OKLAHOMA COUNTY
HEALTH BENEFIT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2015

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INTRODUCTION AND PURPOSE

Oklahoma County has established the Plan for the benefit of Eligible Employees, on the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by Oklahoma County or may be funded solely from the general assets of Oklahoma County. Plan Participants may be required to contribute toward their benefits.

Oklahoma County's purpose in establishing the Plan is to help offset, for Plan Participants, the economic effects arising from non-occupational Injury or Illness. To accomplish this purpose, Oklahoma County must be cognizant of the necessity of containing health care costs through effective plan design; of abiding by the terms of the Plan Document and Summary Plan Description; and to allow Oklahoma County to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

This Plan Document represents both the Plan Document and the Summary Plan Description.

The Plan is intended to meet the requirements of Section 162 to the extent of Employer contributions.

The purpose of this Plan Document and Summary Plan Description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for Hospital and/or medical benefits. The Plan Document and Summary Plan Description is maintained by Oklahoma County and may be inspected at any time during normal working hours by any Covered Person.

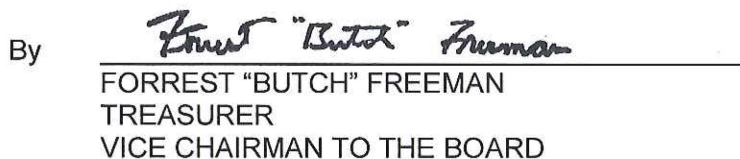
It is the intention of Oklahoma County that this document replace and supersede all previous plan documents, summary plan descriptions and amendments.

IN WITNESS WHEREOF, Oklahoma County has acknowledged and executed this Plan Document and Summary Plan Description as of the 1st day of January, 2015.

Approved on the_____________ day of _______________________, by the **OKLAHOMA COUNTY BUDGET BOARD.**

By

BRIAN MAUGHAN
CHAIRMAN TO THE BOARD

By 

FORREST "BUTCH" FREEMAN
TREASURER
VICE CHAIRMAN TO THE BOARD

ATTEST:

CAROLYNN CAUDILL, COUNTY CLERK
SECRETARY TO THE BOARD

APPROVED AND ADOPTED by **OKLAHOMA COUNTY by OKLAHOMA COUNTY BOARD OF COUNTY COMMISSIONERS** this ______day of ____________________, 2015.

By ________________________________
Chairman

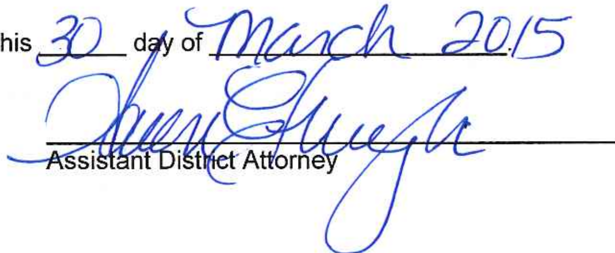
By ________________________________
Member

By ________________________________
Member

ATTEST:

____
County Clerk, Oklahoma County

APPROVED as to form and legality this 30 day of March 2015.



____
Assistant District Attorney

HELPFUL TIPS FOR GETTING CLAIMS PROCESSED

Following the suggestions listed below will facilitate prompt consideration of your claim.

When a claim is filed as a result of an accident the Plan is required to obtain all the details of the accident. An accident claim cannot be processed without this information. The Plan will need to know where the accident occurred, when it happened, who was involved and what happened. You may send a letter to HealthSmart Benefit Solutions, Inc. outlining all the details of the accident or you may complete an Accident/Injury Questionnaire. This form can be obtained from your Benefits Department or downloaded from the Oklahoma County Clerk's benefit website.

An "Annual Data Form" may be required for each family once each year. It is required that you let the Benefits Department or HealthSmart know if anyone **participating** in the Plan has other coverage. This form is available from the Benefits Department or can be downloaded from the Oklahoma County Clerk's benefit website. Please complete all areas of the form completely and clearly. Be sure to answer any questions about other insurance that may be in effect. This information helps us process your claim faster and more accurately. Remember to sign and date the form. Incomplete or unsigned forms could cause a delay in the processing of any claims.

A Covered Person will be provided a certificate of creditable coverage regarding this Plan if he/she requests one either before losing coverage or within 24 months after coverage under the Plan ceases.

Promptly answer any letters received from HealthSmart Benefit Solutions, Inc. requesting additional information. The claim cannot be processed without the requested information. If you have any questions concerning the request, call HealthSmart Benefit Solutions, Inc. at 405.848.1975, or if calling from outside the Oklahoma City area, 800.825.3540.

Canceled checks, cash register receipts and "balance forward" statements cannot be accepted. Copies of bills will only be accepted if the patient has other health coverage and this health plan is assuming the role of secondary payor.

Send all correspondence to:

HealthSmart Benefit Solutions, Inc.
P. O. Box 42096
Oklahoma City, OK 73123-3005

HELPFUL NUMBERS		
For Claims Information	For Hospital Admission Certification*	For Verification Of Coverage*
HealthSmart Benefit Solutions, Inc.	HealthSmart Benefit Solutions, Inc.	HealthSmart Benefit Solutions, Inc.
405.848.1975	405.848.1975	405.840.0128
800.825.3540	800.825.3540	800.648.9652
*Verification of Coverage and/or Certification is not a guarantee of coverage. Payment of benefits is subject to all Plan provisions, limitations and exclusions.		

PREFERRED PROVIDER ORGANIZATION (PPO)

What Is A PPO (Preferred Provider Organization)?
Utilizing PPO providers can save you money! A PPO is a managed health care network of medical providers who have contracted to provide their quality services to member patients at very favorable rates. PPO Providers include physicians, hospitals, outpatient facilities and other ancillary providers located in many cities throughout the United States.

The Plan saves money when you use PPO Providers, so these savings are shared with you by offering better benefits than if you use a Non-PPO Provider. Deductible and out-of-pocket expenses are reduced due to the discounts that PPO providers give.

Note: If the physician you currently use is not a member of the network, their office can contact the PPO network for information on becoming a member.

How Does the PPO Work?
The PPO is easy to use. Each Plan Participant will receive information regarding how to access the PPO Providers. When seeking care, the patient simply selects any provider, regardless of specialty, in the network and presents their identification card to the provider's office staff. The PPO's freedom-of-choice allows you to use the network of providers as you please. The patient may always seek care outside the network and receive non-network benefits according to the plan design. To locate an in-network provider for the medical plan, please call FirstHealth at 1.800.266.5116 or you can locate one on their website at www.myfirsthealth.com. To locate a participating pharmacy, please call CVS/Caremark at 1.866.475.0056 or you can locate one on their website at www.caremark.com .

What Are the Advantages of Using the PPO?

You do not have to file a claim. The PPO Provider's office will do it for you.

You do not have to worry about being billed for charges over the Reasonable and Customary amount.

You save money through reduced costs because you pay less since the deductible and out-of-pocket expense maximum is less than if you use a Non-PPO provider.

How to Use the PPO

When you need to see a doctor or other medical care provider, select a provider and make an appointment with one of the providers. Ask the provider if they are still a member of the PPO. It is possible that some providers may have been added to or deleted from the network.

Show your identification card to the provider so they will know that you are a PPO member. Their billing office will file the claim for you.

If you must be referred to another medical care provider for treatment or services, tell the provider that you would like to be referred to a provider who is a member of your network. This is important since not all providers are members of the network and it is possible that providers may have been added to or deleted from the network.

Free Choice of Physician

Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, together with his physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO provider.

SCHEDULE OF BENEFITS

CALENDAR YEAR DEDUCTIBLE (PPO and Out of Network Deductibles are accumulated separately)	**In Network - PPO**	**Out of Network**
Per Individual	$500	$1,000
Per Family	$1,500	No maximum limitation
CALENDAR YEAR OUT-OF-POCKET MAX:	**In Network - PPO**	**Out of Network**
Per Individual	$3,000	No maximum limitation
Per Family	$9,000	No maximum limitation
HOSPITAL, FACILITY, INDEPENDENT LABORATORY & OTHER SERVICES:		
Inpatient Hospital Admissions **(Requires Case Management)**	Deductible, then 20%	Deductible, then 50%
Inpatient Physician Visit	Deductible, then 20%	Deductible, then 50%
Emergency Room	Deductible, then 20%	PPO Deductible, then 20%
Outpatient Hospital Services	Deductible, then 20%	Deductible, then 50%
Outpatient Surgery **(May require Case Management)**	Deductible, then 20%	Deductible, then 50%
Surgeon or Anesthesiologist Fees	Deductible, then 20%	Deductible, then 50%
100% Covered Surgery/Procedure Benefit To obtain more info., or to obtain pre-certification approval, call 1.800.825.3540 Ext. 2675	No Deductible then 100%	
Mammograms, colonoscopies and prostate exams (including PSA tests)	**No Deductible, then 100%**	**No Deductible, then 100%**
HealthCheck Radiology including MRI, CT, PET Scans, Preventative Body Scan and Virtual Colonoscopy, X-rays and Ultrasounds – Utilization the HealthCheck screening benefit (To access call 405.486.7444)	**No Deductible, then 100%**	
Skilled Nursing Facility Care **(Requires Case Management)**	Deductible, then 20%	Deductible, then 50%
Home Health Care **(Requires Case Management)**	Deductible, then 20%	Deductible, then 50%
Outpatient Physical Therapy **(Requires Case Management after 12 Visits)**	Deductible, then 20%	Deductible, then 50%
Non-surgical TMJ Treatment	Deductible, then 20%	Deductible, then 50%
Other Covered Expenses	Deductible, then 20%	Deductible, then 50%
MRI, CT and PET Scans - **Utilizing the One Call Medical Program (To access One Call Medical call 888.458.8746 or www.onecallmedical.com)**	$100 Copay, then 100%	
Laboratory, Pathology, Radiology, MRI, CT & PET Scans	Deductible, then 20%	Deductible, then 50%
LabCard **(Must use LabCard to get 100% benefit)** Laboratory & Pathology	**No deductible, then 100%**	

Physical Therapy, Speech Therapy & Occupational Therapy **(Requires Case Management after 12 Visits)**	Deductible, then 20%	Deductible, then 50%
Chiropractic Treatment **(Limited to 24 visits per year)**	Deductible, then 20%	Deductible, then 50%
Early Pre-Natal Care Management **(Requires Case Mgmt; applies to Obstetrician's Global Delivery Fee Only)** 100% - copay and/or deductible waived **(Only applies to PPO Providers)**		
Ambulance	Deductible, then 20%	
Second Surgical Opinions **(When authorized by Utilization Management)**	100% - copay and/or deductible waived	
PHYSICIAN OFFICE VISITS & URGENT CARE:	**In Network - PPO**	**Out of Network**
IMWell Clinic	**No deductible, then 100%**	
Physician Office Visits & Urgent Care (Includes x-ray, ultrasounds, injections performed in the doctors office) **LAB WOULD BE DEDUCTIBLE & COINSURANCE WHEN BILLED BY DOCTOR - USE LAB CARD FOR 100% BENEFIT**	$25 copay per visit	Deductible, then 50%
Other Covered Expenses	Deductible, then 20%	Deductible, then 50%
CHEMICAL DEPENDENCY TREATMENT:		
Inpatient Care **(Requires Case Management)**	Deductible, then 20%	Deductible, then 50%
Outpatient Practitioner Office Visits **(Limited to 24 visits per year)**	$25 copay per visit	Deductible, then 50%
PSYCHIATRIC TREATMENT:		
Inpatient Care **(Requires Case Management)**	Deductible, then 20%	Deductible, then 50%
Outpatient Practitioner Office Visits **(Limited to 24 visits per year)**	$25 copay per visit	Deductible, then 50%
WELLNESS BENEFITS:	**In Network - PPO**	**Out of Network**
Routine Wellness Benefit	**No Deductible then 100%**	NOT COVERED
Mammograms, colonoscopies and prostate exams **(including PSA tests)**	**No Deductible then100%**	No Deductible, then 100%
Routine Childhood Immunizations	**No Deductible then 100%**	NOT COVERED

OUTPATIENT PRESCRIPTION CARD BENEFIT:			
Prescription Plan Out of Pocket Annual Maximum	Single: $3,600 Family: $4,200		
Covered Prescription Drug Expenses	**RETAIL**	**RETAIL 90**	**MAIL**
Per Prescription Limit:	34 day supply	90 days	90 days
Generic:	$5	$15	$10
Formulary Brand:	20% with $20 min. and $60 max.	20% with $60 min. and $180 max.	$55
Brand Name: (if a generic or formulary brand is available and the member chooses the brand name drug, then the member will pay the entire cost; unless deemed medically necessary by medical review)	30% with $40 min. and $80 max.	30% with $120 min. and $240 max.	$75
Life Threatening Emergency Care	PPO Deductible, then 20% (coinsurance applies to PPO out-of-pocket maximums)		
Emergency Out-Of-Area Treatment			
Services for which there are No Network Providers			
Participants Residing Out-of-Area			

The Retail 90 is available only at participating pharmacies. For a complete list of these pharmacies, please visit the Oklahoma County Clerk's website at: http://countyclerk.oklahomacounty.org/hr/forms

County Pharmacy – Free generic maintenance prescriptions (Please see enrollment information in the Annual Enrollment Guide)

Please refer to the Plan Document for a full explanation of benefits, definitions, limitations, and exclusions.

