CommunityCare™

Summary Plan Description and Handbook

Tulsa FOP 93 Health Benefits Plan
Standard Plan Option

July 1, 2023

Tulsa FOP 93 Health and Welfare Trust
HEALTH BENEFITS PLAN

Standard Plan

Tulsa FOP 93 Health and Welfare Trust (the "Plan Sponsor") sponsors the Tulsa FOP 93 Health Benefits Plan (the "Plan") for its eligible Participants.

This handbook describes the Standard Plan option under the Plan. This handbook and the Schedule of Benefits constitute the "summary plan description" for your Plan coverage. This handbook is effective July 1, 2023. Please take time to review this handbook and keep it available for reference. It describes how the Plan works and contains information you'll find useful when you require medical services.

The Plan Sponsor has contracted with CommunityCare HMO, Inc. ("CommunityCare") to provide third-party administration and managed care services for the Plan, which is self-funded. If you have any questions regarding Plan benefits, please call CommunityCare's Customer Services department. Representatives are available from 7 a.m. until 6 p.m., Monday through Friday. The phone number is (918) 594-5201 in Tulsa or (888) 589-5214 statewide. You can also contact Rooney Insurance Agency for additional information at (918) 878-3425.

CommunityCare has also prepared a "Summary of Benefits and Coverage" for each coverage option. These brief summaries describe the covered benefits, cost-sharing provisions, and coverage limitations and exceptions, and are available online at fop.ccok.com. You may also request a paper copy of a Summary by contacting CommunityCare Customer Services.

All funds contributed by the Employer and Plan Participants are paid to and maintained by the "trust fund" which is operated by the "trustees" according to the Tulsa FOP 93 Health and Welfare Trust Agreement (the "Trust"). The Trust was established pursuant to a "collective bargaining agreement" between the Employer and the Lodge 93, Fraternal Order of Police (the "Union"). A copy of the Trust Agreement and the Collective Bargaining Agreement may be obtained, upon request and free of charge, by contacting the Plan Administrator.

In this handbook, covered persons are called "Participants, you or your." Many of the terms (words) used throughout this handbook are capitalized. These terms are important to understanding your coverage and can be found in the DEFINITIONS section located at the back of this handbook.

CommunityCare - Quick Reference 2023

- CommunityCare's offices are open Monday through Friday, 7 a.m. to 6 p.m., but are closed on the following holidays: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving (two days) and Christmas (two days). You may call your Primary Care Physician (PCP) or CommunityCare's nurseline 24 hours a day, seven days a week.
- Call Customer Service to change your PCP, change your address, ask questions about your benefits, etc.
- If English is not your primary language, Customer Service will assist you in connecting with a translation service.
- For in-person information and support, a member advocate representative can meet with you at the CommunityCare office. All CommunityCare office sites are wheelchair accessible.
- Use the website to search for providers, search the formulary, view and print your benefit materials, learn tips on self-managing your care, obtain evidence-based health information and more.
- Pharmacy formulary information can be found atwww.medalistrx.com.

Customer Service:
(918) 594-5201 (Tulsa)
(888) 589-5214 (Statewide)
(800) 722-0353 (TTY/TDD)
7 a.m. to 6 p.m.
Monday through Friday

MedalistRX:
(855) 633-2579

Behavioral Health Services:
(918) 594-5262, option 1 (Tulsa)
(800) 774-2677, option 1 (Statewide)
Answered 24 hours a day/seven days a week

24-Hour Nurseline:
(918) 594-5242 (Tulsa)
(800) 777-4890 (Statewide)

Mailing Address:
CommunityCare
Williams Center Tower II
Two West Second Street, Suite 100
Tulsa, OK 74103

E-mail:
ccare@ccok.com

Website:
fop.ccok.com

Nondiscrimination and Accessibility

CommunityCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CommunityCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact CommunityCare's Senior Manager of Quality Improvement/Compliance. If you believe that CommunityCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CommunityCare
Attn: Senior Manager of Quality Improvement/Compliance
P.O. Box 3249 Tulsa, Oklahoma 74101
(918) 594-5303 (phone)
(918) 879-4048 (fax)
CustomerServiceReview@ccok.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, CommunityCare's Senior Manager of Quality Improvement/Compliance is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Table of Contents

CommunityCare™ Employer's Choice

Standard Plan Option

	In-Network	Out-of-Network
Calendar Year Deductible		
Per Member	$1,000	$2,000
Per Family	$2,000	$4,000
Out-of-Pocket Limit Per Calendar Year		
Per Member	$1,500	$3,000
Per Family	$3,000	$6,000
Total Medical Annual Expense Risk		
Per Member	$2,500	$5,000
Per Family	$5,000	$10,000
Physician Services		
(Additional Coinsurances/Copayments may apply)		
Primary Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Pediatrician Office Visits	$25 Copayment per Visit	50% Coinsurance *
(Up to age 19)		
Specialty Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Preventive Care	No Copayment	50% Coinsurance *
(Please see Handbook for details)		
Virtual Visits		
Primary Care Office Visits	No Copayment	50% Coinsurance *
Specialty Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Preventive Care	No Copayment	50% Coinsurance *
Outpatient Mental, Alcohol and Drug Services	No Copayment	50% Coinsurance *
Emergency Care and Urgent Care		
(Additional Coinsurances/Copayments may apply) (Benefits will be denied if not medically necessary)		
Hospital Emergency Room	20% Coinsurance *	20% Coinsurance *
Urgent Care Facility	$60 Copayment per Visit	50% Coinsurance *
Medwise Urgent Care	$40 Copayment per Visit	
Inpatient Hospital Care		
Room and Board	20% Coinsurance *	50% Coinsurance *
(Including all other medically necessary services)		
Mental Health, Alcohol and Drug Services		
Inpatient	20% Coinsurance *	50% Coinsurance *
Outpatient	$40 Copayment per Visit	50% Coinsurance *
Synergy Wellbeing	$20 Copayment per Visit	

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Oakwood Springs		
Inpatient		
Active and Retired Officers	100% paid, No Coinsurance	
Non-Officer Spouse and Dependents	20% Coinsurance*	
Outpatient	$40 Copayment per Visit	
Summit Detox Center		
Inpatient		
Active and Retired Officers		
First Admission per calendar year:	100% paid, No Coinsurance	
Subsequent visits:	20% Coinsurance*	
Non-Officer Spouse and Dependents	20% Coinsurance*	
Transformations Treatment Center		
Inpatient and Partial Hospitalization with Supportive Housing		
Active and Retired Officers		
First Admission per calendar year:	100% paid, No Coinsurance	
Subsequent visits:	20% Coinsurance*	
Non-Officer Spouse and Dependents	20% Coinsurance*	
Mending Fences Treatment Center		
Inpatient and Partial Hospitalization with Supportive Housing		
Active and Retired Officers		
First Admission per calendar year:	100% paid, No Coinsurance	
Subsequent visits:	20% Coinsurance*	
Non-Officer Spouse and Dependents	20% Coinsurance*	
Outpatient Surgery		
Primary Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Pediatrician Office Visits	$25 Copayment per Visit	50% Coinsurance *
(Up to age 19)		
Specialty Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Outpatient Surgical Facility	20% Coinsurance *	50% Coinsurance *
Outpatient Diagnostic Services		
(Additional Coinsurances/Copayments may apply, regardless of where outpatient services are rendered)		
Laboratory	No Additional Copayment	50% Coinsurance *
Outpatient Radiology	No Additional Copayment	50% Coinsurance *
MRI, CT Scan and PET Scan	20% Coinsurance *	50% Coinsurance *
Various Heart and Calcium CT Scans	***No Coinsurance when performed at Ascension St. John, Saint Francis, Hillcrest or Oklahoma Heart Institute. All other locations, please refer to Outpatient Diagnostic Services.***	

Rehabilitation Therapy

(Up to 60 treatment visits per benefit type)		
Inpatient Rehabilitation	20% Coinsurance *	50% Coinsurance *
Outpatient Physical, Occupational and Speech Therapy	$40 Copayment per Visit	50% Coinsurance *

Other Covered Services

(Quantity limits may apply)		
Allergy Serum/Injections	Subject to the PCP or Specialist Copayment	50% Coinsurance *
Allergy Testing & Treatment	If an office visit is charged, subject to the PCP or Specialist office visit Copayment	50% Coinsurance *
Allergy Testing & Treatment not in a Physician's Office	20% Coinsurance *	50% Coinsurance *
Ambulance	20% Coinsurance *	20% Coinsurance *
(Emergency only)		
Chiropractic Care	$40 Copayment per Visit	50% Coinsurance *
(limited to a total of 60 visits per calendar year, to include direct contracts and insurance contracts combined)		
Diabetic Supplies	20% Coinsurance *	50% Coinsurance *
Durable Medical Equipment	20% Coinsurance *	50% Coinsurance *
Fertility Evaluation	20% Coinsurance *	Not Covered
General Anesthesia *(for eligible dental procedures only)*	20% Coinsurance	50% Coinsurance *
Hearing Aids (Children under the age of 19)	20% Coinsurance *	50% Coinsurance *
Home Health Services	20% Coinsurance *	50% Coinsurance *
Hospice Care *(Inpatient requires pre-certification)*	20% Coinsurance *	50% Coinsurance *
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	20% Coinsurance *	50% Coinsurance *
Infusion		
(Must be medically necessary and may be subject to prior authorization)		
Administered in a physician's office	$40 Copayment per Visit	50% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Administered in an outpatient facility	20% Coinsurance *	50% Coinsurance *
Administered in a home setting	20% Coinsurance *	50% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		

Organ Transplants *(Must be medically necessary and may be subject to prior authorization)*	20% Coinsurance *	Not Covered outside the transplant network
Orthotics and Prosthetics	20% Coinsurance *	50% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance *	50% Coinsurance *
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit ^	See Outpatient Prescription Drug Benefit ^
Radiation Therapy	20% Coinsurance *	50% Coinsurance *
Skilled Nursing Facility Care *(Up to 60 treatment days per disability per calendar year)*	20% Coinsurance *	50% Coinsurance *
Specialty Drugs from a medical provider *(Must be medically necessary and may be subject to prior authorization)*	20% Coinsurance	50% Coinsurance *
All Other Covered Services	20% Coinsurance *	50% Coinsurance *

Comments

- Deductible must be satisfied before Coinsurance begins, where it applies.
- Copayments do not apply toward the Deductible.
- Prescription drugs and non-covered items do not apply toward the medical calendar year Deductible.
- Expenses incurred during the last three months of the calendar year and applied to the current year's Deductible may be used to help meet the Deductible requirement of the next year.
- Any number of members of the family may combine to meet two times the individual medical Deductible to satisfy the family medical Deductible requirement.
- All covered medical out-of-pocket expenses will accrue toward a separate prescription drug out-of-pocket limit.
- A calendar year is defined as the time period from January 1 - December 31.
- Deductible amounts and out-of-pocket limitations are separate for in-network provider and out-of-network provider benefits.

Out-of-Network Requirements

- All out-of-network provider calculations are based on the out-of-network fee schedule as described in your Handbook. The enrollee is also responsible for any amount charged by a provider in excess of the out-of-network fee schedule.
- Call the phone number on the back of your ID card before an elective surgery or 7 days in advance of a hospital stay arranged through a non-network healthcare provider. Failure to follow these procedures will result in eligible benefits for out-of-network hospital care or surgery being reduced by $500.
- For emergencies, call your primary care physician for follow-up care.
- "Balance Billed Amounts" do not apply to out-of-pocket limitation.

Urgent and Emergency Care

It is important that you follow-up with your PCP within 48 hours of any Urgent or Emergent Care Services. This will allow your PCP to direct or coordinate all of your follow-up care. Follow-up care that is not arranged by your PCP may not be covered. Your PCP is available 24 hours a day, seven days a week.

If you have an emergency that is considered life or limb threatening, go to the nearest hospital or emergency room. After you have sought emergency care, please notify your PCP to arrange for any follow-up care that may be necessary. Forward any bills to CommunityCare Plus for reimbursement. Consult your Handbook for examples of medical emergencies.

For a list of Exclusions and Limitations, please see Handbook.

THIS IS NOT A CONTRACT. This Schedule of Benefits does not contain a complete listing of conditions which apply to the benefits shown. Please refer to this handbook for additional information, including exclusions and limitations.

Prescription Drug Schedule of Benefits

Prescription Benefits Do Not Apply To Medical Only Coverage

Pharmacy Only Out-of-Pocket Limit per Calendar Year (includes Copayments):

Per Individual	**$2,000**
Per Family	**$4,000**

BENEFIT COPAYMENTS

Please note that Quantity Limits or Prior Authorization may apply. Refer to your prescription drug formulary guide for additional information. If the cost of the prescription is less than the applicable Copayment, you will only be charged the cost of the prescription.

RETAIL PHARMACY

Up to a 30-day supply for each prescription.

Tier 1 - Preferred Generic Drugs	$15 Copayment
*Tier 2 - Preferred Brand Drugs	$35 Copayment
*Tier 3 - Non-Preferred Brand Drugs	$60 Copayment
	Prescriptions $1,000 or more 20% Coinsurance Copayment
	90-day retail supply available at 2 Copayments.

MAIL ORDER PHARMACY

Up to a 90-day supply for each prescription. Certain prescriptions, including specialty drugs, are not eligible for mail order Copayments. Refer to your prescription drug formulary guide for additional information.

Tier 1 - Preferred Generic Drugs	$30 Copayment
*Tier 2 - Preferred Brand Drugs	$70 Copayment
*Tier 3 - Non-Preferred Brand Drugs	$120 Copayment
	Prescriptions $1,000 or more 20% Coinsurance Copayment

SPECIALTY DRUGS

Up to a 30-day supply for each prescription. Refer to your formulary guide for a list of speciality drug medications. Specialty drugs can be obtained from a retail pharmacy or specialty pharmacy provider.

Specialty Drugs	$200 Copayment for < $1,000
	Prescriptions $1,000 or more 20% Coinsurance Copayment

Please consult your pharmacy directory for a list of Participating Pharmacies.
Visit www.medalistrx.com for a Pharmacy directory.
For all other questions, please call MedalistRx™ at (855) 633-2579.

Prescription drugs purchased from an Out-of-Network pharmacy-100% Coinsurance Copayment at time of purchase. Can be reimbursed at a later date. Reimbursement will be based on the lowest contracted amount of a Participating Pharmacy minus the applicable Copayment or Coinsurance Copayment as shown in the Schedule of Benefits.

For a list of Exclusions and Limitations, please see your Handbook.
THIS IS NOT A CONTRACT. This summary does not contain a complete listing of conditions which apply to the benefits shown. It is intended only as a source of general information and is subject to the Plan Document and Summary Plan Description. See your Handbook for additional information regarding exclusions and limitations.

+Products are excluded except as required by law.
*When a brand medication is selected over its generic equivalent, the member will be responsible for non-preferred brand copayment and the difference in cost.

MedalistRx Variable Copay Program*
Pharmacy Benefit Outline

PROGRAM DETAILS

Variable Copay Program is designed to combat the rising cost of brand and specialty medications. Self-insured employers and their employees can experience significant savings on high-cost brand and specialty drugs when enrolled in the Variable Copay Program. The total amount of a manufacturer's copay assistance program can be divided by 12 months to become the new monthly copayment for all patients on the drug or the copayment is adjusted to 100% of a drug's copay offset program and is not evenly dispersed throughout the year. This option provides 100% of the offset program savings for members who may not continue the therapy, terminate coverage or initiate therapy on calendar year program later in the year.

VARIABLE COPAY PROGRAM

- Members will never pay more than standard plan copay for high cost brand or specialty drugs. For most medications with manufacture copay cards support, member pays minimal or no copay compared to not using the manufacturer copay card as secondary transaction.

- Not all high cost brand and specialty meds have an associated manufacturer program - in these cases, only the standard Plan copay will apply.

- Manufacturer programs have maximum dollar limits and can change program details at any time. Once a member has used all manufacturer dollars, MedalistRx will adjust member's copay to $0.00, if the variable program was utilized.

- Maximums (copay support allocation) reset at Manufacturer's program dates (generally Jan 1 each year, possible rolling 12 months from enrollment).

- Manufacturer's payments do not count toward the patient's deductible and or out-of-pocket maximum obligations.

* Program effective 7/1/18

Every Claim, Every Day.

General Plan Information

Name of plan:	Tulsa FOP 93 Health and Welfare Trust Health Benefits Plan
Plan Sponsor: **(Named Fiduciary)**	Tulsa FOP 93 Health and Welfare Trust P.O. Box 691764 4700 S. Garnett Road, Suite 200 Tulsa, OK 74146 (918) 878-3425
Plan Administrator:	Tulsa FOP 93 Health and Welfare Trust P.O. Box 691764 4700 S. Garnett Road, Suite 200 Tulsa, OK 74146 (918) 878-3425
Plan Sponsor EIN:	26-0639106
Plan Year:	July 1 - June 30
Plan Type:	Welfare benefit plan providing medical and prescription drug benefits. The Plan is maintained pursuant to one or more collective bargaining agreements. For a copy of such agreement, please contact the Plan Administrator.
Plan Funding:	All benefits are paid through a Trust that has been established by the Plan Sponsor for the exclusive benefit of Plan Participants.
Contributions:	The cost of coverage under the Plan is funded in part by Employer and Plan Participant contributions, and in part by Trust subsidies.
Third Party Administrator:	CommunityCare Williams Center Tower II Two West Second Street Suite 100 Tulsa, OK 74103 (918) 594-5200

Pharmacy Benefit Management:	MedalistRx (855) 633-2579
COBRA Administrator:	Rooney Insurance Agency P.O. Box 691764 4700 S. Garnett Road Suite 200 Tulsa, OK 74146 (918) 878-3425
Medical Management Program Administrator:	CommunityCare Williams Center Tower II Two West Second Street Suite 100 Tulsa, OK 74103 (918) 594-5200
Agent for Service of Legal Process:	Tulsa FOP 93 Health and Welfare Trust P.O. Box 691764 4700 S. Garnett Road, Suite 200 Tulsa, OK 74146 (918) 878-3425
Trustee:	The Trustees of the Tulsa FOP 93 Health and Welfare Trust P.O. Box 691764 Tulsa, OK 74169 (918) 878-3425

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.

Right to Terminate or Amend

The Plan Sponsor has the right, in its sole discretion, to terminate the Plan at any time without any liability for that action. The Plan Sponsor has the right, in its sole discretion, at any time and without notice to modify, alter, or amend any or all of the rules of the Plan or any of the Plan's benefits.

The Plan Sponsor may also make any changes or amendments to the Plan retroactively that are necessary or appropriate to qualify or maintain the Plan as meeting the requirements of the Internal Revenue Code.

If the Plan Sponsor terminates the Plan or any benefits under the Plan, participation in the terminated benefits ends on the date of termination. In addition, termination of an insurance contract with respect to a benefit program will constitute termination of that particular

benefits program, unless the Plan Sponsor obtains a substitute contract of insurance.

No Right to Continued Participation

Participation in the Plan does not give you any right to continued participation in the Plan beyond those described in this Handbook.

Your Responsibilities

Participation in the Plan requires that you provide the Plan Administrator and any third-party administrator with the information requested upon your initial eligibility and from time to time thereafter for purposes of operating and administering the Plan. Your failure to provide such information may result, in the discretion of the Plan Administrator, in the delay or denial of benefits under or participation in the Plan or in any other action determined in the discretion of the Plan Administrator as necessary or appropriate for purposes of operating and administering the Plan. In addition, participation in the Plan requires that you provide the Plan Administrator with your current address. Any notices required or permitted to be given under the Plan shall be deemed given if directed to such address and mailed by regular United States mail. The Plan Administrator does not have any obligation or duty to locate you. Additional responsibilities include:

- Understand your own health and work with your primary care physician (PCP) to have a satisfactory physician-patient relationship.
- Supply Information to CommunityCare's plan providers so that they can provide health services.
- Cooperating with your PCP in coordinating care and service through the Plan's referral/authorization process, where necessary.
- Work with your physician to develop and follow an agreed upon treatment plan.
- Complying with the treatment prescribed by your physician.
- Providing your complete health status information for accurate diagnosis and appropriate treatment.
- Keeping appointments for care and giving required notice when canceling.
- Learning how to use health benefits by reading and understanding all of the materials about your coverage and being informed about your options.
- Reading and understanding all of the materials about your coverage and being informed
- about your health care benefits.
- Notifying the Plan and CommunityCare of any other health care coverage you have and cooperating with the Plan in its coordination of benefits (COB) efforts.
- Refraining from conduct that is disruptive, unruly, abusive or uncooperative, or that seriously impairs CommunityCare's ability to furnish managed care services on behalf of the Plan or your PCP's, or other provider's ability to provide Medically Necessary care.
- Providing documents that may be requested by CommunityCare or the Plan in order to assign benefits to the Plan and obtain reimbursement from Workers' Compensation, Medicare and other third-party coverages and cooperating with the Plan, CommunityCare and your Provider in reimbursement of third-party payments.
- Paying any cost-sharing amounts required under the Plan (e.g., Copayments, Coinsurance, and Deductibles).

- Calling Rooney Insurance Agency at (918) 878-3425 or CommunityCare Customer Services at (918) 594-5201 whenever you have questions concerning your coverage.
- If you leave the hospital against medical advice (AMA), you may be responsible for the financial consequences as indicated in this handbook and the Plan's list of Exclusions and Limitations.

Please note: It is the responsibility of the Primary Participant to provide notification of the Plan's requirements and benefit information to any party (e.g., parent, stepparents, grandparents, daycare workers, babysitters, etc.) who is responsible, either permanently or temporarily, for obtaining medical care for the Participant's covered Dependents.

Privacy Information

The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its related Standards for Privacy of Individually Identifiable Health Information ("the Privacy Rule") require group health plans to protect certain information about you (such information being referred to as "protected health information" or "PHI") from unauthorized use or disclosure. The Plan maintains a Notice of Privacy Practices that describes how PHI may be used and disclosed and how Participants can access PHI. If you have not already received a copy of the Plan's Notice of Privacy Practices, you may request one from Rooney Insurance Agency.

