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Employee
Benefits®





Your
benefit
plan ...

choices for your life

Oral Roberts University
All Employees

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This document provides a general overview. All insurance policies and products contain limitations, exclusions, restrictions, and may contain reductions and terms under which the policy or plan may be continued in force or discontinued. We reserve the right to cancel the policy or plan with advance written notice to the policyholder or group. Issued insurance contracts and agreements determine all plan features and benefits. Products are subject to state variations and availability. Benefits provided and premium amounts depend on the plan selected. Contact us for costs and complete details.

Assurant Employee Benefits is the brand name used for insurance products underwritten and issued by Union Security Insurance Company.



Benefit Summary

What can these benefits do for me?

The products in this benefit plan were selected with your and your family's well-being in mind. They're an important part of your compensation package. Please take the time to review the benefits carefully to be sure you select the ones that best fit your needs.

The products listed below are offered through Assurant Employee Benefits, one of the largest providers of employee benefits in the United States. These products are backed by financial strength and stability you can count on. Assurant Employee Benefits is a part of Assurant Inc., a Fortune 500 company and a member of the S&P 500 Index.

You can learn more about these benefits and how to choose the coverage that's right for you on the following pages. Because these products are offered through your employer, premium rates may be more competitive than similar products you could buy as an individual.



What benefits are available to me?

- **Accident insurance** provides a range of benefits for accidental injuries.
- **Cancer insurance** can provide financial assistance for early detection and treatment of cancer.

How do I enroll?

1. Review the information in this booklet to see which benefits suit your needs.
2. Attend your benefits enrollment meeting.
3. Complete your enrollment form.
4. Sign and give your form to the program administrator.

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Choosing to expect the unexpected

Accident Insurance

Have you ever thought about what you would do if you or a family member were accidentally injured or died as a result of an accident?

Accidents are unexpected and can strike any member of your family. The costs associated with treatment can mount quickly.

- One in six U.S. residents require medical treatment from an injury each year.¹
- Over 40 million Americans visit a physician's office for unintentional injuries each year.²
- The 2007 national economic impact of unintentional injuries mounted to \$684.4 billion.²



How can accident insurance help?

For covered accidental injuries, fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more.

If you or a covered dependent should die as a result of an accidental injury within 365 days while the coverage remains in force, a death benefit is payable.

How do I know if I'm eligible to participate in this plan?

You can participate in this plan if you are a full-time employee of the policyholder or an associated company. Full-time means working 20 hours or more per week. Temporary or seasonal workers are not eligible.

This product is inappropriate for those persons who are eligible for Medicaid coverage.

Key Advantages of This Plan

- Provides coverage for on-and-off-the-job accidents.
- Benefits are payable directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- No health questions or pre-existing conditions limitations.
- Fast and accurate claims service.
- Coverage is fully portable - if you change jobs you can take your coverage with you.

Sources: ¹ Center for Disease Control, Congressional Testimony, May 1, 2008

² National Safety Council, "Injury Facts" 2008

This is an accident only insurance policy. It provides limited benefits and has some specific benefit limits. It does not pay benefits for sickness or loss from any other cause and is not a policy of Workers' Compensation. Please refer to the issued insurance policy for complete details and all benefit requirements including all limitations, exclusions and restrictions. We reserve the right to cancel the policy with advance written notice to the policyholder. Insurance policies and certain policy benefits are subject to state variations and may not be available in all states. Issued insurance contracts determine all plan features and benefits.

Accident Q&A

Q. What about coverage for my family?

- A. If you elect coverage for yourself, you can elect coverage for your eligible family members. Eligible family members include your spouse and children from live birth to less than age 26. See your certificate or group insurance policy for additional eligibility details.

Q. When will my coverage become effective?

- A. Your coverage starts on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties. If a family member is in a hospital on the day insurance would otherwise take effect, then insurance will take effect on the day after the family member leaves the hospital.

Q. What is the Annual Wellness Screening Benefit?

- A. If you and your dependents enroll in the plan, each of you are eligible for \$50 per benefit year for any one Wellness Screening test from a list of more than 20 covered tests. Covered tests include: Blood test for lipids including total cholesterol, LDL, HDL and triglycerides; breast ultrasound or mammography; chest x-ray; colonoscopy; pap smear; PSA (blood test for prostate cancer); electrocardiogram (EKG); echocardiogram (Echo) and more. In order to receive this benefit, you must submit proof that the wellness screening test was performed by providing us with documentation from your or your dependent's doctor.

How much does Accident insurance cost?

The financial assistance that Accident insurance provides doesn't have to take a big bite out of your wallet. Review the costs and benefits below to determine if Accident insurance is right for you. We've included an example of how benefits can be paid under this plan to help you with your decision.