Deductible Requirement

"**Deductible**" shall mean a fixed amount of charges for Eligible Expenses during each Calendar Year for which there is no reimbursement under the Plan and which the Covered Person must pay.

The Deductible is applicable to all Eligible Expenses, except as otherwise stated.

Once the individual Deductible has been satisfied for three family members in a Calendar Year, the Deductible requirement will be considered satisfied for all covered family members for the remainder of that Calendar Year.

The Plan will apply the PPO deductible listed above for the following Eligible Expenses when a Non-PPO provider is used:

1. Treatment for which there is no PPO Provider in the PPO network.
2. Urgent emergency care, including admission to a Non-PPO hospital, until the patient is stabilized and can be safely transferred to a PPO hospital.
3. Ancillary services such as but not limited to: Lab and Anesthesia charges rendered by Non-PPO providers while confined in a PPO hospital.

Out-Of Pocket Expense

"**Out-of-Pocket Expense**" shall mean the coinsurance amount paid by the Covered Person for Eligible Expenses.

The following expenses do not count toward the annual out-of-pocket limit: amounts in excess of Reasonable and Customary, and expenses which are not covered by this Plan.

Coinsurance Provision

Coinsurance Percentage payable by the Plan:

PPO .... 80% (unless stated otherwise)
Non-PPO ....50% (unless stated otherwise)

All benefits are subject to the provisions of the Utilization Management section of this Plan Document.

The Plan will allow the PPO coinsurance percentage listed above for the following Eligible Expenses when a Non-PPO provider is used:

1. Treatment for which there is no PPO Provider in the PPO network.
2. Urgent emergency care, including admission to a Non-PPO hospital, until the patient is stabilized and can be safely transferred to a PPO hospital.
3. Ancillary services such as but not limited to: Lab and Anesthesia charges rendered by Non-PPO providers while confined in a PPO hospital.
4. Services or treatment rendered by a Non-PPO provider when negotiated directly with the provider or through an intermediary.

Questions Concerning Benefits

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of HealthSmart Benefit Solutions, Inc. or the Plan Administrator is not binding. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of this Plan Document.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable). A written reply will be sent, which will be kept on file.

MAJOR MEDICAL EXPENSE BENEFITS

Major Medical Expense Benefits for Eligible Expenses not otherwise limited or excluded, shall be paid in accordance with the following benefit provisions. All benefits are subject to provisions, exclusions and limitations as outlined in the excluded charges section immediately following this section.

Acne Treatment
Charges for Acne Treatment are payable. Cystic Acne is covered when Medically necessary and/or is considered standard of care.

Acupuncture
There are no benefits under this Plan for this type of Treatment/service.

Allergy Testing/Treatment
Charges for Allergy Testing, Injections and Serums are payable.

Ambulance
Ambulance Charges rendered by a professional ambulance service for urgent emergency care to the nearest Hospital equipped to furnish the necessary treatment are Eligible Expenses.

Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD)
Charges for ADD or ADHD, including applicable testing, are Eligible Expenses.

Audiological Services
(Read below for Case Management requirement)

For the purposes of this provision, the following definition is added:

"Audiologist" means any person who evaluates, examines, counsels or provides rehabilitative services for persons who have or are suspected of having a hearing disorder. An audiologist also may provide consultation regarding noise control and hearing conservation, may conduct tests of vestibular function, may prepare ear impressions, and may provide evaluations of environment or equipment, including calibration, used in testing auditory functioning. A person represents himself or herself to be an audiologist when such person holds himself or herself out to the public by any title or description of services incorporating the terms "audiology", "audiologist", "audiometry", "audiometrist", "hearing therapy", "hearing therapist", "hearing conservation". "hearing conservationist", "hearing clinician", "hearing clinic", "hearing center", "audiological" or "audiometrics".

Benefits will be provided for audiological services and hearing aids for Covered Dependent children, provided by a licensed Audiologist or Physician subject to all applicable plan provisions and any applicable deductible and/or coinsurance. All treatment for Audiological Services must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Covered charges include audiological services and hearing aids. Hearing aids must be prescribed, filled and dispensed by a licensed Audiologist. Coverage for hearing aids is limited to one hearing aid every 48 months for each hearing-impaired ear for Covered Dependent child. Coverage will include up to four additional ear molds each year for children up the child's third birthday. This benefit does not include charges for Cochlear Implants or implantable hearing aids.

Cardiac Rehabilitation Therapy
(Read below for Case Management requirement)

All treatment for Cardiac Rehabilitation Therapy must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Chemical Dependency and/or Substance Use Disorders
Charges for Chemical Dependency and or Substance Use Disorders are Eligible Expenses. The applicable coinsurance percentage shall apply to all Eligible Expense.

Inpatient Treatment
(Read below for Case Management requirement)
Charges incurred for the treatment of Chemical Dependency and/or Substance Use Disorders while confined to a Hospital, Special Care Facility or Psychiatric Day Treatment Facility must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management. If charges are incurred at a Day Treatment facility the Plan will allow two days of treatment to equal one day of Inpatient care.

Chemotherapy
Eligible Expenses include charges for chemotherapy regardless of method of administration

Clinical Trials - Routine Patient Costs
Charges for Routine Patient Costs for items and services furnished in connection with a Qualified Individual's participation in an Approved Clinical Trial. Subject to the provisions of this paragraph, this Plan will provide coverage of Routine Patient Costs for a Qualified Individual in connection with an Approved Clinical Trial. If one or more In-Network Healthcare Providers are participating in an Approved Clinical Trial, this Plan may require that a Qualified Individual participate in the Approved Clinical Trial through such In-Network Healthcare Provider if the In-Network Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial. If one or more In-Network Healthcare Providers are participating in an Approved Clinical Trial and one such In-Network Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial, this Plan will not provide coverage for Routine Patient Costs for items and services furnished in connection with an Approved Clinical Trial rendered by an Out-of-Network Healthcare Provider.

Definitions

Approved Clinical Trial: a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

A. 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:

    1. The National Institutes of Health.
    2. The Centers for Disease Control and Prevention.
    3. The Agency for Health Care Research and Quality.
    4. The Centers for Medicare and Medicaid Services.
    5. Cooperative group or center of any of the entities described in subsections (i) through (iv) above, or the Department of Defense or the Department of Veterans Affairs.
    6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    7. The Department of Veterans Affairs, The Department of Defense, or the Department of Energy, provided that the study or investigation has been reviewed and approved through a system of peer review that the U.S. government 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.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Life-threatening Condition: any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Patient Costs: all items and services consistent with the coverage provided by this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Individual; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Qualified Individual: a Covered Individual who meets the following conditions:

1. The Covered Individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-threatening Condition; and
2. Either –
   a. The referring Healthcare Provider is participating in the Approved Clinical Trial and has concluded that the Covered Individual's participation in the Approved Clinical Trial would be appropriate based upon the individual meeting the conditions in Paragraph 1, above; or
   b. The Covered Individual provides medical and scientific information establishing that the Covered Individual's participation in the Approved Clinical Trial would be appropriate based upon the Covered Individual meeting the conditions described in Paragraph 1, above.

Experimental or Investigational. For the purposes of determining eligible expenses under the Plan, a treatment (other than off label drug use) will be considered to be experimental or investigational if:

- The treatment is governed by the US Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
- The treatment is subject to ongoing phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute, or FDA; or
- There is documentation in published US peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine safety, toxicity or efficacy of the treatment.

Except for the Routine Patient Costs for items and services furnished in connection with participation for a Qualified Individual in an Approved Clinical Trial, any expenses for experimental or investigational treatment, or any Hospital confinement or treatment that results from the experimental or investigational treatment will be excluded from coverage by the Plan.

Contact Lenses or Eyeglasses
Benefits are payable for one set of lenses (contacts or frame-type), if needed, following cataract surgery.

Contraceptives – See Prescription Contraceptives

Cosmetic Surgery
"Cosmetic" shall mean any Surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

The Plan will not consider expenses for Cosmetic procedures as Eligible Expenses unless they are incurred:

1. To correct a condition resulting from an accidental bodily Injury or Illness;
2. To correct a congenital anomaly, or;
3. For reconstructive Surgery and treatment in accordance with the Women's Health and Cancer Rights Act of 1998. (See also Reconstructive Surgery)

Diabetic Supplies
Diabetic Supplies are covered under the Prescription Drug Card benefit. Please see Attachment.

Diagnostic Laboratory and X-rays
Eligible Expenses include charges for diagnostic X-ray examinations, microscopic and laboratory tests and fees billed for a radiologist or pathologist.

Dialysis
Eligible Expenses include charges for dialysis treatment.

Durable Medical Equipment
(Read below for Case Management requirement)

"Durable Medical Equipment" (DME) shall mean equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

DME does not include:

1. Domestic or recreation equipment such as air conditioners, spas and exercise equipment even if prescribed by a Physician;
2. Clothing or any kind of perishable items such as shoes or shoe attachments;
3. Items of convenience unless such item serves a primary medical purpose, and;
4. Motorized wheelchairs or vehicles.

Rental of DME required for temporary therapeutic use, or the purchase of such equipment if economically justified as determined by the Case Manager and approved by the Plan Administrator, must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Repair or replacement will be considered only when required due to growth or development of a dependent child, medical necessity because of a change in the Covered Person's physical condition, or deterioration from normal wear and tear if recommended by the attending Physician. However, replacement will be considered only if it is likely to cost less to buy a replacement than repair the existing equipment. Charges for the same or similar purpose are not covered. DME items include, but are not limited to; a durable brace specially made for and fitted to the Covered Person, and rental of wheelchairs and hospital beds.

Employees' Prescription Program - Free
The Employees' Prescription Program (EPP) is made available to you as part of the County Employees Benefit Plan. The program is operated by the Oklahoma County Pharmacy (OCP), which is a division of the Oklahoma County Social Services Department, of the Board of County Commissioners. The RPP

Radiology sprovides affordable, free, low-cost, generic maintenance medications of employees, retirees, and dependents that are covered under the county health insurance plan. Some of the major benefits to participation in the EPP are:

- Prescriptions may be filled for up to a ninety (90) day supply.
- You have options as to how to get your medication –you may pick up you medications at the county pharmacy or you may elect to have your medications mailed to you.
- There is no charge (no copay) for participation in the EPP as long as you are covered under the county insurance plan.

Oklahoma County Pharmacy: 7401 N.E. 23rd Street (between Air Depot and Midwest Blvd)
Oklahoma City, OK 73141
Phone: (405) 713-1891 (or if from a county office, ext. 5870)
Fax: (405) 713-6518
The County Pharmacy enrollment form is located on the County Clerk's benefit website.

HealthCheck Radiology
Radiology services including MRI, CT, PET scans, preventative body scan and virtual colonoscopy, x-rays and ultrasounds – utilizing the HealthCheck screening benefit (to access call 405.486.7444)

Home Health Care
(Read below for Case Management requirement)

All treatment for Home Health Care must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management. All care must be given by a Home Health Care Agency on its own behalf for covered services and supplies furnished in the patient's home in accordance with a Home Health Care Plan submitted by the attending Physician.

Home Health Care shall not include:
1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who ordinarily resides in the patient's home or is a member of the patient family or dependents of the patient;
3. Transportation services, or;
4. Custodial care.

Hospice Care
"Hospice Care" shall mean a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. It must have an interdisciplinary group of personnel, who includes at least one Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and one Registered Nurse (RN); maintain central clinical records on all patients; and meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital Expenses

Hospital Room and Board (Inpatient)

Private rooms are not covered under this Plan for Out of Network Hospitals. However, the Plan will allow the average semiprivate room charge, or in the case of a Hospital with all private rooms, 90% of the room and board charge. The Plan will allow the Reasonable and Customary or negotiated charge cost of an Intensive Care Unit.

