

OSMA HEALTH

HEALTH PLAN

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE FUNDED BY CONTRIBUTIONS FROM EMPLOYERS, EMPLOYEES, AND OTHER INDIVIDUALS ELIGIBLE FOR COVERAGE. RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE OSMA HEALTH AND WELFARE BENEFIT CORPORATION.

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PART I INTRODUCTION

This document is a description of the OSMA Health - Health Plan (the Plan). **No oral interpretations can change the Plan.** The Plan described provides benefits for Covered Persons to help offset certain health expenses.

The Plan Sponsor fully intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverages, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an Injury or Illness that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for Covered Persons and is divided into the following parts:

Part II. Employer Participation Provisions and Contributions. Describes the requirements that an Employer must meet to participate in the Plan, and how the Plan is funded.

Part III. Eligibility, Funding, Effective Date and Termination Provisions. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Part IV. Schedule of Benefits. An outline of the Plan reimbursement formulas as well as payment limits on certain services are provided in the applicable schedule of benefits booklet.

Part V. Medical Benefits. Explains when the medical benefit applies and the types of charges covered.

Part VI. Outpatient Prescription Drug Benefit. Explains when the outpatient prescription drug benefit applies and the types of charges covered.

Part VII. Specialty Drug Benefit. Explains when the specialty drug benefit applies and the types of charges covered.

Part VIII. Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Covered Person is required to take action to assure that the maximum payment levels under the Plan are paid.

Part IX. Defined Terms. Defines those Plan terms that have a specific meaning.

Part X. Plan Exclusions and Limitations. Describes what charges are not covered.

Part XI. Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Part XII. Coordination of Benefits. Describes the Plan payment order when a person is covered under more than one plan.

Part XIII. Third Party Recovery Provisions. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries or illness sustained. Describes the Covered Person's responsibilities to establish a valid claim when a third party may be liable for Covered Expenses.

Part XIV. COBRA Continuation Options. Explains when a person's coverage under a plan ceases and the continuation options which may be available.

Part XV. Privacy Provisions. Summarizes protection of Covered Persons' health information, rights under federal law and how they may control the use of their information.

Part XVI. Responsibilities for Plan Administration. Explains how the Plan is operated and managed by the Plan Sponsor.

Part XVII. ERISA Disclosures and Information. Discloses important plan information as required by ERISA.

Part XVIII. ERISA Rights Statement. Discloses Covered Persons' rights under ERISA.

PART II EMPLOYER PARTICIPATION PROVISIONS & CONTRIBUTIONS

Eligible Employer. The Plan is operated and maintained for the benefit of Employer Members of the Association, their Active Employees and Retired Employees. An Employee or Retired Employee is eligible subject to the provisions of Part III, Eligibility, Funding, Effective Date and Termination Provisions, only if their Employer has complied with requirements of participation and the provisions of this part. Subject to the requirements of federal and state laws, the Plan reserves the right to decline or revoke participation of any Employer who does not meet the Plan's rules and underwriting requirements, the rules of the Plan Sponsor and the by-laws and rules of the Association.

An eligible Employer must meet the following requirements:

- (1) Be a Member in good standing of the Association;
- (2) Have executed the required enrollment application for participation in the Plan;
- (3) Have paid all contributions as described herein; and
- (4) Complies with all Plan rules regarding Employee eligibility and the Plan's required percentage of eligible Employee participation, which is 70% for physician Employees (MD or DO) and 70% for non-physician Employees.

Contributions. Each participating Employer and Retired Employee must remit to the Plan the required contributions. The sources of these contributions are the Employer and/or the participating Employees or Retired Employees, as determined by the Employer's policies. In the event that an Employer fails to remit contributions in a timely manner, the fact that a contribution has been collected by the Employer from an Employee or Retired Employee is not binding on the Plan.

All contributions must be paid on or before the first day of the period for which they are due. A 31-day grace period will be granted. Benefit payments may be suspended at the discretion of the Plan Administrator during the grace period. If payment is not made during the 31-day grace period, the Employer's and/or Retired Employee's participation will be terminated and coverage cancelled for all persons covered under that Employer or Retired Employee retroactive to the date for which contributions were last paid.

If any claims are paid for a non-covered period as the result of the Employer's or Retired Employee's failure to make timely contributions, the Plan will recover such payments from the Employer or Retired Employee. An Employer will not be considered for reinstatement until such amounts are recovered by the Plan.

The contributions required will be determined by the Plan Administrator as its discretion. The contributions will be modified to accommodate any changes in Plan benefits, increased benefit expense, changes in administrative expenses and the maintenance of appropriate reserves. Contributions will be determined in a manner consistent with applicable laws and regulations. The Plan Administrator will be free to adjust contribution levels from time to time as necessary.

Contribution rate levels will be based on those factors characteristic of a class of persons such as but not limited to age or gender.

In the event that contribution levels will be changed, Employers and Retired Employees will be provided with a minimum of one calendar month notice. It is the responsibility of the Employer to notify its participating Employees and Retired Employees of any change that will affect their withholding amount. As long as the Plan's participation requirements and other rules have been met, Employee and Retired Employee payment amounts are at the discretion of the Employer, subject to any applicable law.

PART III
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of an eligible Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is an Active Employee.
- (2) completes a Waiting Period, if required by the Employer, as an Active Employee.

Eligible Classes of Retired Employees. All eligible Retired Employees of an eligible Employer.

Eligibility Requirements for Retired Employee Coverage. A person is eligible for Retired Employee coverage from the first day that he or she is a Retired Employee. Failure to elect coverage as a Retired Employee when first eligible shall waive any future rights to apply for retiree coverage.

Eligible Classes of Dependents. A Dependent is any of the following:

- (1) (a) A Spouse.
- (b) A Child through age 25.

After the Child reaches age 26, coverage continues to age 30, **if** the Child is: (i) a Full Time Student; (ii) dependent upon the Participant for support and maintenance; **and**, (iii) not married. The Plan Administrator may require documentation proving Full Time Student status and dependency.

- (2) A Child of a Participant who is an alternate recipient under a qualified medical child support order.
- (3) A Child who is: (a) Totally Disabled; (b) not capable of maintaining employment due to mental retardation or physical handicap; (c) dependent upon a Participant for support and maintenance; (d) not married; and, (e) covered under the Plan when an age limit is reached.

At reasonable intervals during the 2 years after Dependent reaches an age limit, the Plan Administrator may require subsequent proof of Total Disability and dependency. After this 2-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, for the existence of incapacity.

The following are excluded as Dependents.

- (1) Other persons that live in the Participant's home, but are not eligible.
- (2) The legally separated or divorced former Spouse.
- (3) A person on active duty in military service of any country.
- (4) A person covered under any OSMA Health plan as a Participant.

Eligibility Requirements for Dependent Coverage. A Participant's family member becomes eligible for coverage on the first day that the Participant is eligible for coverage and the family member satisfies the requirements for coverage. The Plan Administrator may require proof that a Spouse or a Child qualifies or continues to qualify as a

Dependent. The Participant is solely responsible to notify the Plan Administrator of changes in the status of a family member that may affect dependent coverage.

If a person covered by the Plan changes status from Participant to Dependent or Dependent to Participant, and the person is covered continuously under the Plan before, during and after the status change, credit will be given for deductibles and out-of-pocket payments. All amounts applied to Calendar Year maximums under any Option under the Plan will be applied to the person.

If both husband and wife are Participants, their Children will be covered as Dependents of the husband or wife, but not both.

RESIDENCY REQUIREMENT

Covered Persons must be residents of the State of Oklahoma or Active Employees of Oklahoma domiciled Employers.

FUNDING

Cost of the Plan. The Employer is responsible for paying the cost of coverage under the Plan. These costs may be shared with participating Employees and Retired Employees at the discretion of the Employer. The required Employee and Retired Employee participation for making contributions is determined by each eligible Employer and is not governed by the Plan.

The level of contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of contributions.

EMPLOYEE ENROLLMENT

If an Employee does not enroll when first eligible, the Employee may only enroll at a later time according to the special enrollment period provisions or as a Late Enrollee during open enrollment. Please read this section carefully.

Employee Enrollment Requirements. An Employee must apply for coverage by completing an enrollment application. The Employee is also required to enroll Dependents, if Dependent coverage is desired.

Enrollment Requirements for Newborn Children. A newborn Child of a covered Employee who has full family or dependent child coverage on the newborn Child's date of birth is automatically enrolled in this Plan, subject to provision of required enrollment information. Eligible claims will be applied to the coverage of the newborn Child.

Any other newborn Child must be enrolled in this Plan on a timely basis, as defined under "Timely Enrollment" below. There will be no payment from the Plan for the newborn Child's claims if the Employee does not elect to cover such newborn. If the newborn Child is not enrolled within 31 days of birth, the enrollment is a late enrollment.

Rehiring a Terminated Employee. A rehired terminated Employee is treated as a new hire and is required to satisfy all eligibility and enrollment requirements, except an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period, if any.

Timely or Late Enrollment.

- (1) **Timely Enrollment.** The enrollment is timely if the completed form is received by the Plan Administrator within 31 days after the person initially becomes eligible for coverage.

If two Employees (husband and wife) are covered under the Plan and the person who covers the Children terminates coverage, the dependent coverage may be continued by the other person with no Waiting Period if coverage has been continuous. To continue the dependent coverage, notice must be provided to the Plan Administrator within 31 days of termination.

- (2) **Late Enrollment.** An enrollment is late if the completed form is received by the Plan Administrator later than 31 days after the person initially becomes eligible for coverage.

If a person loses eligibility for coverage due to termination of Association membership, employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of Association membership, employment or coverage, only the most recent eligibility period will count in deciding whether the enrollment is a late enrollment.

The time between the date a person enrolled late first becomes eligible for enrollment and the first day of coverage is not treated as a Waiting Period. **Coverage begins the first of the month after enrollment.**

Special Enrollment Periods. The Enrollment Date for anyone enrolled in a special enrollment period is the first date of coverage. The time between the date a special enrollee first becomes eligible for enrollment and the first day of coverage is not treated as a Waiting Period.

- (1) **Persons losing other coverage.** Any person who is eligible, but not enrolled, may enroll if (a) through (c) are met.
- (a) The person was covered under a group health plan or had health coverage at the time coverage was previously offered to the person.
 - (b) The person lost the health coverage, because:
 - (i) COBRA coverage was exhausted;
 - (ii) The non COBRA coverage terminated due to legal separation, divorce, death, termination of employment or reduced employment hours;
 - (iii) The non-COBRA coverage terminated, because the employer ceased contributions towards the coverage; or,
 - (iv) The person incurred a claim that would meet or exceed a Lifetime limit on all benefits under the non-COBRA health coverage.
 - (c) The person requests enrollment within 31 days after the date of COBRA coverage exhaustion or the termination of coverage or employer contributions.

If the person lost the other coverage due to the person's failure to pay required contributions or for cause (such as making a fraudulent claim), that person does not have a special enrollment right.

- (2) **Dependent beneficiaries.** If the Employer or Employee is a Participant (or has met the Waiting Period and is eligible to be enrolled but for failure to enroll in a prior enrollment period) and a person becomes a Dependent through marriage, birth, adoption or Placement for adoption, then the Dependent (and if not otherwise enrolled, the Employer or Employee) may be enrolled. With birth or adoption of a Child, the Spouse may be enrolled if the Spouse is otherwise eligible for coverage.

The Dependent special enrollment period is 31 days and begins on the date of marriage, birth, adoption or Placement for adoption. The request for enrollment must be received by the Plan Administrator within 31 days following that date.

The coverage of the Dependent enrolled in the special enrollment period is effective as follows.

- (a) With marriage, the date of marriage.

(b) With birth, the date of birth.

(c) With adoption or Placement for adoption, the date of adoption or Placement.

RETIRED EMPLOYEE ENROLLMENT

Retired Employee Enrollment Requirements. A Retired Employee must apply for retiree coverage by completing an enrollment application and submitting it to the Plan Administrator within 31 days after the person initially becomes eligible for such coverage. Failure to elect retiree coverage when first eligible shall waive any future rights to apply for retiree coverage.