CommunityCare and MedalistRx also maintain a Notice of Privacy Practices that describes the types of PHI it obtains, creates and maintains concerning individuals who are covered by health plans that CommunityCare insures or administers. If you have not already received a copy of CommunityCare's Notice of Privacy Practices, you may request one from CommunityCare, or you may view a copy on CommunityCare's website at fop.ccok.com. For a Notice of Privacy Practices, please contact MedalistRx at (855) 633-2579.

Answers to Your Questions

If you need help with your coverage or have any questions, please write, call or e-mail:

CommunityCare Customer Services
218 W. 6th Street
Tulsa, OK 74119

(888) 589-5214 (Statewide) / (918) 594-5201 (Tulsa)

MedalistRx
(855) 633-2579

fop.ccok.com
ccare@ccok.com (CommunityCare's e-mail address)

For in-person information and support, a Customer Representative can meet with you at CommunityCare's primary office located at 218 W. 6th Street, Tulsa, OK, 74119.

- To find a Network Provider:
- Visit fop.ccok.com to search our on-line, up to date Provider directory or call Customer Services to request a printed directory.
- To view or print your CommunityCare benefit materials:
- Visit fop.ccok.com to access your "Benefits-At-A-Glance."
- To access the current drug formulary:
- Visit www.medalistrx.com access Prescription Drug and pharmacy information.
- To receive maintenance drugs via mail order:
- Call (855) 633-2579 or visit www.medalistrx.com to enroll in the mail order program.
- For pre-certification
- Call CommunityCare at (800) 544-8922

When you call, write or e-mail, be sure to give your CommunityCare Participant identification number. This number can be found on your ID Card.

If your question involves a bill for authorized medical services, also provide the following information:

- The date of service
- The name of physician or hospital
- The kind of service you received
- The charges involved

Please also include a copy of the itemized statement or have the statement available when you call. Personal itemizations and statements showing only the balance due cannot be accepted.

REMEMBER: Always make copies of your itemized statements for your files before mailing any documents to CommunityCare.

Section I. How to Obtain Medical Care

How the Standard Plan Works

The Standard Plan combines the managed care benefits of an HMO with the flexibility of an Out-of-Network option, giving you the ability to choose the option that best meets your need each time you access medical care.

Managed Care Benefits (In-Network)

You will receive the highest level of benefits and incur the least amount of out-of-pocket expense by accessing your managed care benefits. You will receive managed care benefits by having Medically Necessary Covered Services provided or arranged by your PCP – obtaining authorized referrals for all specialty and hospital care. You may also receive managed care benefits for most specialty care you receive from an In-Network Provider, regardless of whether you obtain a referral from your PCP or prior authorization from CommunityCare. There are, however, some specialty services that require CommunityCare's prior authorization, regardless of whether they are rendered by an In-Network or Out-of-Network Provider. Please contact CommunityCare in advance of receiving any specialty care at (918) 594-5201 or (888) 589-5214 to determine whether your situation requires prior authorization.

The Importance of Obtaining Referrals for Health Services

The referral is a critical component of your Standard Plan coverage:

- It is how your PCP initiates a request for Medically Necessary specialty and follow-up care on your behalf

- Only Medically Necessary transplants are covered and only if they occur at a Network transplant facility; prior authorization is required. Call Customer Services for more information

Point-of-Service (POS) Benefits (Out-of-Network)

Unlike a traditional HMO, your Standard Plan offers you the flexibility of receiving services from Out-of-Network Providers and without seeking prior authorization from CommunityCare. Your POS benefits provide less coverage than your managed care benefits, and typically require you to assume a larger financial responsibility in the form of Coinsurance, Copayments, Deductibles and the difference, if any, between the Plan's payment and the Provider's full billed charges. You will also be responsible for filing claim forms if your Provider does not file them on your behalf.

All non-pre-certified services that you receive from an Out-of-Network Provider will apply toward your POS benefits. You will also receive POS benefits if you seek specialty care from a Provider who is not in your PCP's hospital Network, or if you receive services from an In-Network Provider but at an Out-of-Network facility. Whenever you access your POS benefits, all of the services you receive during that instance of care will be paid at the POS level. For example, if you receive services from an In-Network Provider at an Out-of-Network facility, both the Provider's charges and the facility's charges will pay at the POS level of benefit even though the Provider participates with CommunityCare.

If you self-refer for hospital care, you are still required to obtain pre-certification for the full duration of your hospital confinement to avoid penalty. Failure to follow this procedure will result in eligible benefits being reduced by 20%. For pre-certification, please call CommunityCare at (800) 544-8922.

The Standard Plan provides no coverage for services that are not Medically Necessary or that are specifically excluded from coverage, as set forth in more detail in your Plan's list of Exclusions and Limitations.

The following conditions apply only to care obtained directly from Providers without an authorized referral from your PCP:

- You must satisfy an annual Deductible before benefits are paid.
- Emergent Services:
    - The lesser of the actual billed amount or the Qualified Payment Amount (QPA), as defined in the Federal No Surprises Act, will be applied to non-contracted emergent services. The QPA is calculated by identifying the median of the contracted rates recognized by the Plan on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in the same Metropolitan Statistical Area (MSA) or geographic region that is linked by social and economic factors. You are not responsible for any amount charged in excess of the QPA allowable. The member share for Copay, Coinsurance and Deductible is due from the member.

- Non-Emergent Services:
  - After satisfying any applicable Deductible, payments to your Provider will be based on a percentage of Medicare rates. You are responsible for any amount charged by your Provider in excess of this percentage.
- The Medicare rates are as follows:
  - 150% of Medicare rates for Inpatient Hospital
  - 250% of Medicare rates for Outpatient Surgery
  - 145% of Medicare rates for Other Outpatient Facility
  - 125% of Medicare rates for Primary Care Physician Fees
  - 140% of Medicare rates for Specialist Physician Fees
  - 145% of Medicare rates for Ancillary Services
  - 145% of Medicare rates for Home Health Services
  - 145% of Medicare rates for Durable Medical Equipment
  - 200% of Medicare rates for Ambulance Services
  - 400% of Medicare rates for Emergency Facility Services
  - 250% of Medicare rates for Administration of Anesthesia

Note: The Plan allowable for services for which there is no defined Medicare rate is 60% of billed charge.

The Plan will pay eligible expenses for Covered Services up to the maximum benefit limitation shown on your Schedule of Benefits.

Pre-certification versus Preauthorization

It is important for you to understand the difference between pre-certification and Preauthorization in relationship to your In and Out-of-Network benefit. Pre-certification means your condition meets medical necessity criteria and that services are warranted. Pre-certification does *not* mean that those services have been authorized. It simply means that you are going for Out-of-Network services that meet medical necessity criteria. This is an important distinction since some conditions that you may want to take care of (cosmetic surgery for example) do not meet medical necessity criteria and those services would not be covered at all.

Preauthorization means medical necessity criteria have been established *and* services have been authorized at an In-Network level of benefit. It also means your Provider and hospital have been notified that CommunityCare is authorizing those services for the highest possible level of benefit.

Participant ID Card

Please review your ID Card to verify that all the information is correct. If information on your card is not correct, your card is lost or if you have questions about your ID Card, call CommunityCare's Customer Services department at (918) 594-5201 or (888) 589-5214. Carry your card with you at all times. Your ID Card provides your PCP's telephone number, specifies Copayment information and includes your personal identification number. All of your Dependents who are Plan Participants will also receive a card. Any time you change your PCP, a new ID Card will be

mailed to you. Upon receipt, destroy your old ID Card.

You cannot let anyone use your ID Card or receive your benefits. To do so may result in your card being recalled and all of your rights to obtain Plan benefits being terminated immediately, subject to the Plan's appeal procedures. When your coverage under the Plan terminates, your ID Card is to be destroyed.

You and Your Primary Care Physician (PCP)

A satisfactory physician-patient relationship is the key to your health and medical needs. As a Participant, the selection of a PCP is your initial step to obtain routine Plan benefits. If you require specialty care and want to receive the highest level of benefits (i.e., managed care benefits), you must receive those services through specialists and hospitals that are affiliated with your PCP's Network. Please contact an in-network specialist from the directory of specialists found at fop.ccok.com.

When selecting a PCP, consideration needs to be given to the PCP's, location, office hours and type of physician. To meet the individual needs of your Dependents, each Participant may have a different PCP.

PCPs include the following types of Physicians:

- **Family/General Practitioners** who specialize in the primary health care of people of all ages. Some also provide maternity and minor surgical care.
- **Internists** who specialize in the primary health care of adults (some also care for adolescents).
- **Pediatricians** who specialize in the primary health care of infants, children and adolescents.

Your Plan requires the designation of a PCP. You have the right to designate any PCP who participates in the Network and who is available to accept patients. For children, you may designate a pediatrician as the PCP. If you do not indicate a PCP selection at the time you enroll (in the manner required by CommunityCare), then CommunityCare Enrollment Services will assign a PCP to you. A letter indicating the physician's name, address, and phone number will be mailed to you. Your PCP will also be listed on your ID card. If you wish to change the PCP that was assigned to you, please contact Customer Services. For information on how to select a PCP, and for a list of the In-Network PCPs, contact Customer Services at (888) 589-5214 or (918) 594-5201 in Tulsa.

Changing Your PCP

If you wish to change your PCP, simply call CommunityCare Customer Services at (888) 589-5214 or (918) 594-5201 in Tulsa. A Customer Services representative will assist you with your PCP change, request a new ID card for you, and inform you if your new PCP selection will alter any of your existing Network Providers and referrals.

Generally, all PCP changes will become effective the first day of the following month. For example, if we receive your request on April 8, your change will take place on May 1. However, if you need for your change to take place immediately,

please let the customer service representative know. Changes are subject to physician availability.

Provider Directories

The Provider directory is a source for information concerning CommunityCare's Network, available PCPs, specialty Networks and hospital affiliations. A searchable directory is available on the FOP's website at fop.ccok.com. You may also ask to receive a Provider directory by mail by calling our Customer Services department. The Provider directory will advise you if the PCP you are selecting is:

- Open (accepting new patients)
- Established only (only accepting previous patients)

REMEMBER: Medically Necessary transplants are covered only if they occur at a Network transplant facility; prior authorization is required. Call Customer Services at (918) 594-5201 or (888) 589-5214 for more information.

Provider Termination

If your Provider leaves the Network for reasons other than "for cause", the Plan will allow coverage with the terminated Provider on an In-Network basis if you are in an active course of treatment. This coverage extension will be for the shorter of until that treatment is complete or for up to 90 days from the date CommunityCare notifies you of the Provider's termination. An active course of treatment means:

- An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
- An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.
- The second or third trimester of pregnancy, through the postpartum period.
- An ongoing course of treatment for a health condition for which a treating physician or health care Provider attests that discontinuing care by that physician or health care Provider would worsen the condition or interfere with anticipated outcomes.

PCP Appointments

PCPs see patients by appointment. Present your ID card when you arrive at your PCP's office. You are required to pay any applicable Copayment at the time of service.

Primary Care Services

Managed Care Benefits (In-Network):

If you require primary care services and wish to receive the highest level of coverage, you must receive those services from your PCP. If your PCP is out of the office, the physician's staff will help you find a covering physician.

In order to receive the highest level of coverage, Dependents who temporarily reside or attend school outside of CommunityCare's Service Area must select a PCP within CommunityCare's Network and Service Area and receive all services from the PCP or have those services coordinated by the PCP from

within the PCP's Network. The only exception to this is Emergency Medical Care, as defined in this handbook. Therefore, if a Dependent is away from his or her selected Network (e.g., attending college), he or she is still required to travel to the selected Network for all services except for emergency medical care.

POS Benefits (Out-of-Network):

You may obtain primary care services from other than your PCP using your POS benefits. This does not require an authorization. You must contact the physician's office to schedule an appointment, and you may be required to file the claim form with CommunityCare. CommunityCare will process your claim at the reduced level of benefits, and you must pay any applicable Deductibles, Coinsurance, and you will be responsible for the difference between the Plan's payment and your Provider's billed charges.

Section II Types of Care

Preventive Care

The Plan's standards for preventive care are those adopted by most international preventive health care groups, including evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Health Care Task Force (USPSTF), immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) and, with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA (subject to the exclusions described below with respect to certain contraceptives and related items and services). These evidence-based guidelines are designed to ensure that the Plan covers preventive care that can make a difference in their health. The list below indicates those elements that should be included in periodic preventive care. You should discuss with your physician if these screenings are appropriate for you and their suggested intervals.

The following services are considered preventive care and are covered without cost-sharing. This list is representative and is not all-inclusive.

Screenings*

- Well Baby/Well Child Exams: Provided at appropriate age intervals from birth to age 21

- Lead Screening: Once per lifetime
- Vision, Hearing Screening: As performed by your PCP
- Periodic Adult Exams
- Blood Pressure, Height and Weight: Periodically
- Cholesterol/Lipids
- Cancer Screenings
- Pap Smear: women, annually
    - Mammography: women, Once every 12 months beginning 7/1/23, the first visit per benefit type should be processed at zero cost share regardless of diagnosis code(s) on the claim. Subsequent claims for the same benefit type in the same 12-month period will be processed with member cost share.

- Routine Colon Cancer Screening
    - Fecal Occult: annually
    - Flexible Sigmoidoscopy: every 3 years
    - Colonoscopy: Once every 12 months beginning 7/1/23, the first visit per benefit type should be processed at zero cost share regardless of diagnosis code(s) on the claim. Subsequent claims for the same benefit type in the same 12-month period will be processed with member cost share.
- Prostate Cancer Screening: men, any age, annually (no cost share applies to this service)
- Osteoporosis screening: Women 65 and older and men or women at risk

***Discuss with your physician any risk factors that would require earlier or more frequent screenings.**

Health-related Interventions and Accident Prevention Counseling

- Child Development
- Safety and Accident Prevention (helmets, seat belts, car seats, etc.)
- Lifestyle Issues
- Nutrition
- Physical Activity
- Use of Aspirin, Vitamins or Calcium Supplements
- Tobacco Cessation, Drug and Alcohol Use
- Sexually Transmitted Diseases and HIV
- Skin Cancer Counseling
- Oral Health

Covered Immunizations (Note: This list is representative and may not be all-inclusive. Health risks and age restrictions may apply):

Birth to age 21 (No cost share applies to these services)

- Diphtheria, Pertussis, Tetanus (DPT)
- Diphtheria, Tetanus, Acellular Pertussis (DTaP)
- Influenza
- Hemophilus Influenza Type B (HIB)
- Hepatitis A and B
- Human Papilloma Virus
- Measles, Mumps, Rubella (MMR)
- Meningococcal
- Pneumococcal
- Polio
- Rotavirus
- Varicella
- Covid Vaccine

Adult Immunizations

- Influenza

- Hepatitis A and B
- Human Papilloma Virus
- Measles, Rubella, Varicella: Women of childbearing age – if necessary
- Pneumococcal
- Tetanus-Diphtheria Booster: every 10 years (TD)
- Tetanus, Diphtheria, Acellular Pertussis Booster (DTaP)
- Varicella
- Shingrix
- Covid Vaccine

Immunizations that are required as a condition of employment or travel, for entry into a vocational school, institutes of higher education or the military are not covered unless the immunization is currently rated A or B by the USPSTF or is recommended for adults by ACIP.

Please note that for existing diseases and medical conditions, follow-up care and disease monitoring are not considered to be preventive care services or screening.

Women's Preventive Health Services

The federal Patient Protection and Affordable Care Act (PPACA) generally requires non-grandfathered group health plans to cover women's preventive health services obtained from an In-Network Provider, including Food and Drug Administration (FDA)-approved contraceptive services, without any Premium, Copayment, Coinsurance or Deductible.

If you have any questions, please contact CommunityCare's Customer Services department at (918) 594-5201 or (888) 589-5214 Monday through Friday, from 7 a.m. to 6 p.m.

The Benefits for the following contraceptive items and services are covered:

Surgical Procedures

- Tubal Ligation (1 per lifetime)
- Insertion of IUD
- Levonorgestrel Implants/IUS/IUD
- Implantable Rods
- Sterilization Implants (1 per lifetime)
- Birth Control Injections

Counseling

- Counseling for Domestic Violence
- Contraceptive Counseling
- Counseling for STD/STI including HIV (1 annually)
- Breast Feeding Counseling

Prenatal Care Visits

Screenings/Testing

- Screening for HIV
- Screening for Gestational Diabetes
- HPV Testing (women 30 years and older every 3 years)

Pharmacy (requires prescription)

- Birth Control Pills
- Vaginal Ring
- Birth Control Patch
- Cervical Caps
- Birth Control Injections
- Morning After Pill
- Diaphragm

***Exceptions to the above may occur as required by law.**

Annual Well Woman Examination

The annual well woman exam is for preventive care only. This exam may include a pelvic exam, Pap smear and breast exam by your PCP or an OB/GYN who participates in the same Network as your PCP. Participants may self-refer for this service.

If you need additional related medical services, please contact your PCP. Some services may require prior authorization from CommunityCare.

Customer Services will be available to assist with your OB/GYN selection or answer any additional questions you may have. For a complete listing of OB/GYNs in your Network, check your Provider directory or visit CommunityCare's website at fop.ccok.com.

Routine Medical Care

Primary Care Services

Managed Care Benefits (In-Network):

Your PCP is available to see you for medical care during his or her regular office hours. Your PCP will see you for routine health care services and can assist in directing specialty care and inpatient and outpatient hospital services. Your PCP is prepared to discuss treatment options including the benefits and risks in order for you to make informed decisions about your care.

POS Benefits (Out-of-Network):

Routine medical care, elective surgical procedures and obstetrical care are not covered if they are obtained outside of your selected Network without prior authorization from CommunityCare.

Specialty/Hospital Care

Managed Care Benefits (In-Network):
You will receive managed care benefits when you obtain covered specialty or hospital care with an authorized referral from your PCP. To obtain maximum benefits and avoid costly and unnecessary Specialist or hospital bills, follow these steps:

- Always consult your PCP before obtaining medical care. If your PCP believes that you need specialty or hospital care, your PCP will submit a referral request to his or her Network's Medical Management department or, when appropriate, to CommunityCare, for authorization. Authorized referrals are valid for 60 days, provided you remain a Participant in that same Network
- Discuss your options with your PCP in order to understand what specialty or hospital services are being recommended and why
- Some services that a Specialist performs in his or her office must be authorized by the referral. If the Specialist recommends any additional treatments or tests that are covered benefits, you can receive full coverage by obtaining a separate referral for those additional services from your PCP prior to receiving the services. If you obtain non-Emergency specialty services without an authorized referral, you may be subject to the annual Deductible, Coinsurance and maximum Plan

benefit outlined in your Schedule of Benefits.

OB/GYN Care

You do not need authorization from the Plan, CommunityCare or your Primary Care Physician in order to obtain obstetrical or gynecology care from a health care professional in the Network who specializes in obstetrics or gynecology. Your obstetrical or gynecological physician may, however, be required to comply with certain Plan requirements, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following the Plan's procedures for making referrals.

Customer Services is available to assist with your OB/GYN selection or answer any additional questions you may have. For a complete listing of health care professionals who specialize in obstetrics or gynecology, check your Provider directory, or visit CommunityCare's website at fop.ccok.com.

POS Benefits (Out-of-Network):

Your POS benefits may apply to any specialty care you receive from a Specialist outside your PCP's Network.

Using your POS benefits, you also have the option of going directly to a Specialist or hospital for non-Emergency Services without obtaining an authorized referral from your PCP. However, you are still required to obtain pre-certification for the full duration of any hospital confinement, and any Covered Services, including follow-up care, are subject to any Deductibles and Coinsurance. You may also be responsible for filing claim forms, and the difference between the Plan's payment and your Provider's billed charges.

The toll-free number for this pre-certification approval process is (800) 544-8922. Failure to pre-certify may lead to substantially reduced benefits, as outlined in your Schedule of Benefits.

Urgent Care Services

Managed Care Benefits (In-Network):

Urgent Care Services refers to Covered Services that are Medically Necessary to treat unexpected illnesses and injuries that are severe or painful enough to require treatment within 24 hours but are NOT Emergency Services.

Please see Provider Directory for In-Network Urgent Care facilities. Urgent Care Services rendered at Out-of-Network facilities will be considered as In-Network only if Emergency Medical Criteria are met. Emergency Medical Criteria are defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; (ii) serious impairment to bodily function; or (iii) serious dysfunction of any bodily organ or part.

If you are not sure of the severity of your condition, you may call the 24-Hour Nurseline to speak with a registered

nurse. The nurse can give you direction and education for providing treatment. Call (918) 594-5201, or toll-free, (888) 589-5214 to reach the 24-Hour Nurseline.

POS Benefits (Out-of-Network):

If you choose to utilize your POS benefits to obtain Urgent Care Services, you may see a physician or use a facility of your choice as soon as possible. Covered Services, outlined in your Schedule of Benefits, including follow-up care, are subject to any Deductibles and Coinsurance. You may also be responsible for filing claim forms, and the difference between the Plan's payment and your Provider's billed charges.

It is important that you follow-up with your PCP within 48 hours of any Urgent Care Services. This will allow your PCP to assist in directing or coordinating your follow-up care if any additional care is needed. Follow-up care that is not arranged by your PCP may not be covered. Your PCP is available 24 hours a day, seven days a week.

Emergency Services

Emergency Services are services and supplies that are: (1) Medically Necessary to treat an Emergency Medical Condition; and (2) furnished by a provider who is qualified to furnish such services.

Emergency Services are covered worldwide.

For purposes of your Plan, an "Emergency Medical Condition" is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

How to Obtain Emergency Services

If you need Emergency Services, go to the nearest emergency room. Please notify your PCP within 48 hours of receiving Emergency Services. If you require follow-up care, your PCP can initiate the authorization process and coordinate those services for you. Follow-up care that is not arranged by your PCP, as well as any non-authorized follow-up care, will be covered at the reduced POS level of benefit.