Necessary Services and Supplies (Inpatient)

Emergency Room Services

Outpatient Services

IMWell
Medically necessary services provided to Plan Participants at the IMWell Clinic will be covered at 100% with no copayment or deductible applicable. The IMWell benefit is only available to participants that have the County Health Plan coverage as their primary coverage.

Infertility
Charges for Infertility treatment are not Eligible Expenses; however, charges for the initial infertility diagnosis will be considered Eligible Expenses.

"Infertility" shall mean the inability of a couple to achieve conception or to bring a pregnancy to term. Treatment of Infertility includes expenses such as: artificial insemination, fertility drugs, GIFT (Gamete Intrafallopian Transfer), in-vitro fertilization, reversal of a sterilization procedure, expenses of a surrogate mother, donor eggs or any type of artificial procedure designed to accomplish impregnation, whether or not such procedure is successful.

Infusion or Injectibles
Eligible Expenses include services, supplies, care or treatment in connection with the continuous slow introduction of a solution into the body, e.g. blood and other fluids including medications.

LabCard Program (Quest Diagnostics)
1-800-646-7788 www.labcard.com
This is a consumer driven benefit that allows you to obtain outpatient laboratory testing services at no cost to you.

Mammography Screenings (Mammograms)
Eligible Expenses will include routine low-dose mammography screening for the presence of occult breast cancer.

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

Medical Supplies
Medical and surgical supplies prescribed by a Physician, e.g. casts, splints, trusses, surgical dressings, initial crutches and braces, necessary due to Injury or Illness occurring while covered.

Morbid Obesity – See Weight Control

Mouth and Oral Cavity Treatment
Eligible Expenses under Major Medical Expenses for treatment to the mouth and/or oral cavity are limited to:

1. Emergency repair due to Injury to sound natural teeth, including replacement of such teeth, if the repair is made within 12 months from the date of the Injury (unless otherwise required by applicable law or delay is medically necessary);
2. Medically necessary surgery to correct accidental Injury to the jaw, cheek, lips, tongue, floor and roof of the mouth;
3. Removal of tumors, lesions or cysts;
4. Excision of benign bony growths of the jaw and hard palate;
5. Surgical treatment of sinuses, salivary glands, ducts and tongue;
6. Treatment to correct a non-odontogenic congenital defect that results in a functional defect of a Covered Dependent child;
7. Anesthesia and facility charges related to dental surgery which is found to be medically necessary.

Newborn Care
"Newborn Care" shall mean medical care of an infant from the date of birth until the initial Hospital discharge, or until the infant is 14 days old, whichever comes later.

Eligible Expenses for a healthy newborn child of a Covered Person include initial nursery charges, Physician's charges and a surgeon's charge for circumcision. Eligible Expenses, which will be considered under the baby's own claim independent of the mother's charges and are payable only during the mother's Inpatient confinement.

The newborn must be added within 31 days of the date of birth for any charges to be covered.

Any expenses Incurred by a newborn child whose date of birth is after the Termination of Coverage of the Plan Participant are not covered and no benefits will be paid.

Occupational Therapy
(Read below for Case Management requirement)
All treatment for Occupational Therapy must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Charges will be considered for services rendered by a registered or licensed occupational therapist, but only for those services requiring the technical proficiency and skills of a recognized occupational therapist and rendered in accordance with a physician's specific instructions as to type and duration to restore or improve lost or impaired function. Services for outpatient occupational therapy are covered only when the patient is able to actively participate in such therapy and there is documented continuous physical improvement. Eligible Expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Orthognathic Surgery
There are no benefits under this Plan for this type of Treatment/service.

Orthotic Devices
Orthotic Devices used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body will be considered Eligible Expenses; however, supportive devices for the feet and orthopedic shoes will not be covered. Repair or replacement of covered Orthotic devices will only be covered when required due to growth or development of a dependent child or due to medical necessity because of a change in the patient's physical condition.

Oxygen
Charges for Oxygen and rental of equipment for its administration including Intermittent Positive Pressure Breathing (IPPB) equipment are Eligible Expenses.

Physical Therapy
(Read below for Case Management requirement)

All treatment for Physical Therapy must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Charges will be considered for services of a licensed physical therapist for physical therapy, but only for those services requiring the technical proficiency and skills of a recognized physical therapist and rendered in accordance with a physician's specific instructions as to type and duration.

Physician Services

Office Visits
PPO - $25 Copay   Non-PPO – 50%

(Includes x-rays, ultrasounds and injections billed by the doctor during office visit. All other services billed by the doctor will be covered subject to the deductible and coinsurance.)

Eligible Expenses are those services rendered by a Physician for Treatment including, but not limited to, office visits, consultations, examinations, surgery, anesthesia and Inpatient medical care. Additional Plan provisions for Surgery are contained below under the Surgical Expense heading.

Podiatry Services
Eligible Expenses for podiatry services are limited to open cutting procedures unless such expenses are prescribed by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) in conjunction with the Treatment of a metabolic or peripheral-vascular disease.

Pre-admission or Pre-operative Testing
Eligible Expenses include charges for tests or exams related to surgery when performed on an outpatient basis within 7 days prior to a scheduled Hospital confinement or covered outpatient procedure. Charges for the tests are covered provided:

1. the surgery is an Eligible Expense;
2. the tests are not repeated when the patient is confined for the surgery;
3. the tests would have been covered had the patient been confined as a hospital patient;
4. the test results are part of the patient's medical records; and
5. the tests are identified as preadmission or preoperative testing.

Pregnancy Expenses
Upgraded PPO benefits are available for participating in Early Prenatal Care Management below.*

Claims for Pregnancy Expenses are covered as any other medical expense for an Eligible Employee, an Eligible Employee's spouse or a person covered under the Continuation of Coverage section. All expenses relating to a Pregnancy of a dependent child, including pre-natal, delivery and post-natal care, treatment of miscarriage and complications due to Pregnancy of a dependent child are specifically excluded as Eligible Expenses.

Benefits for Pregnancy Expense are payable at the time of delivery unless coverage ceases. If coverage ceases, benefits will be considered for expenses Incurred as of the date of Termination of Coverage.

There are no benefits after Termination of Coverage for Pregnancy Expenses except as provided under the Continuation of Coverage section. If a person is pregnant at the end of the allowable time under Continuation of Coverage, no benefits will be paid with the exception of those Incurred during the period that coverage was in effect.

Early Prenatal Care Management
A comprehensive obstetrical Case Management program has been developed to promote the health and well-being of the expectant mother, fetus, infant, and entire family. This benefit has been designed with the welfare of both the expectant mother and the unborn child in mind. It is vital that all requirements of the program be followed in order to receive the maximum benefits available under the Plan.

One call is all that is needed to initiate this benefit. The Covered Person must call HealthSmart Benefit Solutions, Inc. (405.848.1975 or 800.825.3540) during the first trimester (first three months) of pregnancy and the obstetrician must be a PPO provider. If the Covered Person complies with the requirements of this program, any Deductible will be waived and the coinsurance will be 100% for routine obstetrical examinations and the delivery charge when billed as a global fee.

Diagnostic x-ray and laboratory services, including but not limited to ultrasounds, sonograms, amniocentesis and other such procedures will be covered under the appropriate Plan provisions, subject to any applicable deductible, coinsurance and/or limitation.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal

delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prosthetic Device
(Read below for Case Management requirement)
An external breast prosthesis, after a covered mastectomy, is an Eligible Expense. Bras made solely for use with an external breast prosthesis are Eligible Expenses, limited to two every 12 months.

All other charges for a prosthesis or prosthetic device must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Prosthetic device repair or replacement will only be covered when required solely to a change in the physical condition of the Covered Person or due to growth or development of a Dependent child and only if approved by the Case Manager in advance. In no case will a special prosthesis, such as those used for athletic competition, be covered under this Plan.

Psychiatric Care
"Psychiatric Care" as used in this section shall mean Treatment for Mental Illness. The applicable coinsurance percentage shall apply to all Eligible Expense.

Reconstructive Surgery
Eligible Expenses include those in accordance with the Women's Health and Cancer Rights Act of 1998. The Plan will provide coverage for reconstructive Surgery and prostheses following mastectomies. This law mandates that a Covered Person who is receiving benefits for a covered mastectomy and who elects breast reconstruction with the mastectomy, will also receive coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and Treatment of physical complications of all stages of mastectomies including lymphedemas.

This coverage will be provided in consultation with the patient and the patients' attending Physician and will be subject to the same annual Deductible and/or coinsurance provisions otherwise applicable under the Plan.

If you have any questions about this Plan's coverage of mastectomies and reconstructive surgeries or about benefits under the Women's Health and Cancer Rights Act of 1998, please contact the Plan Administrator.

Rehabilitation Facilities and/or Services
(Read below for Case Management requirement)

Charges for Rehabilitation Facilities and/or Services must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

For consideration of Inpatient Rehabilitation the patient must be under the continuous care of a Physician and the attending Physician must certify that the patient requires nursing care 24 hours a day. Nursing care must be rendered by a RN, a LPN or a LVN. The confinement cannot be primarily for domiciliary, custodial, personal type care, care due to senility, blindness, deafness, mental deficiency or tuberculosis.

Skilled Nursing Facility
(Read below for Case Management requirement)
Charges for Skilled Nursing Facility and/or Services must be approved in advance and case managed by

a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Sleep Apnea
(Read below for Case Management requirement)
Charges related to Sleep Apnea or other sleep disorders must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Consideration will be given by the Case Manager to charges for evaluation and treatment of sleep disorders and adult apnea monitors. Charges for corrective Surgery for sleep disorders, including sleep apnea, are not Eligible Expenses.

Specialty Drugs
"Specialty Drugs" shall mean drugs with special handling requirements such as high cost medications, medications requiring special handling, injectables, oral medications requiring intense clinical management, medications with a significant risk of adverse effects and medications that must be closely monitored for compliance.

Eligible Expenses shall include charges for Specialty Drugs regardless of the method of administration of the drug where such drug is not otherwise covered under an applicable Prescription Drug Benefit Program.

Speech Therapy
(Read below for Case Management requirement)
Charges for Speech Therapy must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

Eligible Expenses may include charges for a legally qualified Speech Therapist who is under direct supervision of a Physician for restorative speech therapy for speech loss or impairment due to an Illness or Injury, or due to Surgery performed on account of an Illness or Injury, other than a functional nervous, mental, psychoneurotic or personality disorder. If the speech loss is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy.

Spinal Subluxation and Manipulation (Chiropractic Services)
Services, supplies and associated Treatment, including x-rays rendered for the analysis and adjustment of spinal subluxation,

Sterilization
Charges incurred as a result of voluntary sterilization procedures are Eligible Expenses. All charges Incurred for reversal of sterilization and charges for tests or procedures to determine the feasibility of a reversal are expressly excluded from benefits under the Plan.

100% Covered Surgery/Procedure Benefit
This Plan has contracted directly with several providers to provide services to covered persons. Covered services include, but are not limited to: certain surgical and diagnostic procedures. For additional information on the services available, please call HealthSmart Benefit Solutions at 405.607.2675. This benefit is only available to participants that have the County Health Plan coverage as their primary coverage.

Limitations and Disclosures:

The 100% Covered Surgery/Procedure Benefit is an alternate benefit and will be available when mutually beneficial to both the patient and the Plan ,including but not limited to locally available services. The Plan's decision to allow this alternative benefit shall be determined on a case-by-case basis in conjunction with the treating provider and the Covered Person. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefit for the same or any other Covered

Person, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan.

Surgical Expense
This Plan will cover as an Eligible Expense professional services of an operating Physician including necessary pre-operative and post-operative care Incurred as a result of an accidental bodily Injury or Illness.

Oral Surgery is covered in relation to the bone, including tumors, cysts and growths, not related to the teeth.

If a PPO physician is not used the surgical allowance will be determined in accordance with the Reasonable and Customary guidelines for the particular procedure in the geographical area in which the procedure was performed. The Plan will also cover an assistant surgeon when services are rendered in connection with an eligible surgical procedure by other than an intern, a resident or an employee of the facility where Surgery is performed. Fees for assistant surgeons are limited to 20% of the Reasonable and Customary or negotiated fee of the primary surgeon.

If two or more surgical procedures are performed during the course of a single operation, the allowable amount will be:

For two or more surgical procedures at the same site or incision:
1. 100% for the primary procedure,
2. 70% for each additional procedure performed through a separate incision, and
3. 50% for each additional procedure performed through the same incision.

Two or more procedures not performed through the same site or incision will be considered as though separate operations were performed.

