such as Alpha-1-antitrypsin deficiency, Wilson's disease, and primary hemochromatosis); and
  - has normal kidney function; and
  - has no serious concurrent systemic diseases, including but not limited to: sepsis, neoplasm, insulin dependent diabetes, collagen vascular or auto-immune disease, major neurologic disorders, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; and
  - is psychosocially stable and has a supportive social milieu.

No benefits will be provided for a Covered Person with end-stage liver disease as a result of viral hepatitis (hepatitis B or hepatitis C or others) where the Covered Person remains antigen positive; or for a Covered Person whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Covered Person has abstained from alcohol for a period of no less than 24 months.

Precertification will be considered for an allogeneic or syngeneic bone marrow transplant (a transplant with a donor other than the patient), with or without high-dose

Chemotherapy and/or Radiation Therapy, only in the following cases:

- There is a six out of six major histocompatibility complex antigen match between the patient and the donor; and
- The mixed leukocyte culture is non-reactive; and
- One of the following conditions is being treated;
  - Aplastic anemia;
  - Acute leukemia;
  - Stage IV intermediate or high-grade lymphoma with bone marrow involvement;
  - Severe combined immunodeficiency;
  - Wiskott-Aldrich syndrome;
  - Infantile malignant osteopetrosis;
  - Chronic myelogenous leukemia;
  - Stage III or IV neuroblastoma in children over one year of age;
  - Thalassemia major.
- Precertification will be denied, *and Benefits will not be provided*, for any other allogeneic or syngeneic bone marrow transplants (or for high-dose Chemotherapy or Radiation Therapy performed in conjunction with such transplants), such as:
  - Cases in which five out of six or fewer major histocompatibility complex antigens match;
  - Cases in which mixed leukocyte culture is reactive;
  - Polycythemia vera;
  - Intermediate or high-grade lymphoma other than Stage IV with bone marrow involvement;
  - Multiple myeloma;
  - Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection.
- Precertification will be considered for an autologous bone marrow transplant or peripheral stem cell rescue (in which the patient is the donor), with high-dose Chemotherapy or Radiation Therapy, only for the following conditions:
  - Breast cancer;
  - Stage III or IV Hodgkin's disease which has come back after an initial complete remission, with no bone marrow involvement;
  - Stage III or IV intermediate or high-grade non-Hodgkin's lymphoma which has come back after an initial complete remission, with no bone marrow involvement;
  - Stage III or IV neuroblastoma, without bone marrow involvement;
  - Acute lymphocytic or non-lymphocytic leukemia which has come back after an initial complete remission.
- Precertification will be denied, *and Benefits will not be provided*, for autologous bone marrow transplants, peripheral stem cell rescue, or high-dose Chemotherapy or Radiation Therapy for any other cases, such as:
  - Acute leukemia in first remission, except for acute myeloblastic leukemia with chromosome 5 and/or 7 abnormalities documented on cytogenetics. No Benefits will be available for any other acute leukemias in first remission;
  - Hodgkin's or non-Hodgkin's lymphoma in first remission;
  - Intrinsic brain tumors;
  - Multiple myeloma;

- Ovarian cancer;
  - Lung cancer;
  - Testicular cancer;
  - Colon cancer;
  - Wilms' tumor;
  - Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection.
- The transplant must be performed in and by an approved Medical Provider that meets the criteria established by Utilization Management Corp. for assessing and selecting Providers in the performance of human bone marrow, liver, heart, lung, or heart/lung transplants.
  - Benefits for Organ Procurement Services will not exceed \$15,000 for each liver, heart, lung, or heart/lung transplant performed.

Benefits are not provided for any of the following:

- Any services considered to be Experimental or Investigational in nature. These include, but are not limited to:
  - Intestinal transplants;
  - Adrenal to brain transplants;
  - Islet cell transplants;
  - Pancreas transplants, except:
    - when performed simultaneously with a kidney transplant for a Covered Person who is a Severe Type I Diabetic and who would otherwise be considered a suitable candidate for a kidney transplant; and
    - when the Covered Person has obtained Precertification for such transplant.
 No Benefits will be provided for a pancreas transplant which is not performed in conjunction with a kidney transplant, or which is performed *after* the Covered Person has received a kidney transplant.
- More than one organ or tissue of the same type, with the exception of a double-lung transplant done at one time. For the purposes of this Plan, a heart-only, lung-only or heart/lung transplant will be considered the same type organ.
- Any organ or tissue transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.
- Any artificial device for transplantation/implantation, including, but not limited to an artificial or mechanical heart, lung, liver, or pancreas.
- Any organ or tissue transplant procedure which is not specifically listed as a Covered Service in this Plan.