If you are uncertain about the severity of your condition, contact your PCP. Your PCP is available 24 hours a day, including weekends and holidays. Your PCP will direct you to the appropriate place and will coordinate your medical care. If you have a chronic condition that has persisted for several days, your PCP may want to see you during his or her regular office hours. You can also contact CommunityCare's 24-Hour Nurseline at

(918) 594-5201, or toll-free, (888) 589-5214 to speak with a registered nurse who can provide direction for obtaining treatment.

REMEMBER: You may be held financially responsible for emergency room charges that do not qualify as "Emergency Services." Some Emergency Room charges may be deemed ineligible for payment based on medical necessity criteria. Claims of this nature will be considered on a case-by-case basis.

Emergency or Urgent Care Services When Traveling Outside of the United States

If you need Emergency Services or Urgent Care Services while traveling outside of the United States, please go to the nearest medical facility and contact your PCP within 48 hours for coordination of care. To qualify as Emergency Services, Emergency Medical Criteria are defined as a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

If you receive Emergency or Urgent Care Services, you may then forward the medical bills to CommunityCare for reimbursement minus any copay that would apply. Some providers may file claims directly with CommunityCare on behalf of the patient.

Please note: You may be held financially responsible for emergency room and/or urgent care facility charges that do not qualify as Emergency Services.

Observation

There are times when a patient's condition requires additional evaluation but does not require admission to the hospital. In those instances, the patient may be transferred from the emergency room to the hospital floor and placed under observation until the attending physician determines that it is safe to discharge the patient. If the hospital claim indicates that you were placed under observation, you will incur an emergency room Copayment, but not an inpatient admission Copayment.

Inpatient Admission

If it is Medically Necessary for you to be admitted to the hospital as an inpatient, you will incur the inpatient admission Deductible and/or Copayment/Coinsurance for the Plan. If you are admitted from the emergency room, however, the emergency room Copayment is waived. Your financial liability for these services depends on how the hospital bills the Plan for your stay.

Behavioral Health Services

Mental Health and Chemical Dependency services (outpatient or crisis intervention) are available through self-referral by calling (918) 594-5262, option 1 in Tulsa, or (800) 774-2677, option 1 outside Tulsa. PCPs may also refer Participants by calling CommunityCare Behavioral Health Services at the above numbers. As long as you use a Plan Provider, you will receive the highest level of coverage under your Managed Care benefits. If you use an out-of-network Provider, you will be covered at the POS level of benefits

For assistance in locating an appropriate Provider, please call (918) 594-5201, in Tulsa or (888) 589-5214, outside Tulsa.

Organ Transplant

Managed Care Benefits Only (In-Network): CommunityCare will arrange to have your case reviewed by one of the approved transplant centers. The initial evaluation, the organ transplant and all follow-up services must be Prior Authorized from CommunityCare to be a covered benefit.

Transplant Evaluation

The Plan covers the cost of the transplant consult and/or evaluation. If you receive an organ transplant, the Plan will reimburse you for reasonable out-of-pocket expenses you incurred for transportation, lodging and meals. In order for your out-of-pocket expenses to be reimbursable, the transplant must take place while you are an eligible Participant and within one year from the date of the evaluation. You must submit original, itemized receipts for out-of-pocket expenses to CommunityCare within six months after the date of transplant for those expenses to be reimbursable. The Plan will not reimburse your out-of-pocket expenses related to the transplant evaluation if you do not subsequently undergo a transplant procedure.

Transplant-Related Procedures

The Plan covers the cost of transplant-related procedures that take place during the transplant period, as well as out-of-pocket expenses for meals, lodging and transportation (subject to the requirements described below). The transplant period starts 10 days prior to the transplant and extends 355 days from the date of transplant. In order for your out-of-pocket expenses to be reimbursable, the transplant must take place within one year from the date of the evaluation, and the patient must submit original itemized receipts to CommunityCare within six months after the transplant.

Transplant – Meals, Lodging and Transportation

If the Participant receiving the organ transplant lives more than 100 miles from the transplant facility, the Plan will reimburse reasonable expenses for meals, lodging at a lodging establishment and non-emergency transportation, up to $10,000 per transplant (subject to the following conditions and restrictions). Meals and lodging are subject to a daily combined limit of $200 (inclusive of the patient and any companions). The Plan reimburses lodging for the patient and one companion (two companions if the patient is a minor) while the patient is confined in the hospital for transplant. The Plan also reimburses local housing after the transplant, if Medically

Necessary. The Plan does not reimburse expenses for alcoholic drinks.

The Plan will reimburse reasonable expenses for transportation using your personal vehicle for one round trip related to the actual transplant procedure for the patient and a companion (two if the patient is a minor), as well as post-discharge transportation to and from the transplant facility for outpatient follow-up during the transplant period (365 days). Reimbursement is based on mileage at the standard rates for medical purposes established by the IRS. The Plan does not cover or reimburse expenses for personal items, car rental or personal use of an automobile (i.e., mileage incurred for purposes other than getting directly to and from the transplant facility). In the event that a Participant chooses to travel by air, the Plan will reimburse at the economy passenger rate (regardless of flight availability).

In order for expenses related to meals, lodging and transportation to be reimbursable, you must submit original itemized receipts to CommunityCare Within six months after the transplant

Transplant – Emergency Transportation (Air Ambulance)

Transportation by air ambulance requires prior approval from CommunityCare. CommunityCare will approve emergency air ambulance only in the event that the life of the patient or the viability of the organ to be transplanted may not be sustained by normal commercial means of transportation. The Plan will pay the cost of the emergency air ambulance for the patient and a companion (two companions if the patient is a minor) to the transplant facility, in accordance with the Schedule of Benefits. The Plan will not cover air ambulance services back from the transplant facility.

There are no POS (Out-of-Network) benefits for organ transplants.

Dialysis

Covered Services for dialysis include inpatient services, outpatient hemodialysis, home dialysis equipment and supplies and certain home support services when those services are arranged and authorized in advance by CommunityCare.

Vision Screening

Managed Care Benefits Only (In-Network): The Plan covers one vision screening every 12 months through In-Network vision Providers. This screening is not a comprehensive eye exam, but includes a brief history, vision and glaucoma screenings and refraction for glasses. Fitting and sizing for contact

lenses are not covered benefits. You may find a list of vision Providers at fop.ccok.com. If you have additional questions, you may call Customer Services at (918) 594-5201 or (888) 589-5214, Monday-Friday, 7 a.m.-6 p.m.

If your vision Provider finds a potential medical problem with your eyes, you will need to contact your PCP for further treatment options and referral to a vision Specialist.

Anesthesia During Medically Necessary Dental Procedures

The Plan covers anesthesia expenses, including anesthesia practitioner expenses for the administration of the anesthesia, hospital, ambulatory surgical center expenses and lab and x-ray expenses associated with any Medically Necessary dental procedure when provided to a Plan Participant who is either (1) severely disabled; or (2) who has a medical or emotional condition which requires Hospitalization or general anesthesia for dental care, or (3) who in the judgment of the practitioner treating the Participant, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia. Authorization requirements apply. Please see your Plan's Schedule of Benefits for any Deductibles and/or Coinsurance limitations that apply to these services.

Medically Necessary Coverage is limited to:

- Surgical treatment of fractures and dislocations of the jaw or for treatment of injury to sound natural teeth including replacement of such teeth provided the replacement or re-implantation of teeth occurs within 30 days of the injury;
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth, provided such injuries occur while an individual is covered under this plan;
- Removal of non-odontogenic lesions, tumors or cysts;
- Incision and drainage of non-odontogenic cellulitis;
- Surgery on accessory sinuses, salivary glands, ducts and tongue;
- Treatment to correct a non-odontogenic congenital defect that results in a functional defect of a covered Dependent Child;
- Charges for surgical facility and anesthesia charges for outpatient oral surgical procedures when systemic disease or other physical condition is present that would warrant a place of service other than a dental office to safeguard the patient's health that are not covered by dental insurance.

Audiological Services

The Plan covers audiological services and hearing aids for Children up to 18 years of age. Coverage for hearing aids is limited to one for each hearing-impaired ear in any 48-month period; however, up to four additional ear molds per year for Children up to two years of age may be obtained. Expenses for audiological services and hearing aids must be authorized in advance by CommunityCare. Please see your Plan's Schedule of Benefits for any Deductibles and/or Coinsurance limitations that apply to these services.

Treatment of Mental Illness

The Plan covers treatment of mental illness and substance abuse disorders. The Plan does not impose any authorization requirement, financial requirement (such as a Copayment or Coinsurance) or quantitative treatment limitations (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance use disorder benefits that is more restrictive than the authorization requirements, financial requirements or quantitative treatment limitations that apply to at least two-thirds of medical/surgical benefits in the same classification. Please see your Plan's Schedule of Benefits for any Deductibles and/or Coinsurance limitations that apply to the treatment of mental illness and substance abuse disorders.

Child Health Supervision Services

The Plan covers Child health supervision services (i.e., the periodic review of a Child's physical and emotional status by a physician or other primary health care Provider or pursuant to a physician's supervision) at the following specified intervals from the moment of birth through the age of eighteen years: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years and eighteen years. Services must be rendered by or under the supervision of a single physician or other primary health care Provider during the course of one visit. Please see your Plan's Schedule of Benefits for any Deductibles and/or Coinsurance limitations that apply to coverage of Child Health Supervision Services.

Hospice Services

Hospice Services are covered for Participants with a terminal illness if the disease follows its natural course. Hospice Services are provided in accordance with the plan of care developed by the Participant's interdisciplinary team, which may include, but need not be limited to, the Participant, the Participant's In-Network PCP and/or In-Network Specialist, a registered nurse, a social worker and a spiritual caregiver.

The term "Hospice Services" includes inpatient hospital, skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse; respite care; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Participant to maintain activities of daily living and basic functional skills. Hospice Services do not include services rendered to treat the Participant's terminal condition.

Diabetes

The Plan covers diabetic equipment, supplies and services related to Type I, Type II and gestational diabetes, when Medically Necessary and when recommended or prescribed by a physician or other health care Provider. The Plan covers the following supplies: blood glucose monitors (including types

for the legally blind); test strips for glucose monitors; visual reading and urine test strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin infusion devices; oral agents to control blood sugar; and podiatric appliances to prevent diabetic related complications, podiatry and diabetes self-management training. Insulin pumps, continuous glucose monitors and their supplies must be authorized in advance by CommunityCare.

Diabetic services include Provider services for podiatric health care that are Medically Necessary to prevent complications from diabetes.

Scalp and Wig Prostheses

When a Participant is treated with chemotherapy or radiation, the Plan will provide reimbursement for a wig or scalp prosthesis up to one hundred and fifty ($150) dollars, annually. The Participant must purchase the wig or scalp prosthesis and submit a receipt for reimbursement to CommunityCare at the address listed in the front of this handbook. Please see your Plan's Schedule of Benefits for any Deductibles, Copayments and/or Coinsurance limitations that apply.

Mammography Screening

A mammography screening should be performed by a provider who participates in the same network as your PCP. The screening would include coverage for diagnostic examination and imaging and if medically necessary breast magnetic resonance imaging or breast ultrasound CommunityCare Members may self-refer for the mammogram screening. Some services may require prior authorization.

Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, Act of 1998 (WHCRA), the Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient. Please see your Plan's Schedule of Benefits for any Deductibles and/or Coinsurance limitations that apply to coverage under the WHCRA.

Breast Cancer Treatment

For hospital stays for Medically Necessary mastectomies for the treatment of breast cancer, the Plan covers not less than 48 hours of inpatient care. The Plan also covers Reconstructive Surgery following Medically Necessary mastectomies, including reconstruction of the non-cancerous breast to achieve symmetry. For Medically Necessary lumpectomies and lymph node dissections for the treatment of breast cancer, the Plan covers not less than 24 hours of inpatient care.

Maternity Care and Newborn Infant Hospital Stays

If you suspect that you are pregnant, please contact your PCP or OB/GYN for a test to confirm pregnancy. Your physician can evaluate your current medications and make suggestions concerning your health and that of the baby. In addition, the PCP can provide information about pregnancy and start you on prenatal vitamins and folic acid.

Your maternity care visits begin after the physician confirms pregnancy.

Managed Care Benefits (In-Network):

The Plan shall provide coverage for 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. Visits shall include at a minimum: physical assessment of mother and newborn, parent education to include importance of, resources for obtaining and the recommended childhood immunizations schedule, training or assistance with breast or bottle feeding, and performance of any Medically Necessary tests.

Breast Pump

A Breast pump purchased as an over-the-counter item is to be submitted by the Participant with a claim form and a written prescription from an in-network physician. The breast pump has a maximum reimbursement of $300 for purchase in conjunction with each birth. A Hospital grade breast pump is only available as a monthly DME rental up to $1,000- or twelve-months rental, whichever occurs first. The hospital grade breast pump must be returned to provider upon end of use.

24-Hour Nurseline

The 24-Hour Nurseline is a staffed, multi-lingual information line for Participants that is available 24 hours a day. Participants may speak to a registered nurse who can provide direction and education for obtaining treatment for medical conditions or problems. Call (918) 594-5201 or (888) 589-5214.

Section III Be More Involved in Your Health Care

One way you can make sure you receive quality health care is to be an active member of your health care team.

Patients who talk with their doctors tend to be happier with their care and have better medical results.

Before Your Appointment

- Bring all the medicines you take to your appointment. This includes:
  - Prescription medicines
  - Non-prescription medicines, such as aspirin or antacids
  - Vitamins
  - Dietary or herbal supplements
- Write down the questions you have for the visit
- Know your current medical conditions, past surgeries, and illnesses

During Your Appointment

- Explain your symptoms, health history, and any problems with medicines you have taken in the past
- Ask questions to make sure you understand what your doctor is telling you
- Let your doctor know if you are worried about being able to follow his or her instructions
- If your doctor recommends a treatment, ask about options
- If you need a test, ask:
  - How the test is done
  - How it will feel
  - What you need to do to get ready for it
  - How you will get the results
- If you need a prescription, tell your doctors if you are pregnant, are nursing, have reactions to medicines,

or take vitamins or herbal supplements

- Find out what to do next. Ask for:
  - Written instructions
  - Brochures
  - Videos
  - Web sites

After Your Appointment

- Always follow your doctor's instructions.
- If you do not understand your instructions after you get home, call your doctor.
- Talk with your doctor or pharmacist before you stop taking any medicines that your doctor prescribed.
- Call your doctor if your symptoms get worse or if you have problems following the instructions.
- Make appointments to have tests done or see a specialist as directed by your doctor.
- Call your doctor's office to find out test results. Ask what you should do about the results.

Section IV Referral/Authorization Process

Managed Care Benefits (In-Network):

If your PCP determines that you need more tests, specialty care or hospitalization, your PCP may ask CommunityCare to authorize those services.

Your PCP and, when appropriate, your specialist will be notified of the referral decision and recommendations. If more tests or treatments are recommended or if hospitalization is needed, an authorization will be sent to the appropriate Provider.

Some referrals are automatically approved by CommunityCare using Network and national criteria. Your PCP knows which services are automatically approved and can arrange your initial visit without the need for further action by CommunityCare. If you require Urgent Care Services that require CommunityCare's prior authorization, CommunityCare will process the referral within 24-48 hours. If CommunityCare lacks sufficient information to determine whether the services are Medically Necessary, CommunityCare will request the specific information from the Provider before making a decision. In this case, you will receive notification of the decision within 72 hours after CommunityCare receives the additional information.

If you require specialty or inpatient care, your PCP will typically refer you to a specialist or hospital affiliated with your PCP's Network, but can also use other contracted specialists or hospitals. If the referral requires CommunityCare's authorization, you will receive written notice of CommunityCare's decision. You may also call Customer Services at (888) 589-5214, or at (918) 594-5201 in Tulsa. Your PCP and/or specialist will be notified if CommunityCare denies the

referral, and you and your PCP and/or specialist will have the right to appeal that denial in accordance with the Plan's pre-service claim determination appeal procedures.

If your PCP or specialist submits a referral for Medically Necessary care that is not available within CommunityCare's Provider Network, CommunityCare will identify an appropriate Out-of-Network Provider and issue a preauthorization for 8that service. You will be financially responsible for applicable Copayments, Coinsurance, and/or Deductible and other non-medical expenses, such as transportation and lodging.

If an In-Network Provider fails to obtain authorization for a Covered Service in accordance with the Plan's referral authorization process, you are not responsible for these services.

If medically appropriate care is available within CommunityCare's Provider Network, but you choose to receive care from an Out-of-Network Provider, payment may be made at reduced POS (Out- of-Network) benefit levels with Deductibles and Coinsurance, and you will be responsible for the difference between the Plan's payment and your Provider's billed charges.

POS Benefits (Out-of-Network):

If you wish to receive specialty services without first obtaining an authorized referral from your PCP, you may use your POS benefits and seek care directly from a Specialist of your choice. If you seek care without an authorized referral, you will only receive POS level benefits, you will bear a greater financial responsibility for the cost of your care in the form of Deductibles and Coinsurance, and you will be responsible for the difference between the Plan's payment and the Provider's billed charges. You will also be responsible for ensuring that a claim is submitted to CommunityCare for those services.

Concurrent Care Decisions

If CommunityCare has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination of such course of treatment by the Plan before the end of such period of time or number of treatments (other than by Plan amendment or termination) shall constitute an Adverse Benefit Determination. CommunityCare will notify you of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision concerning that Adverse Benefit Determination before the benefit is reduced or terminated.

CommunityCare will make a determination regarding a Participant's request to extend the course of treatment beyond the period of time or number of treatments as soon as possible, taking into account the medical urgency. CommunityCare shall notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Urgent Care Claim Determinations

In the case of a claim involving Urgent Care (as described below for purpose of the Plan's claims procedures), CommunityCare shall notify the Participant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical urgency, but no later than 72 hours after CommunityCare's receipt of the claim, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, CommunityCare shall notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim.

The Participant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. CommunityCare shall notify the Participant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- The Plan's receipt of the specified information; or
- The end of the period afforded the Participant to provide the specified additional information.

For purposes of the Plan's claim procedures, the term "Urgent Care" refers to a pre-service claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function or, in the opinion of the treating Physician, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies. The use of this term for this purpose is different from the definition of the term "Urgent Care Services" as described above.

Pre-Service Care Claim Determinations (Referrals/Authorizations)

In the case of a pre-service claim (e.g., referral authorization request), CommunityCare shall notify the Participant of its benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after CommunityCare's receipt of the claim.

CommunityCare may extend the time period one time for up to 15 days, provided that CommunityCare both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time, and the date by which CommunityCare expects to render a decision.

If such an extension is necessary due to a Participant's failure to submit information necessary to make a determination, the notice of extension shall specifically describe the required information, and the Participant shall be

given at least 45 days from receipt of the notice to provide the specified information.

In the case of a Participant's failure to follow the Plan's procedures for filing a pre-service claim (e.g., referral authorization request), the Participant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be made as soon as possible, but no later than five days (24 hours in the case of a failure to file a claim involving Urgent Care) following the failure. This notification may be oral, unless the Participant requests written notification.

The notification process regarding a Participant's failure to follow pre-service claim filing procedures shall apply only in the case of a failure that:

- Is a communication by a Participant or his or her authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and
- Is a communication that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or procedure for which approval is requested.

Post-Service Claim Determinations

CommunityCare shall notify the Participant of an adverse post-service claim determination within a reasonable period of time, but no later than 30 days after receipt of the claim. The time period for notification of an adverse post-service claim determination may be extended one time for up to 15 days, provided CommunityCare determines that an extension is necessary due to matters beyond the control of CommunityCare and notifies the Participant, prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which it expects to render a decision.

If an extension of time is necessary due to a Participant's failure to submit the information necessary to decide a claim, the notice of extension shall specifically describe the required information. The Participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Section V Prescription Drug Benefit Information

Benefit Tiers for Prescription Drugs

The Plan covers the cost of outpatient prescription drugs (subject to the requirements described below). The Plan pays benefits at different levels for preferred generic drugs (Tier 1), preferred brand drugs (Tier 2), and non-preferred brand drugs (Tier 3). Each tier is subject to a copayment which will depend on whether you purchase your medications from a retail Participating Pharmacy or use the Plan's mail order option. Please see the Plan's Schedule of Benefits for further details.

If a Participant chooses a non-preferred brand drug (Tier 3) when a generic equivalent is available, the Participant will be responsible for the non-generic copayment plus the difference in cost between the name brand and generic drugs.

For those Participants whose physicians prescribe medication in 90-day supply increments, the retail pharmacy option will be available to purchase at the retail pharmacy copayments.

For those Participants whose physicians prescribe medication in 90-day supply increments, the mail order option is available to purchase at the mail order copayments.

For prescription claims whose network discounted price exceeds $1,000, and if for a 30-day supply, will require a review by MedalistRx to determine if a lower cost alternative is available. For prescription claims whose network discounted price exceeds $3,000, and if

for a 90-day supply, will also require a review by MedalistRx to determine if a lower cost alternative is available.

- Any claim whose network discounted price exceeds $1,000 will require a Participant coinsurance copayment as described in your Plan's Schedule of Benefits.
- Compound medications are covered at a maximum networked discounted Plan cost of $100.

Retail Participating Pharmacies

The Plan uses the MedalistRx network of Participating Pharmacies which includes many large drug store chains. To obtain your prescription from a retail Participating Pharmacy, simply present your ID card and pay your copayment. If you obtain your prescription from an Out-of-Network pharmacy, you must pay the entire cost upfront and file a claim with MetalistRx for reimbursement as described in the Plan's Schedule of Benefits. Contact MedalistRx at (855) 633-2579 or at info@medalistrx.com to receive instructions on Out-of-Network pharmacy reimbursement with billing receipt.

Mail Order

The Plan's mail order pharmacy allows you to purchase up to a 90-day supply for certain covered maintenance drugs through the mail. For more details go to the MedalistRx website at www.medalistrx.com or call MedalistRx at (855) 633-2579.