Special Enrollment Periods, Dependents of Retired Employees. The Enrollment Date for anyone enrolled in a special enrollment period is the first date of coverage. The time between the date a special enrollee first becomes eligible for enrollment and the first day of coverage is not treated as a Waiting Period. If the Retired Employee is a Participant and a person becomes a Dependent through marriage, birth, adoption or Placement for adoption, then the Dependent may be enrolled. With birth or adoption of a Child, the Spouse may be enrolled if the Spouse is otherwise eligible for coverage. The Dependent special enrollment period is 31 days and begins on the date of marriage, birth, adoption or Placement for adoption. The request for enrollment must be received by the Plan Administrator within 31 days following that date. The coverage of the Dependent enrolled in the special enrollment period is effective as follows.

(1) With marriage, the date of marriage.

(2) With birth, the date of birth.

(3) With adoption or Placement for adoption, the date of adoption or Placement.

OPEN ENROLLMENT

December is the only open enrollment period during which Participants are able to change their Option election.

Benefit choices made during open enrollment are effective January 1. They remain in effect until the next January 1 unless there is a family status change during the year. Examples of family status changes are birth, death, marriage, divorce and adoption. Also, benefit choices may be changed during the year if coverage is lost due to loss of a Spouse's employment. When changing from one Option to another Option, credit will be given for the satisfied portions of any Waiting Period.

A Participant who fails to make an election during open enrollment retains the present coverages.

A Participant, other than a Retired Employee and his or her Dependents, who first enrolls during open enrollment and whose enrollment is late will be a Late Enrollee. Retired Employees may not elect coverage during open enrollment.

Upon approval by the Plan Administrator, an Employer may elect an open enrollment period other than December for an effective date other than January 1.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee is covered on the first day that the Employee satisfies all of the following.

(1) The eligibility requirement.

(2) The Active Employee requirement.

(3) The enrollment requirements.

Active Employee Requirement. An Employee must be an Active Employee for coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage takes effect on the day that all of the following are satisfied.

- (1) The eligibility requirement.
- (2) The Participant is covered.
- (3) The enrollment requirements.

Effective Date of Retired Employee Coverage. A Retired Employee is covered on the first day that the Retired Employee satisfies all of the following.

- (1) The eligibility requirement.
- (2) The Retired Employee requirement.
- (3) The enrollment requirements.

Retired Employee Requirement. The person must be a Retired Employee for coverage to take effect.

TERMINATION OF COVERAGE

When coverage under the Plan stops, Covered Persons may request to obtain a certificate that will show the period of coverage under the Plan. Please contact the Plan Administrator for further details.

When Coverage Terminates. Coverage will terminate on the earliest of these dates (except in certain circumstances, a Covered Person may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see Part XIV, COBRA Continuation Options):

- (1) **Plan Discontinuance.** Coverage terminates for all Covered Persons on the date the Plan is terminated.
- (2) **Voluntary Discontinuance.** The Employee may voluntarily terminate coverage by advance written notice to the Plan Administrator. The termination for the Employee and any Dependents takes effect on the last day of the month when coverage was terminated.

The Retired Employee may voluntarily terminate coverage by advance written notice to the Plan Administrator. The termination for the Retired Employee and any Dependents takes effect on the last day of the month when coverage was terminated. If a Retired Employee voluntarily terminates Retired Employee coverage, then the Retired Employee may not reinstate Retired Employee coverage.

- (3) **Non Payment of Contribution.** Coverage is automatically terminated on the contribution due date for all unpaid Covered Persons. A grace period of 31 days is allowed for the payment of every contribution after the initial contribution.
- (4) **Termination of Association Membership.** For a self-employed Member physician, the loss or withdrawal of membership in the Association results in the termination of coverage for that physician and all persons covered under that employer. The termination takes effect on the last day of the month when membership in the Association was lost or withdrawn.

For an Equity Medical Entity, the loss or withdrawal of membership in the Association that results in less than 50% of the voting control being held by Members who are Participants results in the termination of coverage for that Equity Medical Entity and all persons covered under that employer. The termination takes effect on the last day of the month when the requisite membership in the Association was lost or withdrawn.

For a Member physician employed by a Non-Equity Medical Entity, the loss or withdrawal of membership in the Association results in the termination of coverage for that physician and all covered Dependents. The termination takes effect on the last day of the month when membership in the Association was lost or withdrawn.

For a physician Retired Employee, the loss or withdrawal of membership in the Association results in the termination of coverage for that physician and all covered Dependents. The termination takes effect on the last day of the month when membership in the Association was lost or withdrawn.

- (5) **Termination of Employment.** If an Employee terminates or is terminated from employment, coverage ceases for the affected Employee and any Dependents. Coverage ceases on the last day of the month when employment terminated.
- (6) **Loss of Employee Eligibility.** If an Employee loses eligible status as defined, coverage ceases for the affected Employee and any Dependents. Coverage ceases on the last day of the month when eligibility was lost.
- (7) **Loss of Retired Employee Eligibility.** If a Retired Employee loses eligible status as defined, coverage ceases for the affected Retired Employee and any Dependents. Coverage ceases on the last day of the month when eligibility was lost.
- (8) **Military Duty.** If a Covered Person enters the armed forces of any country as a full-time member where active duty is to exceed thirty (30) days, coverage ceases for the Covered Person and all persons covered under that person. Coverage ceases on the last day of the month when military duty began.
- (9) **Loss of Dependent Status for Child.** Coverage for a Child terminates on the earliest of any of the following.
 - (a) The last day of the month when the Child is at least 26.
 - (b) The last day of the month when the Child is no longer dependent upon the Participant for support and maintenance and is at least 26.
 - (c) The last day of the month when the Child is not a Full Time Student and is at least 26.

In the event the Child is no longer a Full Time Student, because the Child is not enrolled in the next scheduled school period, then coverage continues until the last day of the month that next scheduled school period starts, but coverage shall not extend past the last day of the month when the Child is 30.

In the event the Child is no longer a Full Time Student, because the Child graduated from an Accredited School, then coverage may be extended for up to 3 months, but coverage shall not extend past the last day of the month when the Child is 30.
 - (d) The last day of the month when the Child is 30.
 - (e) The last day of the month when the Child becomes eligible for an employer sponsored group health plan and is at least 26.

- (10) **Loss of Dependent Status for Spouse.** Coverage for a Spouse terminates on the date of the following.
 - (a) The last day of the month when there was a legal separation.
 - (b) The last day of the month when there was a divorce decree.
 - (c) The last day of the month when there was an annulment.

- (11) **Loss of Residency.** If a Participant no longer satisfies the residency requirement, coverage ceases for the affected Participant and any Dependents. Coverage ceases on the last day of the month following thirty (30) days after loss of residency.
- (12) **Death.** Coverage terminates on the date of death of the Covered Person for the Covered Person and all persons covered under that person.

Death of a Participant. Upon the death of a Participant, coverage for any Dependents may continue. If the request for continuation of Dependent coverage is received by the Plan Administrator within thirty (30) days of death and contributions are paid, coverage will continue until the earlier of the following.

- (1) The date the Dependents become otherwise ineligible.
- (2) The date the Spouse remarries.

Coverage is that which was in force on the date of death. The persons covered will be those covered on the date of death and any Child of Participant born after that day. Coverage for any person will not be continued beyond the date it would have ceased had Participant not died.

The period for which coverage is continued shall be no less than the duration of any person's continuation rights under COBRA.

Continuation During Periods of Employer Certified Disability or Leave of Absence.

- (1) **Employer Certified Disability.** If Active Work ceases due to an Employee being disabled due to Illness or Injury and the Illness or Injury is certified by the Employer, then coverage may continue during the disability. Coverage may continue until the **earlier** of the month end that the Employer ceases to certify the disability **or** the month end following 90 days from the day that Active Work ceased. To continue coverage, contributions must be paid for the Employee.
- (2) **Leave of Absence.** If Active Work ceases due to a leave of absence, then coverage may continue during the leave of absence. Coverage may continue until the **earlier** of the month end that the leave of absence ends **or** the month end following 90 days from the day that Active Work ceased. To continue coverage, contributions must be paid for the Employee.

Coverage is that which was in force on the last day of Active Work. If benefits reduce for others in the class, they also reduce for the continued person.

Continuation During Family and Medical Leave. The Plan shall comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor. As such, the following provisions shall only apply to employers subject to FMLA.

During any leave taken under FMLA, the Employer will maintain coverage on the same conditions as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

If coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and any Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage when the FMLA leave started. It will be reinstated to the same extent that it was in force when that coverage terminated.

Continuation During Military Leave. Covered Persons going into or returning from military service may elect to continue coverage mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to persons covered before leaving for service.

- (1) The maximum period of coverage under an election shall be the lesser of the following.
 - (a) The 24-month period beginning the date the person's absence begins.
 - (b) The day after the date the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue coverage may be required to pay up to 102% of the full contribution. A person on active duty for 30 days or less cannot be required to pay more than the Employee or Retired Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not terminated due to service. An exclusion or Waiting Period may be imposed for coverage of an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during service.

**PART IV
SCHEDULE OF BENEFITS**

ALL BENEFITS ARE AS LISTED IN THE APPLICABLE SCHEDULE OF BENEFITS BOOKLET, WHICH IS INCORPORATED HEREIN BY REFERENCE, AND ALL BENEFITS ARE SUBJECT TO ALL OTHER PROVISIONS OF THE PLAN AS DESCRIBED IN THE PLAN DOCUMENT.

ALL BENEFIT PERCENTAGES AND OTHER LIMITS APPLY TO THE MAXIMUM ALLOWABLE CHARGE AS DEFINED WITHIN THE DEFINITIONS SECTION OF THIS PLAN DOCUMENT.

IF YOU DO NOT HAVE THE APPLICABLE SCHEDULE OF BENEFITS BOOKLET, PLEASE CONTACT YOUR EMPLOYER.

PART V
MEDICAL BENEFITS

COVERED EXPENSES

Medical benefits apply when Covered Expenses are incurred by a Covered Person for Medically Necessary care of an Injury or Sickness while the person is covered. Covered Expenses are the Maximum Allowable Charge incurred for the following items of service and supply. These expenses are subject to the benefit limits, exclusions and other provisions. An expense is incurred on the date that the service or supply is performed or furnished.

- (1) **Home Health Care Services and Supplies.** Expenses are covered only for care and treatment of an Injury or Sickness when a Hospital or Skilled Nursing Facility stay would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and contained in a Home Health Care Plan.
- (2) **Hospice Care Services and Supplies.** Expenses are covered only when the attending Physician has diagnosed the Covered Person's condition as terminal. The Physician must have determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.
- (3) **Hospital Care.** The medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or Birthing Center.

After 23 observation hours, a stay is treated as an inpatient stay.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Expenses for multiple surgical procedures are covered subject to the following.

- (a) If bilateral or multiple surgical procedures are performed by 1 surgeon, benefits are determined based on the Allowable Charge that is allowed for the primary procedures. Benefits for each additional procedure that is not incidental are allowed at 50% of the Allowable Charge. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis is treated as incidental. No benefits are provided for incidental procedures.
 - (b) If multiple unrelated surgical procedures are performed by 2 or more surgeons on separate operative fields, benefits are based on the Allowable Charge for each surgeon's primary procedure.
 - (c) If 2 or more surgeons perform a procedure that is normally performed by 1 surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure.
 - (d) If 2 surgeons perform a procedure that is normally performed by 2 surgeons, benefits shall not exceed 125% of the Allowable Charge for that procedure.
 - (e) If an assistant surgeon is required, the assistant surgeon's Covered Expense will not exceed 20% of the surgeon's Allowable Charge.
- (5) **Pregnancy.** Expenses for the care and treatment of Pregnancy are covered the same as any other Sickness.

Genetic analysis to determine the gender of a fetus is not a Covered Expense.

Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay following a Cesarean section may not be limited to less than 96 hours for both the mother (if a Covered Person) and the newborn child.

Postpartum home care following a vaginal delivery if childbirth occurs at home or in a Birthing Center shall provide for 1 home visit or 1 visit to a facility with a licensed health care provider whose scope of practice includes providing postpartum care.