Treatment	Benefit*	Treatment	Benefit*
Broken Finger (no surgery)	\$175	Broken Leg (no surgery)	\$800
Emergency Treatment	\$150	Emergency Treatment	\$150
Follow-up Visit (2)	\$50	Ambulance	\$200
Total Payment	\$375	Initial Hospitalization	\$1,000
		Hospital Benefit (1 day)	\$250
		Crutches	\$125
		Follow-up Visit (3)	\$75
		Physical Therapy (2x)	\$50
		Total Payment	\$2,650

*These hypothetical examples are for illustrative purposes only.

Your Bi-Weekly Premium Deduction	
24-Hour Coverage	
For you	\$8.88
For you and your spouse	\$12.96
For you and your child(ren)	\$14.83
For you and your family	\$18.91

Premiums will not change due to age changes.

What benefits are payable for covered accidents?

Accident Insurance Schedule	
<i>Initial Emergency Treatment: Pays a benefit for accident emergency treatment, ambulance transportation for medical treatment of a covered accident and certain other services.</i>	
Ambulance*	\$200 - Ground ambulance \$1,500 - Air ambulance
Accident Emergency Treatment*	\$150 - Emergency Room \$75 - Non-Emergency Room Limited to once each accident and once in any 24-hour period.
Major Diagnostic Exams	\$200 per benefit year. Initial treatment must be provided within 6 days of the accident.
Blood/Plasma/Platelets	\$200 payable once for any accident
<i>Hospital Care: Traditional health insurance policies may have deductibles and co-payments associated with hospital stays. Accident benefits can help cover your out-of-pocket costs resulting from a hospital admission due to a covered accident.</i>	
Initial Accident Hospitalization	\$1,000 limited to once per benefit year. Increases to \$1,500 if immediately admitted to the ICU.
Daily Hospital Confinement	\$250 not to exceed 365 days
Daily Intensive Care Unit Confinement	\$500 not to exceed 15 days per Accident. Paid <u>in addition</u> to the daily Hospital Confinement Benefit.
<i>Accidental Injuries: Benefits are payable for many injuries.</i>	
Dislocation (Separated Joint)*	Up to \$4,000 for Open Reduction (Surgical). Up to \$1,000 for Closed Reduction (repair by manipulation). Limited to 2 dislocations per accident. If reduction is administered without general anesthesia, 25% of the Closed Reduction benefit is payable.
Fractures (Broken Bones)	Up to \$5,000 for Open Reduction (Surgical). Up to \$2,500 for Closed Reduction (repair by manipulation). Limited to 2 fractures per accident. Chip fractures and other fractures not reduced by Open or Closed Reduction will be payable at 25% of the amount otherwise payable for the Closed Reduction.
Emergency Dental Work*	\$200 - Broken teeth repaired with crowns \$65 - Broken teeth resulting in extractions Limited to 1 benefit per accident.
Concussion*	\$100
Eye Injury	\$300 - Surgical repair \$65 - Removal of foreign body by a doctor
Lacerations*	\$35 to \$500
Burns*	Third Degree Burns - \$1,000 to \$20,000** Second Degree Burns - \$400 to \$2,000** Skin Grafts - 50% of the total burn benefit* payable **Burn benefit is a fixed amount determined by the surface area burned.
<i>Surgical Care: Provides a benefit for covered surgical procedures performed within 90 days of the accident.</i>	
\$1,250	Open abdominal (including exploratory laparotomy), cranial (head), hernia, or thoracic (chest) surgery.
\$625	Repair of tendons and/or ligaments, torn rotator cuffs, ruptured discs, or torn knee cartilages.
\$300	Arthroscopy without surgical repair, or miscellaneous surgery requiring general anesthesia that is not covered by any other specific-sum injury benefit. Miscellaneous surgery limited to one surgery per 24-hour period.

Transportation: Assists when you or your covered dependent require medical care or treatment as prescribed by an attending doctor that is not available within 100 miles of the accident or your or your covered dependent's residence.

Transportation	\$600 limited to 3 round trips per benefit year for you and each covered dependent. Benefit is payable upon completion of the round trip. Excludes ground or air ambulance.
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Lodging Assistance: If you or your covered dependent are hospital confined more than 100 miles from your or your covered dependent's residence due to an injury, the Accident policy can help with costs.

Lodging	\$100 per day Limited to one benefit per day and 30 days per accident per benefit year.
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Accidental Death and Dismemberment: If injury results in death or dismemberment, a lump sum benefit is payable.

Accidental Death Benefit	Employee - \$25,000 ; Spouse - \$25,000 ; Child - \$5,000
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Common Carrier Death Benefit	Employee - \$100,000 ; Spouse - \$100,000 ; Child - \$20,000 Either the accidental death or the common carrier accidental death benefit will be paid, but not both.
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Dismemberment	Loss of Finger, Toe, Hand, Foot, Arm, Leg, Eye - \$750 to \$15,000
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Follow-up care: Helps with expenses for additional care or support that might be required after the initial treatment for an accident. Certain benefits may not be payable if provided on the same day.