Covered Services

The Plan covers the following drugs and devices (this list may not be all inclusive):

- Federal legend drugs that require a prescription under federal/state law
- Compounds which are the combination of two or more drug products containing at least one federal legend drug in a therapeutic amount
- Compounds of raw chemicals or combinations of federal legend drugs in a non-FDA approved dosage form for medical necessity
- Injectable/infused drugs, including insulin, epinephrine and glucagons, blood glucose strips or lancets
- Anti-migraine medication
- Therapeutic drug class prescriptions for ADD &/or ADHD
- Injectable (unless listed as contraceptive implants, IUDs, diaphragms, contraceptive devices, contraceptive kits, emergency contraception, oral/injectable/patch contraceptives
- Drugs used for chemical dependency/alcohol treatment
- Immunizations (no copayment applies to childhood immunizations from birth-age 21 and preventive care)
- Immune response modifiers and immunosuppressive drugs

Exclusions and Limitations

The Plan does not cover the following (this list may not be all inclusive):

- Non-legend drugs other than insulin
- Therapeutic devices or appliances, support garments and other non-medical substances
- Drugs intended for use in a physician's office or another setting other than home use

- Experimental or Investigational drugs, including compounded medications for non-FDA approved use
- Prescriptions which a covered Participant is entitled to receive without charge under any Workers' Compensation law, or any municipal, state, or federal program, or with respect to which the Participant has no obligation to pay in the absence of insurance
- Fertility medications
- Human growth hormones and other drugs used to stimulate growth
- Weight loss medications and other drugs used for weight management, including anorexiants and body building
- Immunization agents, biological serum, blood products, vaccines, unless specifically covered
- Prescription vitamins
- Drugs used for cosmetic purposes
- Anti-fungal drugs used for nail fungus
- Oral antihistamines and antihistamine/decongestant combinations
- Convenience or unit dose packaging
- Drugs and their equivalents that may be purchased without a prescription; for example, over-the-counter medications are not covered
- Lost, damaged or stolen prescriptions
- Any drug or medication that is not a covered drug
- Any drug, medication or device purchased from a non-Participating Pharmacy

Quantity Limitations

Some drugs may have quantity limitations at the time of dispensing. If a Participant requires a quantity above limits a prior authorization will need to be approved.

MedalistRx Specialty Medications

Special medications used for treating complex or chronic health conditions are dispensed through MedalistRx specialty pharmacy network. The purpose of MedalistRx specialty management is to assist Participants with monitoring their medication needs and providing education for conditions such as:

- Hepatitis C
- HIV
- Osteoarthritis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Cystic Fibrosis
- Cancer
- Certain Hereditary Diseases

MedalistRx specialty pharmacies have expertise in the delivery of the drugs they provide. They maintain stock of medications at all times and can deliver them with the medical supplies needed such as syringes, needles, or tubing necessary for their use. In addition, Participants will receive instructions and assistance in the administration of their medications. These biotech/injectable medications are dispensed up to a 30-day supply due their high cost, short shelf life, and to prevent wastage should the physician deem it necessary to change their therapy.

Specialty Medications Participant Cost Coverage

Specialty medications are covered as described in your Plan's Schedule of Benefits. MedalistRx has a team of staff

to assist Participants with obtaining a manufacturer copay card to cover a majority of their copay.

Contact MedalistRx member services for guidance on locating and applying for a manufacturer copay card.

MedalistRX
2431 East 61st Street, Suite 450
Tulsa, OK 74136
www.medalistrx.com
(855) 633-2579 opt. 1

Rebates and Other Discounts

MedalistRx may, at times, receive rebates for certain drugs. MedalistRx does not pass these rebates and other discounts on to you nor does MedalistRx take them into account when determining your copayments.

Section VI General Provisions

Discretionary Authority of CommunityCare and the Plan Administrator to Interpret Plan Terms

The Plan has engaged CommunityCare to provide third party administration services and MedalistRx as the pharmacy benefit manager with respect to the Plan, including but not limited to administration of claims and appeals. The Plan Administrator also has specific responsibilities with respect to the Plan. In carrying out these responsibilities on behalf of the Plan, CommunityCare, MedalistRx, and the Plan Administrator have discretionary authority to interpret the terms of the Plan, including terms governing eligibility for and entitlement to Plan benefits. Any interpretation or determination by CommunityCare, MedalistRx, or the Plan Administrator pursuant to their discretionary authority will be given full force and effect and will be final and binding on all persons, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Release of Information and Confidentiality

As a condition of participating in the Plan, you agree that CommunityCare and MedalistRX, on behalf of the Plan, and the Plan Administrator may request, and anyone may give to CommunityCare, MedalistRX and the Plan Administrator, any information about any illness or injury for which you are claiming insurance benefits. Also, CommunityCare and the Plan Administrator may give similar information, if requested, to anyone providing insurance benefits to you.

Information from your medical records and information from Providers or

hospitals is kept confidential. In addition, CommunityCare and the Plan Administrator will not disclose such information without your written consent, except:

- When non-identifiable information is used as part of medical research and education
- When reasonably necessary in connection with the administration of the Plan
- When non-identifiable information is used for compiling aggregate statistical data
- When required or permitted by law or pursuant to a valid court order
- When necessary to administer and fulfill state and federal requirements, including review programs to achieve quality and cost-effective medical care

CommunityCare's and the Plan's use and disclosure of your protected health information (PHI) is governed by federal privacy regulations enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These regulations may restrict CommunityCare's and the Plan Administrator's ability to disclose your PHI to others, including members of your family and your friends. You can find a complete explanation of how HIPAA's privacy regulations affect the use and disclosure of your PHI in the Plan's Notice of Privacy Practices. A copy of the Plan's HIPAA Authorization form is available from Rooney Insurance Agency.

Assignment of Benefits

Your right to receive coverage under the Plan is personal to you and may not be assigned to anyone else. Only Participants are entitled to receive Plan benefits and the right to receive Plan benefits may not be transferred to anyone else.

The Plan will pay In-Network Providers directly for Covered Services. If CommunityCare authorizes an Out-of-Network Provider to render services to a Participant, the Plan may pay the Out-of-Network Provider directly, or the Plan may satisfy its financial obligation by paying the Participant, and in that event, the Participant is responsible for paying the Provider. The Plan does not cover services that a Participant receives from an Out-of-Network Provider without CommunityCare's prior authorization, and Participants may not assign to an Out-of-Network Provider a right to receive payment for those services. Any attempt by a Participant or his or her representative to assign benefits to an Out-of-Network Provider is invalid.

Independent Contractor Relationship

CommunityCare, the Plan Sponsor and In-Network Providers are independent contractors. That means, among other things, that there is no employer/employee relationship between CommunityCare or the Plan Sponsor and any In-Network Providers, and vice versa.

Experimental and Investigational Therapies

For purposes of Plan benefits, a drug, device or medical treatment or procedure is experimental or investigational if any of the following apply:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) or: (i) approval for marketing has not been given at the time he drug or device is furnished; (ii) it has FDA approval only under its treatment investigational new drug regulation or a similar regulation; or (iii) it has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. An "accepted off-label use" is a use that is included and favorably recognized for treatment of the indication in one or more of the following medical publications: The American Medical Association Drug Evaluations, the American Hospital formulary Service Drug Information; or the United States Pharmacopoeia Information;
- Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing clinical trials including, but not limited to, Phase I, II, III, or IV clinical trials or a study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the currently-accepted standard means of treatment or diagnosis (e.g. "standard of care"); or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard of care.

"Reliable evidence" means only: (1) published reports or articles in the authoritative medical and scientific literature; (2) regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, the (FDA), the Centers for Medicare and Medicaid Services (CMS) or any other appropriate technological assessment body; (3) the written protocol(s) used by the treating facility or another facility studying substantially the same drug, device or medical treatment or procedure; or (4) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Neither the Plan nor CommunityCare authorizes or denies Participants' participation in clinical trials. The decision to accept a Participant into a clinical trial is made by the sponsor of the clinical trial in consultation with the Participant's physician(s). Knowing whether or not a Participant is accepted into, and agrees to participate in, a clinical trial is important to CommunityCare to be able to determine the extent to which the Plan may be financially responsible for covering "standard of care" services that are rendered during the clinical trial, and/or coordinating care that is rendered other than as part of the clinical trial.

The Plan will cover the costs of services incurred as part of a qualifying clinical trial that are considered the "standard of care" for patient's condition. The Plan will also cover the cost of items and services that are Medically Necessary and appropriate to treat complications arising from participation in a clinical trial. To qualify for coverage of

"standards of care" for a clinical trial, the qualified individual must be a participant in an approved clinical trial (a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or other life-threatening disease or condition). In general, routine standard of care costs mean all items and services that are otherwise covered under the Plan for a Participant who is not enrolled in a clinical trial. In order for the routine costs to be covered, a clinical trial must: (1) be conducted under an investigational new drug application (IND) reviewed by the FDA or as defined by Medicare; or (2) be enrolled in the Medicare clinical trials registry. Some clinical trials are deemed to be automatically qualified, such as trials approved by funded by National Institutes of Health (NIH), The Department of Defense, The Department of Energy, Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ) and the Veterans Administration (VA) or that involve is exempt from an investigational new drug. For additional information please call Customer Services.

Advance Directives

An advance directive is a written legal document that allows you to instruct your attending physician whether or not you wish to be given life-sustaining treatment and artificially administered nutrition (e.g., food) and hydration (e.g., water) and to give other medical directions that impact end of life. Advance directives may include a living will, the appointment of a health care proxy, and directions for anatomical gifts (e.g., organ donation).

An advance directive must be signed before two witnesses who are age 18 or older. The witnesses cannot be beneficiaries under your will or be anyone who would inherit your property if you died without a will. The advance directive need not be notarized.

Oklahoma's Advance Directive Act governs advance directives, including when an advance directive takes effect, the conditions that are covered by an advance directive (e.g., terminal conditions; persistent unconsciousness; and end-stage conditions), what should happen if you physician does not want to comply with your expressed wishes, and what you need to do to revoke an advance directive.

Advance Directive Distribution

If you choose to complete an advance directive, it is your responsibility to provide copies of your advance directive to your health care Providers, including your PCP and the hospital where you primarily receive your hospital care.

More Information About Advance Directives

If you wish to obtain an advance directive form, you may contact the Customer Services department at (918) 594-5201 or (888) 589-5214, or download one from the Oklahoma Department of Human Services website at http://www.okdhs.org/OKDHS%20Publication%20Library/87-07W.pdf .

Fraudulent Activity

If an individual (including an Employee, Retiree or Dependent) or a person seeking coverage on behalf of such individual: (1) performs an act, practice

or omission that constitutes fraud (including but not limited to submission of a fraudulent application for participation or a fraudulent claim for benefits under the Plan); or (2) makes an intentional misrepresentation of material fact, the Plan Administrator may: (1) cause such individual and all members of his family unit to forfeit all rights to participate in the Plan; and (2) recover any payments made under the Plan with respect to such fraudulent application, fraudulent claim or intentional misrepresentation. If a termination of coverage will have retroactive effect, the Plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be terminated on a retroactive basis.

Applicable Law

The Plan shall be construed and interpreted in accordance with the laws of the State of Oklahoma to the extent those laws are not superseded by federal law.

Section VII Payment and Claims Information

Please note: For purposes of the Plan's claims and Appeals procedures, the terms "claim for benefits" and "claim" do not include the following: (1) casual inquiries about benefits or the circumstances under which benefits might be paid under the terms of the Plan; (2) mere requests for advance information on the Plan's possible coverage of items or services or advance approval of covered items or services that do not require advance approval; and (3) the submission of a prescription to a pharmacy or a pharmacist. A determination of eligibility under the Plan (including a request or application for such determination) will not be treated as a claim under the Plan and will be determined by the Plan Administrator in accordance with a procedure established by the Plan Administrator. (CommunityCare does not make determinations regarding eligibility to participate in the Plan.) However, if an individual files a request for benefits in accordance with the Plan's procedure for filing claims, and that claim is denied because the individual is not eligible for coverage under the Plan, the coverage determination will be considered to be part of a claim.

Managed Care Benefits (In-Network)

Plan Participants receive managed care benefits from the first day of coverage with designated applicable Copayments, Deductibles, and Coinsurance required.

POS Benefits (Out-of-Network)

If you receive care from a Non-Network Provider or care that is not arranged by your PCP through an authorized referral, payment will be made at the reduced POS benefit level and you will be required to pay applicable Deductibles and Coinsurance, and you will be responsible for the difference between

the Plan's payment (CommunityCare's Out-of-Network fee schedule) and your Provider's billed charges.

Explanation of Benefits

An Explanation of Benefits (EOB) is a statement provided to patients indicating what action the Plan has taken on your claims. The EOB is not a bill. The EOB verifies that your claim was processed and is provided to you for your information and records. EOBs are provided to you within 10 days after CommunityCare processes your claims.

After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must follow the process outlined in Section IV of this handbook.

You can register to receive your EOBs online at www.ccok.com/Members and select Secure Login.

Costs

You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copayment, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance

Coinsurance is a percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Schedule of Benefits.

Copayment

A Copayment is the portion of the medical expense that is your responsibility, as shown in the Schedule of Benefits. A Copayment is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductibles and Out-of-Pocket Expenses

Deductibles and other out-of-pocket expenses constitute an obligation of the Participant as a condition of coverage. Deductibles and out-of-pocket expenses may be collected at the time services are rendered.

Deductible Information

A Deductible is a set amount of covered charges that a Participant must pay each calendar year before the Plan is responsible for the payment of benefits on behalf of such Participant.

Individual Deductible

A Participant meets the individual Deductible requirement when the amount paid by or on behalf of the individual for covered medical expenses subject to the Deductible each calendar year equals the Deductible amount shown in the Schedule of Benefits. You are required to pay this amount. The Plan will not reimburse you for any expense subject to your Deductible. The individual Deductible applies separately to the Employee and to his or her Dependent(s). On or after the date the individual Deductible is met, no further charges will be applied to the Deductible for that individual for that calendar year. Only after a Participant meets the individual Deductible does that

Participant start receiving benefits under the Plan that are subject to the Deductible.

Family Deductible

Each calendar year, the Family Deductible will be met when the amount paid by or on behalf of the Primary Participant and his or her Dependent(s) together for covered medical expenses equals the Family Deductible amount reflected on the Schedule of Benefits. On or after the date the Family Deductible is met, no further charges will be applied to the Deductible for that family for that calendar year, regardless of whether any Participants have met their Individual Deductible.

Fourth Quarter Deductible Carryover

Amounts you incur for Covered Services during the last three months of the calendar year, and which are applied toward your Deductible for that calendar year, will also be carried over and applied to your Deductible for the following calendar year. Copayments and Coinsurance amounts you must pay under the Plan, amounts you incur that apply toward the out-of-pocket maximum for a Covered Service, and amounts that are applied toward your Deductible for covered Prescription Drugs, may not be carried over.

Out-of-Pocket Limit

Managed Care Benefits (In-Network):

To ensure that out-of-pocket Copayments and Coinsurance do not become a hardship to Participants, there is a maximum Copayment/Coinsurance provision in place for the Plan. (Check your Schedule of Benefits for your applicable maximum.) If you reach your Copayment/Coinsurance maximum for the year, any Covered Services you need for the rest of that Plan year will be covered without a Copayment/Coinsurance.

The annual out-of-pocket Copayment/Coinsurance limit does not apply to some services. Please refer to your Schedule of Benefits for additional information.

Please note: There are separate out-of-pocket limits for the medical benefit versus the prescription drug benefit plan.

CommunityCare keeps track of the Copayments/Coinsurances applied to eligible claims submitted on your behalf.

POS Benefits (Out-of-Network):

For POS benefit Out-of-Pocket Maximums, refer to your Schedule of Benefits.

If You Receive a Bill

You should not receive bills for authorized medical services. However, if you do receive a bill, please call:

CommunityCare Customer Services
(888) 589-5214 (Statewide)
(918) 594-5201 (Tulsa)

Our Customer Services representatives will be available to assist you. Please be sure to have the following information:

- The date of service
- The name of physician or hospital
- The kind of service you received
- The charges involved

Filing a Claim

In some situations, you may be required to submit the bills to CommunityCare in order to receive reimbursement; for example, if you receive Covered Services from an Out-of-Network Provider or over-the-counter pharmaceuticals. Include all of the following information:

- The name of patient
- The name of Provider
- The tax ID number of Provider
- The date of treatment
- The procedure code
- The diagnosis code
- The amount of charge

Save a copy of each claim you file, as well as copies of the supporting documentation. By filing a claim, you are authorizing your Provider to furnish to the Plan information and records relating to your treatment. You are responsible for any charges imposed related to the acquisition of such information.

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying CommunityCare in writing of that person's designation. In that case, all subsequent notices and decisions concerning that claim will be provided to you through your authorized representative. In urgent care situations, the designation of an authorized representative may be made orally or a health care professional with knowledge of your condition may be recognized as your authorized representative.

Submitting Bills

Managed Care Benefits (In-Network):

When you use your managed care benefits, you do not need to submit claim forms, and you should not receive any bills for authorized Covered Services other than applicable Copayments, Coinsurance, Deductibles and charges that exceed the maximum Plan benefits outlined in your Schedule of Benefits. However, if you do receive a bill for an authorized Covered Service, please retain a copy for your records and send the itemized bill for payment, with your ID number, to:

CommunityCare Customer Services
P. O. Box 3249
Tulsa, OK 74101-2967

POS Benefits (Out-of-Network):

Unless your Provider agrees to file a claim on your behalf, you may receive a bill for services, and you will need to file a claim with CommunityCare. You will also be subject to the annual Deductible, Coinsurance, and maximum Plan benefit limitation outlined in your Schedule of Benefits and the difference between the Plan's payment and your Provider's billed charges.

Deadline to File Claim

A claim will not be reimbursed unless written notice of the claim and all information needed to process the claim is provided to CommunityCare no later than 120 days from the date the services giving rise to the claim were provided.

Third Party Payments

The Plan has very specific provisions regarding situations in which you become ill or are injured through the fault of someone else. You should notify your Provider at the time you seek treatment that the illness or injury is the result of a third party. Your Provider may seek payment directly from you or the responsible third party before seeking payment from the Plan, and your Provider may file a lien on any payments or settlement you receive from the responsible third party. If the Provider seeks payment directly from the Plan, rather than from the responsible third party, the Plan is not obligated to pay such amounts and may conditionally advance benefits subject to the Plan's subrogation and reimbursement provisions. If the Plan advances such benefits, the Plan reserves the right to be reimbursed for those expenses from any money you receive from the responsible third party, including your uninsured motorist carrier. Please refer to Section VII. Subrogation and Rights of Recovery for more specific information regarding the Plan's subrogation and reimbursement rights.

Reimbursement

The Plan and your Providers have the right to receive payment or reimbursement regardless of whether or not you file a lawsuit against the responsible third party. The Plan has first priority with respect to its right to reduction, reimbursement and subrogation. The Plan's right to reimbursement applies when a judgment, payment or settlement is made to you, and the Plan is entitled to recover 100% of its cost of your medical benefits at the time the payment or settlement is received by you, your attorney or other person on your behalf. The Plan's right to be reimbursed applies regardless of whether the judgment, payment or settlement you received was designated as compensation for pain and suffering, medical expenses, any other general or special damages, and regardless of whether you have been made whole or fully compensated for your injuries. This right of payment or reimbursement takes precedence over your right to receive any money paid by or on behalf of the responsible third party, including your uninsured motorist carrier. In no event will a Provider's payment exceed his or her billed charges. The Plan and your Providers may, at their discretion, accept an amount that is less than the full amount of payment or reimbursement to which they are entitled.

You are required to furnish information or sign legal documentation that your Provider or the Plan may require in order to obtain payment or reimbursement.

In addition, you may not take any action, including settling a lawsuit against the responsible third party, that might impair, prejudice or discharge your Provider's right to payment or the Plan's right to reimbursement.

Please refer to Section VII. Subrogation and Rights of Recovery for more specific information regarding the Plan's subrogation and reimbursement rights.

Work-Related Injury or Illness/Workers' Compensation

Coverage under the Plan is not designed to duplicate benefits you may receive under the laws of any governmental unit, any policy of Workers' Compensation coverage 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.

If you receive any money in settlement of your employer's liability, regardless of how the settlement is structured, the Plan must be reimbursed from any amounts received. This reimbursement may not exceed 100% of the benefits paid by the Plan.

As a Participant, you agree to:

- Pursue your rights under applicable Workers' Compensation laws;
- Take no action prejudicing the rights and interests of the Plan; and
- Cooperate and give the information and assistance CommunityCare, MedalistRX, or the Plan Administrator requires to facilitate enforcement of the Plan's rights.

Non-Covered Services

Covered Services are set forth in the Schedule of Benefits and Exclusions. Unauthorized services, and services specifically excluded from the Plan, are not covered. You are responsible for full payment of Non-Covered Services.

Claims Payment Recovery for Non-Eligible Individuals and Non-Covered Services

If the Plan pays a claim for Covered Services rendered to an individual who was not eligible for coverage at the time services were rendered, the ineligible individual must reimburse the Plan for the value of the Covered Services within 30 days after CommunityCare requests reimbursement on behalf of the Plan.

If the Plan pays a Participant's claim for Non-Covered Services by mistake, the Plan will attempt to collect the payment from the Provider; however, the Participant remains liable for reimbursing the Plan for the amount of the payment.

Participants are financially responsible for paying a Provider's full billed charge for Non-Covered Services or services obtained through the Participant's own fraud.

Refusing Treatment

You may refuse your physician's treatment advice; however, your physician may regard your refusal as incompatible with maintaining an acceptable physician-patient relationship. In the event treatment advice is refused, you or your physician may request that a new physician be assigned to you.

The Plan may not be financially responsible for any services rendered to treat a condition if you leave the hospital against your treating physician's medical advice after you have been informed: (1) of the reasons the services are being recommended; (2) of the

consequences to your condition if treatment is refused; and (3) that your treating physician believes no medically acceptable alternative exists. The Plan may not be responsible for providing or paying for services you might need to treat any reoccurrence or aggravation of that same condition if you refuse treatment for that condition or leave the hospital against your treating physician's medical advice. Charges related to a service provided to you before you leave against medical advice may be denied. In that event, you will be financially responsible for the cost of those services.