The Plan will <u>not</u> cover:

1. Any professional fees whatsoever other than the fees of the primary surgeon or assisting surgeon for performing the surgical procedure; or
2. Expenses subject to any limitations or exclusions in this Plan.

Temporomandibular Joint (TMJ) Dysfunction and Myofacial Pain Disorder (MPD)
Non-surgical Treatment for TMJ and MPD is an Eligible Expense payable under this Plan. There are no benefits for surgical treatment of TMJ or MPD.

Transplants
(Read below for Case Management requirement)
Charges for Transplants and any related treatment must be approved in advance and case managed by a RN Case Manager. The Physician or patient should telephone HealthSmart Benefit Solutions, Inc. (800.825.3540 or 405.848.1975) to initiate such Case Management.

This benefit applies to all transplants, charges related to or in connection with a transplant, including but not limited to: follow-up Treatment, other Illnesses and/or complications of any other Illness that could be attributed to the transplant and any other related charges.

Approved Transplant Services:
Services and supplies for such as, but not limited to, Physician charges, organ procurement, tissue typing and ancillary services rendered during the benefit period. Benefits are provided for non-Experimental transplants such as but not limited to Kidney, Kidney/Pancreas, Liver, Heart, Heart/Lung, Lung, Bone Marrow (allogeneic and autologous) and stem cell transplants. A second opinion must be obtained prior to undergoing any transplant procedure and must be arranged by calling HealthSmart Benefit Solutions, Inc. at 405.848.1975 or 800.825.3540.

If both the donor and recipient are covered under this Plan, Eligible Expenses Incurred by each will be treated separately. No benefits will be provided for the donor when benefits are available through any other group coverage, or if benefits for the donor or recipient are available through any government funding of any kind which the donor or recipient is entitled to receive.

Charges are limited to those that are the legal responsibility of the Covered Person in the absence of this coverage.

Experimental, Investigative, or Unproved Procedures:
Please refer to page 36 for a detailed explanation.

Weight Control
Non-surgical charges related to morbid obesity (which is the lesser of 100 pounds over normal weight or twice normal weight) are Eligible Expenses. Charges incurred on account of any Surgery or complications of a Surgery for obesity, morbid obesity or weight control (even if the Covered Person has other health conditions which might benefit by weight reduction) are not Eligible Expenses and no benefits will be paid.; however, the Plan will consider benefits for the surgical treatment of "Morbid Obesity" or complications of such surgery, if the following conditions are met:

1. The patient has been Covered under this Plan for 60 consecutive months; and
2. The patient has been diagnosed with a related co-morbid condition, such as, but not limited to: cardiovascular disease, diabetes, hypertension, sleep apnea, hypothyroidism, Cushing's disease, hypothalamic lesions or other endocrine conditions; and
3. The patient has completed growth (18 years of age or documented bone growth); and
4. The patient has participated in a physician supervised nutrition and exercise program (not Covered under this Plan) which is documented in the medical record and meets all of the following criteria:
   a. Must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists;
   b. Must be six months or longer in duration;
   c. Must occur within the 2 years prior to surgery; and
   d. Must be documented in the medical record by an attending physician who does not perform bariatric surgery; and
5. The patient has obtained a psychiatric evaluation that demonstrates the patient's motivation and ability to adhere to a life long change in lifestyle.

For the purposes of this provision, "Morbid Obesity" shall mean a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 pounds **and** the BMI (body mass index) exceeds forty (40) and the attending physician has stated Morbid Obesity is now a life threatening condition.

Covered Charges under this section will be payable at 50% and charges excluded will not apply toward any annual coinsurance maximum. Benefits will never be paid at 100%. Benefits paid are limited to one lifetime surgical treatment including any complications of such surgery. There is no time limit for applying charges for complications of any surgery covered under this section.

Wellness Benefit (Preventive Care)
The Plan will provide benefits for routine service (billed with no illness or injury diagnosis) as stated in the Schedule of Benefits. Services will include but are not necessarily limited to: routine physical exams and

related laboratory services, annual gynecological exams and related laboratory services, annual prostate exams and related lab services, routine mammograms and Well Child exams.

Eligible Expenses also include the following expenses:

Preventive Services Covered under the Affordable Care Act

If you have a new health insurance plan or insurance policy beginning on or after September 23, 2010, the following preventive services must be covered without your having to pay a copayment or coinsurance or meet your deductible, when these services are delivered by a network provider.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** interventions to support and promote breast feeding
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Folic Acid** supplements for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b

- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

ALL BENEFITS ARE SUBJECT TO PROVISIONS, EXCLUSIONS AND LIMITATIONS AS OUTLINED IN THE EXCLUDED CHARGES SECTION IMMEDIATELY FOLLOWING THIS SECTION.

EXCLUDED CHARGES

All exclusions in this section include complications resulting from any excluded coverage, including, but not limited to, any reversal procedure unless stated otherwise.

1. Charges for the following services are eligible for benefits **only** if initiated, approved and monitored by HealthSmart Benefit Solutions, Inc., or the Case Manager selected by the Plan Administrator: Complicated or extended Hospital admissions; Catastrophic Diagnoses such as Cancer, Premature births, Organ failure; Treatment with High Dollar Medications; Transplants; Prosthesis; Skilled Nursing Facility; Special Care Services; Extended Care Facilities and/or Services; Rehabilitation Facilities and/or Services. Please contact HealthSmart Benefit Solutions, Inc. at 405.848.1975 or 800.825.3540 to initiate evaluation and assistance;

2. Any charges for Treatment on or to the teeth or gums, including Surgery or appliances; the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges, except charges Incurred for dental work which is necessary due to accidental bodily Injury to sound and natural teeth; or oral Surgery performed in relation to the bone, including tumors, cysts and growths, and not related to the teeth unless expressly included as a benefit of this Plan or medically necessary hospital charges in connection with covered dental treatment;

3. Charges Incurred for or in connection with eye refractions, eye glasses, contact lenses, or

examinations for the fitting or prescription of such, except examinations required as the result of an accidental bodily Injury or Illness unless expressly included as a benefit of this Plan.

4. Charges for a radial keratotomy or other eye Surgery to correct refractory error such as, but not limited to, near-sightedness; lasik Surgery or charges made for therapy or training relating to muscular imbalance of the eye (orthoptics) that does not have a disease etiology; (This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.);

5. Treatment for bunions, corns and calluses (unless open cutting procedure); trimming of nails, routine hygienic care; services and supplies for fallen arches or flat feet unless prescribed by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) in conjunction with the Treatment of a metabolic or peripheral-vascular disease;

6. Orthopedic shoes and other supportive devices for the feet unless they are an integral part of a leg brace and the cost is included in the orthotist's charge;

7. Charges Incurred as a result of the following:
   (a) Surgery to the upper or lower eyelid (blepharoplasty) unless procedure is determined to be Medically Necessary, certification is issued and Treatment is monitored by the Case Manager selected by the Plan Administrator;
   (b) Breast augmentation;
   (c) Breast reduction mammoplasty unless procedure is determined to be Medically Necessary, certification is issued and Treatment is monitored by the Case Manager selected by the Plan Administrator;
   (d) Full or partial facial lift;
   (e) Derma or chemo abrasion;
   (f) Scar revision;
   (g) Otoplasty;
   (h) Lift, stretch or reduction of abdomen, buttocks, thighs or upper arm;
   (i) Silicone injections or implants;
   (j) Rhinoplasty;
   (k) Abdominoplasty;
   (l) Gastric bypass or other similar surgery;
   (m) Lipectomy;
   (n) Any Surgery, procedure or Treatment to enhance or change the external appearance;
   (o) Complications of such Surgery, procedure or Treatment listed above unless it is:
      1. To correct a condition resulting from an accidental bodily Injury or Illness; or
      2. To correct a congenital anomaly; or
      3. Initial reconstructive Surgery due to a diagnosed cancerous condition;

9. Charges for Treatment of Infertility and fertilization attempts;

10. Charges for sexual transformation, sexual alteration or Treatment of sexual dysfunctions not related to organic disease;

11. Charges for elective abortions unless the life of the mother is endangered by the continuation of the Pregnancy;

12. Charges for reversal or attempted reversal of sterilization;

13. Pregnancy expenses for a dependent child, including pre-natal, delivery and post-natal care, Treatment of miscarriage and complications due to Pregnancy of a dependent child;

14. Hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care or, for care in a health resort, nursing home, or any institution providing Custodial care, or an admission to control or change the patient's environment and/or during which

the patient receives psychiatric care that could have been safely and adequately provided on an outpatient basis, except as specifically provided for in this Plan;

15. Custodial care for a Covered Person who is mentally or physically disabled and is not under specific medical, surgical or psychiatric treatment which is likely to reduce the disability or enable the patient to live outside an institution providing care;
16. Physical or psychological therapy where the method of treatment is art, play, music, drama, reading, massage, home economics or recreational activities;
17. Biofeedback;
18. Charges for Treatment of substance abuse required by a court or in lieu of a conviction;
19. Charges for learning deficiencies, including associated diagnostic testing; for tuition or special education, or for educational testing or training.
20. Charges for marriage or family counseling; any goal-oriented therapy; or services by a counselor or therapist other than those rendered by a Physician or Psychologist as defined in this Plan;
21. Charges in connection with Custodial Care, education or training, or related expenses actually Incurred by other persons;
22. Charges Incurred for services or supplies which constitute personal hygiene, comfort or convenience items, including, but not limited to, air conditioners, humidifiers, air purification units, electric heating units, orthopedic mattresses, scales, elastic bandages or stockings and first aid supplies;
23. Charges Incurred for routine medical examinations or routine health check-ups, gamma globulin injections or immunizations not necessary for the Treatment of an Injury or Illness, except as specifically provided for in this Plan;
24. Charges for hypnotism or holistic medicine;
25. Charges Incurred for room and board in connection with a Non-Emergency Hospital Admission on a Friday or Saturday if Surgery is not to be performed until the following week;
26. Travel or accommodations, whether or not recommended by a Physician, except as specifically provided herein;
27. Wigs (except following chemotherapy or radiation therapy), artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness;
28. Food, food products, Nutritional supplements including, but not limited to, prescription or over-the-counter vitamins, except as may be specifically provided herein;
29. Nutritional or dietary education, except nutritional counseling or education for diabetics;
30. Charges for failure to keep a scheduled visit, telephone consultations, preparing medical reports or itemized bills, online counseling, online consultations or charges for completion of a claim form;
31. Charges and/or treatments that are considered to be Overutilization;
32. Charges for mailing or sales taxes;
33. Charges for which there are no procedure or diagnosis codes;
34. Expenses Incurred for the Treatment of injuries resulting from a motor vehicle accident to the extent

such expenses are eligible for payment under a motor vehicle insurance contract or under similar provisions of a motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payments is made under the motor vehicle insurance contract;

35. Expenses Incurred in regards to an injury to a Covered Person while the Covered Person was engaged in the illegal use of alcohol or drugs; expenses will be covered for injured Covered Persons other than the person illegally using alcohol or drugs;

36. Expenses Incurred in regards to an injury or accidental overdose resulting from a Covered Person voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician; expenses will be covered for injured Covered Persons other than the person using the controlled substances not administered on the advice of a Physician; (However, the Plan does not exclude benefits otherwise provided for treatment of an injury arising out of substance use disorder.)