If a human organ or tissue transplant is provided from a *living* donor to a human transplant recipient:

- When both the recipient and the donor are Covered Persons, each is entitled to the Benefits of this Plan.
- When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of this Plan. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under this Plan.

- When only the donor is a Covered Person, the donor is entitled to the Benefits of this Plan. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program available to the recipient. No Benefits will be provided to the non-Covered Person transplant recipient.
- If any organ or tissue is sold rather than donated to the Covered Person recipient, no Benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Covered Person recipient's Plan limit.
- Donor Benefits for bone marrow transplants are limited to Covered Services Incurred by the Covered Person recipient's blood-related family members only.

#### DAY SURGERY MISCELLANEOUS

Ambulatory Hospital-type services, not including Doctor's services, given to you in and by an Ambulatory Surgical Facility only when:

- Such services are Medically Necessary;
- An operative or cutting procedure which cannot be done in a Doctor's office is actually performed; and
- The operative or cutting procedure is a Covered Service under this Plan.

#### PSYCHIATRIC CARE SERVICES - **Available only under Plan I**

Psychiatric Care Benefits will be provided for the following Covered Services:

- Inpatient Facility Services - Limited to a maximum of 30 days or \$25,000, whichever comes first, per Covered Person per lifetime.  
Covered Inpatient Hospital Services provided by a Hospital or other Approved Medical Provider.
- Inpatient Medical Services  
Covered Inpatient Medical Services provided by a Doctor or other approved Medical Provider:
  - Medical Care visits limited to one visit or other service per day;
  - Individual and group psychotherapy;
  - Psychological testing;
  - Convulsive therapy treatment;  
Electroshock treatment or convulsive drug therapy including anesthesia when given together with treatment by the same Doctor or other approved Medical Provider.

Benefits will not be provided for both an Inpatient Medical Care visit and individual psychotherapy when performed on the same day by the same Doctor.

- Outpatient Psychiatric Care Services - **Available only under Plan I. Limited to 20 visits per Covered Person per benefit period.**
  - Facility and Medical Services  
Covered Inpatient Facility and Medical Services when provided Outpatient treatment of Mental Illness by a Hospital, Doctor, or other approved Medical Provider.

Outpatient Convulsive Therapy Treatment is excluded.

Benefits for Psychiatric Care Services are limited as specified in the Schedule of Benefits.

## AMBULANCE SERVICES

- Ambulance Services providing Medically Necessary local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - From your home to a Hospital when you are admitted as an Inpatient;
  - From the scene of an accident to a Hospital;
  - From the scene of a medical emergency to a Hospital when you are admitted as an Inpatient;
  - Between Hospitals;
  - Between a Hospital and a Skilled Nursing Facility.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

## PRIVATE DUTY NURSING SERVICES

Services of a practicing RN, LPN or LVN when ordered by a Doctor and when Medically Necessary. The nurse cannot be a member of your immediate family or have resided in your home prior to providing this service.

## DENTAL SERVICES RELATED TO ACCIDENTAL INJURY

Dental Services for accidental injury to the jaws, sound natural teeth, mouth or face that occurs on or after your Effective Date. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury, regardless of whether you knew the object or substance was capable of causing such injury if chewed or bitten.

## PRESCRIPTION DRUGS DISPENSED THROUGH CATALYST RX PROVIDER ONLY

Except for vacation packs for maintenance drugs, not to exceed a 60 day supply, benefits are not provided for Prescription Drugs dispensed in excess of a 34-day supply or 100 dose units, whichever is less, except nitroglycerin, natural thyroid products and other maintenance legend Prescription Drugs designated by Catalyst Rx which may be dispensed in 100 or 200 unit dosage quantities or a 34-day supply, whichever is greater.

Benefits for Prescription Drugs are limited as specified in the Catalyst Rx Formulary and the Schedule of Benefits.