Follow-up Treatment*	\$25 per day, not to exceed 6 payments
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Physical Therapy*	\$25 per day, for up to 10 days of treatments
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Appliances	\$125 - Wheelchairs, leg or back braces, crutches or walkers Limited to one appliance per accident
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Rehabilitation Unit	\$150 per day; limited to 30 days per period of confinement and limited to 60 days per benefit year
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Prosthesis	\$500 limited to one per accident
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Serious Accidents: Serious accidents can result in life changing losses. Benefits are payable for the following conditions as a result of a covered accidental injury.

Coma	\$20,000
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Paralysis	\$50,000 for Quadriplegia; \$25,000 for Paraplegia Payable only once per lifetime
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*Initial treatment must be provided within 72 hours of the accident.

Important Definitions

Hospital means an institution which is primarily engaged in providing, by and under the supervision of doctors, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons; or rehabilitation services of injured, disabled, or sick persons. It must meet all of the following requirements: maintain clinical records on all patients; have every patient be under the care of a doctor; provide 24-hour nursing service provided by a licensed practical or registered nurse and supervised by a registered professional nurse; be licensed or be approved by the state or local licensing agency; meet other health and safety requirements found necessary by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and is not primarily a clinic, nursing, rest or convalescent home.

Hospital confined or hospital confinement means admission to a hospital as an inpatient for at least 24 consecutive hours by a doctor for an injury. A hospital stay that does not result in charges to you or your covered dependent is not a hospital confinement under this policy unless there is no charge because the hospital is a United States government facility.

State variations can exist; please contact Assurant Employee Benefits for additional information.

Limitations, exclusions, restrictions and reductions

Please carefully review the Other Important Plan Provisions section for additional important plan limitations, exclusions, restrictions and reductions that may apply.

*Choosing to focus on
winning the battle*

Cancer Insurance



ASSURANT
Employee
Benefits®

What are the chances that I might be diagnosed with cancer?

While 1 in 3 Americans are expected to get cancer in their lifetime¹, advances in early detection, medicines, surgical procedures, and chemotherapy, as well as alternative treatments, have improved the odds of surviving. In fact, recent data shows the five-year survival rate to be 66%¹.

With increases in cancer treatment options comes increased costs. In 2007, the National Institute of Health estimated the overall cost of cancer to be in excess of \$219 billion.

How can cancer insurance help?

Cancer insurance provides fixed benefits for early detection and treatment of certain kinds of cancer, including related expenses such as screenings, hospital confinement, radiation, chemotherapy, surgery and more. Benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose.



How do I know if I'm eligible to participate in this plan?

You can participate in this plan if you are a full-time employee of the policyholder or an associated company. Full-time means working 20 hours or more per week. Temporary or seasonal workers are not eligible.

This product is inappropriate for those persons who are eligible for Medicaid coverage.

Key Advantages of This Plan

- Benefits are payable directly to you to be spent any way you choose.
- Pays in addition to any other coverage you may have.
- Fast and accurate claims service.
- Coverage is fully portable - if you change jobs you can take your coverage with you.

Sources: ¹ American Cancer Society, National Cancer Facts & Figures, 2008

This is a cancer only insurance policy. It does not pay benefits for loss from any other cause. This policy provides limited benefits and has some specific benefit limits. This is not a medical insurance policy, a Medicare Supplement policy, or a high deductible health plan, or a policy of Workers' Compensation insurance. Please refer to the issued insurance policy for complete details and all benefit requirements, including all limitations, exclusions, and restrictions. We reserve the right to cancel the policy with advance written notice to the policyholder. Insurance policies and certain policy benefits are subject to state variations and availability. Issued insurance contracts determine all plan features and benefits. Always review your insurance certificate booklet for complete contract provisions.

Cancer Q&A

Q. What about coverage for my family?

- A. If you elect coverage for yourself, you can elect coverage for your eligible family members. Eligible family members include your spouse and children from live birth to less than age 26. See your certificate or group insurance policy for additional eligibility details.

Q. Do I need to answer any medical questions to enroll?

- A. You do need to complete a simple health questionnaire on yourself and any dependents you wish to cover. Once approved, a pre-existing conditions limitation will apply.

A pre-existing condition means a sickness, symptom or physical finding, or any related sickness, symptom or physical finding, for which you or your covered dependent consulted with or received advice from a licensed medical or dental practitioner; or received medical or dental care, treatment or services, including taking drugs, medicine, insulin or similar substances during the 6 months that end on the day before you or your covered dependent became insured under the policy. We will not pay benefits for claims resulting, directly or indirectly, from a pre-existing condition unless you or your covered dependent are diagnosed with cancer after 12 consecutive months during which you or your covered dependent are continuously insured under this plan.

See your certificate for additional pre-existing condition details.