37. Medical expense Incurred on account of any accidental bodily Injury or Illness to the extent of reimbursement of such medical expense under any contract of property, casualty, liability, marine or vehicle insurance;

38. Charges related to Injuries or Illness caused by the act or omission of another person or party; or for which another person or party may be liable or legally responsible for payment of such charges including payment of any future charges for related Illnesses or Injuries;

39. Charges for which the individual is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made;

40. Charges for services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

41. Charges Incurred as a result of any intentionally self-inflicted Injury or Illness and any complications thereof, except as otherwise required by applicable law;

42. Charges for which benefits are payable under the Coordination of Benefits section;

43. Charges for Treatment resulting from injuries received in war, any act of war (declared or undeclared but not acts of terrorism that are later deemed as acts of war) or caused during service in the armed forces of any country, or from participation in a riot or civil disobedience;

44. Charges resulting from or occurring during the commission of a crime or while engaged in an illegal act, illegal occupation, felonious act or aggravated assault whether or not criminal charges are filed;

45. Charges for any Injury or Illness which results from or in the course of any occupation or employment for compensation or profit, unless the expenses are denied by the Worker's Compensation carrier;

46. Charges for Treatment or care by a Physician, nurse or licensed therapist who is a Close Relative of, or ordinarily resides with, the Covered Person;

47. Charges Incurred outside the United States if the Covered Person traveled to such a location without the prior written approval of the Plan Administrator for the sole purpose of obtaining medical services, drugs, or supplies;

48. Charges which are in excess of Reasonable and Customary or negotiated charge or are not recommended and approved by a Physician, or are for services and supplies which are not Medically necessary and/or considered standard of care for Treatment of an Injury or Illness;

49. Charges for services, supplies or Treatments not recognized by the American Medical Association as

generally accepted and Medically necessary and/or considered standard of care for the diagnosis and/or Treatment of an active Illness or Injury, except as specifically provided herein, and procedures deemed Experimental, Investigative or Unproved;

50. Charges that are expenses to the extent paid, or which the Covered Person is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;
51. Charges which are not certified by a Physician as being required for the Treatment of Injury or disease and performed by an appropriate Provider;
52. Charges for any Hospital confinement, Surgery, Treatment, services or supply, which is payable by or through any Plan or program of any government or governmental agency, except in accordance with applicable law;
53. Charges that are not actually rendered;
54. Charges Incurred before the effective date of coverage or after coverage has been terminated;
55. Charges that are not payable due to the application of any specified Deductible provisions contained herein;
56. Charges that are for or in connection with Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any licensed Physician, facility, or other provider of medical services; or for any medical expenses that are deemed 'Never Events' as determined by Medicare and the Centers for Medicare and Medicaid Services (CMS);
57. Charges for any condition, Illness or Injury, or complication thereof, arising out of engaging in a hazardous hobby or activity, which is an unusual activity characterized by a constant threat of danger, such as but not limited to: skydiving, auto racing, hang gliding and bungee jumping. This does not include common recreational activities, such as water or snow skiing, jet ski operating, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding and team sports;
58. Charges to the extent that payment under this Plan is prohibited by law; and
59. Charges that are not specifically covered under this Plan.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for Treatment of the Injury if the Injury results from an act of domestic violence or a medical condition which includes physical, psychiatric or substance use conditions.

All exclusions in this section include complications resulting from any excluded coverage, including, but not limited to, any reversal procedure unless stated otherwise.

UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM

Utilization Management is a combination of review programs designed to help control the rising costs of medical coverage while being able to maintain the high level of benefits provided under this Plan. The programs include: Hospital Admission Certification, Concurrent Review, Length of Stay Management, Surgery Approval, and Case Management Intervention.

Hospital Admissions
You must notify the appropriate Utilization Management Company of a hospital admission within 72 hours following such admission. In order to comply with the notification, the Covered Person, Physician or Hospital must call the appropriate Utilization Management Company. It is recommended that such notification be given at least three (3) days prior to any hospital admission; however, you are not required to do so except for those services listed below under Case Management.

Surgery Approval
You must notify the appropriate Utilization Management Company of a surgical procedure within 72 hours following such surgery. The Covered Person, Physician or Hospital must call the appropriate Utilization Management Company. It is recommended that such notification be given at least three (3) days prior to any surgery; however, you are not required to do so except for those services listed below under Case Management.

In some cases the Plan may recommend a second opinion be obtained and, if the opinion of the second doctor is different from the attending Physician, a third opinion can be arranged, if the Covered Person so desires. The cost of the second opinion consultation, and the fee for the third opinion, if applicable, will be borne by the Plan unless the Covered Person fails to keep the appointment, without 24 hours notice of cancellation.

Other Services requiring Utilization Management certification or authorization
Authorization or certification may be required for the following services, so please contact HealthSmart Benefit Solutions, Inc. for approval: Speech Therapy; Home Health Care, Occupational Therapy; Durable Medical Equipment (rental or purchase); Growth Hormone Therapy; Cardiac Rehabilitation Therapy; Psychiatric Day Treatment Facilities and/or Services.

Large Case Management
In cases where the patient's condition is expected to be or is of a serious nature, the Plan Administrator through the appropriate Utilization Management Company will arrange for review and/or Case Management Services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care.

Benefits for services such as those listed below, require case management: Complicated or extended Hospital admissions; Catastrophic Diagnoses such as Cancer, Premature births, Organ failure; Treatment with High Dollar Medications; Transplants; Prosthesis; Skilled Nursing Facility; Special Care Services; Extended Care Facilities and/or Services; Rehabilitation Facilities and/or Services that are Medically Necessary **will be considered under this Plan only if initiated, approved and monitored by the Case Manager** selected by the Plan Administrator. If a Physician feels services of the nature listed above are in the best interest of the patient, the Physician should contact HealthSmart Benefit Solutions at 405.848.1975 or 800.825.3540. **You MUST call HealthSmart Benefit Solutions prior to receiving any of the services listed in this paragraph, failure to call and receive prior approval for these services will result in denial of benefits.**

ALL HOSPITAL ADMISSIONS, DAYS IN THE HOSPITAL AND SURGICAL PROCEDURES MUST BE MEDICALLY NECESSARY. In order to expedite the processing of these claims, it is recommended that prior notification be given to the appropriate Utilization Management Company, even though not required to do so. In some cases, it will be necessary for the Plan to obtain medical records, operative reports and treatment plans in order to ascertain benefits.

ELIGIBILITY REQUIREMENTS AND TERMINATION OF COVERAGE

Eligible Employee
The term "Eligible Employee" shall mean a Full-time, Employee of the Employer. An Employee is considered to be Full-time if he or she normally is scheduled to work an average of thirty (30) hours per week. For the purposes of this provision, the term week shall mean any period of seven consecutive days, which need not be the same as a calendar week, during which the Employee works thirty (30) hours, except law enforcement hours which can be based on a twenty-eight (28) consecutive day period of one hundred seventy one (171) total hours.

Eligible Elected Official
The term "Eligible Elected Official" shall mean a person officially elected for a specific term to an Oklahoma Counted elected office. Elected Official shall be considered to be an Eligible Employee during any active term in the office regardless of the actual hours worked. The Oklahoma County Elected Officials are as follows: Assessor, County Clerk, Sheriff, District 1 Commissioner, District 2 Commissioner, District 3 Commissioner, Treasurer and Court Clerk.

Waiting Period: 1st of the month following 60 days of employment

Effective Date of Employee Coverage
Each Participant shall become effective on the first day of the month after he or she completes the employment Waiting Period of sixty days (60) as an Employee and completes an application for coverage on or before that date. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. An exception to the sixty-day waiting period is made for a full-time Employee coming directly to the employ of Oklahoma County from other full-time governmental service within the State of Oklahoma, without a break in employment and for elected officials. For purposes of this exception, "without a break in employment" shall be defined as employment, which begins at Oklahoma County within six (6) months of said employee's departure from the previous full-time governmental service.

Variable Employee
The term Variable employee shall mean an employee of Oklahoma County, based on the facts and circumstances on the first day of employment with Oklahoma County, whose reasonable expectation of average hours per week cannot be determined. A Variable Employee may be eligible for coverage on the first day of the month following the end of the Administrative Period as defined below, if it is determined that the employee has worked an average minimum of 30 hours of service per week.

Initial Measurement Period for Variable Employee
The period starting on January 1st, ending on October 31st of each calendar year, during which Variable Employee's hours worked will be taken into consideration to determine the average hours worked during each service week.

Administrative Period for Variable Employee
The period immediately following the Initial Measurement Period, from November 1st until December 31st of each calendar year, during which the average hours worked calculation will be finalized and coverage offered to the Variable Employee who is determined to be eligible for benefits.

Stability Period for Variable Employee
The Period immediately following the Administrative Period, from January 1st until October 31st of each year, during which the Eligible Variable Employee's benefit coverage will commence and remain in place, barring any unforeseen circumstances (Special Event).

Termination of Coverage for Employees
Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee 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 the section entitled COBRA Continuation Option):

1. The date the Plan is terminated.

2. The last day of the month in which employment at Oklahoma County terminates unless the Employee qualifies as an Eligible Retiree and remits the required contributions to the Employer.

3. The last day of the month in which a participant no longer qualifies as being eligible for coverage under this Plan.

4. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

5. The day of the month in which a Participant enters into active duty with any military service of any country.

6. The end of the month in which an Elected Official is sworn out of the office.

7. The end of the stability period for variable employee.

Eligible Retiree
An Employee who has coverage under this Plan at the time of his/her approved retirement and who is eligible for retiree benefits as provided by Oklahoma County shall be considered an "Eligible Retiree". An Eligible Retiree must elect to continue coverage within thirty-one (31) days of the date that employment ceases. If no election is made or the retiree refuses any coverage within the thirty-one (31) day period, he/she **<u>will not be eligible to elect benefits at a later date</u>**.

Effective Date Of Retiree Coverage
Each Eligible Retiree shall become effective on the day following date that active employment with Oklahoma County ceases, subject to election to continue coverage by completion of an application for coverage on or within 31 days of the date that employment ceases and payment of any required contributions.

All coverage under this Plan shall commence at 12:01 A.M., on the date such coverage is effective.

Termination Of Coverage For Retired Employees
Retiree coverage will terminate on the <u>earliest</u> of these dates:

1. The date the Plan is terminated.

2. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

3. The day of the month in which a Participant enters into active duty with any military service of any country.

Please note that once coverage terminates, it cannot be reinstated.

Survivorship Provision
The spouse of a deceased covered retiree and employee can elect to continue coverage with no lapse in coverage under this Plan, subject to the following:

1) The spouse was covered under this Plan as of the date of the retiree's or employee's death; and

2) The spouse completes an application, on a form approved by the Plan Administrator, electing to

continue coverage and remits any required contributions within a period not to exceed thirty-one (31) days from the date of the covered retiree's date of death.

Furthermore, subject to the above and all other Plan provisions, coverage will continue, upon election by the surviving spouse, to only the eligible dependent children already covered under the Plan as of the covered retiree's date of death. The survivorship provision does not allow adding any potentially eligible persons to the Plan after the covered employee's or retiree's date of death.

Eligible Dependent
"Eligible Dependent" shall mean:

1. The Plan Participant's legal spouse who has met all requirements of a valid marriage contract in the State of Oklahoma. The Plan Participant's common law spouse who has met all requirements for a valid common law marriage under such state law shall be an Eligible Dependent.

2. The Plan Participant's child who is less than 26 years of age. "Plan Participant's Child" shall include a Plan Participant's natural or legally adopted son or daughter (including a son or daughter placed for adoption with the Plan Participant), a Plan Participant's stepson or stepdaughter (meaning a natural or adopted son or daughter of the spouse of the Plan Participant), a child who is less than 26 years of age and has been placed under the legal guardianship of the Plan Participant, a foster child as defined below, or a son or daughter for whom the Plan Participant is required to provide coverage in accordance with a Qualified Medical Child Support Order (QMCSO) or other applicable law and who meets the following condition:

    a. Is not a child of the Plan Participant's dependent children, except in the case of legal adoption or legal guardianship;

3. The Plan Participant's son or daughter who satisfies the definition of a "Plan Participant's Child", above, is 26 years of age or over and who is:

    a. Mentally or physically incapable of earning a living;
    b. Primarily supported by the Plan Participant; and
    c. The child is continuously disabled through the date an Eligible Expense is Incurred; provided that
    d. The Plan Participant submits proof of the child's incapacity and dependency within 31 days after the date the child fails to qualify under this plan and at reasonable intervals thereafter at the Plan's request.

Any person who is entitled to Employee Coverage under this Plan (or entitled to benefits under any extension of such Employee Coverage) or on active full-time duty in the armed forces of any country is excluded from coverage as a Dependent.

During any period that a husband and wife are concurrently eligible for coverage as Eligible Employees, each Eligible Dependent child of such husband and wife shall be deemed to be a dependent of only one.

Eligible Dependent shall **not** be interpreted to mean a mother, father, grandchild or any other person claimed as a dependent for income tax purposes unless such person is a spouse or child as defined above or a child who is eligible for coverage in accordance with a QMCSO or other applicable law.

"Foster Child"
For the purposes of this Plan, the term "foster child" shall mean an individual who is placed with the taxpayer by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

1. The child lives in the Plan Participant's home and depends on the Plan Participant for primary support; and

2. The Plan Participant can legally claim the child as a federal income tax deduction.

A "foster child" is not a child:

1. Temporarily living in the Plan Participant's home;

2. Placed with the Plan Participant by a social service agency which retains control of the child; or

3. Whose natural parent may exercise or share parental responsibility and control.

Qualified Medical Child Support Order (QMCSO)
If the Plan Administrator receives a court order to provide medical coverage for an Eligible Employee's natural or adopted child, the Plan Administrator must notify the employee and determine if the child is eligible for coverage under this Plan. Eligibility determinations will be made in accordance with federal and/or state child support laws. The Eligible Employee will be responsible for any contributions required under this Plan.