- (6) **Private Duty Nursing Care.** Expenses are covered for inpatient nursing care or private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). The care must not be Custodial in nature. The Hospital's ICU must be filled or the Hospital has no ICU.
- (7) **Skilled Nursing Facility Care.** Following a Hospital stay, the room and board and nursing care provided by a Skilled Nursing Facility are covered subject to the following.
 - (a) The patient is confined as a bed patient in the Skilled Nursing Facility within 3 days following discharge from a Hospital stay.
 - (b) The attending Physician certifies that the stay is needed for further care of the condition that caused the Hospital stay.
 - (c) The attending Physician completes a treatment plan. The plan must include a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.
- (8) **Long Term Acute Care Facility.** Following a stay in ICU, the room and board and nursing care provided by a Long Term Acute Care Facility are covered subject to the following.
 - (a) The patient is confined as a bed patient in the Long Term Acute Care Facility.
 - (b) The attending Physician certifies that the patient is acutely ill and requires more specialized programs and intensive nursing intervention.
 - (c) The attending Physician completes a treatment plan. The plan must include a diagnosis, the proposed course of treatment and the projected date of discharge from the Long Term Acute Care Facility.
- (9) **Other Medical Services and Supplies.** The services and supplies not included above are covered as follows.

Emergency only professional land or air **ambulance** service. Expenses for this item are covered only if the service is to the nearest Medical Care Facility where necessary treatment can be provided.

Anesthetic. Intravenous injections and solutions. Administration of these items is covered.

Blood. Blood and blood derivatives that are not donated or replaced.

Breast prostheses and breast reconstruction. Charges for or in connection with the implantation or removal of breast prostheses or breast reconstruction. The Covered Person must be at least age 18:

- (i) Treatment of breast cancer. Pursuant to 36 O.S. § 6060.5, coverage is provided for not less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection. The attending Physician with the patient may determine that a shorter stay is appropriate. Reconstructive surgery performed on the diseased breast due to partial or total mastectomy is covered. When reconstructive surgery is performed on the diseased breast, all stages of reconstructive surgery performed on the nondiseased breast to establish symmetry is covered so long as the reconstructive surgery and any adjustments made to the nondiseased breast occur within 24 months of reconstruction of the diseased breast.
- (ii) For reconstruction after mastectomy, cancer treatments or therapeutic or prophylactic mastectomy for other medical reasons. This category includes cancer patients who were previously reconstructed without satisfactory results. Complications of Cosmetic Treatments and Services are not covered.

(iii) For reconstruction due to severe breast or chest deformity not related to breast cancer or previous mastectomy. This category includes patients certified by a Physician as having a severe breast deformity including a deformity due to congenital or developmental problems, Injury or medical or surgical complications of prior breast reconstruction. Complications of Cosmetic Treatments and Services are not covered.

Cardiac rehabilitation. The services must be rendered under a Physician's supervision in a Medical Care Facility. The services must be connected with a myocardial infarction, coronary occlusion or coronary bypass surgery. The service must be initiated within 12 weeks after other treatment for the medical condition ends.

Chemotherapy or radiation and treatment with radioactive substances. The materials and services of technicians are covered. Covered Expenses for proton beam therapy, including professional and technical services listed in the schedule of benefits booklet.

Initial **contact lenses** or glasses required following cataract surgery.

Diabetes services including self-management training mandated by 36 O.S. § 6060.2. Also, related provider services mandated by OAC § 310:590-3-2 and podiatric health care provider services mandated by OAC § 310:590-3-3.

Durable Medical Equipment (DME). Rental of Durable Medical Equipment. Items may be purchased rather than rented if rental would be more costly, or if rental of the item is not available from any provider, but only if agreed to in advance by the Plan Administrator. Replacement of purchased DME will be covered when it is no longer functional or repairable. Covered Expenses shall exclude any cost for maintenance, repair, alteration or additions to any structure or vehicle and are listed in the schedule of benefits booklet.

Electrical Stimulators. Covered Expenses include the Electrical Stimulator and any associated equipment needed for the Electrical Stimulator to be fully functional. Covered Expenses are listed in the schedule of benefits booklet.

Genetic analysis. Genetic analysis to determine the gender of a fetus is not a Covered Expense.

Intraoperative monitoring. Charges are a Covered Expense only when required for posterior instrumentation of the cervical, thoracic or lumbar spine. The monitoring must be provided by a Physician who is present in the operating room or a directly adjacent room, who is not a member of the operating team and who is only monitoring a single case. Results of the monitoring must be available immediately during the surgical procedure. Charges will be considered for a period of time commencing with the surgical incision and concluding with the closing of the surgical wound. Submission of the operative report and monitoring report is required as substantiation of the claim.

Lab studies.

Treatment of **Mental Health and Substance Use Disorders.** Expenses for the care and treatment of Mental Health and Substance Use Disorders are covered the same as any other Sickness. Counseling charges are covered only when the patient is in attendance.

Mouth, teeth and gums. Expenses are covered only if care is for the following oral surgical procedures or treatments.

- (i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- (ii) Emergency repair or replacement of adult sound natural teeth due to Injury. This repair or replacement must be made within 12 months from the accident date. Dental implants, orthodontia and related services are not covered.

- (iii) Surgery needed to the jaws, cheeks, lips, tongue, floor and roof of the mouth due to Injury.
- (iv) Excision of benign bony growths of the jaw and hard palate.
- (v) External incision and drainage of cellulitis.
- (vi) Incision of sensory sinuses, salivary glands or ducts.
- (vii) Removal of wisdom teeth, numbers 1, 16, 17 and 32 only.

Expenses for anesthesia administration and Hospital and Ambulatory Surgical Center expenses for dental procedures are covered when provided to a Covered Person with a medical or emotional condition which requires hospitalization or general anesthesia for dental care and who is severely disabled or age 8 or younger.

No expense is covered for dental and oral surgical procedures involving orthodontic teeth care, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

OT by a licensed therapist. Therapy must be ordered by a Physician. Therapy must follow an Injury or Sickness. Therapy must be to improve a body function. Expenses for recreational programs, Supportive or Maintenance care or treatment or OT supplies are not covered.

The initial purchase, fitting, repair and replacement of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body due to a disabling congenital condition, Injury or Sickness.

Oxygen. Covered Expenses are listed in the schedule of benefits booklet.

PT by a licensed therapist. Therapy must follow a Physician's exact orders as to type, frequency and duration. Therapy must be to improve a body function. Expenses for Supportive or Maintenance care or treatment are not covered.

Prescription Drugs subject to the provisions in Part VI.

Routine **preventive care.** Expenses are covered for routine wellness services listed in the schedule of benefits booklet and elsewhere in the Plan.

The initial purchase, fitting, repair and replacement of fitted **prosthetic devices** that replace body parts.

Reconstructive Surgery. Procedures that are not defined as Cosmetic Treatments and Services.

Specialty Drugs subject to the provisions in Part VII.

Speech therapy by a licensed therapist. Therapy must be ordered by a Physician. Therapy must follow surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), an Injury or a Sickness that is other than a learning disorder. Expenses for Supportive or Maintenance care or treatment are not covered.

Spinal Manipulation services by a licensed M.D., D.O. or D.C. Expenses for Spinal Manipulation are subject to the Calendar Year maximum listed in the schedule of benefits booklet.

Sterilization procedures. Expenses for reversal of sterilization are never covered.

Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

Transplants. Expenses otherwise covered that are incurred for the care and treatment due to an organ or

tissue transplant from human to human are subject to the following.

- (i) The transplant must be performed to replace an organ or tissue.
- (ii) Expenses for obtaining donor organs or tissues are covered only when the recipient is a Covered Person. In such instances, the donor's medical plan pays first, and the benefits under the Plan are reduced by those payable under the donor's plan. Donor charges include those for the following.
 - (a) Evaluating the organ or tissue.
 - (b) Removing the organ or tissue from the donor.
 - (c) Transporting the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- (iii) Transplants only include those transplants that are approved for Medicare coverage on the date the transplant is performed and are not otherwise excluded by the Plan.
- (iv) Charges for organ or tissue transplants are subject to the limit listed in the schedule of benefits booklet.

Expenses associated with the purchase of a **wig or other scalp prostheses after chemotherapy or radiation therapy** is subject to the limit listed in the schedule of benefits booklet.

Diagnostic **x-rays**.

- (10) **Participation in approved Clinical Trials.** The Plan will not pay for any treatment or any services, supplies, devices or other items or technology that are provided in connection with Experimental or Investigational treatment except that, the Plan will pay for Routine Patient Costs incurred by a Qualified Individual associated with approved Clinical Trials subject to the following additional conditions, definitions and requirements:
- (a) Any payment for Routine Patient Costs will be subject to the conditions and limitations that apply to all Covered Expenses such as co-payment requirements and the requirement that charges not exceed the amount that is reasonable and customary.
 - (b) "Routine patient costs" include items and services typically provided under the plan for a participant not enrolled in a clinical trial. However, such items and services do not include:
 - (i) the investigational item, device or service itself;
 - (ii) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis;
 - (iii) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis;
 - (iv) services or items which in the absence of private healthcare coverage are provided by a clinical trial sponsor or other party without charge to a trial participant (e.g., a device, drug, items or services supplied by a manufacturer and not yet FDA approved).
 - (c) "Qualified Individual" is a Covered Person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other Life-threatening disease or condition and either:

- (i) the referring health care professional is a participating provider and has concluded that the Covered Person’s participation in the clinical trial would be appropriate; or
 - (ii) the Covered Person provides medical and scientific information establishing that the Covered Person’s participation in the clinical trial would be appropriate based the individual meeting the conditions of the trial protocol.
- (d) “Approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other Life-threatening disease or condition and is described in any of the following subparagraphs (i) through (iv):
- (i) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - A. The National Institutes of Health.
 - B. The Centers for Disease Control and Prevention.
 - C. The Agency for Health Care Research and Quality.
 - D. The Centers for Medicare & Medicaid Services.
 - E. cooperative group or center of any of the entities described in clauses (A) through (D) or the Department of Defense or the Department of Veterans Affairs.
 - F. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - G. Any of the following if the conditions described in paragraph (iv) are met:
 - aa. The Department of Veterans Affairs.
 - bb. The Department of Defense.
 - cc. The Department of Energy.
 - (ii) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
 - (iii) The study or investigation is a drug trial that is exempt from the requirements for having such an investigational new drug application.
 - (iv) Conditions for departments. The conditions described in subparagraphs C(i)E and G above, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the federal Department of Health and Human Services determines—
 - A. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and
 - B. assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- (e) “Life-threatening condition” is a disease or condition likely to result in death unless the disease or condition is interrupted.

- (f) If one or more Participating Providers participates in an approved Clinical Trial, the Plan may require a Qualified Individual to receive the Routine Patient Services through a Participating Provider if the provider will accept the Qualified Individual as a patient.

The Plan Administrator may request documentation or other evidence to establish that the conditions and requirements described above have been satisfied and may withhold payment or reimbursement until such documentation is received.

PART VI
OUTPATIENT PRESCRIPTION DRUG BENEFIT (Administered by MaxCare)

Benefits are provided for outpatient Prescription Drugs when a Prescription Order is dispensed by a Participating Pharmacy. The Covered Person is required to make the appropriate copayment to the Participating Pharmacy at the time the Prescription Order is dispensed.

Copayments made for benefits for outpatient Prescription Drugs are applied to the out-of-pocket maximum.

Covered Benefits. Benefits for outpatient Prescription Drugs are provided when the Prescription Order is dispensed by a Participating Pharmacy. A Prescription Order not dispensed by a Participating Pharmacy may be reimbursable subject to the provisions of the Plan and the Covered Person filing the required documentation.

New Medications: When a new medication receives FDA approval, it is subject to evaluation by the Plan for coverage status and formulary placement prior to inclusion in the Outpatient Prescription Drug Benefit or the Specialty Drug Benefit. The evaluation process applies to new drugs with novel chemical structures, as well as to newly-approved formulations of existing drugs.

Covered Products Include. Prior authorization requirements and/or quantity limits may apply.