## **DURABLE MEDICAL EQUIPMENT - Available only under Plan I**

The rental (or, at the Plan's option, the purchase if it will be less expensive) of Durable Medical Equipment (such as respirators and oxygen tents) including replacement, repair and adjustment of purchased equipment, provided such equipment is prescribed by a Doctor and Medically Necessary for your therapeutic use. Also covered are wheelchairs, hospital beds, crutches, and other items determined by the Plan to be Durable Medical Equipment, but not including disposable items or supplies.

Benefits for Durable Medical Equipment will not exceed \$5,000 per Benefit Period per Covered Person.

## **MEDICAL EVACUATION**

Evacuation of the Covered Person to his/her natural country, provided:

- the Covered Person has been confined to a Hospital for at least five consecutive days;
- evacuation is recommended by the attending Doctor, and Macori has approved evacuation as payable under the Plan.

Benefits for Medical Evacuation are limited to \$10,000.

## **REPATRIATION**

If a Covered Person dies, Benefits will be provided for the necessary preparation and transportation of the deceased's body to his/her natural country.

Benefits for Repatriation are limited to \$7,500.

## **EXCLUSIONS:**

The following are not covered services:

EXCLUSIONS APPLICABLE TO PLAN I ONLY - Except as specifically provided in the Plan, we do not provide benefits for services, supplies or changes for or related to transplantation of donor organs or tissues other than musculoskeletal, parathyroid, cornea, heart-valve, kidney, kidney/pancreas, bone marrow, liver, heart, lung, or heart/lung when performed by or under the auspices of an approved transplant program.

EXCLUSIONS APPLICABLE TO PLAN II ONLY - Except as specifically provided in the Plan, we do not provide benefits for services, supplies or charges for the following:

1. For treatment of acne, allergies, including allergy testing, or non-malignant moles, warts or lesions, except at Goddard Health Center;
2. For rehabilitation care, home health care, services of a skilled nursing facility or hospice;
3. For Speech Therapy, Occupational Therapy and any related diagnostic testing;
4. For treatment of Mental Illness or alcohol/substance abuse, except for a medical procedure at Goddard Health Center;
5. For sterilization;
6. For routine newborn baby care, well-baby care, well-baby nursery care (including hospital except as mandated for newborns) and related medical doctor charges or for circumcision;
7. For or related to organ or tissue transplants;
8. For medical supplies.

EXCLUSIONS APPLICABLE TO BOTH STUDENT HEALTH PLANS - Except as specifically provided in the Plan, we do not provide benefits for services, supplies or charges for the following:

1. Which are not prescribed by or performed by or upon the direction of a Doctor;
2. Which are not Medically Necessary, except as specified;
3. Incurred during a Hospital confinement, regardless of Medical Necessity, when such services, supplies or charges are not approved in accordance with the Pre-certification process;
4. Which are in excess of the Allowable Charge;
5. Which are Experimental/Investigational in nature;
6. For 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 government unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party;
7. To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion);
8. For which you have no legal obligation to pay in the absence of this or like coverage;
9. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
10. For cosmetic treatment including prescription drugs, Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless: needed to repair conditions resulting from a covered accidental injury which occurs after your Effective Date, provided treatment begins within three months from the date of the accident. In no event will any care and services for breast reconstruction and implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of Medically Necessary mastectomy;
11. For reverse sterilization;
12. Received from a member of your immediate family;
13. Treatment received before your Effective Date or during an Inpatient stay that began before your Effective Date;
14. For any Inpatient care and services unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient;
15. Expenses for treatment rendered after your termination date;
16. For personal hygiene and convenience items regardless of whether or not recommended by a Doctor. Examples include but are not limited to: air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills;
17. For telephone consultations, missed appointments, or completion of a claim form;
18. For flu vaccines;
19. For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures;
20. For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like;
21. For routine or periodic physical examinations, except at Goddard Health Center or as specifically provided.