Q. When will my coverage become effective?

- A. Your coverage starts on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties. If a family member is in a hospital on the day insurance would otherwise take effect, then insurance will take effect on the day after the family member leaves the hospital.

How much does Cancer insurance cost?

The financial assistance that Cancer insurance can provide doesn't have to take a big bite out of your wallet. Because issue age rating applies, your premiums will not increase due to age changes. Your premiums are based on your age as of the effective date.

Cancer Insurance Bi-Weekly Premium Deduction Level 2					
Issue Age	<40	40-49	50-59	60-64	65+
For you	\$13.58	\$13.58	\$16.75	\$26.71	\$35.76
For you and your spouse	\$23.09	\$23.09	\$28.47	\$45.40	\$60.79
For you and your child(ren)	\$14.94	\$14.94	\$18.11	\$28.07	\$37.12
For you and your family	\$24.45	\$24.45	\$29.83	\$46.76	\$62.15

What benefits are payable under this Cancer insurance plan?

The following Level 2 benefits are available. The issued policy controls all benefit amounts.

Covered Services	Level 2 Benefits
Cancer Screening Includes the following tests or procedures for internal cancer for which you or your covered dependent are charged: colonoscopy, CA 125 test, chest x-ray, flexible sigmoidoscopy, mammogram, pap smear, biopsy, PSA, CT scans or MRI scans, BRCA testing, or Hemocult stool specimen. This benefit is limited to once per benefit year.	\$75
Second Surgical Opinion This benefit is payable if you or your covered dependent are diagnosed by a doctor with internal cancer requiring surgery and obtain a second surgical opinion.	\$200
Surgery and General Anesthesia This benefit is payable if you or your covered dependent are diagnosed by a doctor with internal cancer requiring surgery. A separate benefit amount is paid for the surgery and for general anesthesia. Benefits vary based on the procedure performed. Combined maximum for any one surgery is \$7,500 for Level 2. Surgery for skin cancer and reconstruction is not covered under this benefit.	Anesthesia - \$50 to \$1,815 Surgical - \$150 to \$5,500
Hospital Confinement A daily benefit is payable for each day you or your covered dependent are confined to a hospital for inpatient treatment for internal cancer. Limited to 90 days per period of hospital confinement.	\$400 Daily
In-hospital Blood and Plasma Pays the amount shown for each day you or your covered dependent receive blood and/or plasma due to internal cancer treatment while hospital confined.	\$50 Daily
Outpatient Blood and Plasma Pays the amount shown for each day you or your covered dependent receive outpatient blood and/or plasma transfusions in a doctor's office, clinic, hospital, or ambulatory surgical center directly related to internal cancer treatment.	\$50 Daily
Ambulance This benefit is payable for a licensed professional ambulance to transport you or your covered dependent to a hospital for inpatient internal cancer treatment. Limited to 2 one-way trips per period of hospital confinement per covered person.	Ground - \$250 Air - \$2,000
In-hospital Doctor Visits Pays the amount shown for you or your covered dependent each day you are visited by a doctor other than the operating surgeon while hospital confined for internal cancer treatment. Limited to a maximum of 75 visits.	\$25 Daily

Covered Services	Level 2 Benefits
Prosthesis This benefit is payable if you or your covered dependent receive an implantable or non-implantable prosthetic device, such as a voice box, hairpiece or removable breast prosthesis as a direct result or consequence of the treatment of internal cancer. Lifetime maximum for surgically implanted prosthesis is \$6,000 for Level 2. Lifetime maximum for other devices is \$600 for Level 2. Excludes coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) flap procedure.	Surgically Implanted - \$3,000 Other Devices - \$300
Skin Cancer This benefit is payable for procedures performed if you or your covered dependent are diagnosed with skin cancer and includes the amount payable for anesthesia services. The amount payable varies based on the procedure performed. <ul style="list-style-type: none"> ▪ Biopsy Only ▪ Reconstructive surgery following previous excision of skin cancer ▪ Excision of skin cancer without flap or graft ▪ Excision of skin cancer with flap or graft 	\$100 \$250 \$375 \$600
Radiation and Chemotherapy If you or your covered dependent receive cytotoxic medications or radiation (approved by the FDA or NCI-listed) administered by medical personnel in a hospital, clinic or doctor's office as internal cancer treatment for the purpose of changing or destroying abnormal tissue, the following benefits will be paid: <ul style="list-style-type: none"> ▪ Injected Cytotoxic Medications ▪ Pump Dispensed Cytotoxic Medications ▪ Oral Cytotoxic Medications ▪ Cytotoxic Medications Administration by Any Other Method ▪ External Radiation Therapy ▪ Insertion of Interstitial or Intracavity Administration of Radioisotopes or Radium ▪ Oral or I.V. Radiation 	\$1,000 Weekly \$1,000 First Prescription & per Refill \$500 per Prescription \$1,000 Weekly \$600 Weekly \$750 Weekly \$600 Weekly
This benefit is not payable for the same day the Experimental Treatment benefit is payable. These benefits are not payable for treatment planning, therapeutic devices, immunotherapy, laboratory tests, diagnostic x-rays, dosimetry or simulation associated with these procedures. Maximums apply: Oral Cytotoxic Medications are subject to a \$1,500 monthly maximum for Level 2. A \$12,000 benefit year maximum applies to each of the other listed treatments for Level 2.	
Extended-care Facility Pays the amount shown for you or your covered dependent for each day you are confined in an extended-care facility. This benefit is payable if the extended care confinement occurs within 30 days of a period of hospital confinement due to internal cancer and you have received a Hospital Confinement benefit. Limited to a maximum of 90 days per benefit year per covered person. This benefit is not payable for any day the Hospital Confinement benefit is payable.	\$200 Daily
Hospice Pays the daily amount shown for hospice care for you or your covered dependent for terminal illness as a result of internal cancer. Limited to a maximum of 100 days during the covered person's lifetime. This benefit is not payable for any day the Extended-Care Facility benefit, the Home Health Care benefit or the Hospital Confinement benefit is payable.	\$100 Daily