- (1) Drugs that require a Prescription by law.
- (2) Compound medications where at least 1 active ingredient is a Prescription Drug.
- (3) Diabetic products.
 - (a) Blood glucose meters (1 device per year).
 - (b) Supplies (alcohol swabs, lancets and lancet devices).
 - (c) Test strips and tablets (urine, blood glucose and ketone).
 - (d) Insulin and syringes.
 - (e) Insulin injecting devices (1 device per year).
 - (f) Glucagon (auto injection).
 - (g) Other oral and injectable drugs used to treat diabetes.
- (4) Injectables.
 - (a) Anaphylaxis agents. Epi-Pen, etc.
 - (b) Growth hormones. Treatment is limited to Growth Hormone Deficiency diagnosed in children based on lab evidence.
 - (c) Migraine treatments.
- (5) Other Devices.
 - (a) Aerochamber, Aerochamber with mask (1 device per year).
 - (b) Peak flow meter (1 device per year).

- (6) Preventive Care Medications, as mandated by PPACA.
 - (a) Smoking cessation products – Limit 180 days per year.
 - (b) Aspirin.
 - (c) Contraceptives – Generic products and Branded products with no Generic equivalent.
 - (d) Fluoride Supplements – through age 12.
 - (e) Iron Supplements – age 6-12 months.
 - (f) Prenatal Vitamins.
 - (g) Vitamin D – age 65 and older.
 - (h) Vaccines.
 - (i) Breast Cancer Prevention – tamoxifen, raloxifene.

Supply Limits.

- (1) Retail. 90 days supply.
- (2) Mail order. 90 days supply.
- (3) Early refill. 75% of days supply.
- (4) Compounded medications. 30 days supply.

Exclusions and Limitations Summary.

- (1) Over the counter (OTC) medications and products
- (2) Biological sera and immunization agents.
- (3) Drugs used for cosmetic purposes.
- (4) Blood or blood related products.
- (5) Drugs covered under government programs.
- (6) Experimental and/or Investigational medication.
- (7) Medication administered while in a Hospital or other care facility.
- (8) Medication administered by a healthcare provider or charges for administration.
- (9) Electrolyte replacement fluids.
- (10) Infant formulas.
- (11) Nutritional supplements, including food.
- (12) Anti-obesity/Weight Loss medications.

(13) Durable medical equipment

(14) Therapeutic devices or appliances, including support garments and other non-medical substances regardless of their intended uses.

(15) Vitamins – other than those listed under Preventive Care Medications.

(16) Fertility agents.

(17) Growth hormones. Age 19 and older.

(18) Unit-dose packaged medications. Exception: drugs that would otherwise be covered that are available only in unit-dose packaging.

All other exclusions and limitations listed in Part X apply.

PART VII
SPECIALTY DRUG BENEFIT

The drugs listed in the schedule of benefits booklet are considered specialty drugs. The specialty drug list is subject to change. Benefits hereunder are excluded from the Outpatient Prescription Drug Benefit in Part VI.

The Plan has entered into pharmacy network of specialty pharmacies that includes both retail and mail service pharmacies. Specialty drugs must be dispensed by a participating specialty pharmacy. Please contact the prescription benefits manager to locate a participating specialty pharmacy.

All specialty drugs require prior authorization.

New Medications: When a new medication receives FDA approval, it is subject to evaluation by the Plan for coverage status and formulary placement prior to inclusion in the Outpatient Prescription Drug Benefit or the Specialty Drug Benefit. The evaluation process applies to new drugs with novel chemical structures, as well as to newly-approved formulations of existing drugs.

**PART VIII
COST MANAGEMENT SERVICES**

The Covered Person is required to make sure the Plan is notified within 2 business days of the beginning of a Covered Person's hospital inpatient stay, Long Term Acute Care Facility stay, skilled nursing facility stay, home health care or purchase or rental of durable medical equipment in excess of \$1,000. Please review this part carefully to avoid a benefit reduction.

Post-service Notification & Cost Management Services Phone Number

CareValent Care Management

855-316-5115

The Covered Person or family member must call this number to provide post-service notification. This call must be made within 2 business days of services being rendered.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the out-of-pocket maximum. Refer to the schedule of benefits booklet for details.

UTILIZATION MANAGEMENT

Utilization management is a program designed to help assure that all Covered Persons access appropriate health care, avoid unnecessary expenses and receive the maximum benefit level afforded by the Plan.

The program consists of the following:

- (1) Post-service notification within 2 business days of the commencement of the following services.
 - (a) Hospitalizations for inpatient services, including but not limited to, acute care, rehabilitation services and mental health and substance use treatment services;
 - (b) Long Term Acute Care Facility stay;
 - (c) Skilled Nursing Facility stay;
 - (d) Home health care, including but not limited to, infusion and injectable drug therapy;
 - (e) DME that will exceed a purchase or rental value of \$1,000; and
 - (f) Dialysis treatment.
- (2) Retrospective review of the Medically Necessary requirement for services for which claims have been made.
- (3) Concurrent review, based on the admitting diagnosis, of the services requested by the attending Physician.
- (4) Review of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

Mothers and Newborns. Post-service notification is not required for a maternity stay that is 48 hours or less for a vaginal delivery, or 96 hours or less for a cesarean delivery. If newborn dependents are inpatients for longer than 2 business days, post-service notification is required. If a Covered Person, including a newborn dependent, is not discharged within these time periods, post-service notification is required.

In order to maximize benefits, please read the following provisions carefully.

Here's how the program works.

Post-service Notification. Within 2 business days of the beginning of a service or treatment program that requires post-service notification, the Covered Person or the representative must contact the utilization management administrator. Even though the provider can make notification, **it is the Covered Person's responsibility to make sure that required notice is given.**

Contact the Plan's utilization management administrator at the following.

CareValent Care Management
855-316-5115

Have all of the following information at hand.

The name of the patient and relationship to the Participant or Retired Employee.

The name, identification number and address of the Participant or Retired Employee.

The name of the Employer.

The name and telephone number of the attending Physician.

The name of the Medical Care Facility, date of admission, and proposed length of stay.

The diagnosis and/or type of surgery.

The proposed rendering of listed medical services.

Concurrent review and discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization management program. The Plan's utilization management administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services. The Plan's utilization management administrator will coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay, or extension or cessation of the use of other medical services.

CASE MANAGEMENT

When a catastrophic condition occurs, a person may require long term, perhaps lifetime care. After the person's condition is diagnosed, the person might need extensive services or might be able to be moved into another type of care setting, even to home.

Case management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following.

Personal support to the patient.

Contacting the family to offer assistance and support.

Monitoring Hospital or Skilled Nursing Facility.

Determining alternative care options.

Assisting in obtaining any necessary equipment and services.

Alternate benefits may be approved when they are beneficial to both the patient and the Plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan will cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note. Case management is a voluntary service. There are no benefit reductions or penalties if the patient and family choose not to participate.

Each treatment plan is personally tailored to a specific patient. Treatment plans should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

PART IX DEFINED TERMS

The following terms and any additional terms in the schedule of benefits booklet have special meanings. When used in the Plan, they will be capitalized.

Accredited School. A public or private institution of higher education. A vocational school licensed and certified by an instrumentality of the government.

Active Employee. An Employee on the Employer's regular payroll and scheduled to perform the duties of his or her job in the Employer's medical practice on a Full Time Basis. An Employee is considered an Active Employee even if the Employee is not at work due to disability, Sickness or Injury on the day that coverage would become effective. An Employee who is a Member and under the age of 65.

Active Work. Performance of all customary duties of a person's job in the Employer's medical practice on a Full Time Basis.

Adverse Benefit Determination – Any of the following: (1) a denial in benefits; (2) 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 based on a determination of a Claimant's eligibility to participate in the Plan; (3) a reduction in benefits; (4) a rescission of coverage, even if the rescission does not impact a current claim for benefits; (5) termination of benefits; (6) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; (7) a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Allowable Charge. The Maximum Allowable Charge for a given supply or item of service.

Ambulatory Surgical Center. A licensed facility that is used mainly for performing outpatient surgery. The facility must have a staff of Physicians. The facility must have continuous Physician and nursing care by R.N.s. The facility must not provide for overnight stays.

Anticipation Of Adoption. Refers to a child whom the Participant or Retired Employee intends to adopt, whether or not the adoption has become final, who has not attained age 18 as of the date of Placement for adoption.

Assignment of Benefits. An arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and deductibles, co-payments and the coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke an assignment of benefits at its discretion and treat the Covered Person as the sole beneficiary.

A provider which accepts an assignment of benefits in accordance with this Plan does so as consideration in full for services rendered, and is bound by the rules and provisions set forth within the terms of this document.

Association. The Oklahoma State Medical Association.

Birthing Center. Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home like atmosphere. The facility must be licensed and operated in accordance with the laws in the jurisdiction where the facility is located. It must provide facilities for obstetrical delivery and short-term recovery after delivery. It must also provide care under the full-time supervision of a Physician and either an R.N. or a licensed nurse-midwife. It must have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require a pre- or post-

delivery stay.

Calendar Year. January 1 through December 31 the same year.

Child (Children). All natural-children, legally adopted children, children Placed with a Participant or Retired Employee in Anticipation Of Adoption, or stepchildren. Also, all children for whom the Participant or Retired Employee is the Legal Guardian and all children that the Participant or Retired Employee is legally required to support.

Clinical Trials. Benefits will be excluded for the expense incurred for treatment for a clinical trial that does not meet the requirements outlines in PART V MEDICAL BENEFITS.

Claimant – A participant of the Plan, or entity acting on the participant’s behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Treatments and Services. Treatments and services intended primarily to improve appearance. Any procedure or service to change the size of any body part or increase or decrease the height of a Covered Person.

Covered Expenses. The Maximum Allowable Charge for Medically Necessary services, supplies and medical equipment authorized or provided by a Physician.

Covered Persons. Employers, Employees, Retired Employees and their Dependents that are covered under the Plan.

Custodial Care. Care that is given principally for personal hygiene or for assistance in daily activities or rest cure. Care that can, according to generally accepted medical standards, be performed by persons who have no medical training. Custodial Care includes room and board needed to provide that care. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication that could normally be self-administered.

Dependents. Those persons specified in Part III who are eligible for coverage.

Durable Medical Equipment (DME). Equipment which (a) can withstand repeated use, (b) is primarily and customarily used for a medical purpose, (c) generally is not useful to a person absent an Illness or Injury and (d) is appropriate for home use.

Electrical Stimulators. Electrical stimulator devices may provide direct alternating, pulsating or pulsed waveform forms of energy. Some devices are used to exercise muscles by stimulation through electrodes placed on the skin. Some are used to demonstrate a muscular response to stimulation of a nerve, relieve pain, cause contraction of muscles or stimulate bone growth. Electrodes for such devices may be implanted, indwelling, transcutaneous (needles) or surface. Electrical stimulators may have a generator/receiver, electrode leads, a programmer/transmitter, and may have controls to set the pulse length, pulse repetition frequency, pulse amplitude, and triggering modes.

Employee. A person in the employment of an Employer, including a Member physician (MD or DO) Employee, or a self-employed Member physician who qualifies as an Employer. A non-Member physician is an Employee if that physician does not have an ownership interest in the employing Equity Medical Entity.

Employer. A self-employed Member physician; the individual physician and his or her Dependents may be covered under the Plan if all eligibility requirements are satisfied. Employer includes an Equity Medical Entity. Employer also includes a Non-Equity Medical Entity.

Enrollment Date. The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Equity Medical Entity. A legal entity comprised of Members where at least 50% of the voting control is held by Members who are Participants.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational. Medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II, III or IV). Benefits will be excluded for the expense incurred for treatment for a clinical trial that does not meet the requirements outlined in PART V MEDICAL BENEFITS. A service device or supply will also be considered Experimental/Investigational if the Covered Person is required to sign a consent form which indicated the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.

The determination of whether services, supplies and/or treatment are experimental and or investigational shall be made by the Plan Administrator.

Family Unit. The Participant or Retired Employee and his or her Dependents under the Plan.

Final Post-Service Appeal – A post-service appeal, which constitutes the second and final internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term “Final Post-Service Appeal” shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Claimant; otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator or “PACE.”

Full Time Basis. Employment of 24 hours or more per week.

Full Time Student. A Participant’s Dependent Child who enrolls at the beginning of the Spring academic session or the Fall academic session in an Accredited School for the minimum number of hours required by that institution to meet full time student status. The time period covered by the Spring academic session is January 1 through August 31 each year. The time period covered by the Fall academic session is July 1 of each year through January 31 of the next year. It is the Participant’s responsibility to submit proof of full time student status to the Plan Administrator each academic session.