The coverage provided in accordance with a QMCSO will be effective as of the date of the child support order and subject to all provisions of the Plan except:

1. A qualified dependent may be covered without the employee's personal coverage in effect under this plan.

2. Any child of a Plan Participant who is an alternate recipient under a QMCSO shall be considered as having a right to Dependent Coverage under this Plan.

In addition to the reasons for termination of coverage shown in the Termination of Coverage Provision, the coverage required by a QMCSO will cease on the earlier of the date the support order expires or the date the dependent is enrolled for similar coverage, whichever is earlier.

If Eligible Expenses for an Eligible Dependent child covered under this provision are paid by a custodial parent or legal guardian who is not a Plan member, benefits will be paid directly to the custodial parent or legal guardian rather than the Eligible Employee. A custodial parent or legal guardian may also sign claim forms and assign Plan benefits.

Effective Date of Dependent Coverage
Each Participant who completes an application for Eligible Dependents for coverage under this Plan shall become covered for dependent benefits in accordance with the following:

1. If the Participant makes such written request on or before the date the Participant becomes effective then the dependent will become covered on the same date as the Participant;

2. If the Participant makes such written request on or before the thirty first (31st) day immediately following the day that he/she is eligible for Dependent Coverage and Actively At Work, the dependent shall become covered on the first of the month following approval of the completed application;

3. A Newborn dependent child will be covered from the date of birth if the coverage is requested within the thirty-one (31) days immediately following the date of birth. The Employee shall also be required to submit a "Change in Family Status" form, which must meet the approval of the Plan Administrator The Participant must pay any required contributions for the dependent's coverage;

4. A newly acquired Eligible Dependent of a Participant may be enrolled in this Plan if the Participant submits a written application within thirty-one (31) days after the dependent is acquired. The Employee shall also be required to submit a "Change in Family Status" form, which must meet the approval of the Plan Administrator. Coverage will become effective on the first of the month following approval of said application. The Participant must pay any required contributions for the dependent's coverage

Termination of Coverage for Dependents
The coverage on any Covered Dependent will automatically terminate on the earliest of the following subject to the provisions contained in the section entitled "Continuation of Coverage":

1. The date the Plan or Dependent coverage under the Plan is terminated.

2. The end of the month in which the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)

3. The end of the month in which a covered Dependent loses coverage due to loss of dependency status. (See the COBRA Continuation Option.)

4. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation of Coverage
The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives certain persons, known as "Qualified Beneficiaries", the right to continue their health care benefits beyond the date that they might otherwise terminate. If a Qualified Beneficiary was covered by this Plan's health care benefits prior to termination, that person may, but is not required to, continue them under COBRA. Which benefits are to be continued, if any, will be indicated by the Qualified Beneficiary at the time of COBRA enrollment.

Generally, for purposes of any benefits payable under this continuation coverage, Qualified Beneficiaries will be considered the same as any similarly situated beneficiary covered under the Plan.

The entire cost plus an administrative fee must be paid by the Qualified Beneficiary. Coverage will end if the Qualified Beneficiary fails to make timely payment of contributions. Once coverage is elected, payment for the cost of the initial period of coverage must be made within 45 days. Thereafter, payments are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, coverage will be canceled and will not be reinstated.

Maximum Time Periods
Continuation of health benefits is available for a Qualified Beneficiary up to the maximum time period shown in items 1, 2 or 3 below. A circumstance that makes a Qualified Beneficiary eligible for continuation of coverage benefits is called a "Qualifying Event." Combined Qualifying Events will not continue a beneficiary's coverage for more than 36 months beyond the date of the original Qualifying Event.

1. Up to 18 months for an Eligible Employee and his Covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

2. A Qualified Beneficiary who is disabled may have COBRA coverage extended (and an extra fee charged) from 18 months to 29 months provided that:

   The Qualified Beneficiary is determined to be disabled for Social Security purposes on the date of the Qualifying Event or within the first 60 days of COBRA coverage; and the Qualified

Beneficiary notifies the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18 month COBRA period which applies to the Qualified Beneficiary. All other non-disabled Covered Dependents may also continue to be Covered during this extended period.

3. Up to 36 months for:

    a. A covered child who ceases to be an Eligible Dependent;

    b. A covered Eligible Dependent if coverage ceases due to the Eligible Employee's death;

    c. A covered spouse whose coverage ceases due to divorce or legal separation; or

In all cases, the only individuals who are eligible to continue COBRA coverage after a Covered Person becomes entitled to Medicare are the employee's spouse and dependent children, if any.

The Eligible Employee is entitled to continue COBRA coverage on account of retirement as long as he or she became entitled to Medicare before retirement.

If an Eligible Employee becomes entitled to Medicare prior to a termination or reduction of hours, the affected Qualified Beneficiaries must be allowed to elect COBRA coverage for up to the longer of 36 months from the earlier date of Medicare entitlement or 18 months from the later termination of coverage or reduction in hours of employment, whichever is greater.

If Medicare entitlement occurs after a Qualifying Event which is a termination of coverage or reduction in hours of employment, then affected Qualified Beneficiaries will be allowed to continue COBRA coverage for the remainder of the 18 month period.

There is a special continuation of coverage period for retired Eligible Employees who retired on or before the date of substantial elimination of coverage and their Eligible Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the Retired Employees and their Eligible Dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. For this Item 3, coverage does not terminate when the Eligible Employee becomes entitled to Medicare. The maximum coverage period for the retired Eligible Employee is the retired Eligible Employee's date of death. The maximum coverage period for the spouse, surviving spouse or dependent child of the retired Eligible Employee is 36 months after the date of the retired Eligible Employee's death.

Continued coverage may cease on the earliest of the following to occur:

1. The last day of the applicable 18, 29 or 36 month time limit;

2. The date that the Employer ceases to provide a group health plan to all employees;

3. The date that the Qualified Beneficiary first becomes, after the date of election, either:

    (a) Entitled to benefits under Medicare Part A or Part B; or

    (b) Covered under any other group health plan (as an employee or otherwise).

    However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA coverage for the length of a pre-existing condition limit or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the Qualified Beneficiary becomes covered under a group health plan with a pre-existing condition limit, if the pre-existing condition limit does not apply to (or is satisfied by) the Qualified Beneficiary by reason of the group health plan portability, access and renewability requirements of HIPAA or the Public Health Services Act; or

4. The date the cost of continued coverage is not paid by the due date.

5. For an Eligible Employee who has extended COBRA coverage of 29 months due to disability, COBRA coverage will end on the first day of the month that begins more than 30 days after a final determination has been made by the Social Security Administration that the individual is no longer disabled.

Notice Requirements
When coverage terminates due to an Eligible Employee's death, termination or eligibility for Medicare, the Employer has 30 days in which to notify the Plan Administrator or the designated agent of the Qualifying Event.

When coverage terminates due to divorce, legal separation or change of Eligible Dependent status, the Qualified Beneficiary has 60 days from the Qualifying Event or from the date coverage terminates to notify the Employer or Plan Administrator, in writing, that the Qualifying Event has occurred. If the Plan Administrator is not notified of any one of the Qualifying Events above within 60 days of the Covered Dependent's ceasing to be eligible, COBRA will not be offered.

Complete instructions on COBRA and how to elect continuation will be provided by the Plan Administrator or the designated agent within 14 days of receiving notice of a Qualifying Event. Qualified Beneficiaries then have 60 days in which to elect continuation coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the COBRA notice. If continuation is not elected in the 60-day period, then the right to elect continuation of coverage ceases.

Notice to a Qualified Beneficiary who is the Employee's spouse will be considered notice to all other Qualified Beneficiaries residing with the spouse when the notice is given. Any election by the Employee or spouse will be deemed an election by all other Qualified Beneficiaries, unless the Qualified Beneficiary makes an individual election. Each Qualified Beneficiary is entitled to an individual election of COBRA continuation coverage. A Qualified Beneficiary may waive COBRA continuation coverage during the 60-day election period. This waiver of coverage may be revoked at any time before the end of the election period. In this case, coverage will be effective on the date the waiver revocation notice is received by the Employer or its representative. Coverage will not be provided retroactively.

Leave Of Absence
A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence.

Coverage under this Plan will be continued a maximum of six (6) months during the duration of an approved Leave of Absence. This will be subject to the employee making the required contributions, if any. An approved Leave of Absence must be evidenced by a written document signed by a representative of the Employer.

If an Employee fails to return to work at the end of an approved Leave of Absence, benefits will be terminated as of the end of the Leave of Absence and the leave time will apply to the time limitations allowed under the "Continuation of Coverage" provision.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person

Family and Medical Leave Act (FMLA)

Employers subject to FMLA are those employers with 50 or more employees for 20 or more workweeks in the current or preceding year.

If an Eligible Employee ceases to be at work due to an Employer approved FMLA leave of absence in accordance with the requirements of Public Law 103-3 (or in accordance with any applicable state or local law which provides a more generous medical or family leave and requires continuation of coverage during

leave), coverage will be continued under the same terms and conditions which would have been provided had the Eligible Employee continued to be at work, provided the Eligible Employee continues to pay the contributions, if required. Contributions will remain at the same Employer/employee percentage as prior to the leave (unless contributions change for other employees in the same classification). Eligible Employees may either prefund their contributions to the Plan through salary reduction, pay their share of the contribution payments on the same schedule as payments would be paid by Eligible Employees or pay under any other system voluntarily agreed to between the Employer and the employee.

If the Eligible Employee does not return to work after the approved FMLA leave, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan effective with the date notification is given to the Employer and provided the Eligible Employee elects to continue under the COBRA provision. The Eligible Employee will be responsible for all contributions during the COBRA continuation, if elected. Coverage continued during a FMLA leave will not be counted toward the maximum COBRA continuation period.

If the Eligible Employee fails to make the required contribution for coverage to continue during FMLA leave within 30 days after the date the contribution was due, the Eligible Employee's coverage will terminate effective on the date the contribution was due. If during FMLA leave, the Eligible Employee informs the Employer of the intent not to return to work, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan provided the Eligible Employee pays all unpaid contributions required for the time coverage had lapsed by the time the initial COBRA payment is due. Coverage continued during the FMLA leave will not be counted toward the maximum COBRA continuation period.

If coverage under this Plan was terminated during an approved FMLA leave due to non-payment of required contributions by the Eligible Employee and the Eligible Employee returns to work immediately upon completion of that leave, coverage will be reinstated on the date the Eligible Employee returns to work as a full-time Employee without having to satisfy any Waiting Period in this Plan provided the Eligible Employee makes any necessary contribution(s) and enrolls for coverage within 31 days of the return to work.

Military Leave Act
Eligible Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights include up to a maximum of 24 months of continued health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage upon return from military service. These rights apply only to Qualified Beneficiaries covered under the Plan before leaving for military service.

Plan exclusions and Waiting Periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, military service.

Change In Family Status

The following is a list of events qualifying as Changes in Family Status:

New Employee	Loss of coverage due to loss of a Spouse's employment	Marriage
Loss of dependent's coverage		
Divorce	Birth or Adoption of a Child	Death of Spouse or Child

Special Enrollment
If an Eligible Employee or Eligible Dependent losses coverage under another health plan and makes application for coverage within 31 days of the loss, such individual shall be a Special Enrollee provided such person submits documentation and written verification. An Eligible Employee who seeks to enroll in this Plan as a result of obtaining a new dependent through marriage, birth, legal guardianship, adoption or placement for adoption shall be a "Special Enrollee, if the Eligible Employee enrolls for coverage within 31 days of the acquisition of the new dependent. Coverage for a special enrollee (other than a newborn

or newly adopted child) shall begin as of the first day of the calendar month following the special event. Coverage for a newly adopted or newborn Special Enrollee shall begin as of the date of the birth, adoption or placement for adoption.

Special Enrollment provision in connection with
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Special Enrollment Rights. This Plan will permit employees and dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or

2. the employee or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the plan within 60 days after eligibility is determined.

Annual Enrollment

Eligible Employees may enroll for coverage for themselves and their Eligible Dependents during Annual Enrollment Periods. The Annual Enrollment Period will be November. Coverage for individuals enrolling during an Annual Enrollment Period will become effective on January 1, unless the Eligible Employee has not satisfied the Waiting Period, in which event coverage for the Eligible Employee and his Eligible Dependents will become effective on the first of the month following completion of the Waiting Period.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.

Alternate Recipient
"Alternate Recipient" means any child of a Plan Participant who is recognized under a Qualified Medical Child Support Orders (QMCSO) as having a right to enrollment under a group health plan with respect to such Plan Participant.