Covered Services	Level 2 Benefits
National Cancer Institute Evaluation/Consultation Pays the amount shown if you or your covered dependent obtain an evaluation or consultation at a National Cancer Institute designated cancer center strictly to determine the appropriate course of cancer treatment as a result of receiving a prior diagnosis of internal cancer. This benefit is not payable for the same day the Second Surgical Opinion benefit is payable. This benefit is limited and only payable once per lifetime.	\$500
Medical Imaging When a follow-up evaluation is performed using any imaging test as directed by a doctor after an initial diagnosis of internal cancer, (except breast mammography and breast ultrasound) this benefit is payable. You may receive this benefit twice per benefit year provided you or your covered dependent are charged for these procedures and they are performed on an outpatient basis.	\$100
Home Health Care If a doctor prescribes home health care or health support services for you or your covered dependent after being released from the hospital due to internal cancer this benefit is payable. The service must begin within 7 days of the date you or your covered dependent are released from hospital confinement. This benefit is not payable for any day the Hospice benefit is payable. Caregivers must be licensed or certified. Limited to a maximum of 10 visits per period of hospital confinement; up to 30 visits per benefit year.	\$50 per Visit
First Occurrence Pays the amount shown when you or your covered dependent are diagnosed for the first time as having internal cancer. A 30-day waiting period applies. This benefit is only payable once per lifetime.	\$5,000
Outpatient Hospital Surgical When a doctor performs a surgical procedure on an outpatient basis in a hospital or ambulatory surgical center on you or your covered dependent for internal cancer this daily benefit is payable. This benefit is not payable for surgery performed in a doctor's office or if you or your covered dependent are hospital confined on the same day. Limited to a maximum of 3 days per procedure.	\$250 Daily
Transportation Pays the amount shown for round trip transport (not including ambulance) to a hospital or clinic for the purpose of obtaining internal cancer treatment prescribed by your or your covered dependent's local attending doctor. The hospital or clinic must be more than 100 miles away from your or your covered dependent's residence. The benefit will also be paid for commercial travel by bus, train or airplane for a parent or guardian if the medical care is for a covered dependent child and he or she is accompanied by a parent or guardian. Limited to 3 round trips per benefit year, per covered person.	\$500
Lodging This benefit is payable daily for hotel lodging during treatment for internal cancer at a hospital or clinic. The hospital or clinic must be more than 100 miles away from your or your covered dependent's residence. Limited to 1 benefit per day up to 90 days per benefit year, per covered person.	\$100 Daily
Bone Marrow or Stem Cell Transplant Pays the amount shown if you or your covered dependent is charged for a bone marrow transplant or a peripheral stem cell transplant as the result of internal cancer. A benefit is paid for either a bone marrow transplant or a stem cell transplant, not both. Payable once per lifetime, per covered person.	Bone Marrow - \$10,000 (Donor - \$1,500) Stem Cell - \$2,500