A Dependent Child that meets the definition of Full Time Student will be considered a Full Time Student for purposes of eligibility under this Plan for the entire length of the applicable academic session, as defined above, including the academic session of graduation.

A Dependent Child that enrolls at the beginning of either the Spring or Fall academic session in an Accredited School for the minimum number of hours required by the institution to meet full time student status and subsequently drops to part time student status during that academic session, will be considered a Full Time Student for purposes of eligibility under this Plan for the remainder of that academic session as defined above. A Dependent Child who withdraws from the institution during the academic session is no longer eligible as of the date of withdrawal.

Genetic Information. Information about genes, gene products and inherited characteristics that may derive from a person or a family member. This includes information regarding carrier status and information derived from lab tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Growth Hormone Deficiency. Children who are three or more standard deviations below normal and whose growth progression are in the 3rd to the 10th percentile. Children who have Turner's Syndrome with evidence of growth hormone deficiency. Also, children who have chronic renal deficiency with evidence of growth hormone deficiency.

Healing Arts. Podiatry. Chiropractic. Dentistry. Medicine and surgery. Optometry. Osteopathy. Psychology. Speech and language pathology. Audiology.

Health Maintenance Organization (HMO). An entity organized to provide defined health care services to members in a specific geographic area in return for fixed, periodic premiums paid in advance.

Home Health Care Agency. An entity whose main function is to provide Home Health Care Services and Supplies. It is federally certified as a home health care agency. It is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan. A formal written plan made by the patient's attending Physician that is reviewed at least every 30 days. The plan must state the diagnosis, certify that the home health care is in place of a Hospital stay and specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services and Supplies. Part-time or intermittent nursing care by or under the supervision of a R.N. Part-time or intermittent home health aide services provided through a Home Health Care Agency. PT, OT and speech therapy. Medical supplies. Lab services by or on behalf of the Hospital. Home Health Care Services and Supplies do not include general housekeeping services.

Hospice Agency. An entity whose main function is to provide Hospice Care Services and Supplies. It is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan. A plan of terminal patient care that is established and conducted by a Hospice Agency. The plan must be supervised by a Physician.

Hospice Care Services and Supplies. Services and supplies provided through a Hospice Agency and under a Hospice Care Plan. The services and supplies include inpatient care in a Hospice Unit or other licensed facility, home care and family counseling during bereavement.

Hospice Unit. A facility or separate Hospital unit that provides treatment under a Hospice Care Plan. It must admit at least two unrelated persons who are expected to die within six months.

Hospital. An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense. It must be approved by Medicare as a Hospital. It must maintain diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians. It must continuously provide on the premises 24-hour-a-day nursing services by or under the supervision of R.N.s. It must be operated continuously with organized facilities for operative surgery on the premises.

The definition of Hospital shall be expanded to include the following.

- (a) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health. The facility must be so licensed by the state in which the facility operates.
- (b) A facility operating primarily for the treatment of Substance Use Disorders. The facility must maintain permanent and full-time facilities for bed care. The facility must maintain full-time confinement of at least 15 resident patients. The facility must have a Physician in regular attendance. The facility must continuously provide 24 hour a day nursing service by a R.N. The facility must have a full-time psychiatrist or psychologist on staff. Also, the facility must be primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Illness. A bodily disorder, disease, physical Sickness, Mental Health or Substance Use Disorder. Illness includes Pregnancy, childbirth or miscarriage. Illness does not include genetically predisposed diseases, disorders or conditions prior to onset of the disease, disorder or condition.

Injury. An accidental physical injury to the body caused by unexpected external means.

Intensive Care Unit (ICU). A separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the Hospital. It has special life saving equipment that is immediately available at all times. It has at least 2 beds for the accommodation of the critically ill. Also, it has at least 1 R.N. in continuous and constant attendance 24 hours a day.

Late Enrollee. An Employee or Dependent who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian. A person recognized by a court of law as having the duty of taking care of a minor and managing the minor's property and rights.

Long Term Acute Care Facility. A facility that provides extended Hospital care following ICU for medically complex patients who are critically ill, have multisystem complications and/or failures, and require hospitalization, averaging 25 days, in a facility offering specialized treatment programs and aggressive clinical and therapeutic interventions on a continuous basis. The goal is medical recovery and return to home versus stabilization.

Maximum Allowable Charge. the benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]), in conjunction with the Scheduled Benefit Amount, as defined below;
- Visium Medicare Equivalency tables (prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS), in conjunction with the Scheduled Benefit Amount, as defined below;
- Visium Approximation tool (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care), in conjunction with the Scheduled Benefit Amount, as defined below;
- Visium Care Crosswalk (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings), in conjunction with the Scheduled Benefit Amount, as defined below;
- Medicare cost data as reflected in the applicable individual provider's cost report(s);
- the fee(s) which the provider most frequently charges the majority of patients for the service or supply;
- amounts the provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO);
- average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply;
- the prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s). When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge.

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

When applicable, the "Scheduled Benefit Amount" will be determined based on multiplying the most applicable of the following by 160%:

- for inpatient hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values
- for outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values, or the current Medicare allowable fee for the appropriate area;
- for Ambulatory Surgical Centers (ASC), the current Medicare allowable fee for the appropriate area.

For non-participating providers, when applicable, the "Scheduled Benefit Amount" will be determined based on multiplying the following by 125%:

- for physicians and other eligible providers, the current Medicare allowable fee for the appropriate area.

Medical Care Facility. A Hospital. A facility that treats one or more specific ailments. A Skilled Nursing Facility. A Long Term Acute Care Facility.

Medical Emergency. An Illness or Injury which is sudden, life or limb threatening which requires prompt medical treatment and would result in serious effects on the Covered Person's health if not immediately treated.

Medically Necessary. Care and treatment recommended or approved by a Physician. Care and treatment consistent with the patient's condition or accepted standards of good medical practice. Care and treatment medically proven to be effective treatment of the condition. Care and treatment not performed mainly for the convenience of the patient or provider of medical services. Care and treatment not conducted for research purposes. The most appropriate level of services that can be safely provided to the patient. All of the above criteria must be met. Merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicaid. A government funded program in the United States that provides medical expense coverage for

eligible people under age 65 who are indigent and meet certain other criteria.

Medicare. The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member. Any person who is accorded membership status, of any class, in the Association.

Mental Health Disorder. Any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services. Any disease or condition listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance. The basic reparation provision of a law that provides for payments without determining fault connected with automobile accidents.

Non-Equity Medical Entity. A legal entity that employs Member physicians and agrees to comply with the Plan.

Option. Any benefit choice set forth in a schedule of benefits booklet associated with the Plan.

OT. Occupational therapy.

Outpatient Care. Treatment including services, supplies and medicines provided and used at a Hospital under a Physician's direction to a person not admitted as a registered bed patient. Services rendered in a Physician's office, lab or x-ray facility, an Ambulatory Surgical Center or the patient's home.

Participants. All Employers, Active Employees and Retired Employees covered under the Plan. Also, a Medicare eligible retired employee that is covered under the 65 Plus Health Plan solely for purposes of Dependent eligibility under the Plan.

Participating Pharmacy. A pharmacy that has entered into a participating pharmacy agreement with the Plan.

Patient Protection and Affordable Care Act is the federal statute that was signed into law on March 23, 2010 and any amendments to this statute.

Physician. Any practitioner of the Healing Arts licensed by Oklahoma and certified physician assistants.

Placed or Placement. The assumption and retention by Participant or Retired Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced. A child who is in the custody of the Participant or Retired Employee pursuant to an interlocutory decree issued under Section 60.15 of Title 10 of the Oklahoma Statutes vesting temporary care of the child in the Participant or Retired Employee, is an adopted child during the pendency of the adoption proceeding, regardless of whether a final decree of adoption is ultimately issued.

Plan. The OSMA Health - Health Plan that includes this written document, all booklets containing a schedule of benefits associated with the Plan, the enrollment documents and any attached amendments.

Plan Administrator. The Board of Directors of the OSMA Health and Welfare Benefit Corporation.

Plan Appointed Claim Evaluator or "PACE" – An entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which

the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by, and make determination in accordance with, the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

Plan Sponsor. The OSMA Health and Welfare Benefit Corporation.

Pregnancy. Childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug. A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription." Injectable insulin. Hypodermic needles or syringes, but only when dispensed upon a Prescription.

Prescription. A written order, and each refill, for a Prescription Drug issued by a Physician.

PT. Physical therapy.

Reconstructive Surgery. A procedure performed on body structures to restore bodily function or correct deformity due to disease or Injury. Procedures to correct congenital anomalies.

Retired Employee. For non-physician Employees, the following apply: (a) be a former Active Employee of the Employer, under the age of 65, who retired while employed by the Employer; (b) the retiree must have seven years service with that same Employer; (c) the retiree must qualify under that Employer's formal written plan; (d) the retiree must not be gainfully employed in any capacity for 24 or more hours per week; and (e) the retiree must elect to contribute to the Plan the required contribution.

For physician Employees, the following apply: (a) be a former Active Employee of the Employer, under the age of 65, who retired while employed by the Employer; (b) the retiree must not be gainfully employed in any capacity for 24 or more hours per week; (c) the retiree must elect to contribute to the Plan the required contribution; and (d) be a Member in good standing of the Association.

R.N. A registered nurse.

Sickness. A person's Illness, disease or Pregnancy.

Skilled Nursing Facility. A facility that fully meets all of the following.

- (a) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a R.N. or by a licensed practical nurse (L.P.N.) under the direction of a R.N. Services to help restore patients to self-care in essential daily living activities must be provided.
- (b) Its services are provided for compensation. Its services are under the full-time supervision of a Physician.
- (c) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time R.N.
- (d) It maintains a complete medical record on each patient.
- (e) It has an effective utilization review plan.
- (f) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial Care, educational care or care of Mental Health Disorders.

(g) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature except a long term acute care facility.

Spinal Manipulation. Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the body. Treatment is done by a Physician to remove nerve interference due to, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse. The person recognized under law as the Participant or Retired Employee's husband or wife. The Plan Administrator may require documentation proving such legal marital relationship. A Spouse of a physician that is also a physician is not required to be a Member to be eligible for Dependent coverage.

Substance Use Disorder. The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Supportive or Maintenance. Non-corrective care or treatment. Care or treatment when evidence of improvement or recovery within a reasonable and generally predictable period of time is not established.

TMJ. The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Total Disability or Totally Disabled. For Employers and Active Employees, Total Disability is the inability to perform any of the duties pertaining to their occupation. For Dependents, Total Disability is the inability to perform a majority of the normal activities of a person of like age and gender.

Waiting Period. The time, established by the Employer for all Employees, between the first day of employment and the first day of coverage under the Plan. The Employer may change the Waiting Period by notifying the Plan Administrator in writing; the new Waiting Period will be effective upon approval by the Plan Administrator and will be applied to Employees hired on or after the approval date.

PART X
PLAN EXCLUSIONS AND LIMITATIONS

For all medical benefits listed in the schedule of benefits booklet, the following are not covered.

Academic/ability testing. Charges for learning disorders academic/ability testing.

Alternate therapies. Charges for alternate therapies, including, but not limited to, acupuncture, biofeedback, holistic medicine, hypnotherapy, massage therapy, music therapy, nutritional consultation, psychosurgery, recreational therapies, reflexology, sexual issues therapies and physical and meditative therapies including, but not limited to, yoga.

Ambulance. Charges for ambulance services. Charges for emergency transportation to nearest Medical Care Facility where necessary treatment can be provided are covered.

Assistant Surgery. Charges incurred for assistant surgery unless performed by a Medical Doctor (MD) or a Doctor of Osteopathic Medicine (DO).

Blood. Charges for donated or replaced blood, blood plasma and blood storage fees.

Complications of non-covered treatments. Charges for care, services or treatment required due to complications from a treatment not covered under the Plan.

Cosmetic Treatments and Services. Charges for Cosmetic Treatments and Services.