Birthing Center
"Birthing Center" shall mean a facility, either free standing or as part of a Hospital, equipped and operated for the primary purpose of delivering babies and which a patient is admitted to and discharged from within a 24-hour period unless complications arise.

Calendar Year
"Calendar Year" shall mean the period from January 1 through December 31.

Certificate of Creditable Coverage
"Certificate of Creditable Coverage" shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Chemical Dependency and/or Substance Use Disorders
"Chemical Dependency and/or Substance Use Disorders" shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical intolerance or withdrawal. The term "Chemical Dependency and/or Substance Use Disorders" shall also mean alcoholism, drug addiction, alcohol and/or drug or substance abuse or any mental, nervous or emotional disorder related to alcoholism, drug addition or alcohol, drug or substance abuse.

Close Relative
"Close Relative" shall mean the parent, grandparent, brother, sister or child of a Plan Participant or Plan Participant's spouse.

COBRA
"COBRA" shall mean the Consolidated Omnibus Budget reconciliation Act of 1985, as amended.

Complications of Pregnancy
"Complications of Pregnancy" shall mean conditions requiring Hospital confinement (when the Pregnancy is not terminated), whose diagnoses are distinct from Pregnancy but are adversely affected or caused by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; or non-elective cesarean section, ectopic Pregnancy which is terminated, spontaneous termination of Pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

"Complications of Pregnancy" do not include false labor, occasional spotting, physician-prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, or similar conditions associated with the management of a difficult Pregnancy not constituting a medically distinct complication of Pregnancy.

Copay
"Copay" shall mean the cost-sharing, expressed as a dollar amount. Copayments expressed as a dollar amount and are the amounts paid by the Covered Person before Plan payment.

Coinsurance
"Coinsurance" shall mean the cost-sharing expressed as a percentage which is the amount payable by the plan for Eligible Expenses after the Covered Person satisfies the Calendar Year Deductible.

Covered Dependent
"Covered Dependent" shall mean any Eligible Dependent the Covered Person has enrolled for coverage and who meets all of the requirements of the Plan for participation.

Covered Drug
"Covered Drug" means any drug or medication which may be lawfully dispensed only on the prescription of a Physician, including injectible insulin, except for the following:

1. Any drug not prescribed for Treatment of an Injury, Illness, Mental Illness or Pregnancy;
2. Any therapeutic device or appliance;
3. Any drug labeled "Caution – limited by federal law for investigational use" or any Experimental drug; and
4. Any biological sera, blood or blood plasma, dietary supplement, beauty aid or cosmetic.
5. If this Plan has a Prescription Drug Benefit that is outlined in a separate section of this Plan Document, any definition of Covered Drug contained in that section will supercede the above definition.

Covered Charges or Covered Service
"Covered Charges" or "Covered Service" shall have the same meaning as "Eligible Expense."

Covered Person
"Covered Person" shall mean any Plan Participant or Covered Dependent.

Creditable Coverage
"Creditable Coverage" shall mean prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Custodial Care
"Custodial Care" shall mean the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to, bathing, dressing, feeding or preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible
"Deductible" shall mean a fixed amount of charges for Eligible Expenses during each Calendar Year for which there is no reimbursement under the Plan and which must be paid by the Covered Person before benefits are payable.

Dependent Coverage
"Dependent Coverage" shall mean that a Plan Participant's Eligible Dependents are enrolled for, and meet the requirements for, coverage under the Plan.

Disabled or Disability
An Eligible Employee will be considered "Disabled" during any period when, as a result of Injury, Illness or Complications of Pregnancy, the Eligible Employee is unable to perform the duties of his occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit.

An Eligible Dependent will be considered "Disabled" during any period when, as a result of Injury, Illness or Complications of Pregnancy, the Eligible Dependent is unable to perform substantially all of the normal activities of a person of like sex and age in good health.

Eligible Expense
"Eligible Expense" shall mean a Medically Necessary, Reasonable and Customary item of expense Incurred by a Covered Person for Illness, Injury or covered Pregnancy and for which benefits are payable under the terms of the Plan.

Employee Coverage
"Employee Coverage" shall mean that an Eligible Employee is enrolled for, and meets the requirements for, coverage under the Plan.

Employer
"Employer" shall mean Oklahoma County.

Enrollment Date
"Enrollment Date" shall mean the first day of coverage or, if a Waiting Period applies, the first day of the Waiting Period. The first day of employment will be the first day of any Waiting Period. Since the effective date is determined by the Plan's eligibility guidelines, the Enrollment Date may or may not be the same as an individual's effective date of coverage under the Plan.

Experimental, Investigative or Unproved
"Experimental", "Investigative", or "Unproved" shall mean a drug, device, medical Treatment or procedure that meets any one of the following:

1. The drug or device cannot be lawfully used or marketed without approval by the appropriate federal or other governmental agency which has not been granted, such as, but not limited to, the U.S. Federal Drug Administration (FDA). For purposes of this subparagraph, a drug or device being used for an indication or at a dosage that reliable evidence shows is an accepted off label use will not be considered to be "experimental", "investigative" or "unproved"

2. The drug, device, medical Treatment or procedure, or the patient informed-consent document utilized with the drug, device, Treatment or procedure, is subject to an ongoing review by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval. For purposes of this subparagraph, a transplant procedure which otherwise qualifies as medically necessary and or is consistent with the standard of care will not be considered to be "experimental", "investigative" or "unproved".

3. Reliable Evidence shows that the drug, device, medical Treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis; or

4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical Treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of Treatment or diagnosis.

"Reliable Evidence" shall mean only consensus findings, opinions or recommendations published in the authoritative medical and scientific literature or peer-reviewed literature; reports of clinical trial committees

and other technology assessment bodies; consensus opinions of local and national health care providers in the specialty or subspecialty that would typically manage the sickness or injury for which the drug, device, technology, treatment, supply or procedure is proposed; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical Treatment or procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical Treatment or procedure.

Extended Care Facility
"Extended Care Facility" shall have the same meaning as Skilled Nursing Facility.

Full-time Employee
"Full-time Employee" shall mean an employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

HIPAA
"HIPAA" shall mean Public Law No. 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Home Health Care Agency
"Home Health Care Agency" shall mean a public or private agency or organization that specializes in providing medical care and Treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO), and at least one Registered Nurse (RN) to govern the services provided;
3. It must provide for full-time supervision of such services by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO) or Registered Nurse (RN);
4. It maintains a complete medical record on each individual; and
5. It has a full-time administrator.

Home Health Care Plan
"Home Health Care Plan" shall mean a program for continued care and Treatment of a patient,

1. Which is established and approved in writing by the patient's attending Physician;
2. Certified by the attending Physician that the proper Treatment of the Illness or Injury would require continued confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospital
"Hospital" shall mean, if a Covered Person requires Inpatient services while within the United States, an institution which:

1. Is accredited by the Joint Commission of Accreditation of Hospitals,
2. qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital and is a provider of services as defined by Medicare; or
3. Is a Psychiatric Day Treatment Facility, as defined herein.

If a Covered Person becomes confined as a registered bed patient while traveling outside the United States, then the following definition of "Hospital" will apply to that period of confinement:

"An institution constituted, licensed and operated in accordance with the laws pertaining to Hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical Treatment of Injury and Illness, and which provides such Treatment for compensation, by or under the supervision of Doctors of Medicine (MD) or Doctors of Osteopathy (DO) on an Inpatient basis with continuous 24 hour nursing service by registered graduate nurses."

"Hospital" will not include an institution, which is, other than incidentally, a place of rest, a place for care of

aged persons, or a nursing home.

Illness
"Illness" shall mean physical or mental sickness, a bodily disorder, disease, functional nervous disorder, Pregnancy or Complications of Pregnancy. The term "illness" when used in connection with a newborn child shall include, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred
"Incurred" shall mean, with respect to an Eligible Expense, the date the service is rendered or the supply is obtained. With respect to a course of Treatment or procedure which includes several steps or phases of Treatment, Eligible Expenses are "Incurred" for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Eligible Expenses for the entire procedure or course of Treatment are not incurred upon commencement of the first stage of the procedure or course of Treatment.

Injury
"Injury" shall mean physical harm sustained as the direct result of an accident, affected solely through external, violent and accidental means, and all related symptoms and recurrent conditions resulting from that same accident.

Inpatient
"Inpatient" shall mean while confined to a Hospital, assigned to a bed in any department of the Hospital other than its outpatient department and for which a charge for room and board is made by the Hospital.

Late Entrant
"Late Entrant" shall mean an individual who did not apply for coverage at the earliest date on which coverage could have become effective under the Plan.

Lifetime
"Lifetime" shall mean while a person is covered under this Plan, as well as any prior or subsequent Plans sponsored by the plan Sponsor. Lifetime does not mean during the Lifetime of the Covered Person.

Life-Threatening Emergency Treatment
"Life-Threatening Emergency Treatment" shall mean the sudden and unexpected onset of a medical condition requiring immediate medical or surgical care within 24 hours after the onset of the condition, such as but not limited to: profuse hemorrhaging, unconsciousness, multiple injuries or trauma, ingestion of poisonous substance, severe chest pain, difficulty in breathing or sudden onset of paralysis of a body part.

Major Medical Expense
"Major Medical Expense" shall mean Eligible Expenses Incurred on account of Illness, Injury or covered Pregnancy and for which benefits are payable under the provisions of this Plan.

Medically Necessary
"Medically Necessary" are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice; and
2. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient, physician or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Medicare
"Medicare" shall mean the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and which includes Parts A and B and Title XVIII of the Social Security Act, as amended from time to time.

Mental Illness
"Mental Illness" shall mean any disease or condition, regardless of whether the cause is organic, 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; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Myofacial Pain Disorder (MPD)
"Myofacial Pain Dysfunction" (MPD) shall mean a disorder involving muscles surrounding and adjacent to the Temporomandibular Joint (TMJ) area which is characterized by:

1. Preauricular, temporal, occipital and/or jaw pain;
2. Spasm and/or tenderness of the masticatory muscles; or
3. Limited jaw movement.

Named Fiduciary
"Named Fiduciary" shall mean the Plan Administrator.

National Medical Support Notice (NMSN)
"National Medical Support Notice (NMSN)" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Covered Person under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

Necessary Services and Supplies
"Necessary Services and Supplies" shall mean any charges, other than charges for room and board, made by a Hospital on its own behalf for necessary medical services and supplies actually administered during Hospital confinement. The term shall also include any charges, by whoever made, for the administration of anesthetics during Hospital confinement, but the term shall not include any charges for special nursing fees or medical fees made by the Hospital.

Out-of-Area
"Out-of-Area" shall mean any area in which a PPO Hospital or Provider is not available.

Out-of-Pocket Expense
"Out-of-Pocket Expense" shall mean the amount paid by the Covered Person for Eligible Expenses.

Outpatient Surgical Facility
"Outpatient Surgical Facility" shall mean an institution or facility, or the outpatient department of a Hospital's day Surgery center. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Outpatient Surgical Facility.

Overutilization
"Overutilization" shall mean:

1. the practice of applying more than what is necessary to evaluate and treat the Illness or Injury;
2. a redundancy in treatment options; or
3. practices which most practitioners in the same discipline would consider to be in excess of sufficient measures.

Physician
"Physician" shall mean a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Audiologist, Nurse Practitioner, Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (OD), Physician Assistant (PA), Physiotherapist, Psychiatrist, Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Administrator
"Plan Administrator" shall mean Oklahoma County.

Plan Document
"Plan Document" shall mean this Plan Document and Summary Plan Description.

Plan Participant
"Plan Participant" shall mean a person who satisfies the Eligibility requirements of this Plan and for which coverage has become effective pursuant to the provisions of this Plan.

Plan Year
"Plan Year" shall mean the period beginning on January 1 and ending on December 31.

Preferred Provider Organization (PPO)
"Preferred Provider Organization (PPO)" shall mean a network of Hospitals, Physicians and other related provider services with which the Plan Administrator has contracted to provide services to Covered Persons at reduced fees or set rates.

Preferred or PPO Providers
"Preferred" or "PPO Providers" shall mean those providers with whom the Plan Administrator may have entered into arrangements with, whereby such providers will offer special discounts or special arrangements to the Covered Persons. It is not required for Covered Persons to use such providers. To locate an in-network provider for the medical plan, please call FisrtHealth at 1.800.226.5116 or you can locate one on their website at www.myfirsthealth.com.

The Plan Administrator may terminate any, or all, Preferred Provider arrangements by giving notice to Plan Participants currently covered under the Plan.