Covered Services	Level 2 Benefits
Nursing Services Pays the daily amount shown if a doctor prescribes a private nurse for full-time care in addition to those provided by the hospital while you or your covered dependent are hospital confined for internal cancer. Care must be provided by a licensed registered graduate nurse or vocational nurse, but not by a family member. Limited to 30 days per benefit year per covered person.	\$125 Daily
Immunotherapy This benefit is payable when you or your covered dependent receive immunotherapy prescribed by a doctor as treatment for internal cancer. We will not pay benefits under this provision for the same treatment under either the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit. Lifetime maximum of \$3,500 applies, per covered person.	\$450 Monthly
Reconstructive Surgery Pays the amounts shown for internal cancer related reconstructive surgery listed below. In addition, 30% of the surgery amounts listed is paid for general anesthesia used during these procedures. <ul style="list-style-type: none"> ▪ Breast Symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast) ▪ Breast Reconstruction ▪ Facial Reconstruction ▪ Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap 	\$350 \$700 \$700 \$2,500
Alternative Care Pays the amount shown per visit to an accredited practitioner for you or your covered dependent upon the diagnosis of internal cancer for Palliative care (acupuncture, massage therapy, bio-feedback and hypnosis), and Lifestyle training (smoking cessation, Yoga, meditation, relaxation techniques, Tai Chi and nutritional counseling). Limited to 20 visits per benefit year under either category, per covered person and lifetime maximum of 2 benefit years. There is also a one-time benefit (\$150) for Integrative Assessment and Education when performed by an accredited practitioner following the diagnosis of internal cancer.	\$50 per Visit
Experimental Treatment This benefit is payable for doctor prescribed experimental treatments intended to destroy or change abnormal tissue. Treatment must be administered by medical personnel in a doctor's office, clinic, or hospital; maximum monthly benefit is \$1,050. We will not pay benefits under this provision for laboratory tests, immunotherapy, diagnostic x-rays and therapeutic devices or other procedures related to these treatments. This benefit is not payable for any day the Radiation or Chemotherapy benefit is payable.	\$150 Daily
Anti-nausea Pays the amount shown for each month you or your covered dependent are charged for drugs prescribed by a doctor to control nausea related to chemotherapy or radiation treatments for internal cancer.	\$100 Monthly
Post-hospital Doctor Visits If you or your covered dependent visit the doctor after being released from the hospital, this benefit is payable per doctor visit once every 6 months. Benefits payable up to 5 years after the diagnosis of internal cancer for the purpose of ongoing cancer evaluation.	\$50 per Visit

Important Definitions

Cancer means you or your covered dependent have been diagnosed with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. Cancer includes carcinomas in situ (in the natural or normal place, confined to the site of origin without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, leukoplakia, hyperplasia, and nonmalignant melanoma will not be considered cancer.

Diagnosed, diagnosis or diagnoses means an evaluation of a medical condition for you or your covered dependent that is performed by a doctor whose specialty is appropriate for the condition being evaluated, and who is board certified in that specialty in accordance with the American Board of Medical Specialties criteria. The evaluation must include conclusions that are definite and supported by presence of symptoms, clinical signs on physical examination, and test results consistent with the most current medically accepted diagnostic standards according to nationally recognized authorities. In addition, the evaluation must meet one or more of the following criteria depending on the condition that is being evaluated: if cognitive function is being evaluated, the conclusions must be confirmed with neuropsychological testing conducted by a clinical psychologist at the doctorate level certified through the American Board of Professional Psychology in the area of clinical neuropsychology; if pulmonary function is being evaluated, the conclusion must be supported by testing performed in accordance with the American Thoracic Society criteria; and if the condition is evaluated using the results of exercise testing, that testing must be performed in accordance with the American College of Sports Medicine or American Heart Association standards.

Hospital means an institution which is primarily engaged in providing, by and under the supervision of doctors to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons; or rehabilitation services of injured, disabled, or sick persons. It must meet all of the following requirements: maintain clinical records on all patients; have every patient be under the care of a doctor; provide 24 hour nursing service provided by a licensed practical or registered nurse and supervised by a registered professional nurse; be licensed or be approved by the state or local licensing agency; meet other health and safety requirements found necessary by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and is not primarily a clinic, nursing, rest or convalescent home.

Hospital confined or hospital confinement means admission to a hospital as an inpatient for at least 24 consecutive hours by a doctor for an injury or sickness. A hospital stay that does not result in charges to you or your covered dependent is not a hospital confinement under this policy unless there is no charge because the hospital is a United States government facility.

Internal Cancer means a cancer contained within the body. Internal cancers do not include cancers of the skin except for melanomas classified as Clark's Level III and higher or a Breslow level greater than or equal to 1.5mm.

State variations can exist; please contact Assurant Employee Benefits for additional information.

Limitations, exclusions, restrictions and reductions

Please carefully review the Other Important Plan Provisions section for additional important plan limitations, exclusions, restrictions and reductions that may apply.

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Other Important Plan Provisions

Accident

For benefits to be payable under this policy, the accident must be due to a sudden, unforeseen, external and unexpected event, which results in an injury and which occurs while you or your covered dependent are insured under this policy. This plan does not cover sickness, cerebrovascular accident (stroke) or any drug overdose unless the drugs were used as prescribed by a doctor. Sickness means a disease, illness or other condition not related to an injury, including diseases or infections resulting from bug bites, stings or infestations by microorganisms.