Court ordered services. Charges for services, testing or therapy when it is court ordered, as a condition of parole or probation, when ordered by a governmental agency, or in lieu of incarceration.

Custodial Care. Charges for services or supplies provided as Custodial Care.

Education. Charges for services for education or training except as mandated by law.

Erectile Dysfunction. Charges for procedures, supplies or devices for erectile dysfunction.

Excess charges. Charges that are not payable under the Plan due to application of any stated Plan maximum or limit, or because the charges are in excess of the Maximum Allowable Charge, or are otherwise not covered by this Plan, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Exercise programs. Charges for exercise programs for treatment of any condition. Charges for Physician-supervised cardiac rehabilitation, OT or PT are covered.

Experimental and/or Investigational. Charges for Experimental and/or Investigational services, supplies, devices and/or treatment are not covered except as described under the exception for Routine Patient Costs in connection with participation in approved Clinical Trials as described under the heading "Covered Expenses" in Part V of this document.

Eye care. Radial Keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, unless covered under the wellness care services, including refractions, frames and lenses for eyeglasses and contact lenses and exams for their fitting. Charges for vision therapy, including eye exercises and orthoptic/pleoptic therapy. Charges for prostheses required due to cataract surgery are covered.

Family, group, marital and religious counseling. Charges for family, group, marital and religious counseling sessions or meetings.

Food. Charges for food required due to treatment.

Foreign travel. Charges for services, supplies and equipment of a Hospital located outside of the United States, except where emergency medical treatment is necessary. Available benefits will be paid to the Participant or Retired Employee in United States' funds according to the published exchange rate on the date of service. Assignment is not accepted on charges for services provided outside the United States.

Gender determination. Charges for genetic analysis to determine the gender of a fetus.

Government coverage. Charges for treatment or supplies which are provided for or which the Covered Person is reimbursed by a public program. Also, charges for services provided by virtue of the Covered Person's past or present service in the armed forces.

Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting. Audiological services and hearing aids for children up to age 18 are covered. The coverage provided for children shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist. The hearing aid benefit payable for each hearing-impaired ear is limited to 1 mold every 48 months. Children up to age 2 may receive up to 4 additional ear molds per year.

Illegal acts. Charges for services received due to Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

Immunizations. Immunizations required for employment or international travel.

Implants and Medical Devices. Charges are limited to twice the invoice cost to the provider. Claims for which an invoice is not provided will be adjudicated and charges for the implants/devices will be denied, subject to reconsideration when documentation is received. Charges for a replaced implant or medical device that is under warranty, guarantee or analogous term regarding the quality or performance of the implant or medical device are not covered, and any recovery under the warranty or guarantee is the sole responsibility of the Covered Person.

Infertility. Charges for diagnosis and treatment of infertility by any means. This includes, but is not limited to, use of pharmaceuticals.

Injury to teeth. Charges for treatment to the teeth are limited to charges for services required due to Injury to normal healthy teeth.

Miscellaneous fees. Miscellaneous fee charges for, including, but not limited to, after hour, data analysis, environmental intervention, handling and conveyance, interpretation or explanation of reports, lab stat charges, lab medical direction and supervision, report preparation, shipping and handling and telephone consultation.

No charge. Charges for care and treatment for which there would not have been a charge if no coverage had been in force, including professional courtesy.

Non-medical equipment and therapies. Charges to buy or rent air conditioners, air purifiers, breast pumps, humidifiers, motorized transportation equipment, vehicles and accessories, escalators or elevators in private homes. Also, charges for swimming pools, waterbeds, whirlpools and hot tubs or supplies, general exercise programs and equipment, challenge courses and similar outings, nonprescription items, drugs, supplies and equipment.

No obligation to pay. Charges for which the Plan has no legal obligation to pay.

No Physician recommendation. Charges for care, treatment, services or supplies not recommended and approved by a Physician. Charges for treatment, services or supplies when the Covered Person is not under a Physician's regular care. Regular care means ongoing medical supervision or treatment that is appropriate care for the Injury or Sickness.

Non duplication of benefits. Expenses will only be covered under one provision of the Plan.

Not accepted practice. Charges for or in connection with experimental procedures or treatment methods not provided in accordance with accepted standards of medical, dental, psychiatric or other specialty practice.

Not Medically Necessary. Charges for services, treatments and supplies that are not Medically Necessary.

Not specified as covered. Charges for services, treatments and supplies that are not specified as covered under the Plan.

Obesity/Morbid obesity. The Plan provides no benefits for the care and treatment of obesity or morbid obesity.

Occupational. Charges for treatment under any workers compensation, employer's liability, occupational disease or similar law or as a result of work for wage or profit.

Off-label uses of Prescription Drugs. Charges for off-label uses of Prescription Drugs that have not been approved by the Federal Food and Drug Administration for that indication in one of the standard reference compendia. Charges for off-label uses of Prescription Drugs for cancer treatment or the study of oncology mandated by 63 O.S. § 1-2604 are covered.

Personal comfort items. Charges for items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses and blood pressure instruments. Also, charges for scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and nonhospital adjustable beds.

Pharmaceuticals and injectables. Charges are limited to 1.5 times the Red Book published Average Wholesale Price at the time when service was received.

Physicals. Charges for employment, camp, school, flight or insurance physicals.

Relative giving services. Charges for professional services performed by a person who ordinarily resides in the Covered Person's home. Charges for professional services performed by a person related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Routine services. Charges for routine services are excluded except as listed in Part V and the schedule of benefits booklet.

Self-Inflicted. Charges for any loss due to an intentionally self-inflicted Injury that is not due to a covered medical diagnosis.

Services before or after coverage. Charges for care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under the Plan.

Sex changes. Charges for care, services or treatment for non-congenital transsexualism, gender dysphoria, sexual reassignment or change.

Shoes. Charges for shoes, custom or otherwise, including shoe lifts, wedges or heels.

Surgical sterilization reversal. Charges for care and treatment for surgical sterilization reversal.

TMJ. The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Third party liability. Care for Injury or Sickness that results from the actions of a third party, whether or not such third party is able to reimburse the Covered Person for such care. Upon compliance by the Covered Person with requirements of Part XIV, Subrogation, Right of Reimbursement, and Third Party Recovery Provisions, the Plan Administrator may provide benefits for such charges subject to the Plan's right of recovery.

Travel or accommodations. Charges whether or not recommended by a Physician. Charges for emergency ambulance transportation to nearest medical facility listed in the schedule of benefits booklet are covered.

Treatment before onset. Charges whether or not recommended by a Physician for treatment for genetically predisposed diseases, disorders or conditions prior to onset of the disease, disorder or condition.

Unlawful acts. Charges for services for Injury or Sickness due to taking part in an unlawful act.

War. Charges for any loss that is due to a declared or undeclared act of war when serving in the military or an auxiliary unit thereto.

PART XI CLAIM PROVISIONS

Filing claims properly and in a timely manner will help avoid delays in prompt payment of any benefits due. To reduce claim filing problems, use a participating provider whenever possible. These providers will normally file claims for Covered Persons for covered services. In the event that additional information is requested to complete a claim, it is the Covered Person's responsibility to make sure that a response is provided.

Assignments. The Plan Administrator may revoke an assignment of benefits at its discretion and treat the Covered Person as the sole beneficiary. Benefits for medical expenses covered under this plan may be assigned by a Covered Person to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan, does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

When a Covered Person submits a claim for payment, that person must attach bills for services rendered for plan benefits to be paid.

ALL BILLS MUST SHOW ALL OF THE FOLLOWING:

- Name of Plan.
- Participant or Retired Employee's name.
- Name of patient and ID number.
- Name, address, telephone number and tax identification number of the provider of care.
- Diagnosis.
- Type of services rendered, with diagnosis and/or procedure codes.
- Date of services.
- Charges.

In lieu of the above, the Plan's claims administrator may, at its discretion, accept a claim filed by a provider.

Properly Filed Claim. Is a statement or claim form regarding a loss that provides sufficient information proving the loss to allow the Plan's claims administrator to accurately and promptly determine available benefits for covered services. Claims from providers must be submitted on a CMS 1500, UB04, their successors, or other forms approved by the Plan Administrator. A properly filed claim would also include an itemized statement of services from the provider. Medical records may be required upon request by the Plan's claims administrator.

Any transaction concluded at the pharmacy or by mail order for prescription drug benefits is not a claim under these procedures. A claim is established when the Plan's claim administrator or the pharmacy benefit manager has received proof of loss as identified above. Upon receipt of the documentation, the claims are subject to all provisions of this section.

Send the above to the Plan's claims administrator at the following address.

Frates Benefit Administrators
13439 Broadway Extension, Suite 110
Oklahoma City, Oklahoma 73114
405-290-5666 or 888-244-5096

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized as an authorized representative until the Plan's claims administrator receives an appointment of authorized representative from the claimant.

Once an authorized representative is appointed, the Plan's claims administrator shall direct all information, notifications, etc., regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

Payment of Benefits. Following satisfaction of the deductible and out-of-pocket requirements, payment of Covered Expenses will be made to the Covered Person, Covered Person's estate or heirs, unless the Covered Expenses have been assigned to the provider. Any payment made by the Plan in good faith shall fully discharge the Plan to the extent of the payment.

The Plan may pay benefits that are later found to be greater than the Allowable Charge. The Plan has 24 months after the payment is made to recover the overpaid amount from the claimant or health care provider to which it was paid. The 24-month time period does not apply if the payment was made because of fraud committed by the claimant or health care provider, or if the claimant or health care provider has otherwise agreed to make a refund for overpayment of a claim.

Facility of Payment of Benefits. If a Covered Person is a minor or otherwise not competent to give valid receipt for payment of any benefit, all or any portion of the medical expenses benefits provided by the Plan may be paid directly to the provider of the benefits. Any payment made by the Plan in good faith shall fully discharge the Plan to the extent of the payment.

Physical Examination. The Plan, at its own expense, has the right to examine any person for whom a claim is pending. This may occur as often as reasonably required. The Plan may also require an autopsy where not prohibited by law.

Legal Action. No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after a claim has been filed. All actions must be brought within three years of the date the claim is filed.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Plan's claims administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (1) It's not reasonably possible to submit the claim in that time; and,
- (2) The claim is submitted within 6 months from the date incurred. This 6 month period will not apply when the person is not legally capable of submitting the claim.

The Plan's claims administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan Administrator reserves the right to have a Covered Person seek a second medical opinion.

A request for benefits will be considered a claim for benefits. It will be subject to a full and fair review. If a claim is wholly or partially denied, the Plan will provide the claimant with a written notice of denial. This written notice will be provided within 30 days after receipt of the claim. The written notice will contain all of the following information.

- (1) Specific reason or reasons for denial.
- (2) Specific reference to the Plan's provisions on which denial is based.
- (3) A description of any additional information or material necessary to correct the claim and an explanation of why the material or information is necessary.
- (4) A description of the Plan's procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court.
- (5) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request).
- (6) If the decision involves scientific or clinical judgment, a disclosure of either (i) an explanation of the scientific or clinical judgment applying the term of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided at no charge upon request.

A claimant will be notified within 30 days of receipt of the claim as to the acceptance or denial of a claim.

If special circumstances require an extension of time for processing the claim, the Plan's claims administrator shall send written notice of the extension to the claimant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim.

CLAIMS REVIEW PROCEDURE

A Covered Person or the authorized representative, has the right to request a review/appeal of any adverse benefit determination regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) medical necessity, propriety or effectiveness.

The Plan offers 2 internal review levels. The first review level is an evaluation by an appropriately qualified person who was not involved with the adverse benefit determination. The second review level is an evaluation by Plan Appointed Claim Evaluator (PACE) who was not involved in either the adverse benefit determination or the first review level decision. A Covered Person or the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency. A Covered Person always has a right to bring a civil action under the appropriate federal law after participating in the review process.

After both internal reviews have been completed, a Covered Person or his authorized representative may request an external review of the adverse benefit decision. The request must be filed within four months of notice of the final internal adverse benefit determination.

Participation in any appeal process waives any privilege of confidentiality the Covered Person may have regarding medical records that any person examines or may examine in connection with the reviewed condition during the appeal process.

To begin the appeal process a Covered Person must do the following.