Coordination of Benefits (COB) Information

Like most group health Plans, your Plan has a COB provision. This provision applies when a Participant is eligible for benefits under more than one health plan and ensures that the Participant's covered expenses will be paid, but that the combined payments of all the health care plans do not amount to more than 100% of Allowable Expenses under this Plan.

It is the responsibility of Participants to advise CommunityCare of their participation in any other health care plan. CommunityCare will request information from a Participant regarding duplicate health coverage upon initial enrollment and annually at the Plan's annual Open Enrollment Period. If you do not provide a response in the required time, the Plan benefits may be denied.

The Plan follows the rules described herein for determining the order in which benefits are to be paid. Participants do not have the option of choosing which health plan they wish to have pay benefits first.

For purposes of COB, the following terms have specific meanings:

Other Agreement means any arrangement providing health care benefits or services through:

- Group and nongroup insurance contracts and subscriber contracts;
- Uninsured arrangements of group or group-type coverage;
- Group and nongroup coverage through closed panel plans;
- Group-type contracts;
- The medical care components of long-term care contracts, such as skilled nursing care;
- The medical benefits coverage in automobile 'no fault' and traditional automobile 'fault' type contracts;
- Medicare or other governmental benefits, as permitted by law, except as provided in a state plan under Medicaid. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and
- Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

Other Agreement does not include:

- Hospital indemnity coverage benefits or fixed indemnity coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage;

- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a 'to and from school' basis;
- Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- A state plan under Medicaid; or
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan; or
- Disability income protection coverage.

Covered Service means a service or supply furnished by a hospital, physician, or Provider where benefits are provided under at least one agreement covering the person for whom the claim is made or service is provided.

Dependent additionally means a person who qualifies as a dependent under an Other Plan.

Primary Plan means the plan that pays benefits or provides services first under the Order of Benefit Determination Rules below.

Secondary Plan means any plan that is not a Primary Plan.

Order of Benefit Determination Rules

When the Plan is the Primary Plan, the Plan will determine the benefits payable without regard to any Other Plan.

When the Plan is the Secondary Plan, the benefits the Plan pays for Covered Services may be reduced and will not exceed the balance of charges remaining after the Primary Plan has paid. Although the Plan may be the Secondary Plan, the Participant must still follow the Plan's procedures related to coverage under the Plan. That means, for example, that the Participant must use Network Providers for routine care and, when necessary, obtain an authorization for specialty care, diagnostic tests and surgeries. The Participant may be held responsible for Plan Copayments, Coinsurance and Deductibles.

Claims should always be submitted to the Primary Plan first. When filing a claim for secondary benefits under the Plan with CommunityCare, be sure to send a copy of the "explanation of benefits" (EOB) you received from the Primary Plan, along with itemized statements of the services rendered for which the claim is made.

Claims cannot be processed without the primary EOB, itemized statements, and prior authorization by CommunityCare.

In Coordination of Benefits, the following rules determine the order of payment:

- The benefits of a health plan that does not contain a coordination of benefits provision is primary.

- When a person who received care is covered as an employee under one health plan, and as a Dependent under another health plan, then the employee coverage pays first.
- When a Dependent Child is covered under two health plans, the plan covering the Child as a Dependent of the parent whose birthday falls earliest in the calendar year pays first. (If one health plan does not follow the "birthday rule" provision, then the rule followed by that plan is used to determine the order of benefits.) However, when the Dependent Child's parents are separated or divorced, the following rules apply:
  - Regardless of which parent has custody, whenever a court decree specifies the parent whom is financially responsible for the Child's health care expenses, the coverage of that parent pays first.
  - If there is no court decree allocating responsibility for the Child's health care expenses:
    - And the custodial parent has re-married, the plan covering the custodial parent will be primary. Secondary coverage will be through the custodial parent's spouse, then the plan covering the non-custodial parent and finally the plan covering the non-custodial parent's spouse;
    - And the custodial parent has not re-married, the coverage of the parent with custody will be primary.
- When none of the above circumstances applies, the coverage the person has had for the longest time pays first, except for those group health plans that cover an individual as a laid-off or retired employee or as a Dependent of such person pays after a group health plan that covers that individual as other than a laid-off or retired employee or Dependent of such person.

In Order to Make This COB Provision Work Properly

Upon request, the Participant is required to furnish CommunityCare, on behalf of the Plan, complete information concerning all other health care plans that cover the person for whom the claim is made. If such information is not furnished after a reasonable time, the claim(s) for Plan benefits may be denied, subject to the Participant's rights under the Plan's Grievance and Appeal procedures.

After CommunityCare receives the necessary information to determine benefits under the Other Plans and establishes the order of benefit determination under the rules listed above, prior payments under this coverage will be adjusted accordingly (if the above rules require it).

If coverage under the Other Plan reduces the Participant's benefits because of payments he or she received under this coverage and the above rules do not allow such reduction, then the Plan will advance the remainder of benefits under this Plan as if the Participant's benefits had been determined in absence of any Other Plan. However, the Plan will be subrogated to all of the Participant's rights under the Other Plan. The Participant must furnish all information reasonably required by the Plan in this event, and the Participant must

cooperate and assist the Plan in the recovery of these sums from the Other Plan.

If the Other Plan later provides benefits to the Participant for which the Plan has made payments or advances under this COB provision, the Participant must hold all payments in trust for the Plan and must pay the amount to the Plan upon receipt.

If payment that should have been made by the Plan has been made under any Other Plan, the Plan, as the primary payer, will reimburse the Provider. This Provider payment will be considered as primary benefits paid by the Plan, and the Plan will be discharged from liability to the extent of the amounts paid for Covered Services.

If the Plan has paid benefits that result in payment in excess of the amount necessary to make this provision work properly, the Plan has the right to recover the excess payment from any person, any insurance company, or any other organization to which the payments were made. The Participant agrees to take reasonably necessary steps to secure the Plan's right to recover the excess payment.

The Plan will not be entitled to request a refund of all or a portion of any overpayment more than twenty-four (24) months after the payment was made, except: (1) when the overpayment is the result of fraud committed by the Plan Participant or health care Provider; or (2) when either the Plan Participant or health care Provider has otherwise agreed to refund the overpayment.

Medicare: If a Participant is a Medicare beneficiary, Medicare will be the Primary Plan, except when the Plan is legally required to be the Primary Plan.

Section VIII Grievance and Appeals Procedures

Introduction

The purpose of the Plan's Grievance and Appeal Procedure is to resolve grievances related to the performance of the Plan and its In-Network Providers, and to facilitate appeals, which are requests for reconsideration of adverse benefit determinations.You have the right to seek and obtain a full and fair review of each request for re-evaluation. Plan Participants must fully pursue the resolution of any grievance or denied claim using the Plan's administrative grievance and appeal process, as applicable, before pursuing independent external review or any other legal remedies in the following situations:

- The Plan or CommunityCare waives an internal appeal;
- Urgent care situations when an expedited external review may be initiated at the same time as an expedited internal appeal; or
- Failure to comply with all requirements of the internal appeals process except in cases where the violation was:
    - De minimis, non-prejudicial; attributable to good cause or matters beyond the Plan's or CommunityCare's c control; in the context of an ongoing good faith exchange or information; and not reflective of a pattern or practice of non-compliance.

For grievance and appeal procedures related to pharmacy claims, please call (855) 633-2579.

What are Grievances and Appeals

A ***grievance*** is also known as a complaint. It is an oral or written expression of concern or dissatisfaction regarding a service or procedure, whether medical or non-medical in

nature. Grievances may include complaints regarding the timeliness, appropriateness of, access to, and/or setting of a provided health service, procedure, or item.

If a Participant has a grievance, an initial attempt should be made to resolve it by communicating with CommunityCare's Customer Services. The phone number is located in the front of this handbook. In most cases, a satisfactory resolution to the grievance can be reached quickly in this manner. However, if a resolution cannot be reached, a formal written grievance can be submitted for review.

A ***formal grievance*** is a grievance that is expressed in writing. CommunityCare will investigate all formal grievances and respond in writing on behalf of the Plan. A grievance is not an appeal.

An ***appeal*** is a request for reconsideration of an adverse benefit determination, as defined below. In the case of a pre-service appeal regarding urgently needed care or treatment, the request may either be oral or in writing. If the appeal concerns non-emergent care or treatment (e.g., a standard pre-service review) or a review of claims (e.g., a post-service review), the appeal must be submitted in writing.

An ***adverse benefit determination*** is any of the following: a denial of benefits, a reduction in benefits, a termination of benefits, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is (1) based on a determination of an individual's eligibility to participate in the Plan; or (2) the result of the application of any utilization review decision, including a determination that the requested item or service is experimental, investigational or not Medically Necessary or appropriate. The term "adverse benefit determination" shall also include any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.) For this purpose, a "rescission of coverage" is a cancellation or discontinuance of coverage that has retroactive effect; provided, however, that a cancellation or discontinuance of coverage is not a rescission if: (1) the cancellation or discontinuance of coverage has only a prospective effect; or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An adverse benefit determination may also be referred to as a "denial" of service or payment.

How to File a Grievance or Appeal

A formal grievance or appeal must be submitted in writing by the Participant or the Participant's authorized representative on their behalf. The Provider is permitted to act as the Participant's authorized representative.

A ***formal grievance*** must be submitted in within 180 days of the occurrence that is the subject of the grievance, or the grievance will be denied as untimely.

A ***mandatory first level appeal*** must be submitted in writing within 180 days after you receive the original notification of an adverse benefit determination, or the appeal will be denied as untimely.

A ***voluntary second level of appeal*** must be submitted in writing within 60 days after you receive the decision following the first appeal, or the appeal will be denied as untimely.

An *authorized representative* is a person appointed to act on the Participant's behalf for a specific purpose. If you wish to appoint a representative for the purpose of filing an appeal or grievance, you must provide a signed statement appointing the representative and authorizing CommunityCare to release protected health information to the representative. You may request authorization forms by calling CommunityCare's Customer Services department at the number in the front of this handbook or download the forms from our website at http://fop.ccok.com/Forms/. Health information relating to the formal grievance or appeal may not be shared with your authorized representative until the required authorizations are received.

When submitting an appeal, the following information is needed: the Participant's name, identification number, address, telephone number, the nature of the request (including the date of service), practitioners involved, place of hospitalization and types of services, and/or procedures received, if applicable, and the desired resolution. Written comments, documents, records, and other information relating to the appeal must be included in the request. A detailed explanation as to why the Participant believes the issue in question qualifies for coverage and all information that supports the position is required. If the basis of the Participant's appeal requires reference to information contained in his or her medical records, the Participant is responsible for obtaining copies of those records and including them with his or her appeal. Failure to provide all pertinent documentation may affect the outcome of the appeal review.

You should submit a ***formal grievance*** or request for ***first level appeal*** **in writing** to:

Mail
CommunityCare
Attn: Grievance & Appeals
P.O. Box 3249
Tulsa, OK 74101

In Person
Williams Center Tower II
Two West Second Street
Suite 100
Tulsa, OK 74103

Facsimile
(918) 879-4048

CommunityCare's Customer Services department can answer your questions about the Grievance and Appeal processes. They can be reached at the number in the front of this handbook.

A request for ***second level appeal*** must be submitted in writing to:

National Medical Review
C/O Rooney Insurance Agency, Inc.
4700 S. Garnett Road, Suite 200
Tulsa, OK 74146
ATTN: Sandra Callahan

Formal Grievance Procedure

Within seven calendar days of the receipt of a Formal Grievance, CommunityCare will acknowledge the grievance on behalf of the Plan and request any additional information it determines is necessary. CommunityCare may also send a copy of the Formal grievance to each Provider named in the grievance and request a response.

When the investigation of the formal grievance is finished, the file and all information received from the Participant will be reviewed by CommunityCare's Quality Improvement /Administrative Review Committee. Upon completion, the Grievance and Appeals Coordinator will advise the Participant and/or the Provider in writing of the committee's determination and suggested action or resolution. This will occur within 60 days of receipt of the Formal Grievance.

First Level Appeal Process

When a first level appeal request is received, CommunityCare's Grievance and Appeals Coordinator will send an acknowledgement letter and request any additional information it determines is necessary within seven calendar days of receipt of the written appeal.

Timing of the Review Process

The timeframe in which a determination will be made is directly related to the type of appeal and the degree of urgency.

Urgent/Expedited Pre-Service Review

If applying the standard timeframe for making a determination could seriously jeopardize the Participant's life, health or ability to regain maximum function, the Participant or physician may request an expedited appeal. Expedited reconsiderations do not include requests involving claims payment.

In the case of an appeal that qualifies for expedited review, CommunityCare will verbally notify the Participant of the Plan's reconsideration as soon as possible, taking into account the medical severity, but not later than 72hours after receipt of the Participant's request for an expedited or urgent pre-service appeal. Written notification will follow within three calendar days of the decision.

Standard Pre-Service Review

In the case of a standard pre-service appeal, CommunityCare will notify the Participant of the Plan's reconsideration within a reasonable period of time appropriate to the medical circumstances. In general, notification is provided within 30 calendar days after the Plan's receipt of the appeal.

Standard Post-Service Review

In the case of a standard post-service appeal, CommunityCare will notify the Participant of the Plan's reconsideration within a reasonable period of time, but not later than 60 calendar days after the Plan's receipt of the Appeal.

Extensions

CommunityCare will consider all documentation and records you provide in making a full and fair review of your appeal. If the basis of your appeal requires reference to information contained in your medical records, you are responsible for obtaining copies of those records and including them with your appeal. If you are unable to respond to the requested information within the specified timeframes, you may voluntarily agree to provide the Plan additional time within which to make the appeal decision. In no event will an extension exceed a period of 45 days from the initial period.

First Level of Appeal

The Plan has a mandatory first level administrative appeal process conducted by CommunityCare internal committees that generally meet monthly.

When the initial investigation is finished, the file will be forwarded to CommunityCare's Quality Improvement/Administrative Review Committee. The committee will consider all comments, documents, records, and other information submitted in connection with the A=appeal, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not show partiality to the initial adverse benefit determination and will be conducted by an authorized and designated individual or group of individuals who is or are neither the individual(s) who made the original adverse benefit determination nor his or her subordinate(s).

During the appeal process, you have the right to: (1) submit written issues, comments, documents, records or any other matter relating to your claim; (2) have reasonable access to, and copies of, all documents, records, and other information relevant to your claim, at your request and free of charge; (3) receive any new or additional evidence considered or generated by the Plan in connection with the claim; and (4) receive any new or additional rationale on which an appeal decision is based.

If any new or additional evidence is received by the Plan so late that it would be impossible to provide it to you in time to have a reasonable opportunity to respond, the period for providing notice of the final adverse determination is tolled until such time as you have had a reasonable opportunity to respond. After you respond or have had a reasonable opportunity to do so, the Plan will notify you of the appeal determination as soon as reasonably possible under the circumstances.

If the Plan's original determination is based, in whole or in part, on a medical judgment that a particular treatment, drug, or other item, is experimental, investigational, or not Medically Necessary or appropriate, CommunityCare will, on review, consult with a health care professional with appropriate training and experience. Any health care professional engaged for these purposes will be an individual who is neither an individual consulted in connection with neither the initial adverse benefit determination nor his or her subordinate.

Upon request, CommunityCare will identify medical experts whose advice was obtained on CommunityCare's behalf in connection with an adverse benefit determination, without regard to whether the advice was used to make the benefit determination.

The Grievance and Appeals Coordinator will advise the Participant of the Plan's decision in writing. If applicable, the notification will include the availability of external review processes and/or other voluntary dispute resolution options.

If the first level determination is adverse, the notification will show the following:

- The date of service, health care, Provider, denial reason code and code meaning and claim amount if applicable.
- The discussion of the decision; the specific reason or reasons for the adverse determination including a reference to the Plan provision, guideline, protocol, or other rules upon which the decision was made. Upon request the Plan will make the specific information available to the Participant free of charge.
- If the denial is based on medical necessity or experimental treatment, a statement that you may receive an explanation of such denial.
- A statement that each Participant, upon request and free of charge, will be provided reasonable access to and copies of all documents, records, and other information relevant to his or her claim for benefits under appeal.
- The description of the external review process, explanation of how to initiate and time limits if applicable.
- Information on consumer assistance or Ombudsman programs to assist Participants with the external review processes or other voluntary dispute resolution options.

Please note that you must exhaust the Plan's claim and first level mandatory internal appeal process before you can initiate a second level voluntary appeal or external review, or seek other remedies related to a claim denial.

Second Level Appeal Process

The Plan has a voluntary second level administrative appeal process conducted by National Medical Review.

You are *not* required to follow this second level **voluntary** appeal process before you can initiate an external review or seek other remedies related to a claim denial.

Request for Second Level Appeal. If you are not satisfied with the decision following the **mandatory** first level appeal, you may appeal the denial a second time within 60 days after you receive the decision following the first appeal.

You have the right to submit written issues, comments, documents, records or any other pertinent information explaining why you believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.

The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit determination. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

If the benefit denial was based, in whole or part, on a medical judgment that a particular treatment, drug, or other item is experimental, investigational, or not medically necessary, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan consulted with medical or vocational experts in connection with the claim, these experts will be identified upon your request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.

After the claim has been reviewed, you will receive written notification letting you know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to you. The notification will provide you with the adverse benefit determination information described above.

Regarding this **voluntary** appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this **voluntary** appeal process. The **voluntary** appeal process is available only after you have followed the first level **mandatory** appeal level as required above. The Plan also agrees that it will not charge you a fee for going through the **voluntary** appeal process, and it will not assert a failure to exhaust administrative remedies if you elect to pursue a claim in court before following this **voluntary** appeal process. Your decision about whether to submit a benefit dispute through the **voluntary** appeal level will have no effect on your rights to any other benefits under the Plan.

External Review Process

The Plan also provides an opportunity to request an external review of certain claim denials that have been upheld during the first and second level appeal process. The external review is performed by an independent review organization (IRO). You must exhaust the Plan's first level mandatory claim and appeal process before commencing an external review (except as provided in the section below titled "Expedited External Review").

Currently, external review is only available for:

- a claim denial that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or its determination that a treatment is Experimental or

investigational), as determined by the external reviewer;
- whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity Act and its implementing regulations;
- determinations relating to a surprise medical bill or surprise air ambulance bill under rules intended to protect consumers from certain surprise medical bills under the No Surprises Act; and
- a rescission (retroactive termination) of coverage (whether or not the rescission has any effect on any particular benefit at that time).

This means that an external review will not be available for all types of claims. For example, an external review is not available for review of a denial, reduction, termination or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the Plan. However, the Plan Administrator has the discretionary authority to approve an external review request that may not otherwise meet this criteria.

Standard External Review

This section sets forth the procedures for a standard external review under the Plan. A standard external review is an external review that is not considered expedited (as described below under "Expedited External Review").

Request for External Review. A claimant may request an external review with the Plan through CommunityCare if the request is filed within four months after the date of the claimant's receipt of a notice of a claim denial following the exhaustion of the internal appeal process (an "appealable internal claim denial"). If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the claimant's receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

A request for an external review must be submitted in writing to:

If sending the request by regular or certified mail, send to: CommunityCare, Attn: Grievance and Appeals Department, P. O. Box 3249, Tulsa, OK 74101. If submitting the request in person, submit to: CommunityCare, Attn: Grievance and Appeals Department, Williams Center Tower II, Two West Second Street, Suite 100, Tulsa, OK 74103.

Preliminary Review. Within five business days following the date of receipt of the external review request, CommunityCare will complete a preliminary review of the request to determine whether:

- the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the

health care item or service was provided;
- the appealable internal claim denial does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- the claimant has exhausted the Plan's internal appeal process (or is not required to exhaust the internal appeals process); and
- the claimant has provided all the information and forms required to process an external review.

Within one business day after completing its preliminary review, CommunityCare will issue a written notice to the claimant. If the request is complete, but not eligible for external review, the notice will include the reasons for its ineligibility. If the request is not complete, the notice will describe the information or materials needed to make the request complete, and CommunityCare will allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notice, whichever is later.

Referral to Independent Review Organization. CommunityCare will assign an IRO that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Within five business days after the request is assigned to the IRO, CommunityCare will provide to the assigned IRO the documents and any information the Plan considered in making the appealable internal claim denial.

Determination by Independent Review Organization. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO, within ten business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the claimant, the assigned IRO will, within one business day, forward the information to CommunityCare. Upon receipt of any such information, CommunityCare may reconsider its appealable internal claim denial that is the subject of the external review. Reconsideration by CommunityCare will not delay the external review. The external review may be terminated as a result of the reconsideration only if CommunityCare decides, upon completion of its reconsideration, to reverse its appealable internal claim denial and provide coverage or payment. Within one business day after making such a decision, CommunityCare will provide written notice of its decision to the claimant and the assigned IRO.

The assigned IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. In addition to the

documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- the claimant's medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and other documents submitted by the Plan Administrator, the claimant, or the claimant's treating provider;
- the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- the opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of the final external review decision to the claimant and the Plan Administrator (or its designee) within 45 days after the IRO receives the request for the external review. The IRO's determination is binding unless other remedies are available to the Plan or claimant under state or federal law.

Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the appealable internal claim denial (if applicable), the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim under review.

Expedited External Review

A claimant may request an expedited external review at the time the claimant receives:

- A claim denial (prior to exhaustion of the internal appeal process) if the denial involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- An appealable internal claim denial (i.e., a claim denial following the exhaustion of the internal appeal process), if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the appealable internal claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant

received emergency services, but has not been discharged from a facility.

A request for an expedited external review must be submitted in writing. If sending the request by regular or certified mail, send to: CommunityCare, Attn: Grievance and Appeals Department, P. O. Box 3249, Tulsa, OK 74101. If submitting the request in person, submit to: CommunityCare, Attn: Grievance and Appeals Department, Williams Center Tower II, Two West Second Street, Suite 100, Tulsa, OK 74103. If sending the request by fax, to: (918) 879-4048.

Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, CommunityCare will assign an IRO. CommunityCare will provide or transmit all necessary documents and information considered in making the claim decision to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for a standard external review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.

Notice of Final External Review Decision. The assigned IRO will provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the assigned IRO receives the request for an expedited external review. If that notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan Administrator. The assigned IRO's determination is binding unless other remedies are available to the Plan or claimant under state or federal law.

Eligibility, Enrollment and Termination Summary

Eligibility

Eligibility for participation in the Plan for an "Employee" or "Retiree" is based on information received by the Plan Administrator from your Employer. **To be eligible to enroll in the Plan, you and your Spouse must live or work in CommunityCare's approved service area.**

Employee Benefits

Employee

You are eligible for coverage described in the Plan if you are in an eligible class. You are in an eligible class, if: (1) you were hired as a permanent, full-time sworn Employee of the Tulsa Police Department; (2) you are the Chief of Police; or (3) you are an Employee entering the police academy.

You become eligible on your "Eligibility Date", which is the first of the month

coincident with or next following the date you complete 30 days of continuous service for your Employer. Employees entering the police academy who are eligible for the City of Tulsa's employee benefit plan(s) will not need to meet the Plan's eligibility waiting period, and the "Eligibility Date" will be the first of the month coincident with or next following the date the Employee enters the police academy program.

Your coverage becomes effective on your Eligibility Date.

Employee and Dependents

Your eligible "Dependents" (described below) may be covered under the Plan:

- Your "Spouse" means any person who is lawfully married to you under any State law, including marriages recognized in States other than where the covered person resides. *The Plan Administrator may require documentation proving a legal marital relationship.*
- Your "Child(ren)" to age 26. Children includes (1) your own biological children; (2) stepchildren, if you live with the child(ren) and his/her/their custodial parent; and (3) other child(ren) who live with you in a parent child relationship and who depend on you for financial support and maintenance. Other child(ren) includes, but is not limited to: foster child(ren), adopted child(ren), or child(ren) "placed with you for adoption", and grandchild(ren) of whom you have been awarded custody or guardianship by a court or agency of competent jurisdiction. Stepchildren and other child(ren) who do not live with you are eligible if a court or agency of competent jurisdiction has placed responsibility with you for relevant expenses. *A copy of a court order or a birth record may be required to demonstrate eligibility.*

  Child(ren) "placed with you for adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such adoption or placement. The term "placed" means assumption and retention by

  you of a legal obligation for total or partial support of the Child in anticipation for adoption of the Child. The Child must be available for adoption and the legal process must have commenced.
- A Dependent also includes your unmarried fully handicapped Child beyond age 26 subject to the following:
  - The Child must have been covered under the Plan immediately prior to reaching age 26 and have been unable to earn his or her own living prior to reaching age 26 because he or she is mentally or physically handicapped and depends on you for financial support. The employee must provide over one-half of the Child's support for the calendar year.
  - The Employee must provide written proof of incapacity and dependency to the Plan Administrator within the 31-day period beginning on the date the Child reaches age 26. *The Plan Administrator may require subsequent proof at reasonable intervals thereafter.*
  - If an individual who is covered as a Dependent under this provision terminates Dependent coverage, he or she will not be eligible to again become covered as a Dependent unless he or she furnishes written proof, for the period of non-coverage of: (i) continuous coverage under other medical insurance coverage; (ii) incapacity; and (iii) dependency on the Employee.

Court Ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your Child(ren). The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under the Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under the Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this provision will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible child under the Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

When You and Your Spouse Are Both Covered Employees

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or Dependent. You may not be covered under the Plan as both an Employee and a Dependent.

Employee Contributions

Cost of coverage is funded in part by your Employer's contributions and in part by your contributions. Active Employee Participant contributions to the cost of coverage under the Plan must be made by payroll withholding, except for Participants who are on unpaid leave. You will need to sign a payroll deduction authorization form to authorize your Employer to make the necessary deduction. You may have your share of the premiums deducted from your paycheck on a pre-tax basis pursuant to the terms of your Employer's Cafeteria Plan. Specific information about the amount you must pay toward your Plan premium will be provided to you before you enroll in the Plan, whether you enroll during your initial enrollment period, during an Open Enrollment Period or under the special enrollment rules.

Enrollment Procedures for Employee and Dependents Coverage

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days after satisfaction of the eligibility

requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to notify your Employer to deduct the required contribution from your pay. *In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your enrolled Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.*

If you fail to complete and submit the appropriate election and enrollment forms within the 30- day period described above, you will not be eligible to enroll in the Plan until the next Open Enrollment Period or unless you experience a Special Enrollment Event or a Status Change Event (described below). Also, see Newborn Children (described below).

Newborn Children

If you have a newborn Child while covered under the Plan, then the following applies:

- If you are enrolled under individual only coverage, you may add coverage for a newborn effective on the Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) to the Plan Administrator within 30 days of the Child's date of birth.
- If you are enrolled under family coverage, no additional contribution is required to add coverage for a newborn and coverage for the newborn will be effective on the Child's date of birth. However, you must notify the Plan in writing of the Child's birth (please submit the election and enrollment forms to the Plan Administrator within 30 days of the Child's date of birth) to avoid any claim delays. If you chose to decline enrollment for the newborn, you should provide a statement to the Plan Administrator indicating the reason you are declining enrollment. If you declined enrollment for the newborn due to other health coverage, if the Child loses such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you a right to enroll the Child in the Plan mid-year due to such loss of coverage.

A contribution will be charged from the first day of coverage for the newborn if an additional contribution is required.

Open Enrollment Period

You and your Dependents may enroll for coverage during the Plan's Open Enrollment Period, designated by the Plan Sponsor and communicated to you prior to such Open Enrollment Period. During this time, you will be permitted to make changes to any existing benefit elections. Benefit elections made during the Open Enrollment Period will be effective as of July 1st and will remain in effect until the next Open Enrollment Period unless you or your Dependent experiences a Special Enrollment Event or Status Change Event.

Special Enrollment Event

A Special Enrollment Event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption (described below):

- Loss of Other Coverage (other than under Medicaid or SCHIP). If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or a tribal organization), you may enroll for coverage for yourself and/or your Dependents under the Plan if the other coverage is lost as a result one of the following:
    - The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;
    - Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or
    - Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the Special Enrollment Event of your Dependent.

You must submit the appropriate election and enrollment forms, including a payroll deduction authorization, if applicable, to the Plan Administrator within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date your election and enrollment forms are received by the Plan Administrator.

- Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy. If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under the Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms (including a payroll deduction authorization if appropriate) to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under

Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date your election and enrollment forms are received by the Plan Administrator.

Administrative Ruling: Effective 11/7/2022

Tricare and SoonerCare members may be added retroactively to the Plan upon submission of documentation that they were terminated from coverage but did not receive proper documentation within the normal qualifying event election time frame.

When documentation is presented that the member received Proof of Loss of Coverage late, and through no fault of their own, Trust administrators may add eligible members and their eligible family members back to the date they were originally eligible, provided member agrees to pay their back premiums, and your Employer agrees to fund their portion per the CBA.

- If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under the Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date you acquire such Dependent.
    - Coverage becomes effective for a newly acquired Dependent due to birth of a Child as of such Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the Child's birth. Failure to enroll in the Plan within this 30-day period will result in no coverage under the Plan.
    - Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after your date of marriage. Failure to enroll in the Plan within this 30-day period described above will result in no coverage under the Plan.
    - Coverage for a newly acquired Dependent due to adoption (or placement for adoption) will be effective as of the date of adoption (or placement for adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement for adoption, as applicable. Failure to enroll in the Plan within this 30-day period described above will result in no coverage under the Plan.

Status Change Event

Generally, your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a "Status Change Event". If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with

the Status Change Event. A Status Change Event includes the following:

- A change in your legal marital status, including divorce, legal separation or annulment;
- The death of your Spouse or Dependent Child;
- Termination or commencement of employment by you, your Spouse or your Dependent child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- A reduction or increase in your hours of employment or those of your Spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;
- A change in the place of residence or work of you, your Spouse or your Dependent Child;
  Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;
- Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;
- A change due to you, your Spouse or your Dependent Child gaining coverage under another employer's plan;
- A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (1) maintain existing coverage and agree to pay the increased cost; (2) revoke your existing election and elect similar coverage under another Plan option (if any); or (3) drop coverage under the Plan, but only if there is no similar option available under the Plan;
  Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;
- Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;
- Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example,

elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and

- Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms (including a payroll deduction authorization if applicable) to the Plan Administrator within 30 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month following the date your election and enrollment forms are received by the Plan Administrator.

Retiree Benefits

Retiree

Individuals who meet at least one of the following requirements will be eligible to continue current benefit elections for Retiree coverage under the Plan:

- You must be a member of the Trust at the time of retirement; *and*
  - Must have at least 10 years with the City of Tulsa Police Department; *and*
  - Must have at least 20 years with the Oklahoma Police Pension and Retirement System (OPPRS); *or*
- You must be a member of the Trust at the time you become medically retired through OPPRS due to an injury in the line of duty with the City of Tulsa Police Department.

Optional Medicare Advantage Plans. In addition, the Trust offers various Medicare Advantage Plan options for Medicare eligible Retirees. If a Retiree leaves the Plan and enrolls in a Medicare Advantage Plan option, then the Retiree shall not be eligible to re-enroll in the Plan at a later date. However, if a Retiree enrolls in a Medicare Advantage Plan option and leaves the Medicare Advantage Plan, then the Retiree shall be eligible to enroll in a Medicare Advantage Plan option offered by the Trust at a later date according to Medicare eligibility rules. In addition, the Clinic Access/CCOK Senior Health Plan options are subject to the Plan eligibility rules.

You are eligible to continue your coverage under the Plan until you become Medicare eligible on the non-Medicare rate tiers. When Medicare (Medicare Part A and/or Part B) benefits are not available, you may remain on the non-Medicare rate tiers until you do qualify for Medicare. If

you do not maintain *continuous* coverage under the Plan after your retirement date or deferred retirement termination date you will lose eligibility. Retirees who become Medicare eligible and have Medicare Parts A and B may continue their coverage under the Plan as their secondary coverage. Coverage may be elected as either *Medical and RX* or *Medical Only*. These Plan options have their own rates and are only available to retired police officers at the single rate. Additionally, members may remain on this health plan with family coverage in the non-Medicare retiree rate tiers if they activate Parts A and B of Medicare and the Trust then becomes secondary for the member that has Medicare.

Retirees who do not maintain *continuous* coverage under the Plan shall not be eligible for Plan re-entry at a later date.

A special eligibility rule for specifically identified Tulsa Police Department Retirees who were employed with the Employer as of December 1, 2007, and who had not yet accumulated five years of service with the Employer. If these named Employees retired from the Employer with less than five years of service, they would be allowed to elect Retiree benefits from the Plan. Once these named Employees had accumulated five years of service with the Employer, they would no longer be eligible for Retiree benefits from the Plan per this rule.

Retiree and Dependents

Spouses and Child(ren) to age 26 may be covered under the Health, Dental and Vision Plans, including your unmarried handicapped Child as described above under ***Employee and Dependents***.

Optional Medicare Advantage Plans. In addition, the Trust offers various Medicare Advantage Plan options for Medicare eligible Spouses. If a Spouse enrolls in a Medicare Advantage Plan option and leaves the Medicare Advantage Plan, then the Spouse shall be eligible to enroll in a Medicare Advantage Plan option offered by the Trust at a later date according to Medicare eligibility rules. In addition, the Clinic Access/CCOK Senior Health Plan options are subject to the Plan eligibility rules.

Your Spouse may continue coverage under the Plan until your Spouse becomes Medicare eligible on the non-Medicare rate tiers, except when Medicare (Medicare Part A and/or Part B) benefits are not available, in which case your Spouse may remain on the non-Medicare tier rates until your Spouse qualifies for Medicare. Retiree Spouses who become Medicare eligible and have Medicare Parts A and B may continue their coverage under the Plan as their secondary coverage. Coverage may be elected as either *Medical and RX* or *Medical Only*. These Plan options have their own rates and are only available to the Medicare eligible Spouse. Continuing Dependent(s) who are not Medicare eligible will be

covered under the non-Medicare rate tiers. Additionally, if Retiree remains on this health plan with family coverage in the non-Medicare Retiree rate tiers as their secondary coverage, spouse and dependents may remain on the family non-Medicare rate tier with the retiree

Retiree Contributions

Cost of coverage is funded in part by Trust subsidies and in part by Retiree contributions.

Optional Medicare Advantage Coverage. CCOK Senior Health Plan Options-Retirees pay 100% of their premiums. Clinic Access/CCOK Senior Health Plan Options-Cost of Clinic Access Clinic Access is funded in part by Trust subsidies and in part by Retiree contributions, however Retirees pay 100% of their CCOK Senior Health Plan Premiums.

Retiree contributions to the cost of coverage under the Plan are required to be made by the first day of each month or pursuant to another schedule agreed upon in advance by the Retiree and the Plan Administrator and must be made by check, money order, debit or credit card or electronic funds transfer (EFT) unless agreed upon in advance by the Retiree and the Plan Administrator.

Enrollment Procedures for Retiree Coverage

Election to continue Retiree coverage under the Plan must be made within 30 days of your retirement date. If you do not elect to continue Retiree coverage under the Plan during this 30-day period, you are not eligible to enroll in Retiree coverage at a later date. The Open Enrollment Period and Special Enrollment Events (described above) do not entitle a Retiree to enroll in the Plan; however, they do allow a Retiree to add Dependents, as applicable, to his or her Retiree health coverage.

At the time of retirement, you may elect to enroll in COBRA Continuation Coverage in lieu of Retiree coverage. If you elect COBRA Continuation Coverage in lieu of Retiree coverage for yourself and any eligible Dependents or if you fail to make any election under the Plan, you and/or your Dependents will not be eligible to enroll in the Retiree coverage under the Plan at a later date, except as described above during the Open Enrollment Period or unless you experience a Special Enrollment Event or a Status Change Event (described in the Plan). If, however, you elect Retiree coverage in lieu of COBRA Continuation Coverage, the Retiree coverage under the Plan will be treated as alternative coverage and you will not be eligible to continue under COBRA once Retiree coverage under the Plan has ended. Provided however, if any of your eligible Dependents would lose Retiree coverage as a result of a COBRA qualifying event (such as divorce or Child ceases to be a Dependent Child) that Dependent would be eligible to continue under COBRA once Retiree coverage under the Plan has ended.

(*See COBRA Continuation Coverage in this Section.)* Provided however, if any of your eligible Dependents would lose Retiree coverage as a result of a COBRA qualifying event (such as divorce or Child ceases to be a Dependent Child) that Dependent would be eligible to continue under COBRA once Retiree coverage under the Plan has ended. (*See COBRA Continuation Coverage in this Section.)*

If you decide to enroll yourself and your eligible Dependents in Retiree coverage, you must enroll by completing all required election and enrollment forms and submitting them to the Plan Administrator within 30 days after your retirement date. Participation in the Plan will begin for you and your eligible Dependents as of your date of retirement provided all required election and enrollment forms are properly submitted to the Plan Administrator. You are required to pay the entire cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by the Plan Sponsor. The amount of any required contribution will be communicated to you prior to the date of your retirement.

If you decide to terminate your Retiree coverage when you become Medicare eligible, your covered Dependents may continue their Retiree coverage. Your Dependent(s) who retains the coverage will be subject to the same rules, rates, and administrative procedures as those Participants covered by COBRA, except for COBRA insurance retention time limit.

Survivor Benefits

Survivor Benefits for Employees

In the event of death of a covered Employee, the eligible Dependent(s) will be allowed to retain continuous coverage under the Plan until the earlier of the following:

- The date the Dependent fails to satisfy the eligibility requirements for coverage under the Plan;
- The date your surviving Spouse becomes Medicare eligible, except when Medicare (Medicare Part A and/or Part B) benefits are not available, in which case they may remain on the Plan until they qualify for Medicare*; or
- The date the monthly premium is not paid.

**Survivor Spouses who become Medicare eligible and have Medicare Parts A and B may continue their coverage under the Plan as secondary coverage. Coverage may be elected as either Medical and RX or Medical only. These Plan options have their own rates and are only available to the Medicare eligible Spouse. Continuing Dependent(s) who are not Medicare eligible will be covered under the non-Medicare rate tiers. Additionally, surviving spouses may remain on this health plan with family coverage in the non-Medicare Spouse Continuee rate tiers if they activate Parts A and B of Medicare and the Trust then becomes secondary for the Surviving Spouse that has Medicare.*

Survivor Benefits for Retirees

If you (the Retiree) die while enrolled in Retiree coverage under the Plan, your covered surviving Dependent(s) may elect to continue Retiree coverage until the earlier of the following:

- The date the Dependent fails to satisfy the eligibility requirements for coverage under the Plan;
- The date your surviving Spouse becomes Medicare eligible, except when Medicare (Medicare Part A and/or Part B) benefits are not available, in which case they may remain on the Plan until they qualify for Medicare*; or
- The date the monthly premium is not paid.

**Survivor Spouses who become eligible for Medicare and have Medicare Parts A and B may continue their coverage under the Plan as secondary coverage. Coverage may be elected as either Medical and RX or Medical only. These Plan options have their own rates and are only available to the Medicare eligible Spouse. Continuing Dependent(s) who are not Medicare eligible will be covered under the non-Medicare rate tiers. Additionally, surviving spouses may remain on this health plan with family coverage in the non-Medicare Spouse Continuee rate tiers if they activate Parts A and B of Medicare and the Trust then becomes secondary for the Surviving Spouse that has Medicare.*

Enrollment Procedures for Survivor Coverage

If your surviving Spouse and/or any eligible surviving Dependents decide to continue their enrollment in coverage (including Retiree coverage) under the Plan, they must enroll by completing all required election and enrollment forms and submitting them to the Plan Administrator within 30 days after the date of your death. Survivor coverage will begin for your Spouse and any eligible surviving Dependents as of the date of your death provided all required election and enrollment forms are properly submitted to the Plan Administrator. The cost of Plan coverage (including Retiree coverage) under this survivor benefit will be communicated to your surviving Dependents by the Plan Administrator. Surviving Dependents (including surviving Dependents of Retirees) who retain their coverage will be subject to the same rules, rates and administrative procedures as those who are covered by COBRA Continuation Coverage, except for the COBRA Continuation Coverage insurance retention time limit. The surviving Spouse becomes the Retiree upon the death of the Retiree and is subject to the same limitations as the Retiree concerning termination of coverage. **If the surviving Spouse and/or any surviving Dependents leaves the Plan, he or she is not allowed to re-enroll at a later date.**

At the time of your death, your surviving Dependents may elect COBRA Continuation Coverage in lieu

of Plan coverage (including Retiree coverage). If any of your surviving Dependents elect COBRA Continuation Coverage in lieu of Plan coverage (including Retiree coverage) available under this survivor benefit, they will not be eligible to enroll in the Plan at a later date. If, however, they elect to continue Plan coverage (including Retiree coverage) under this survivor benefit in lieu of COBRA Continuation Coverage, the coverage (including Retiree coverage) available under this survivor benefit will be treated as alternative coverage and they will not be eligible to continue coverage under COBRA once Plan coverage available under this survivor benefit has ended. Provided however, if your surviving Dependent Child would lose survivor benefits as a result of a COBRA qualifying event (such as Child ceases to a Dependent Child) the Dependent Child would be eligible to continue coverage under COBRA once Plan coverage available under this survivor

benefit has ended. (*See COBRA Continuation Coverage in this Section.)*

Survivor Contributions

Surviving Participants pay 100% of their premiums. Survivor contributions to the cost of coverage under the Plan are required to be made by the first day of each month or pursuant to another schedule agreed upon in advance by the Surviving Participant and the Plan Administrator and must be made by check, money order, debit or credit card or electronic funds transfer (EFT) unless agreed upon in advance by the Surviving Participant and the Plan Administrator.

Plan Identification Cards

After you enroll in the Plan, you will receive an identification card that includes specific information about your coverage under the Plan. In addition, the identification card includes the phone number you should call to obtain pre-authorization when required. You should present the identification card any time you obtain medical services or fill a prescription. If you lose your card, you can contact CommunityCare Customer Services for your coverage option to request a replacement card.

Participants Must Provide Requested Information

Covered persons must provide the Plan Administrator (or Rooney Insurance, as applicable for Cobra continuation coverage) all information necessary to administer the Plan and to process claims (including but not limited to Dependent verification). If an individual (including an Employee or Dependent) or a person seeking coverage on behalf of such individual fails to provide requested information, submits false or inaccurate information or is otherwise determined to be ineligible for coverage under the Plan, the Plan Administrator may cause such individual and all members of his or her family unit to forfeit all rights to participate in the Plan. If an individual or a person seeking coverage on behalf of such individual performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, the Plan Administrator may: (1) terminate any and all existing coverage with respect to such individual and all members of his family unit

effective as of the last date that such individual was eligible for coverage; and (2) recover any payments made under the Plan during the period that such individual was ineligible for coverage under the Plan. The Plan must provide at least 30 days advance written notice to each affected Participant before a retroactive termination of coverage.

Notification of Changes in Eligibility

You (the Employee, Retiree or Surviving Dependent) must notify the Plan Administrator of any change that affects your or any of your Dependent's eligibility for coverage. You are financially responsible for any services obtained during any period in which you or your Dependents are ineligible for coverage under the Plan, and must reimburse the Plan for the cost of any such services to the extent the Plan has made payment.

Leaves of Absence

In the event of an Employee leave of absence (described below), the Plan will follow your Employer's determination of your employed/active and approved leave of absence status.

Family and Medical Leave

If you begin a leave of absence with your Employer that qualifies under the Family and Medical Leave Act of 1993 (FMLA), you can elect to continue your existing Plan coverage for up to 12 weeks (up to 26 weeks for military care givers) at the same premium applicable to active Employees. If you choose to continue coverage during your absence, you and your Dependents will be covered under the Plan while you are absent from work. The coverage will continue as if you were actively working until the earlier of the expiration of your FMLA leave or the last day of the month in which you give notice to your Employer that you will not return from your leave.