We will not pay benefits for you or your covered dependent relating to or resulting from: services or treatment not included in the Schedule; services or treatment for which you or your covered dependent are not charged, unless there is no charge because the facility is a United States government facility; services or treatment provided by a family member; services or treatment rendered or hospital confinement outside the United States; or dental care except for emergency dental work for broken teeth either repaired by crowns or extracted due to an accident. We will not pay benefits for you or your covered dependent if the accident or injury results, directly or indirectly, from: service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not; war or any act of war, whether declared or not; taking part in a riot or insurrection, or an act of riot or insurrection; committing or attempting to commit an assault or felony; incarceration in a penal institution of any kind; intoxication (intoxication means the blood alcohol level for you or your covered dependent exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the injury occurs); use of any drug, unless used as prescribed by a doctor; intentionally self-inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder or an associated company, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; participation in racing, stunting, exhibition work, sport or test driving of a motor vehicle, including but not limited to cars, motorcycles and boats; participation in mountaineering, operating a glider, bungee jumping or skydiving; operating a taxi or any other delivery service for any kind of compensation or profit; any physical or mental sickness or related complications; or treatment or complications of treatment.

Cancer

We will not pay benefits relating to or resulting, directly or indirectly, from any of the following: services or treatment for which you or your covered dependent are not charged, unless there is no charge because the facility is a United States government facility; services or treatment not included in the Schedule; services or treatment provided by a family member; services or treatment rendered or hospital confinement outside the United States; any cancer diagnosed solely outside the United States; services or treatment provided primarily for cosmetic purposes; services or treatment for premalignant conditions; services or treatment for conditions with malignant potential; services or treatment for non-cancer illnesses; service in the armed forces or related auxiliaries such as the National Guard or Army Reserve of any country, combination of countries, or international organization at war, whether declared or not; war or any act of war, whether declared or not; taking part in a riot or insurrection, or an act of riot or insurrection; committing or attempting to commit an assault or felony; incarceration in a penal institution of any kind; treatment of mental illness; intoxication (intoxication means the blood alcohol level for you or your covered dependent exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the injury occurs); intentionally self-inflicted injury, while sane or insane; or suicide or attempted suicide, while sane or insane.

State variations can exist; please contact Assurant Employee Benefits for additional information.

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ASSURANT

Employee 2323 Grand Blvd.
Benefits® Kansas City, MO 64108

All Employees
Oral Roberts University
7777 S Lewis Ave
Tulsa, OK 74171

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Employee Application

Please print clearly in blue or black ink.

ISSUE

Check one — Employer Use

☐ New Employee ☐ Change ☐ COBRA

Employee Information — Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name (last, first, initial)	Employer	Employment location				
↓	Oral Roberts University					
Group policy/participant #	Account # or Bill Group Name	Cert. #	Employee SSN	Employee birthdate		
5469827						
Sex	Job title or position	Employee hire date	# hours per week	Earnings \$	Married	Children
<input type="checkbox"/> M				<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> F				<input type="checkbox"/> Yearly <input type="checkbox"/> Other	<input type="checkbox"/> No	<input type="checkbox"/> No
Address		City	State	Zip		

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

Dependent Information — Required if Dependent coverage applies

Name (Last Name, First Name)	Date of Birth	Gender	Relationship

NOTE — Coverage not elected will be assumed refused even if not specifically refused

Employee Choice Accident, Cancer Benefits

You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Accept Refuse Coverage

- | | | | | | | |
|--------------------------|--------------------------|--|--|--|---------------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Accident | | | | |
| | | <input type="checkbox"/> Employee | | | | |
| | | <input type="checkbox"/> Employee + Spouse | | | | |
| | | <input type="checkbox"/> Employee + Child(ren) | | | | |
| | | <input type="checkbox"/> Employee + Family | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: | <input type="checkbox"/> Level 2 | | | |
| | | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee + Spouse | <input type="checkbox"/> Employee + Child(ren) | <input type="checkbox"/> Family | |

Beneficiaries - Applies to all coverages for which a beneficiary designation is required

Last Name	First	MI	Relationship	
				<input type="checkbox"/> Primary
				<input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary
				<input type="checkbox"/> Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.

- 1) Give FULL names and relationships of each beneficiary.
- 2) Beneficiaries elected will apply to all coverages elected on this form for which a beneficiary designation is required.
- 3) If primary/secondary election is not noted, the beneficiary will be considered primary.
- 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries.
- 5) If your designation does not fit in the above arrangement, or you want to specify a beneficiary by coverage, please contact Union Security Insurance Company for the appropriate forms.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

- 1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company.
- 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company.
- 3) Authorize any required deductions from my earnings.
- 4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death.
- 5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
- 6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
- 7) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's signature _____ Date _____

AGENT, BROKER, AND/OR ENROLLER INFORMATION:

Agency Name: _____

Agent/Broker Name: _____

Enroller Name: _____



Employee Health Statement

Please print clearly in blue or black ink.