- (1) Make an oral or written appeal request at the telephone number or address provided below within 1 year of the appealed decision's adverse benefit determination date. Covered Persons making oral requests will be sent an appeal form to complete and return.

- (2) An appeal coordinator will evaluate all requests regarding **contractual relationships, coverage, payment or reimbursement for health care services**. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding **medical necessity, propriety or effectiveness**.
- (3) A Covered Person is responsible for providing all documentation supporting the appeal request at the time of the request. The Plan's claims administrator will evaluate a request based on the information in its possession.
- (4) The Plan's claims administrator will provide the Covered Person and the requesting provider a written notification of its decision within 30 days of receiving a written appeal request or a completed appeal form. The written notice will contain all of the following information.
 - (a) The specific reason(s) for the appeal decision.
 - (b) A reference to the specific Plan provision(s) on which the decision is based.
 - (c) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the decision (or a statement that such information will be provided free of charge upon request).
 - (d) A statement of the right to sue in federal court.
 - (e) A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.
 - (f) If the decision involves scientific or clinical judgment, a disclosure of either (i) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided at no charge on request.

To begin the second level appeal process a Covered Person must do the following.

- (1) Make an oral or written appeal request at the telephone number or address provided below within 60 days of the first level appeal denial date. Covered Persons making oral requests will be sent an appeal form to complete and return.
- (2) An appeal coordinator will forward the second level appeal to the Plan Appointed Claims Evaluator (PACE) to evaluate all requests regarding **contractual relationships, coverage, payment or reimbursement for health care services**. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding **medical necessity, propriety or effectiveness**.
- (3) A Covered Person is responsible for providing all documentation supporting the appeal request at the time of the request. The Plan's PACE will evaluate a request based on the information in its possession.
- (4) The Plan's claims administrator will provide the Covered Person and the requesting provider a written notification of the PACE decision within 30 days of receiving a written second level appeal request. The written notice will contain all of the following information.
 - (a) The specific reason(s) for the appeal decision.
 - (b) A reference to the specific Plan provision(s) on which the decision is based.
 - (c) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the decision (or a statement that such information will be provided free of charge upon request).
 - (d) A statement of the right to sue in federal court.
 - (e) A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

- (g) If the decision involves scientific or clinical judgment, a disclosure of either (i) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (ii) a statement that such explanation will be provided at no charge on request.

Exhaustion of Internal Claims Procedures

Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE – that benefits and/or coverage are not available from the Plan as they relate to claims for benefits submitted to the Plan, the determination will be final and binding on all interested parties.

Contact Information:

Frates Benefit Administrators:

Appeal Coordinator
13439 Broadway Extension, Suite 110
Oklahoma City, Oklahoma 73114
Telephone: 405-290-5666
Facsimile: 405-290-5717

PART XII COORDINATION OF BENEFITS

Multiple Policies. The Plan will coordinate with any other group health coverage, which covers a Covered Person, on the date the expense is incurred.

Applicability. This part applies when the total benefits that would be payable, in the absence of any coordination of benefits provision under the Plan and all other policies/plans covering the Covered Person exceed the actual expenses incurred during the Calendar Year.

Primary and Secondary Responsibilities. For purposes of this part, "other policies/plans" shall include the following.

- (1) Group or group type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.
- (7) Medical benefits from traditional automobile fault contracts written on a group or group-type basis.

In coordination of benefits, each other policy/plan is considered a separate policy/plan. If only a part of a policy/plan reserves the right to adjust its benefits due to other coverage, the portion of the policy/plan which reserves the right and the portion which does not shall be treated as separate policies/plans.

If a policy/plan provides benefits in the form of services, the cash value of the service will be deemed to be the benefit paid.

HMO/PPO/Managed Care/Network plans. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay benefits due up to 100% of the total Allowable Charge. All other plan provisions, exclusions and limitations will apply. Any part of an Allowable Charge that is paid or contractually reduced by a plan that is primary to this Plan will not be covered. Also, as to HMO plans, the Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full; when an HMO is primary and the Covered Person does not use an HMO provider, the Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO.

Medicare Provisions, Working Aged. This Plan has elected to determine coordination with Medicare with respect to the working aged or dependents of the working aged on the basis of the size of the Employer that provides the Covered Person's eligibility. The Plan will treat such Covered Person, whose eligibility is established by an Employer with fewer than 20 employees as determined by the Social Security Act, as a participant in "small employer" group health plan. As such, benefits will be determined according to the provisions of this section, with Medicare as the primary plan. Covered Persons whose eligibility is established on the basis of the Employee's employment with an Employer with 20 or more employees will have their claims processed by this Plan as the primary plan.

Order of Benefit Determination. Coordination of benefits under the Plan is subject to the following provisions.

- (1) Coordination of benefits will be applied under the Plan whenever the benefits for a Covered Person under

the Plan and the benefits payable under another policy/plan covering the same person exceed the Maximum Allowable Charge under either policy/plan in the absence of the other.

- (2) The Plan will never pay benefits that combined with the benefits paid or payable by another policy/plan results in the Covered Person receiving more than the total actual loss. All benefits under other policies/plans shall be taken into account whether or not a claim has been made.
- (3) If coverage under any other policy/plan is involved, and that policy/plan contains a coordination of benefits provision that stipulates it is secondary in all cases and the order of determination described below results in the other policy/plan being secondary, then the Plan will calculate benefits as if the other policy/plan did not exist. The Plan will be primary.
- (4) In determining the order of benefits, the following rules are used.
 - (a) The policy/plan under which the claimant is covered as an insured/participant shall be primary compared to a policy/plan under which the claimant is covered as a dependent.
 - (b) Dependents. When the Plan and another policy/plan cover the same child as a dependent of different persons, the following rules are used.
 - (i) Parents with different birthdays. The benefits of the parent's policy/plan whose birthday falls earlier in a year are determined before those of the other parent's policy/plan.
 - (ii) Parents with the same birthday. The benefits of the policy/plan that covered a parent longer are determined before those of the other parent's policy/plan. If the other policy/plan does not have the rule in (i) above, but instead has a rule based on the parent's gender, and as a result, the policies/plans do not agree on the order of benefits, the rule in the other policy/plan will determine the order of benefits.
 - (c) An exception to the order of benefit determination is made in the case of children of divorced or separated parents. The following rules are used.
 - (i) Parents are separated or divorced and the parent with custody of the child has not remarried. The benefits of a policy/plan that covers the child as a dependent of the parent with custody of the child are determined before the benefits of a policy/plan that covers the child as a dependent of the parent without custody.
 - (ii) Parents are divorced and the parent with custody of the child has remarried. The benefits of a policy/plan that covers the child as a dependent of the parent with custody are determined before the benefits of the policy/plan that covers the child as a dependent of the stepparent.
 - (iii) The benefits of a policy/plan that covers the child as a dependent of the stepparent are determined before the benefits of a policy/plan that covers the child as a dependent of the parent without custody. If the child is subject to a court decree that decides financial duty for medical, vision, dental or health care expenses, the benefits of a policy/plan that covers the child as a dependent of the parent with the financial duty are decided before the benefits of any other policy/plan which covers the child.
 - (d) When (a), (b) or (c) above do not establish the order of benefit determination, the policy/plan which has covered the person longer shall be determined first.
- (5) When this provision operates to reduce the benefits under the Plan, each benefit that would have otherwise been paid will be reduced proportionately. The reduced amount will be charged against the benefit limits of the Plan.
- (6) When payments should have been paid under the Plan, but were already paid under some other policy/plan,

the Plan will make payment to the other policy/plan of an amount that satisfies this provision. The payment will serve to discharge the Plan's liability. When payments are made under the Plan that exceed the amount calculated under this provision, the Plan will recover the excess payment from one or more of the following.

- (a) A person to whom, for whom or with respect to whom the payments were made.
- (b) An insurance company.
- (c) Another organization.

Claims Determination Period. Benefits are coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. The Plan Administrator may give or obtain needed information from an insurer or any other organization or person as permitted by law. A Covered Person will give the Plan Administrator the information it requests about other plans and their payment.

Facility of Payment. The Plan may repay other plans for benefits paid that the Plan determines it should have paid. That repayment will count as a valid payment under the Plan.

Right of Recovery. The Plan may pay benefits that should be paid by another benefit plan. The Plan may recover the amount paid from the other benefit plan. That repayment will count as a valid payment under the other benefit plan.

PART XIII
SUBROGATION, RIGHT OF REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

In the event a Covered Person receives any benefits arising out of any injury, accident, event, or incident for which the Covered Person has, may have, or asserts any claim or right to recovery under any theory of law or equity, tort, contract, statute, regulation, ordinance or otherwise against any other person, entity or source including, without limitation, any third party, insurer, insurance, and/or insurance coverage (e.g., uninsured and underinsured motorist coverage, personal injury coverage, medical payments coverage, workers' compensation, etc.), then any payment or payments made by the Plan to Covered Person for such benefits shall be made on the condition and with the agreement and understanding that the Plan will be reimbursed by Covered Person and Covered Person's representatives, including, without limitation, attorneys, agents, and all persons acting for, in concert with, or at the direction of or on behalf of, Covered Person to the extent of, but not to exceed the amount or amounts received by Covered Person from such person, entity or source by way of any agreement, settlement, judgment or otherwise.

The Plan shall be subrogated to all rights of recovery the Covered Person has against any party potentially responsible for making any payment to Covered Person as a result of any injury, damage, loss or illness Covered Person sustains to the full extent of benefits provided or to be provided by the Plan to Covered Person or on Covered Person's behalf with respect to that illness, injury, damage or loss immediately upon the Plan's payment or provision of any benefits to Covered Person or on Covered Person's behalf. The Plan's recovery, subrogation and reimbursement rights provided herein exist even where a party allegedly at-fault or responsible for any loss, injury, damage or illness Covered Person sustains does not admit responsibility and regardless of the designation or characterization given to the funds Covered Person receives or agrees to be disbursed from that party or that party's representative.

Covered Person also agrees to notify the Plan of Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation with respect to any matter for which Covered Person has obtained or will obtain any benefits from the Plan. Covered Person will be required to provide all information requested by the Plan or its representative regarding any such claim.

To the extent the Plan has paid benefits to Covered Person or on Covered Person's behalf, the Plan shall have a first priority, a first lien, and a first right to 100% of any payments or monies received by Covered Person from any other person, entity or source arising out of any claims or causes of action Covered Person has, may have, or asserts in connection with the occurrence, incident, accident, injury, illness or event for which the Plan paid any benefits to Covered Person or any third party on Covered Person's behalf. Covered Person agrees to hold, as trustee (or co-trustee) in trust (whether express, implied, constructive or resulting) for the benefit of the Plan all funds Covered Person receives in payment of or as compensation for any injury, illness, damage and loss Covered Person sustained resulting from any such event, incident, accident, injury, illness or occurrence. Any such amounts received by, on behalf of, with the consent of, or at the direction of Covered Person, or to which Covered Person is entitled to receive or direct payment, or over which Covered Person exercises any control, are deemed and shall be considered and treated as assets of the Plan. Failure to hold such funds in trust or to abide by these plan terms will be deemed a breach of Covered Person's fiduciary duty to the Plan. The Plan has a right of subrogation or reimbursement before any funds are paid to Covered Person from the responsible source and no attorneys' fees or costs may be subtracted from such amount. The Plan may, at its option and sole discretion, exercise either its subrogation and/or its repayment rights. The Plan is also entitled to any funds Covered Person receives or is entitled to receive regardless of whether or not the payment represents full compensation to Covered Person. The Plan expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with the Plan's rights herein.

The Plan may further require that (i) Covered Person utilizes the services of attorneys, representatives or agents who will execute a reimbursement agreement and who will not assert the make whole and common fund rule or doctrines, and (ii) Covered Person agrees to terminate any relationship with anyone who refuses to do so, or benefits will not be payable under the Plan in connection with that matter. The Plan is also entitled to receive and has priority to receive the first funds from payments received by Covered Person until the Plan has been repaid for all sums expended. Covered Person shall execute and deliver any instruments and documents reasonably requested by the Plan and shall do whatever is necessary to fully protect all the Plan's rights. Covered Person shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation, including, without limitation, any attempt by Covered Person or others to have payments characterized as non-medical in nature (e.g., for emotional distress, pain and suffering,

embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives or friends).