22. For screening examinations (except as specifically provided), including x-ray examinations without film;
23. Resulting from attempted suicide or intentionally self-inflicted injury or illness;
24. For contraceptive medications or devices, except for oral contraceptives. Alternative prescription drugs as may be prescribed and purchased at Goddard Health Center;
25. For dental treatment or surgery (including complications resulting therefrom), except for: the treatment of accidental injury, to sound natural teeth, mouth or face occurring on or after the Covered Person's Effective Date; or for the improvement of the physiological functioning of a malformed body member, provided the Covered Person has been continuously covered under the Plan since birth;
26. Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures;
27. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a covered service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event;
28. For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring);
29. For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them. Hearing examinations not related to the prescription or fitting of hearing aids will be a covered service only when performed in connection with the diagnosis or treatment of disease or injury;
30. For transsexual Surgery or any treatment leading to or in connection with transsexual surgery;
31. For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability;
32. For treatment of sexual problems not caused by organic disease;
33. For treatment of obesity, regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs; 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;
34. For elective abortion;
35. For or related to acupuncture, whether for medical or anesthesia purposes;
36. For conditions related to autistic disease of childhood, hyperactivity disorders, hyperkinetic syndromes, learning disabilities (except dyslexia), behavioral problems, mental retardation, or for inpatient confinement for environmental change;
37. For which the Provider of service customarily makes no direct charge to a Covered Person;
38. For treatment of an injury received while participating in a riot or civil disorder, war, declared or undeclared, commission of or attempt to commit a felony or fighting, except in self defense;
39. For treatment of an injury received while practicing for, or participating in, any club, intercollegiate, professional sport or traveling to or from such event as a member of an organized team representing the University;
40. For treatment of an illness or injury received while skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any aircraft except as a passenger on a regularly scheduled commercial flight;

41. For treatment of an illness or injury caused by the use of alcohol, illegal drugs or drugs not taken as prescribed;
42. For treatment of temporomandibular joint dysfunction, included but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis;
43. For orthopedic braces or prosthetic appliances and orthotics;
44. Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Plan;
45. Resulting from injury or sickness sustained while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces, the Plan will refund unearned pro-rata contribution;
46. Bobsledding, travel in or upon a snowmobile, an all-terrain vehicle (ATV) or any other 2 or 3-wheeled motor vehicle;
47. Expense for injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable;
48. Treatment of sleep disorders;
49. Gynecomastia, hirsutism and alopecia.
50. Deviated nasal septum, including submucous resection and/or other surgical correction, unless due to an Injury occurring while continuous coverage is in effect.
51. Botox for any reason.

We may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount paid to you or the Provider. You must provide to us all documents needed to enforce our rights under this provision.

#### PREEXISTING CONDITION LIMITATION

Plan I Pre-existing Condition Statement. Benefits will not be provided for a Pre-existing condition for a period of 12 months following your effective date of coverage under the OUSA Student Health Plan unless you have been continuously covered under the OUSA Student Health Plan for a period of 12 consecutive months immediately preceding your Effective Date of coverage under this Plan except for allowable charges received at Goddard Health Center or for covered prescription drugs. A Covered Person will neither be allowed to change choice of plans during any policy year, nor will he/she receive a "gain" in subsequent years by purchasing Plan I for a condition for which benefits or the pre-existing waiting period began or was in effect while covered under Plan II.

Plan II Pre-existing Condition Statement. Benefits will not be provided for a Pre-existing condition for a period of 12 months following your effective date of coverage, except for individuals who have been continuously covered under the OUSA Student Health Plan for at least 12 consecutive months immediately preceding your Effective Date of coverage under this Plan except for allowable charges incurred at Goddard Health Center or for covered prescription drugs. A Covered Person will not be permitted to alter their choice of plans during any policy year.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

**LOSS OF LIFE, LIMB OR SIGHT**

If an injury shall, independently of all other causes and within 180 days from the date of the injury, solely result in any one of the following specific losses, the covered Student or the Student's beneficiary may request the Plan to pay the applicable amount below.

*For Loss of:*

Life .....	\$2,000
Two or More Members .....	\$2,000
One Member .....	\$1,000

Member means, hand, arm, foot, leg, or eye. Loss means, with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint. With regard to eyes, entire and irrecoverable loss of sight.

Only one specific loss (the greater) resulting from any one injury will be paid.

This coverage is available to Students only.

**GENERAL PROVISIONS**

**BENEFITS TO WHICH YOU ARE ENTITLED**

We provide only the Benefits specified in this Plan.

Only Covered Persons are entitled to Benefits from us and they may not transfer their rights to Benefits to anyone else.

Benefits for Covered Services specified in this Plan will be provided only for services and supplies of Providers specified in this Plan.

**CONTRIBUTION PAYMENTS AND PLAN CHANGES**

Your contribution payments are determined by the University of Oklahoma Student Association based upon the Benefits provided in the Plan.