If you elect to continue coverage while on FMLA Leave which is unpaid leave, you will be required to continue to pay your portion of the premium in accordance with a schedule established by the Plan Administrator. If you fail to make the required payment within 30 days after payment is due, your continued coverage will terminate automatically, effective as of the last day of the month for which the last payment was made, and cannot be reinstated while you remain on leave. If your FMLA leave is paid leave, contributions will be made by salary reduction on the same basis as if you were actively working.

If you have elected to continue coverage while on FMLA leave, and then exhaust your FMLA leave and immediately begin approved non-FMLA leave, you will be permitted, for the duration of that leave, to make premium contributions in the same amount as if you were not on leave. If the Non-FMLA Leave is paid leave, contributions will be made by salary reduction on the same basis as if you were actively working. If Non-FMLA leave is unpaid leave, premium payments will be due on the first day of each month to the Plan Administrator.

You may also choose to suspend coverage while you are on FMLA leave. If you choose to suspend coverage during your absence or if your coverage otherwise

terminates, you may choose to reinstate your coverage upon your return to work **Please note** that your election to reinstate your coverage must be made within the 31-day period beginning on the date of your return from FMLA leave.

Non-Family and Medical Leave (Other Approved Leave)

If you begin a personal leave of absence or other approved leave that does not qualify as Family and Medical Leave, you may continue coverage under the Plan for the duration of such leave, provided there has been no termination of employment. During the paid portion of the leave, if any, you can continue coverage at the same

premium applicable to active Employees, with payment to be made by salary reduction on the same basis as if you were actively working. During the unpaid portion of the leave, you will be responsible for paying your portion of the premium associated with your personal and Dependent coverage in accordance with a schedule established by the Plan Administrator. If you fail to make a required premium payment within 30 days after payment is due, your personal and Dependent coverage will terminate as of the last day of the month for which the last payment was made.

If your personal and/or Dependent coverage under the Plan terminates during non-FMLA leave, you will, upon return from non-FMLA leave, again become eligible to participate in the Plan on the terms applicable to an active Employee and will be permitted to choose to be reinstated in the Plan on the same terms as prior to taking non-FMLA leave, subject to any applicable terms and conditions of your Employer's Cafeteria Plan. **Please note** that your election to reinstate your coverage must be made within the 31-day period beginning on the date of your return from non-FMLA leave.

Military Leave

There are specific rules that apply to an Employee who takes a leave of absence for military service under the Uniform Services Employment and Reemployment Rights Act (USERRA). You should contact Rooney Insurance if you will be taking a military leave of absence.

Termination of Coverage

Termination of Employee Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- The date the Plan terminates, in whole or in part;
- If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA);
- The end of the month in which you cease to be eligible for coverage under the Plan;
- The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;
- The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; or

- The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- The date the Plan terminates, in whole or in part;
- The date the Plan discontinues coverage for Dependents;
- The date your Dependent Spouse becomes covered as an Employee under the Plan;
- The date coverage terminates for the Employee;
- If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- The date your Dependent Spouse reports to active military service;
- The end of the month in which your Dependent ceases to be a Dependent as defined by the Plan;
- The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; or
- The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Termination of Retiree Coverage

Coverage under the Plan will terminate for you and any Dependents on the earliest of the following dates:

- The date in which a required contribution has not been paid;
- The date the Plan terminates or no longer provides Retiree coverage;
- The date in which a Dependent no longer satisfies the eligibility requirements as a Dependent under the terms of the Plan;
- The Plan terminates as primary coverage and becomes secondary to Medicare on the date you or your eligible Spouse becomes Medicare eligible;
- The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) performs an act, practice or omission that constitutes fraud; or
- The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively

terminated in cases where required Employee contributions have not been paid by the applicable deadline.

Reinstatement of Coverage

If your coverage ends due to termination of employment, leave of absence, or reduction of hours, and you qualify for eligibility under the Plan again (you are reinstated with the Employer) within one (1) year of your date of separation, your coverage will be reinstated effective on your "Reinstatement Date" if you enroll for coverage within 30 days after satisfaction of the eligibility requirements.

COBRA Continuation Coverage

Important information is provided below about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **The following information contains a summary of the Plan's provisions for COBRA continuation coverage, when it may be available to Employees and certain of their covered family members, and what must be done to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). To the extent required by this law and as described in this summary, COBRA continuation coverage can become available to an Employee and his or her covered Spouse and Dependent children when group health plan coverage would otherwise be lost due to certain "qualifying events" described below. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this summary should be interpreted accordingly. Both you (the Employee) and your Spouse should read this summary carefully and keep it with your records.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day Special Enrollment Period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

This summary does not fully describe continuation coverage or other rights under the Plan. More complete information regarding such rights is available from Rooney Insurance (which provides COBRA-related administrative services for the Plan).

What is COBRA Continuation Coverage?

COBRA continuation coverage is the same coverage that the Plan gives to similarly situated Participants or beneficiaries under the Plan who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage generally will have the same rights under the Plan as other Participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights. In addition, Plan changes for similarly

situated non-COBRA beneficiaries can also apply to COBRA qualified beneficiaries.

After a "qualifying event", COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." An Employee, his or her Spouse and his or her Dependent Children (including a Child covered due to a qualified medical child support order) can be qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for their coverage.

Qualified beneficiaries (including those who are not former Employees) may add Dependents to their COBRA continuation coverage in the same manner as active Employees. These Dependents are generally not qualified beneficiaries and are thus not entitled to make separate continuation coverage elections. Furthermore, coverage for these Dependents will terminate no later than the date the qualified beneficiary's coverage terminates.

COBRA rights in addition to those described under this heading may apply to certain Employees under a Federal law called the Trade Act of 2002 ("Trade Act"). Certain Employees who have experienced a termination of employment or reduction in work hours with the Employer and who qualify for "trade readjustment allowance" or "alternative trade adjustment assistance" may qualify for additional COBRA rights under the Trade Act, including a second COBRA election period if COBRA was not elected when first available. Contact Rooney Insurance at (918) 878-3425 for more information or if you qualify for assistance under the Trade Act.

What are Qualifying Events?

If you are an ***Employee*** of the Employer and are covered by the Plan, you will become a qualified beneficiary if you lose coverage under the Plan because of either of the following two "qualifying events":

- Termination of your employment (for reasons other than gross misconduct); or
- Reduction in the hours of your employment.

If you are the ***Spouse*** of an Employee covered by the Plan, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following four "qualifying events":

- The death of your Spouse;
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Employer:
- Divorce or legal separation from your spouse. (Also, if an Employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the later divorce or legal separation and can establish that the

coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.); or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both).

In the case of a ***Dependent Child*** of an Employee covered by the Plan, the Dependent Child will become a qualified beneficiary if coverage under the Plan is lost because of any of the following five "qualifying events":

- The death of the Employee-parent;
- The termination of the Employee-parent's employment (for reasons other than gross misconduct) or reduction in the Employee-parent's hours of employment with the Employer;
- Parents' divorce or legal separation;
- The Employee-parent becomes entitled to Medicare benefits (under Part A, Part B or both); or
- The Dependent ceases to be eligible for coverage under the Plan as a "Dependent Child".

For retired Employees who are covered under the Plan, and their Dependents, the term "qualifying event" also includes the loss of coverage under the Plan due to the Employer filing for bankruptcy under Title 11 of the United States Code.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator (which has been designated by the Plan Administrator to receive COBRA-related notices) has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction of hours of employment, death of the Employee, filing of a proceeding in bankruptcy by your Employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the Employer must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child ceasing to be an eligible Dependent Child), you or the qualified beneficiary must notify the COBRA Administrator within 60 days after the later of: (1) the date of the qualifying event, or (2) the date the qualified beneficiary would lose coverage due to the qualifying event. **If this notice deadline is not met, the notice will be rejected as untimely and the right to COBRA continuation coverage will be lost. See the Notice Requirements and Procedures below for how you must notify the COBRA Administrator of a qualifying event.**

If the COBRA Administrator is timely provided with notice of a divorce, legal separation, or a Child's losing Dependent status that has caused a loss of coverage, then the COBRA Administrator will notify the qualified beneficiary of the right to elect continuation coverage (but only to the extent that the COBRA Administrator has been notified in writing of the qualified

beneficiary's current mailing address – see the section below titled "Keep Your Plan Informed of Address Changes").

Election Procedures

After the COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Employee's spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several or for all Dependent Children who are qualified beneficiaries. A parent can elect to continue coverage on behalf of any Dependent Children who are qualified beneficiaries. The Employee or the Employee's Spouse can elect continuation coverage on behalf of all of the qualified beneficiaries in a family. A guardian or other legal representative of a qualified beneficiary can elect continuation coverage on his or her behalf.

The election of COBRA continuation coverage must be made within 60 days after Plan coverage ends, or, if later, 60 days after the COBRA Administrator provides the qualified beneficiary with notice of the right to elect continuation coverage. The election must be in writing and must be made in the form and manner required by the Plan Administrator and Rooney Insurance. **If a qualified beneficiary does not elect continuation coverage within this 60-day election period, the qualified beneficiary will lose the right to elect continuation coverage.** A COBRA election mailed to Rooney Insurance is considered to be made on the date of mailing.

A qualified beneficiary may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare as long as such coverage was effective prior to the qualifying event.

COBRA Premiums That You Must Pay

If a qualified beneficiary elects continuation coverage, he or she will be required to pay the entire cost for such coverage, plus an administration fee of up to 2%. (In the case of an extension of continuation coverage due to disability, the qualified beneficiary(ies) may be required to pay up to 150% of the cost of coverage.) The premium payments for the "initial premium months" must be paid for you (the Employee) and for any Spouse or Dependent Child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made. The initial premium payment should be mailed to the address on the election form.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st day of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1st day of the month, with no possibility of reinstatement. A check that has been returned unpaid from the bank for any reason may result in untimely payment and can result in cancellation of coverage. Premium payments after the initial payment should be mailed to the address identified on the premium coupons.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of COBRA Coverage before the End of the Maximum Coverage Period."

36 Months. In the case of a loss of coverage due to an Employee's death, divorce, legal separation, the Employee's becoming entitled to Medicare, or a Dependent Child ceasing to be an eligible Dependent Child under the Plan, then the maximum continuation coverage period (for spouse and Dependent Child qualified beneficiaries) is 36 months from the date of the qualifying event **(or the date of the loss of coverage, if later)**.

18 Months. In the case of a loss of coverage due to the Employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period (for Employee, Spouse and Dependent Child qualified beneficiaries) is 18 months from the date of termination or reduction in hours **(or the date of the loss of coverage, if later)**. There are three exceptions:

- An 11-month extension of coverage may be available if a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled. The disability has to have existed at some time during the first 60 days of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please note that the SSA determination of disability is not required to occur during the 60-day period.

  To be eligible for the 11-month extension, you must provide notice of the SSA's disability determination within the 18-month continuation coverage period and within 60 days after the latest of: (1) the date of SSA's determination of disability; (2) the date of the qualifying event; or (3) the date coverage under the Plan would be lost as a result of the qualifying event. If this notice deadline is not met, the notice will be rejected as untimely and the right to the 11-month extension will be lost. **See the Notice Requirements and Procedures below for how you must notify the COBRA Administrator of a disability.**

  Each qualified beneficiary who has elected COBRA continuation coverage will be entitled to up to 11 months of extended coverage if one of them

qualifies for this extension and remains disabled. If the qualified beneficiary is determined by SSA to no longer be disabled, then COBRA continuation coverage will terminate as of the first of the month that begins more than 30 days after SSA's final determination of no disability. You must notify the Plan Administrator of that fact within 30 days after SSA's final determination of no disability. **See the Notice Requirements and Procedures below for how you must notify the COBRA Administrator that the qualified beneficiary is no longer disabled.**

- If a second qualifying event that gives rise to a 36-month maximum coverage period for a Spouse or Dependent Child who is a qualified beneficiary occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a Spouse or Dependent Child qualified beneficiary) becomes 36 months from the date of the initial termination or reduction in hours **(or the date of the loss of coverage, if later)**. Such second qualifying events may include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a Dependent Child's ceasing to be an eligible Dependent Child under the Plan. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the COBRA Administrator within 60 days after the later of: (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the second qualifying event. If this notice deadline is not met, the notice will be rejected as untimely and the right to the 18-month extension will be lost. **See the Notice Requirements and Procedures below for how you must notify the COBRA Administrator that a second qualifying event has occurred.**

- When the qualifying event is the termination of employment or reduction of the Employee's hours of employment, and the Employee becomes entitled to Medicare benefits less than 18 months before the qualifying event, the maximum coverage period for qualified beneficiaries other than the Employee ends 36 months from the date the Employee became entitled to Medicare.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period

A Child born to, adopted by or placed for adoption with a covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected continuation coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the Child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Termination of COBRA Coverage Before the End of Maximum Coverage Period

Continuation coverage under the Plan will automatically terminate for any affected qualified beneficiary (before the end of the maximum coverage period) when any one of the following six events occurs. Coverage that has been canceled for any of these reasons cannot be reinstated.

- The Employer no longer provides group health coverage to any of its Employees;
- The premium for the qualified beneficiary's COBRA coverage is not timely paid;
- After electing COBRA coverage, the qualified beneficiary becomes covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition of the qualified beneficiary. If the other plan has applicable exclusions or limitations, then COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that preexisting condition limitations are generally prohibited beginning in 2014.);
- After electing COBRA coverage, the qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both). This will apply only to the person who becomes entitled to Medicare;
- A qualified beneficiary has become entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination); or
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their spouses or Dependent Children who have coverage under the Plan for a reason other than the COBRA coverage requirements.

You must notify the COBRA Administrator as soon as reasonably possible if, after electing COBRA continuation coverage, you obtain other group health plan coverage or Medicare benefits as described above, or if a qualified beneficiary is no longer disabled. **See the Notice Requirements and Procedures below for how you must notify the COBRA Administrator of these changes.**

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "Special Enrollment Period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan Administrator and the COBRA Administrator informed of any changes in the addresses of family members. Changes of address should be sent to: Rooney Insurance, 4700 S. Garnett Rd., Suite 200, Tulsa OK 74146. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or to the COBRA Administrator.

Notice Requirements and Procedures

This section summarizes Employees' and covered beneficiaries' notice obligations, as described above, and the procedures for providing such notices.

It is the responsibility of covered Employees and other qualified beneficiaries to provide notice to the COBRA Administrator, of the occurrence of the following qualifying events:

- a divorce or legal separation of a covered Employee from his or her Spouse;
- a qualified beneficiary's ceasing to be covered under the Plan as a Dependent Child of a covered Employee; and
- the occurrence of a second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

If the qualifying event is a divorce, the covered Employee or qualified beneficiary must provide a copy of the divorce decree.

The notice must be provided within 60 days after the later of: (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

It is the responsibility of covered Employees and other qualified beneficiaries to provide notice to the COBRA Administrator that a qualified beneficiary entitled to receive continuation coverage for up to 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage. Notice of the determination of disability under the Social Security Act must be provided to the COBRA Administrator within both the 18-month continuation coverage period and within 60 days after the latest of: (1) the date of the determination of disability; (2) the date of the qualifying event; or (3) the date coverage under the Plan would be lost as a result of the qualifying event. The covered Employee or qualified beneficiary must provide a copy of the Social Security Administration determination.

It is the responsibility of covered Employees and other qualified beneficiaries to provide notice to the COBRA Administrator that a qualified beneficiary, with respect to whom a notice of disability described above has been provided, has subsequently been determined by the Social Security Administration to no longer be disabled. The notice must be provided within 30 days after the date of the final determination by the Social Security

Administration that the qualified beneficiary is no longer disabled.

It is the responsibility of covered Employees and other qualified beneficiaries to provide notice to the COBRA Administrator of the following events that will result in termination of continuation coverage:

- a covered Employee or other qualified beneficiary becomes covered (as an Employee or otherwise) under another group health plan; and
- a covered Employee or other qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both).

If notice is not provided for any event that would result in termination of continuation coverage, the Plan reserves the right to retroactively terminate continuation coverage and pursue reimbursement of benefits paid under the Plan after the date coverage would have terminated due to these events.

All notices must be in writing and must be sent by fax or by mail. Oral notice, including notice by telephone, is not acceptable. **All notices described in this provision of the Plan should be directed to the following, as designated by the Plan Administrator: Rooney Insurance Agency, 4700 S. Garnett Rd., Suite 200 Tulsa, OK 74146, fax number (918) 878-3381.** If mailed, the notice must be postmarked no later than the last day of the required notice period.

The notice must contain the following information, which is necessary for the COBRA Administrator to determine whether continuation coverage rights are available: (1) the name of the Plan; (2) the name and address of the Employee covered under the Plan; (3) the name(s) and address(es) of the qualified beneficiary(ies); and (iv) the qualifying event (or other relevant event) and the date it happened.

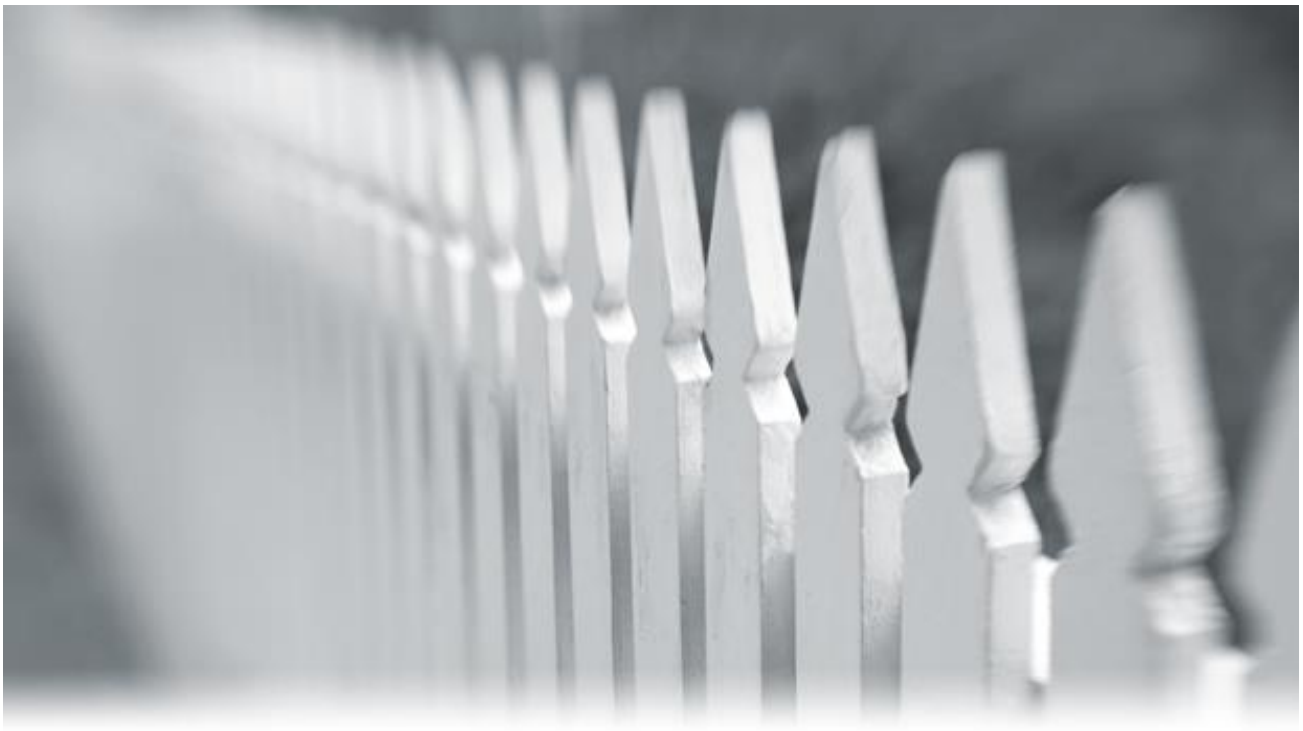
Any individual who is either the covered Employee, a qualified beneficiary with respect to the qualifying event or any representative acting on behalf of the covered Employee or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

For More Information

Please contact the COBRA Administrator to obtain additional information about the Plan and your COBRA continuation coverage rights, or if you wish to receive the most recent copy of a summary plan description. Rooney Insurance Agency can be reached at 4700 S. Garnett Rd., Suite 200, Tulsa OK 74146. Rooney Insurance Agency's phone number is (918) 878-3425.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest or Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or the EBSA website at

www.dol.gov/ebsa. (Addresses and phone numbers are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.



Section X Exclusions and Limitations

The following headings are descriptive in nature and may not indicate a specific type of service. The Plan does not cover the following:

Ancillary Services and Supplies

- Assisted living, halfway house, custodial, intermediate, domiciliary, convalescent or personal care (e.g., in-home meals, childcare, in-home daycare, and housekeeping services) rendered other than as part of skilled nursing services. Respite care or inpatient services primarily for environmental change are not covered.
- Eyeglass frames, corrective lenses, contact lenses (including prescriptions and fittings for contact lenses provided as a supplemental benefit). The Plan will cover corrective eyeglass or contact lenses following cataract surgery (1 pair per lifetime).
- Radial keratotomy, LASIK or other similar refractive eye surgery, vision therapy or orthoptic treatment (e.g., eye exercises).
- Hearing aids except as specifically covered for children up to 18 years of age.
- Replacement of Durable Medical Equipment (e.g., prosthetic devices, orthopedic braces, and hearing aids) necessitated by loss, theft or misuse.
- Blood Gas Measurement Equipment
- Vacuum Erection Systems (VES)
- Non-psychiatric or non-psychological education and

therapy including but not limited to, materials, devices and equipment.

- Personal hygiene and convenience items, including but not limited to, air conditioners, humidifiers, air and water purifiers, hypo-allergenic bedding, physical fitness equipment, whirlpool bathtubs, stair lifts, ramps, or other modifications to the home or automobile.