As further security for the Plan's rights to such reimbursement and subrogation, the payment of benefits may be withheld until Covered Person has executed a reimbursement agreement. If Covered Person fails to reimburse the Plan after receiving a recovery addressed in this Subrogation and Right of Reimbursement portion of the Plan, the Plan may, in addition to all other rights it has against Covered Person for such sums, offset the recovery amount against Covered Person's future medical expenses up to the extent of the amount recovered by Covered Person. Additionally, Covered Person shall be fully responsible for the actions of Covered Person's representatives, attorneys, agents, and all persons acting for, on behalf of, in concert with, or at the direction of Covered Person regarding the Plan or Covered Person's obligations described herein. Covered Person shall be responsible to ensure that such persons cooperate and comply with Covered Person's obligations herein. If Covered Person or Covered Person's agents, attorneys or any other representative fails to fully cooperate with any subrogation, reimbursement, or repayment efforts, or directly or indirectly hinders, impedes, or interferes with any such efforts, Covered Person shall be responsible to pay to the Plan all attorney's fees and costs incurred by or on behalf of the Plan in connection with such efforts. Additionally, the Plan may, in the discretion of Plan Administrator, terminate Covered Person's participation in the Plan. In the event that any claim is made that any wording, term or provision set forth in this Subrogation and Right of Reimbursement portion of the Plan is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the Plan through its Plan Administrator, shall have the sole authority and discretion to construe, interpret and resolve all disputes regarding the interpretation of any such wording, term or provision.

If it becomes necessary for the Plan to enforce this provision by initiating any action against Covered Person, then Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action if the Plan prevails in that action. The Plan may offset any such fees and costs against Covered Person's future medical expenses.

The Plan's subrogation and reimbursement rights described herein are essential to ensure the equitable character of the Plan and its financial soundness, and to ensure that funds are recouped and made available for the benefit of all Covered Persons under the Plan collectively.

PART XIV COBRA CONTINUATION OPTIONS

Applicable only to qualified beneficiaries whose eligibility arises from the employee's employment by an employer subject to COBRA. An employer exempt from COBRA and not subject to these provisions is one that normally employed fewer than 20 employees during the preceding calendar year, or as otherwise determined to be exempt.

The COBRA requirements to offer continuation coverage under certain circumstances are a function of your employment with an employer that provides group health benefits. Your right to continue under the Plan terminates when your Employer no longer participates in the OSMA Health - Health Plan.

Please contact your Employer if you have questions regarding your COBRA options.

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do 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). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become 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 COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan 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's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Employer in accordance with your Employer's requirements.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must provide this notice to your Employer in accordance with your Employer's requirements.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Please contact your Employer if you have questions regarding your COBRA options.

PART XV PRIVACY PROVISIONS

GENERAL OVERVIEW. As a Covered Person in the Plan, you and your medical care providers are required to communicate certain information to the Plan, and its designees such as the claims administrator, in order to have your benefit claims processed in an accurate and prompt manner. The confidentiality of this information and your privacy are very important to us.

In the daily operation of the Plan, we may use your information to facilitate treatment, payment and other healthcare operations. We always guard your privacy and disclose only the minimum information necessary to support those functions. For the most part, we do not disclose information about you or a family member except to facilitate payment for services or to comply with the cost management provisions of the Plan.

We will provide you with the Plan's "Notice of Privacy Practices" as one component of compliance with federal and state guidelines. This information will explain to you special procedures that will be instituted to allow you to control and manage your health information and also describe to you any policies regarding disclosure of information to the Plan Sponsor.

If you have any questions about the use of personal information please contact the Plan Administrator or the claims administrator.

Protected Health Information (PHI). The Plan shall conform with the requirements of Section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the 'HIPAA Privacy Rule') by establishing the extent to which the Employer and Plan Sponsor will receive, use, and/or disclose PHI.

Compliance with HIPAA Privacy Rule. The Plan may disclose PHI (as defined below) to employees of the Plan Sponsor with employee benefits responsibility or to employees with oversight responsibility for third party administrator claims administration. Access to and use by such individuals must be restricted to plan administration functions that the Plan Sponsor performs for the Plan. The applicable claims procedures under the Plan shall be used to resolve any issues of noncompliance by such individuals. The Plan may disclose PHI to such individuals only if the Plan Sponsor certifies that the Plan documents have been amended to incorporate the following specific provisions, and the Plan Sponsor agrees to comply with them. The Plan Sponsor will:

- (1) not use or further disclose PHI other than as permitted by the Plan documents or as required by law;
- (2) ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (4) report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- (5) make available to Covered Persons their PHI in accordance with 45 C.F.R. § 164.524;
- (6) make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.524;
- (7) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (8) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request for purposes of determining compliance by the Plan with applicable regulations regarding use and disclosure of PHI; and

- (9) if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) ensure that adequate separation between Plan and the Plan Sponsor is established.

Designation of Component Subject to the HIPAA Privacy Rule. The Plan provides various types of benefits to Covered Persons, including medical benefits. In accordance with 45 C.F.R. § 164.504(c)(3)(iii), the portion of the Plan that would be considered to be a 'group health plan' (as defined in 45 C.F.R. § 160.103) if such portion was a separate plan will be the only portion subject to the Privacy Rule and this part.

Definition of 'PHI.' For purposes of this part, 'PHI' is 'Protected Health Information' as defined in 45 C.F.R. § 164.501, which is individually identifiable health information that is maintained or transmitted by a covered entity, as defined in 45 C.F.R. § 164.104."

PART XVI
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan Administrator is the Board of Directors of the OSMA Health and Welfare Benefit Corporation. The OSMA Health - Health Plan is a benefit plan of the OSMA Health and Welfare Benefit Corporation, the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA.

The Plan Administrator shall administer the Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of the Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits or the amount, manner and time of payment of any Plan benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

- (1) To administer the Plan in accordance with its terms.
- (2) To construe and interpret the Plan, including the right to resolve and remedy any ambiguities, inconsistencies or omissions with respect to any terms and provisions of the Plan.
- (3) To decide disputes which may arise relative to a Covered Person's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a claims administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to Covered Persons, and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A 'named fiduciary' is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

GENDER AND NUMBER. As used in this plan document, the masculine reference shall include the feminine and the singular shall include the plural.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

ENTIRE CONTRACT. The Plan shall constitute the entire contract of coverage. Any statement made by the Plan Administrator and its designees, including the claims administrator, are deemed to be representation and not warranties. Such statements will not invalidate the Plan as stated in the plan document unless contained in a written statement signed by the Plan Administrator and the Participant or Retired Employee.

PRIOR FAILURE TO ENFORCE AND WAIVER. No provision of the Plan shall be waived, modified or made unenforceable as the result of the Plan's prior failure to apply or enforce such provision. No waiver of the Plan's provisions can be enforced unless it is in writing and signed by the Plan Administrator. The authority to waive any provision of this Plan cannot be delegated.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Plan Sponsor intends to maintain the Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any).

RENEWABILITY

The Plan may not deny an Employer continued access to the same or different coverage under this Plan, other than:

- (1) for nonpayment of contributions;
- (2) for fraud or other intentional misrepresentation of material fact by the Employer;
- (3) for noncompliance with material provisions of the Plan;

(4) because the Plan is ceasing to offer coverage in a geographic area; or

Discretionary Authority

The Plan is administered by the Plan Administrator (which may be the Plan Sponsor or another entity appointed by the Plan Sponsor for this purpose) in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. All other matters, including, but not limited to, other appeals that are "not" Final Post-Service Appeals, and matters the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

Duties and Rights of the PACE – When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

PART XVII
ERISA DISCLOSURES AND INFORMATION

PLAN NAME, NUMBER AND TYPE:

Plan Name. OSMA Health - Health Plan (the "Plan")

Plan Number. 501

Plan Type. Group Health Plan (Employee Welfare Benefit Plan) providing medical benefits.

NAME, ADDRESS, TELEPHONE NUMBER AND TAX IDENTIFICATION NUMBER OF PLAN SPONSOR:

OSMA Health and Welfare Benefit Corporation
13439 Broadway Extension, Suite 110
Oklahoma City, Oklahoma 73114
Phone: 405-290-5666 or 888-244-5096
EIN: 27-0093845

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR:

The Board of Directors of the OSMA Health and Welfare Benefit Corporation
13439 Broadway Extension, Suite 110
Oklahoma City, Oklahoma 73114
Phone: 405-290-5666 or 888-244-5096

PARTICIPATING EMPLOYERS:

A complete updated list of Employers participating in the Plan may be obtained upon written request to the Plan Administrator and is also available in the office of the Plan Administrator for examination.

NAMED FIDUCIARY:

OSMA Health and Welfare Benefit Corporation

NAME AND ADDRESS OF THE AGENT FOR SERVICE OF LEGAL PROCESS:

OSMA Health and Welfare Benefit Corporation
13439 Broadway Extension, Suite 110
Oklahoma City, Oklahoma 73114

SOURCE OF CONTRIBUTIONS AND PLAN FUNDING:

The Plan is self-insured by Employers and Employees and Retired Employees. Required contributions are determined by the Plan Administrator. Each respective Employer then determines its contribution and those of its Employees and Retired Employees toward the required contributions of the Plan. The Plan Sponsor has obtained an excess insurance policy with an insurance company for protection against certain large unexpected claims.

PLAN YEAR:

The Plan year for purposes of maintaining the Plan's records is the annual period from January 1 through December 31.

TYPE OF ADMINISTRATION:

The Plan is self-administered by the Plan Administrator. However, the Plan Administrator has by contract obtained the performance of certain administrative functions such as the review, processing and payment of claims from the claims administrator. The name, address and telephone number of the claims administrator is:

Frates Benefit Administrators
13439 Broadway Extension, Suite 110
Oklahoma City, Oklahoma 73114
405-290-5666 or 888-244-5096

The claims administrator provides claims administration for the Plan and does **not** insure or otherwise guarantee benefits.

ELIGIBILITY:

The Plan’s provisions relating to eligibility are described in detail in Part III, Eligibility, Funding, Effective Date and Termination Provisions.

DESCRIPTION OF BENEFITS:

The Plan provides Covered Persons with the payment of or reimbursement of certain eligible medical expenses, which are described in detail in Part V, Medical Expenses, and the applicable schedule of benefits booklet.

PREFERRED PROVIDER ORGANIZATION (PPO) – FOR PHYSICIAN SERVICES ONLY

OSMA Health Network. Out-of-area, MultiPlan. There are no facility providers in either network.

PROVISIONS LIMITING BENEFITS (Summary Only):

There are provisions that may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of benefits that a Covered Person might reasonably expect the Plan to provide. These provisions include, but are **not** limited to:

- deductibles and maximum annual limits;
- exclusions and limitations;
- subrogation, right of reimbursement and third party recovery rights of the Plan;
- coordination of benefits when a Covered Person is enrolled in more than one plan and the Plan is not the primary plan;
- effects of Medicare;
- possible reductions when private hospital rooms are used and for certain multiple surgical procedures;
- reductions due to charges that exceed the Maximum Allowable Charge;
- reductions or denials due to services that are not generally accepted as appropriate, and/or which are not Medically Necessary, and/or which are considered as over-utilization;
- treatment, services and supplies that are excluded from coverage by the Plan, whether or not Medically Necessary; or
- non-compliance with the Plan’s claims filing deadlines.

These provisions are described in greater detail throughout this document.

PART XVIII
ERISA RIGHTS STATEMENT

Your Rights. As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (previously known as the Pension and Welfare Benefit Administration).

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report, if any is required by ERISA to be prepared. The plan administrator is required by law to furnish each participant with a copy of any required summary annual report.

COBRA and HIPAA Rights. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the plan on the rules governing your COBRA continuation coverage rights.

You should be able to request a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage..

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim if frivolous.

Assistance with Your Questions. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about

your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

BY THIS AGREEMENT, the OSMA Health - Health Plan is hereby adopted and amended as shown.

IN WITNESS WHEREOF, this instrument is executed for the OSMA Health and Welfare Benefit Corporation on or as of the day and year first below written.

By _____
OSMA Health and Welfare Benefit Corporation

Date _____

Witness _____

Date _____