The University of Oklahoma Student Association is authorized to determine, and at its discretion, to change the scope of Benefits provided by the Plan or the amount of contributions. If the contributions are increased, the UOSA Student Health Plan will give you reasonable notice prior to the increase.

All contributions for coverage must be paid to the University of Oklahoma in accordance with the guidelines established by the UOSA.

If you fail to pay your contribution payments on or before the due date, your coverage will automatically, and without notice, may be canceled on your "paid-to-date" of coverage. The UOSA reserves the sole right to determine your new effective date of coverage after cancellation for non-payment of contributions upon the terms and conditions it determines to be acceptable.

A grace period of thirty-one days will be granted for each renewal after the initial contribution. During that period, this Plan shall continue in force but no claims will be paid for that period until the contribution has been received. You shall be liable to the Plan for the payment of the contribution for the period this Plan continues in force.

## PRIOR APPROVAL

The Plan does not give prior approval or guarantee Benefits for any services through the Precertification process, or in any oral or written communication to Covered Persons or other persons or entities requesting such information or approval.

## PROOF OF LOSS

The Plan will not be liable unless proper Proof of Loss is furnished to Macori that Covered Services have been rendered to you. Your claim form or other Proof of Loss should be furnished to Macori within 30 days from the date of treatment. In no event will any payments be issued after February 24, 2010 whether or not expenses were incurred during the term of this Plan.

## RELEASE OF INFORMATION

You agree that Macori may request, and anyone may give to us, any information (including copies of records) about your illness or injury for which Benefits are claimed. Also, that Macori may give similar information, if requested, to anyone providing similar benefits to you.

## LIMITATION OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after Proof of Loss has been given. No such action may be taken later than two years after the expiration of the time within which Proof of Loss is required by the Plan.

## PAYMENT OF BENEFITS

You authorize Macori to make payments directly to Providers giving Covered Services for which we provide Benefits under the Plan. Macori also reserves the right to make payments directly to you.

Benefits will be available for the Allowable Charge (as shown in the Schedule of Benefits).

In no event will benefits be provided to you under this plan until the required contributions for your coverage are paid.

## BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA (EXCEPT PRESCRIPTION DRUGS)

The University of Oklahoma participates in a national program through First Health (Coventry). This national program benefits Covered Persons who receive Covered Services outside Oklahoma. In order to maximize your benefits outside of Oklahoma, you should seek treatment from a First Health (Coventry) provider.

NOTE: The Plan may postpone application of your Deductible, Coinsurance and/or Copayment amounts whenever it is necessary in order to obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

DETERMINATION OF BENEFITS ELIGIBILITY AND UTILIZATION REVIEW - Applicable to Inpatient services only.

Utilization Management Corp. is hereby granted authority to interpret the terms and conditions of the Plan and to determine its Benefits. Such determination as to whether care and services are eligible for Benefits under the Plan may be made by experienced healthcare professionals appointed by Utilization Management Corp. at its election.

Utilization Management Corp.'s medical staff may conduct a medical review of your claims to determine that the care and services received were medically necessary.

The fact that a Doctor or other approved medical Provider prescribes, orders, recommends or approves a service or supply does not, of itself, make it Medically Necessary or a Covered Service, even if it is not specifically listed as an exclusion under the Plan.

To assist Utilization Management Corp. in its review of your claims, Utilization Management Corp. may request that:

- you arrange for medical records to be provided to us; and/or
- you submit to a professional evaluation by an approved Medical Provider selected by us, at our expense; and/or
- a Doctor or panel of Doctors or other approved medical Providers appointed by us review the claim.

If you fail to comply with Utilization Management Corp.'s request for medical records or medical evaluation, Benefits under this Plan may be partially or wholly denied.

## EXCESS PROVISION

All Benefits provided under the Plan are subject to this excess provision. Coverage provided by "Another Health Plan" will not be payable under this plan.

### ▪ Definitions

In addition to the definitions of the Plan and this Plan Document, the following definitions apply to this provision:

"Another Health Plan" means any arrangement providing health care benefits or services through:

- group, blanket or franchise insurance coverage;
- Blue Cross Plan, Blue Shield Plan, health maintenance organization, and other prepayment coverage;

- coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- coverage toward the cost of which any employer shall have contributed, or with respect to which any employer shall have made payroll deduction; and
- coverage under any tax supported or government program to the extent permitted by law.
- Medical benefits available under any automobile insurance coverage

"Covered Service" additionally means a service or supply furnished by a Hospital, Doctor, or other approved medical Provider for which benefits are provided under at least one plan covering the person for whom claim is made or service provided.