VOLUNTARY AND WORKSITE COVERAGE

Check one — Employer Use

☐ New Enrollee ☐ Annual Enrollment ☐ Life Event-Type/Date

Employee Information - Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name (last, first, initial)	:	Employer						
→	:	Oral Roberts University						
Group policy/participant #	:	Account #	:	Cert. #	:	Employee SSN	:	Employee birthdate
5469827	:		:		:		:	

Answer the following questions based upon the coverage for which you are applying for you and your dependents - For CANCER, answer questions 1 and 2.

Applicant Height: _____ Weight: _____ Spouse Height: _____ Weight: _____ YES NO

- Have you or your dependents used tobacco in any form in the past 12 months? ☐ YES ☐ NO
- In the last 10 years, have you or your dependents been diagnosed, treated, or received advice to seek treatment for any tumor, malignancy or any type of internal cancer, melanoma, leukemia, lymphoma, sarcoma or Hodgkin's disease or been diagnosed with an elevated PSA, abnormal Pap or colposcopy? Have you had a hysterectomy or prostate removal? ☐ YES ☐ NO
- In the past 5 years, have you or your dependents been hospitalized, undergone any inpatient or outpatient surgery or procedure or been advised to be hospitalized or have surgery by a physician or medical provider? ☐ YES ☐ NO
- In the past 12 months, have you or your dependents been prescribed or advised to take prescription medication? ☐ YES ☐ NO
- Have you or your dependents ever been diagnosed, received treatment, or been advised to seek treatment for any mental, psychiatric, emotional or eating disorder, alcoholism, alcohol abuse, prescription or illegal drug abuse? Have you or your dependents ever been arrested for DUI, illegal drug possession or use? ☐ YES ☐ NO
- Have you or your dependents ever been diagnosed, received treatment, or been advised to seek treatment for: ☐ YES ☐ NO
(circle all that apply and provide details below)
diabetes, heart or vascular disease, heart attack, blood disorder, stroke, high blood pressure, asthma, emphysema or other lung disorder, kidney disease, liver disease, gallstones, pancreas disorder, colitis, Crohn's disease, glaucoma, seizures, lupus or autoimmune disorder, multiple sclerosis, Parkinson's, Muscular Dystrophy or any paralysis, arthritis, disorder of the back, neck, spine, or joint, including hip or knee?
Have you or your dependents ever been diagnosed, treated, or advised to seek treatment for human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)? ☐ YES ☐ NO
- Have you or your dependents ever been diagnosed with or treated for fibromyalgia, chronic fatigue, chronic pain, carpal tunnel, muscle or nerve disorder, eye or ear disorder, vertigo, bowel or bladder disorder? ☐ YES ☐ NO

NOTE — "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state or structure.

Remarks — If you answered "Yes" to any medical questions above, please provide details below: Sign and date the form on back.

Question No.	First Name	Description of illness, injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual Effects	Name and address of attending physician or hospital (including zip)

Employee name (last, first, initial)			Employer	
			Oral Roberts University	
Group policy/participant #	Account #	Cert. #	Employee SSN	Employee birthdate
5469827				

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

AUTHORIZATION TO RELEASE INFORMATION: To properly underwrite applications, determine eligibility for coverage and issue insurance policies on an equitable basis, we must obtain information about you. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics and information. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

By signing below, I authorize any provider of medical services, physicians, or other medical practitioner, hospital, clinic, pharmacy, pharmacy benefits manager or any pharmacy related services entity, insurance company, employer, consumer reporting agency, or other individual or entity to give Union Security Insurance Company or its reinsurers any information regarding my medical or health history. Such information includes but is not limited to any and all medical/dental records relating to my physical and/or mental health, alcohol or drug abuse information, psychiatric or psychological care or pharmacy records.

I understand that I have the right to refuse to sign this authorization but if I refuse, Union Security Insurance Company may refuse to consider my application for enrollment. I understand that a photocopy or facsimile of this authorization will be as valid as the original.

I understand that this authorization is voluntary and that I may revoke it at any time by writing Union Security Insurance Company, P.O. Box 419052, Kansas City, MO 64141-6052, Attn: Privacy Office. Such revocation will not affect any action taken by Union Security Insurance Company prior to receipt of the revocation. If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.

The authorization is effective from the date signed below until the earliest of denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Union Security Insurance Company, but at no time longer than 30 months.

Federal law requires that we inform you that the information which we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. However, be assured that disclosure will be strictly limited to that which is reasonably necessary and we will comply with all federal and state privacy and security laws and regulations. You have the right to gain access to and request correction of information contained in our files.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

- 1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company.
- 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company.
- 3) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief.
- 4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.
- 5) Understand that coverages include waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.

This will certify that I HAVE read and understand the above important notice.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's signature _____ Date _____

Spouse's signature (if spouse coverage elected) _____ Date _____