- Routine foot care, including but not limited to, trimming or removal of corns, calluses and nails; corn excision, cramping of feet, bunions and muscle trauma, except as Medically Necessary to prevent or treat complications from diabetes.

- Massage of any type.

- Dance, poetry, music or art therapy.

- Surgical treatment of sleep disorders.

- Non-standard speech generating devices (e.g., PDAs) or software or hardware, for non-standard speech generating devices.

- Durable Medical Equipment, oxygen and accessories for travel.

- Charges associated with support groups are not covered.

Cosmetic or Plastic Surgery

- Surgery performed primarily to improve or alter the Participant's external appearance; except for Medically Necessary reconstructive surgery due to accidental injury within 5 years of the initial injury, functional congenital defects, or deformities that are the result of treatment or illness that substantially impairs bodily function.

- Services rendered to treat complications from cosmetic surgery.

- Breast reconstruction surgery, unless post-mastectomy for breast cancer or another breast condition for which mastectomy was Medically Necessary.

- Breast reduction surgery, for cosmetic purposes.

- Breast alteration surgery.

Dental Services

- Treatment on or to the teeth, replacement of teeth, treatment of gums (other than for tumors), restorative care, extractions, root canals, bonding, artificial teeth, crowns, dentures, fillings, orthodontia, dental prostheses or orthoses, splints and similar devices or appliances, or other dental service or surgery. The Plan will cover replacement or re-implantation of teeth within 30 days of the accidental injury and Medically Necessary follow up care

- Correction of occlusive jaw defects, dental implants, grafting of alveolar ridges, except as Medically Necessary to treat a congenital

defect.

- Treatment of soft tissue for the purpose of facilitating dental procedures.

- Orthognathic conservative treatment limits $1,500 per year for non-surgical treatment, as authorized in advance by CommunityCare and as Medically Necessary.

Experimental or Investigational Therapies

- Experimental or investigational medications, surgeries, devices, medical treatment or other health care procedures.

- Services and technologies whose long-term efficacy or effect is undetermined or unproven, or whose efficacy is no greater than that of traditionally accepted standard treatment.

- Orthotripsy to treat plantar fasciitis and all other musculoskeletal conditions.

Genetic Analysis, Services or Testing

- Genetic testing and counseling for family planning purposes.

Medical Care or Hospital Services

- Any confinement, treatment, service or supply for which there is no legal obligation to pay in the absence of this coverage.

- All services not specifically included in the Schedule of Benefits; all non-emergency medical and hospital services rendered without prior authorization from CommunityCare; services provided prior to the commencement of coverage or subsequent to the termination of coverage.

- Services or supplies not deemed Medically Necessary.

- Treatment and related services rendered in a hospital before the Participant leaves against medical advice, as well as services to treat a worsening of the same condition thereafter.

- Charges related to telemedicine or for online, e-mail or telephone evaluation and management services.

- Services or supplies rendered by the Participant or his or her relative (e.g., spouse, Child, brother, sister or the parent of the Participant or spouse).

- Services to treat an injury or illness resulting from war or acts of war, declared or undeclared, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.

- Services to treat conditions for which state or local law requires treatment to be rendered in a public facility.

- Illness or injury resulting from or occurring during the commission of a crime by the Participant or while

the Participant is engaged in an illegal act, illegal occupation, felonious act or aggravated assault. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the illness or injury: (a) resulted from being the victim or an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

- Coverage for services or supplies while the Participant is incarcerated after the adjudication of guilt and sentencing to a penal institution.

- Private rooms, unless Medically Necessary.

- Services and supplies for treatment of conditions where the Participant is entitled to care or reimbursement under Workers' Compensation insurance.

- Examinations or immunizations that are as a condition of employment or travel, for entry into a vocational school, institutes of higher education or the military are not covered, except as specifically covered for preventive care. Other examinations not covered are those required in order to continue or obtain insurance, government licensing, flight, camp, school, athletics, pre-adoption, premarital, or immunizations for travel or occupation, etc.

- Take home drugs provided by a hospital.

Non-Covered Services

- Services or supplies which are incident to an non-covered service or supply. Additionally, inpatient or outpatient care which is necessitated in whole or in part by a non-covered condition or service.

Non-contracted Professionals

- Any confinement, treatment, service or supply not recommended by, or recommended other than by, an In-Network Provider and approved by the Plan.

Non-licensed Professionals

- Any confinement, treatment, service or supply not recommended by, or provided by a Professional who does not hold a license in their specific field.

Obstetrical and Infertility Services

- In-vitro fertilization, artificial insemination, embryo transfers and ovarian transplants; and related testing and procedures (e.g., harvesting and monitoring, etc.).

- Any medical services or pharmaceuticals used in the augmentation of fertility, including but not limited to uterine transplants, services to evaluate patients during treatment with these agents, preparing the patient for treatment or monitoring treatment of these agents or

treating the known complications of these agents.

- Services resulting from the non-emergent delivery of a baby performed by a Provider who is not part of CommunityCare's Provider Network without prior authorization.

- Any expense related to surrogacy or adoption. Maternity charges incurred by a covered person acting as a surrogate mother are not covered. For the purpose of this Plan, the Child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she expresses intent to relinquish custody of the Child following birth to an adoptive or foster parent.

- Reversal of voluntary infertility.

- Contact Customer Services prior to initiating any services for family planning or infertility to determine if those services are excluded under your Plan.

- Abortions, except as allowed by law to protect the life of the mother from imminent danger.

Physical Occupational and Speech Therapy

- Physical, occupational or speech therapy in excess of sixty treatment days (including inpatient and outpatient) per condition per calendar year.

- Any treatment that will not result in significant improvement within sixty treatment days.

Private Duty Nursing Services

Psychiatric Services

- Family and marital counseling unrelated to a mental health condition or substance abuse disorder.

- Psychological testing, except when pre-authorized by CommunityCare and conducted to diagnose a psychiatric disorder or evaluate the need for a change in treatment plans.

- Evaluations other than for diagnosing or treating a medical or mental health condition (e.g., Child custody).

- Educational evaluation and/or intervention for the purpose of improving learning in school.

- Services for treatment or conditions related to autism (except for diagnosis), including applied behavioral analysis (ABA) therapy.

Transplants

- Transplants and related services deemed not appropriate and/or not Medically Necessary by CommunityCare.

- Any transplant services (including evaluations related thereto) that are rendered without prior authorization from CommunityCare or that are rendered by a Provider

that is not within CommunityCare's transplant Network.

- The Plan will not cover services incurred by the Participant to donate an organ to another person who is not also a Participant. The Plan will cover the organ donor's Medically Necessary transplant services if the organ recipient is a Participant.

- Animal to human transplants; transplants, procedures or artificial or mechanical devices that are considered to be experimental, investigational or unproven; transplants rendered at a non-designated transplant facility; and artificial or mechanical devices.

- In the case of a living donor who is donating for the benefit of a recipient Participant, services and associated expenses required by complications arising from an organ donation.

Transportation/Lodging

- Ambulance services, unless Medically Necessary and authorized in advance by CommunityCare, or rendered as Emergency Services. Additionally, ambulance and emergency medical technician services may not be covered if the Participant refuses to be transported to the nearest emergency facility.

- Transportation and lodging are not covered, except in connection with authorized transplants occurring at an In-Network facility.

Transsexual Surgery

- Sex reassignment surgery, including related pre- or post- surgery procedures, services, psychiatric evaluation, treatment, medications and supplies, including services to treat complications arising from transsexual surgery.

Weight Reduction Programs

- Outpatient or inpatient weight loss programs, materials or meal replacements.

- Weight reduction surgery/procedures of any type.

- Weight loss drugs.

- Food, food replacements, food supplements and food substitutes. This is not intended to exclude meals that the Participant receives during a covered inpatient hospital stay.

Items and Services to prevent or terminate pregnancy, including, but not limited to, the following

- Sterilization reversal procedures by any means.

Section XI Subrogation and Rights of Recovery

Subrogation and Reimbursement

If a Participant has medical expenses as a result of an injury, accident, illness or other condition for which a third party is, or may be, held responsible (for purposes of this Section VII, a "covered condition"), such expenses will not be covered by the Plan to the extent they have been paid or may be paid, either currently or in the future, by or on behalf of such third party (which may include, but is not limited to, a Participant's no-fault automobile policy insurer or the insurer of any uninsured motorists coverage). While a claim against a third party is being pursued, the Plan may elect to make conditional advance expense reimbursements to, or payments on behalf of, such Participant, subject to the Plan's subrogation and/or reimbursement rights described in this Section VII.

If a Participant receives any benefits arising out of a covered condition for which the Participant (or the Participant's guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be

reimbursed. Such reimbursement will be made by the Participant (or the Participant's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant (or the Participant's guardian or estate) from: (1) any policy or contract from any insurance company or carrier (including the Participant's insurer); and/or (2) any third party, plan, or fund as a result of a judgment, settlement or otherwise. The Participant (and on behalf of his guardian or estate) acknowledges and agrees that: (1) if any claim is made against a third party, payments under the Plan for benefits must be included in such claim; and (2) the Plan will be reimbursed in full before any amounts (including attorney fees incurred by the Participant or his guardian or estate) are deducted from the policy, proceeds, judgment, or settlement. The Plan will not pay, offset any recovery or in any way be responsible for any fees or costs incurred by the Participant (or his guardian or estate) associated with pursuing a claim unless the Plan agrees to do so in writing.

This Plan will be subrogated to all claims, demands, actions, and rights of recovery of the Participant (or his guardian or estate) against any individual or entity, including, but not limited to, third parties and insurance companies and carriers (including the Participant's insurer) on account of a covered condition to the fullest extent permitted by law in the appropriate jurisdiction. This means that the Plan has rights against any third-party who may have been responsible for the covered condition (including, but not limited to, any person, party, entity, insurance company, corporation, or firm). The Plan shall be entitled to institute an action in its own name or in the name of such Participant (or his guardian or estate) or to intervene in an action brought by such Participant (or his guardian or estate) against such third party and to participate in any judgment, award or settlement to the extent of the Plan's interest. The amount of such subrogation will equal the total amount paid under the Plan arising out of the covered condition for which the Participant (or his guardian or estate) has, may have, or asserts a cause of action. In addition, the Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this Section. The Plan will not pay, offset any recovery or in any way be responsible for any fees or costs incurred by the Participant (or his guardian or estate) associated with pursuing a claim unless the Plan agrees to do so in writing.

By participation in the Plan, the Participant (and on behalf of his guardian or estate) specifically agrees to do nothing to prejudice this Plan's rights to reimbursement or subrogation. In addition, the Participant (and on behalf of his guardian or estate) agrees to cooperate fully with the Plan in asserting and protecting the Plan's subrogation and/or reimbursement rights. The Participant (and on behalf of his guardian or estate) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any third party. The Participant (and on behalf of his guardian or estate) agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the Plan's subrogation and/or reimbursement rights.

By participation in the Plan, the Participant specifically agrees (and on behalf of his guardian or estate) to notify the Plan, in writing, of whatever benefits are paid under the Plan that arise out of any injury or illness that provides or may provide the Plan subrogation and/or reimbursement rights under this Section VII. The Participant (and on behalf of his guardian or estate) and his attorney agree that acceptance of any benefits under the Plan is constructive notice of the provisions in this Section VII and further agree that the Plan shall have an equitable lien on any funds received by the Participant (or his guardian or estate) or his attorney from any source and such funds shall be held in trust until such time as the obligations under this Section VII are fully satisfied. The Participant (and on behalf of his guardian or estate) and his attorney agree to include the Plan's name as co-payee on any and all settlement drafts.

The Plan's rights apply to any and all third-party payments for any expenses or losses related to a covered condition (including, but not limited to, payments or recoveries under no-fault coverage, malpractice, personal injury, pain and suffering, wrongful death, medical reimbursement, financial responsibility, uninsured or underinsured insurance coverage, and medical coverage of any type regardless of the purchaser) without application of the common fund doctrine, make whole doctrine or other similar legal theory. The manner in which any judgment, award or settlement or recovery is classified or characterized by the Participant (or his guardian or estate), a court or any other entity shall not impact the Participant's (or his guardian's or estate's) subrogation and/or reimbursement responsibilities described in this Section VII or the Plan's entitlement to first dollar recovery regardless of whether the Participant (or his guardian or estate) is made whole. The Plan's entitlement to first dollar recovery applies to any funds paid by a third party to a Participant, including a priority over any claim for non-medical charges or damages, attorney fees or other damages, costs or expenses. The Plan shall have an equitable lien that supersedes all common law or statutory rules, doctrines and laws prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement.

The Plan's rights to third-party payments exist with respect to benefits it has already paid, benefits which it has not paid but for which expenses have been incurred and estimated future benefits. The Plan may withhold payment of benefits and/or offset benefits otherwise payable under the Plan if the Plan Administrator determines in its sole discretion that such withholding is necessary or appropriate for the enforcement of the Plan's subrogation and/or reimbursement rights. Failure to comply with the requirements of this Section VII by the Participant (or his guardian or estate) may, at the Plan Administrator's discretion, result in a termination of coverage for the Participant and all members of his family unit and a forfeiture of benefits under the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar legal theory. Accordingly, any lien reduction statutes, which apply to apply such laws and reduce a subrogating plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

In addition to the Plan's right of subrogation, the Plan has a property right to and equitable interest in any and all third-party payments made to or on behalf of a Participant on account of a covered condition. The Plan's rights include an equitable lien on any such third-party payments. These rights to and interests in third-party payments exists without regard to whether the Plan exercises its right of subrogation. The Plan's equitable interest in such third-party payments means that third-party payments made to or on behalf of a Participant on account of a covered condition belong to the Plan, to the extent of benefits paid or expected to be paid in relation to such covered condition. Any third party payments subject to such equitable interest exist separately from the property and estate of the Participant, such that the death of the Participant or filing of bankruptcy of the Participant will not affect the Plan's equitable interest, the funds subject to such interest or the Plan's subrogation and reimbursement rights.

A Participant (or his representative) must: (1) hold in constructive trust for the Plan any third-party payment received in relation to a covered condition and belonging to the Plan pursuant to the terms of this Section VII; and (2) return to the Plan from that third-party payment the amount of any and all benefits that the Plan has paid in relation to the covered condition, as soon as the third-party payment is made, regardless of the source and regardless of fault. This includes payments and recoveries granted by whole, partial or undifferentiated judgments.

If there is more than one party potentially responsible for charges paid by the Plan, the Plan is not required to select a particular party from whom reimbursement is due. If an unallocated settlement fund is meant to compensate multiple injured parties of which the Participant is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

The Plan may initiate legal action against the Participant to enforce its rights under this Section VII. In such event, the Plan shall be entitled to recover all costs and expenses of such legal action, including reasonable attorneys' fees.

Recovery of Payments

In addition to the rights of subrogation and reimbursement described above, without prejudice to any other remedies available to the Plan, the Plan, in its sole discretion, will have the right to: (1) seek reimbursement

directly from the Participant or his assignee; or (2) deduct from any benefits properly payable under the Plan, the amount of any payment which has been made:

- in error; or
- pursuant to a misstatement contained in a proof of loss; or
- pursuant to a misstatement made to obtain coverage under the Plan within two years after the date such coverage commences; or
- with respect to an ineligible person; or
- in anticipation of obtaining a recovery in subrogation if a Participant fails to comply with the subrogation and reimbursement provisions above; or
- pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This paragraph will not be deemed to require the Plan to pay Benefits under the Plan in any such instance.

The Plan may exercise its right of reimbursement and recover any such payments directly against a Participant, or his assignee, to whom the payment was made, or against a Participant with respect to such Participant's covered Dependent. The recovery of payments may be made by any means available at law or equity, including but not limited to restitution and/or imposition of a constructive trust over the payments at issue. The Plan's right to recover payments shall apply regardless of whether the Participant is made whole, and shall not be subject to offset or reduction for any attorney fees incurred by any other party in connection with obtaining an amount from which the Plan is entitled to seek recovery.

Section XII Definitions

Allowable Expense: To determine Coordination of Benefits when an Other Plan provides benefits consisting of services and supplies (rather than a cash payment), the Plan will deem the reasonable cash value of each service and supply rendered to be both an Allowable Expense and a Benefit Paid. An Allowable Expense is also subject to the terms and conditions of the In-Network Provider Network and the Managed Care Program requirements.

Audiological Services: Hearing exams, tests, services and supplies other than to diagnose and treat a medical condition and the purchase or fitting of hearing aids, including the exam.

Child(ren): Is defined in the "Eligibility" section of the Plan.

Chiropractic Care: Those medical services for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation of the skeletal system, when performed by a Provider licensed to perform such services.

Covered Services: Those medical services and supplies that are prescribed by a Provider for the therapeutic treatment of injury, illness or pregnancy, are Medically Necessary, are not excluded under any exceptions of the Plan, and that are listed as covered under the Plan's Schedule of Benefits applicable to the Participant's coverage.

Custodial Care: Personal care that is provided to assist an individual to meet the requirements of daily living, including, without limitation, walking, getting in or out of bed, eating, hygiene, dressing, feeding, using the lavatory, preparation of special diets, or supervising the administration of medication. This care is not reasonably expected to improve the underlying medical condition of a person even though it may relieve symptoms or pain.

Deductible Carryover: If you incurred medical expenses during the last three months of the calendar year and those expenses were applied to meet that year's Deductible, those same expenses may be used again and "carried over" to help meet the Deductible requirement of the next year. (Note: Please refer to your Summary of Benefits for specific information about the Deductible under your Plan coverage option.)

Dependent: The word "Dependent" means the following:

- An Employee's lawful Spouse; and
- An Employee's Child(ren).

Diagnostic mammography: A diagnostic tool that:

a. uses X-ray, and

b. is designed to evaluate abnormality in a breast.

Durable Medical Equipment (DME): Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or

injury, and (d) is appropriate for use in the home. **All** requirements of the definition **must** be met before an item can be considered to be DME. To obtain a listing of In-Network DME Providers or coverage information about specific DME, please contact Customer Services.

Employee: Is defined in the "Eligibility" section of the Plan.

Employer: City of Tulsa, Oklahoma.

In-Network: Services or procedures provided by a contracted Provider or facility.

Medically Necessary: Services or items that are (1) appropriate, given the symptoms and diagnosis, to treat a medical condition, illness or injury; (2) provided in a manner that is consistent with accepted standards of medicine and/or medical practice; and (3) not primarily for the patient's or the provider's convenience. The fact that a provider prescribes, orders or recommends a service or item does not, in itself, make the service or item Medically Necessary or a Covered Service. CommunityCare reserves the right to review all claims and requests for services and items under the Plan and to determine if the service or item is Medically Necessary. In making a determination of medical necessity, CommunityCare may use a variety of established criteria and benchmarks, as well as patient-specific factors. These criteria and patient-specific factors include, but are not limited to: coverage guidelines adopted by Medicare; Solucient Length-of-Stay criteria; Interqual criteria; ECRI technology Assessments; Institute for Clinical Systems Improvement (ICSI) guidelines and protocols; recommendations and protocols promulgated by major medical associations in the U.S.; studies published in peer reviewed medical journals; locally-accepted patterns of practice; and the patient's age and sex, medical condition (including any co-morbidities and complications), psycho-social factors, and progress or prognosis using previously prescribed treatment. .

Other Plan: Any health plan, other than this Plan, providing benefits or services for Hospital or medical care or treatment. The benefits or services of the Other Plan are provided by Group and nongroup insurance contracts and subscriber contracts; uninsured arrangements of group or group-type coverage; Group and nongroup coverage through closed panel plans; Group-type contracts; the medical care components of long-term care contracts, such as skilled nursing care; the medical benefits coverage in automobile 'no fault' and traditional automobile 'fault' type contracts; Medicare or other governmental benefits, as permitted by law, except as provided in a state plan under Medicaid. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care. Other Plan will also include any coverage required or provided by any statute.

Out-of-Network: Services received by a non-contracted provider or facility.

Participant or Plan Participant: Any person who: (1) satisfies the eligibility

requirements to participate in the Plan, as described herein; (2) for or on behalf of whom the Plan Administrator has received a completed enrollment form (which must be completed and filed in the manner required by the Plan Administrator; and (3) for or on behalf of whom the Plan Sponsor has received the required Participant contribution for coverage; and (4) who is participating in the Plan during an applicable coverage period.

Participating Pharmacy: means a licensed pharmacy that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide prescription drug services to Plan enrollees.

Participating Providers: means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Plan: This plan of benefits as sponsored by the Tulsa FOP 93 Health and Welfare Trust.

Plan Administrator: means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

Plan Participant: Any Eligible Person for whom CommunityCare has received a completed enrollment document (electronic or hard copy), and whom the Plan Sponsor has determined is eligible for coverage under the Plan.

Plan Sponsor: means Tulsa FOP 93 Health and Welfare Trust or any successor thereto.

Provider: A provider of medical or health services, acting within the scope of the provider's license (if such licensure is required under applicable state law), who furnishes, bills or is paid for health care in the normal course of business.

Retiree: is defined in the "Eligibility" section of the Plan.

Schedule of Benefits: The description of Covered Services and exclusions from coverage under the Plan.

Spouse: is defined in the "Eligibility" section of the Plan.

Vision: A vision screening is a simple test of your vision that can detect problems early. It's also called an eye test. The test usually involves reading letters on an eye chart. A vision screening is a quick way to find out if you need a comprehensive (complete) eye exam.

An eye exam is a detailed check of your eyes and eye health. An eye exam is a comprehensive eye exam that can diagnoses visual health issues and ocular conditions in a way using special equipment and an in depth examination by an optometrist or ophthalmologist.

Waiting Period: The length of time an Employee must continuously work before he or she is eligible for coverage under the Plan.

Workers' Compensation: The Workers' Compensation Act as adopted by the state of Oklahoma and codified in Title 85 of the Oklahoma statutes, any successor act thereto or any similar act adopted by the United States of America or any political subdivision thereof.

Williams Center Tower II
Two West Second Street, Suite 100
Tulsa, Oklahoma 74103
918.594.5201
1.888.589.5214
FOP.ccok.com