"Dependent" additionally means a person who qualifies as a Dependent under "Another Health Plan".

- Effect on Benefits

The Benefits payable under this Plan for Covered Services received during a Benefit Period will be reduced so that the sum of the reduced Benefits and the benefits payable for Covered Services under other Plans does not exceed the total of Covered Services. Benefits payable under other Plans include the benefits that would have been payable had claims been made.

- Right of Recovery

If this Plan pays more for Covered Services than this provision requires, we have the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure our right to recover the excess payment.

#### PLAN'S RIGHT OF RECOUPMENT

You agree to reimburse the Plan for Benefits it has paid and for which you were not eligible under the terms of the Plan. This payment is due and payable immediately when you are notified by Macori. Also, Macori has the sole right to determine that any overpayments, wrong payments, or any excess payments made for you under this Plan are an indebtedness which it may recover by deducting it from any future Benefits under this Plan.

To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, you agree that the Plan shall have first lien on any settlement proceeds and that you will reimburse and pay the Plan, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from any party or his or her insurer or from any carrier providing no fault, med pay, or uninsured/underinsured motorist coverage. You shall reimburse the Plan on a first-priority basis regardless of whether a lawsuit is filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries.

You are required to hold in trust for the Plan any money (up to the amount of Benefits paid by the Plan) you recover as described above. You are required to cooperate and furnish information and assistance which the Plan may require to obtain this reimbursement, including signing legal documents.

## DISCRETIONARY AUTHORITY OF PLAN SPONSOR

In carrying out its respective responsibilities under the Plan, the UOSA, as Plan Sponsor, (or such other designated Plan fiduciaries) shall have discretionary authority to interpret the terms of this Plan and to determine eligibility for and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be final and binding and given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

## AMENDMENT OR TERMINATION OF PLAN

The University of Oklahoma Student Association intends that this Plan will continue indefinitely, but reserves the right, in its sole and absolute discretion, to amend, change, revoke or terminate the Plan, in whole or in part, at any time in the future.

## CLAIMS FILING PROCEDURES

This Plan begins to pay only after the Deductible amount you incur toward eligible expenses shows on Macori's records (except for services you receive at the Goddard Health Center, or other services which are not subject to the Deductible). When your Doctor, Hospital, or other Provider of health care services submits bills for you, your Deductible will be recorded, and then the Plan will begin its share of the payment. Outside of Goddard, you must submit copies of all your bills and a completed claim form, even those you must pay to meet your Deductible. Then Macori's records will show that you have incurred the deductible amount, and your health care coverage will begin to help pay the balance of your eligible expenses. You may pick up claim forms from the Student Health Plan Office, Goddard or you may download or complete a claim form online at [www.macori.com](http://www.macori.com)

### CARE RECEIVED AT GODDARD HEALTH CENTER

Except for treatment provided to you without charge, Goddard Health Center will forward your claims to Macori offices.

### HOW TO FILE CLAIMS FOR TREATMENT OUTSIDE OF GODDARD OTHER THAN PRESCRIPTION DRUGS

In order to obtain reimbursement for yourself or a Medical Provider, you may obtain a claim form by contacting Goddard Health Center or Macori. Be sure to fill out the claim form completely, sign it, attach the Provider's itemized statement, and your Goddard referral. If you have a new address, be sure to check the appropriate box on the claim form to ensure you receive payment. Send the completed claims to:

Macori Administration  
P.O. Box 2478  
Spring, Texas 77388-2478  
1 800 285-8133  
[www.macori.com](http://www.macori.com)

It is important that all information requested on the claim form be given. Otherwise, the claim may be returned to you for additional information, which could delay payment.

A separate claim form must be completed for each condition per policy year along with that person's expenses. A separate form should accompany each group of statements (if filed at different times).

**IMPORTANT:** Remember to send the itemized statement with all your claims. It gives the following necessary information:

- Full name of patient and Insured Student
- Social Security Number;
- Medical service(s) performed;
- Date of service(s);
- Who rendered service(s);
- Charge for service(s);
- Diagnosis

Canceled checks, cash register receipts, personal itemizations and statements that show only the balance due are not acceptable.

When you file claims, be sure to keep copies of all bills and receipts for your own personal records.