Preferred Provider (PPO) Service Area
"Preferred Provider (PPO) Service Area" shall mean the area in which a PPO Hospital or Provider renders medical care, usually determined by the zip code in which the facility or provider is located.

Pregnancy
"Pregnancy" shall mean carrying a child which will result in childbirth, miscarriage or non-elective abortion. The Plan considers Pregnancy as an Illness for the purpose of determining benefits.

Provider
"Provider" shall mean a Physician, a Hospital or other facility defined or listed herein (except as an excluded service or supply).

Psychiatric Care
"Psychiatric Care" shall mean Treatment for Mental Illness or any related conditions.

Psychiatric Day Treatment Facility
"Psychiatric Day Treatment Facility" shall mean a mental health facility which:

1. Is accredited by the Program for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals;
2. Provides Treatment of acute mental and nervous disorders in a structured psychiatric program for no more than 12 hours in any 24 hour period; and
3. Is clinically supervised by a Licensed Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Psychologist
"Psychologist" shall mean a person who is duly licensed or certified as a Clinical Psychologist, Licensed Professional Counselor or Clinical Social Worker in those jurisdictions where statutory or nonstatutory licensure or certification exists or, in those jurisdictions where neither exists, any individual who is duly qualified as a professional Psychologist by a recognized psychological association.

Qualified Medical Child Support Order (QMCSO)
"Qualified Medical Child Support Order (QMCSO)" shall mean a court order received by the Plan Administrator to provide medical and/or dental coverage for an Eligible Employee's dependent child, the Plan Administrator must notify the employee and determine if the child is eligible for coverage under this Plan. Eligibility determinations will be made in accordance with federal and/or state child support order laws and regulations. The employee will be responsible for any contributions required under this Plan.

Reasonable and Customary
"Reasonable and Customary" shall mean an amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar medical conditions in the locality concerned. In determining whether charges are Reasonable and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or experience.

Rehabilitation Facility
"Rehabilitation Facility" shall mean the same thing as "Special Care Facility."

Significant Break in Coverage
"Significant Break in Coverage" shall mean a period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include waiting periods.

Skilled Nursing Facility
"Skilled Nursing Facility" shall have the same meaning as Convalescent Facility and Extended Care Facility. The facility must be Medicare approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations and:

1. Is operated pursuant to law, licensed and is primarily engaged in providing (for compensation from its patients) skilled nursing care for a patient who requires medical care on account of Injury or Illness;
2. Provides 24-hour-a-day nursing service every day under the supervision of a full-time employee who is a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or a Registered Nurse (RN);
3. Maintains complete clinical records on all patients;
4. Provides for having a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) available to furnish necessary medical care in case of emergency; and
5. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

In no event shall a "Skilled Nursing Facility" include any institution, or part of an institution, which is a clinic, or which is primarily for the care of Mental Illness, drug addiction, alcoholism, or tuberculosis, or which is primarily engaged in providing domiciliary, educational or Custodial Care, or care for the aged.

Special Care Facility
"Special Care Facility" shall mean an institution which is not a hospital, but which specializes in physical rehabilitation of injured or sick patients, the diagnosis and Treatment of Chemical Dependency and/or Substance Use Disorders or Mental Illness, or which qualifies as an Extended Care Facility or a provider of services under Medicare, but only the institution is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions and maintains on its premises all the facilities necessary to provide for the medical Treatment of Injury or Illness, for compensation, by or under the supervision of Doctors of Medicine (MD) with nursing services by Registered Graduate Nurses (RN) or Licensed Practical Nurses (LPN).

Spouse
Spouse means the individual to whom the Employee is legally married, as evidenced by a copy of a valid marriage license or certificate which is fully signed, witnessed and executed by the proper authorities under the laws of the state or other jurisdiction where the marriage ceremony was performed, and as recognized under deferral law. The Pan Administrator may require documentation proving a legal marital relationship. A common law affidavit and the required documentation is available from the Benefits Department.

Standard of Care
Standard of Care refers to an acceptable level of patient care provided by a medical practitioner. It considers how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

Standard of Care is sometimes referred to as "standard therapy" or "best practice" and is generally satisfied by any medicine or treatment that experts agree is consistent with generally accepted standards of medical practice, is appropriate, accepted, and widely used for a certain type of patient, illness, or clinical circumstance. Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

It is not required that every other practitioner would have followed the same course of therapy, so long as the course of therapy followed is one that is accepted by at least a respectable minority of practitioners.

Surgery/Surgical Procedure
"Surgery" and "Surgical Procedure" shall mean any of the following:

1. The incision, excision or electro-cauterization of any organ or part of the body;
2. The manipulative redirection of a fracture or dislocation;
3. The suturing of a wound;
4. The removal by endoscopic means of a stone or other foreign object from the body or the diagnostic examination by endoscopic means of any part of the body;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. The induction of artificial pneumothorax and the injection of sclerosing solutions;
7. Obstetrical delivery and dilatation and curettage;
8. The surgical removal of impacted teeth;
9. Biopsy (removal of tissue); or
10. Dental work or Treatment only if Incurred due to Injury to sound natural teeth.

TEFRA
"TEFRA" shall mean Public Law No. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint (TMJ) Dysfunction
"Temporomandibular Joint (TMJ) Dysfunction" shall mean a disorder of the Temporomandibular Joint (the joint which connects the mandible or jawbone to the temporal bone) which is generally characterized by:

1. Pain or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat or shoulders;
2. Popping or clicking of the jaw;
3. Limited jaw movement or locking;
4. Malocclusion, overbite or underbite; or
5. Mastication (chewing) difficulties.

The Plan
"The Plan" shall mean Oklahoma County Health Benefit Plan, as amended.

Third Party Administrator
"Third Party Administrator" shall mean the firm providing ministerial and clerical services otherwise required by the Plan Administrator in connection with the operation of the Plan, performed under the supervision of the Plan Administrator, including maintaining current Plan data, billing, processing claims for payment by the Plan, and providing the Plan Administrator with any other information it requests. The Third Party Administrator at the time of the effective date of this Plan Document is HealthSmart Benefit Solutions, Inc.

Treatment
"Treatment" shall mean the consultations, tests, procedures, and interventions that are:

1. Customarily applied in the care of persons with similar complaints and finding by similarly trained practitioners; and
2. Generally accepted as the effective elements of care.

Variable Employee
The term Variable employee shall mean an employee of Oklahoma County, based on the facts and circumstances on the first day of employment with Oklahoma County, whose reasonable expectation of average hours per week cannot be determined. A Variable Employee may be eligible for coverage on the first day of the month following the end of the Administrative Period as defined below, if it is determined that the employee has worked an average minimum of 30 hours of service per week.

Initial Measurement Period for Variable Employee
The period starting on January 1st, ending on October 31st of each calendar year, during which Variable Employee's hours worked will be taken into consideration to determine the average hours worked during each service week.

Administrative Period for Variable Employee
The period immediately following the Initial Measurement Period, from November 1st until December 31st of each calendar year, during which the average hours worked calculation will be finalized and coverage offered to the Variable Employee who is determined to be eligible for benefits.

Stability Period for Variable Employee
The Period immediately following the Administrative Period, from January 1st until October 31st of each year, during which the Eligible Variable Employee's benefit coverage will commence and remain in place, barring any unforeseen circumstances (Special Event).

Visit
"Visit" shall mean each attendance of a Physician to the patient, regardless of the type of professional services rendered during such attendance, whether it might be otherwise termed a consultation, a Treatment, a test or given some other name.

Waiting Period
"Waiting Period" shall mean the period of time, as determined by Oklahoma County, that must pass before an employee or dependent is eligible to enroll under the terms of this Plan.

Well Baby Care
"Well Baby Care" shall mean medical Treatment, services or supplies rendered to a child solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury.

Wellness Benefit (Preventive Care)
"Wellness Benefit (Preventive Care)" shall mean medical Treatment, services or supplies rendered solely for the purpose of health maintenance and not for the Treatment of an Illness or Injury.

COORDINATION AND NONDUPLICATION OF BENEFITS

"**Plan**" as used in this section entitled "Coordination and Nonduplication of Benefits" shall mean any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

1. Blanket or franchise insurance coverage;
2. Hospital service prepayment plan, medical service prepayment plan, group practice or other group prepayment coverage;
3. Any coverage under labor-management trusteed plans, employee welfare benefit plans, union welfare plans, employer organization plans or employee benefit organization plans (including, but not limited to, Blue Cross and Blue Shield);
4. Any coverage under governmental programs for which a person is eligible, including Medicare, both Parts A and B; however, Medicaid is excluded, or;
5. Any benefits actually received, directly or indirectly, from any source whatsoever, except for an individual indemnity policy, by reason of Illness, Injury or Pregnancy, regardless of whether or not the benefit so received is the result of an agreement entered into before or after the Illness, Injury or Pregnancy occurs.

"**Allowable Expense**" as used in this section shall mean any item of expense which is an Eligible Expense under this Plan (under the same type of coverage i.e. medical, dental) and also covered by at least one of the other Plans covering the person for whom a claim is made. Note: The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense.

Any amount of differential that is not payable because the Covered Person does not adhere to the provisions of the Plan which are intended to reduce unnecessary medical care or make medical services available at a reduced cost and full benefits would have been payable if the Covered Person adhered to the Plan provisions will not be considered an Allowable Expense under this Plan. Examples of such provisions are admission certification, surgery approval and Preferred Provider arrangements.

Automobile Limitation
When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle insurance Deductibles. This Plan shall always be the secondary carrier regardless of the individual's election under personal injury protection coverage with the auto carrier or uninsured motorist coverage.

Coordination and Nonduplication of Benefits
The Coordination of Benefits Provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Plan Participant or Covered Dependent is also covered by any other Plan(s). When more than one coverage exists, one Plan normally pays its benefits in full and the other Plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other Plan(s), will not exceed 100% of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

All benefits contained in this Plan Document are subject to this provision. The Coordination of Benefits Provision applies whether or not a claim is filed under the other Plan(s)

This Coordination will apply in determining the benefits payable with respect to an individual for any claim for the Allowable Expenses Incurred if the sum of

1. The benefits that would be payable under this Plan in the absence of coordination; and

2. The benefits that would be payable under all other Plans in the absence of provisions for coordination in those Plans would exceed the Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The rules for establishing the order of benefit determination are:

No Coordination Provisions. If a Plan contains no provision for Coordination of Benefits, then it pays before all other plans.

Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

Dependent Child/Parents not Separated or Divorced. When a child is covered under both parents' Plans (not including stepparents) and the parents have not separated or divorced:

1. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

2. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   The preceding paragraph establishes a widely accepted order of benefits determination. Therefore, in the event that any other Plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, this Plan will apply the rule in (1) immediately above in accordance with the remaining provisions in this section.

Dependent Child/Parents Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. First, the Plan of the parent with custody of the child;
2. Then, the Plan of the spouse of the parent with the custody of the child; and
3. Finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the secondary Plan. This paragraph does not apply with respect to any period during which any benefits are actually paid or provided before the entity has that actual knowledge.

Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off or retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored and the industry standard will apply.

Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term, unless such person is covered with this Plan under the Continuation of Coverage (COBRA) section. In such a case, this Plan will pay benefits after any other coverage.

Whenever payments which should have been made under this Plan in accordance with the above provisions have been made under any other Plans, the Plan Administrator will have the right, exercisable alone and at its sole discretion, to pay to any organization making these payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this

manner will be considered to be benefits paid under this Plan; and to the extent of these payments, the Plan will be fully discharged from liability.

MEDICARE

Coordination with Medicare
It is the intent of this Plan to comply with mandated federal standards affected through the Age Discrimination Employment Act (ADEA), the 1986 Omnibus Budget Reconciliation Act (OBRA) and TEFRA with respect to proportioning of benefits between this Plan and Medicare and any other applicable federal laws, all as amended from time to time.

Benefits will be payable in accordance with the following provisions:

1. Each Eligible Employee, aged 65 or older, and any Eligible Employee's dependent spouse, aged 65 or older, is entitled to coverage under this Plan under the same conditions and at the same levels of coverage as any Eligible Employee and the spouse of such Eligible Employee under age 65 who is in the same class of employees. This paragraph will also apply to an Eligible Employee under age 65 whose dependent spouse is age 65 or older.

2. Medicare will be the primary payor for each Eligible Employee and any Eligible Dependents who are disabled (as determined by Title II of the Social Security Act), if the Employer has less than 100 employees, or in the event that an Eligible Employee elects to have Medicare assume the role of primary payor.

The amount payable under this Plan will be reduced so that the total amount payable by this Plan and Medicare will be no more than 100% of the Allowable Expenses Incurred. This provision will **not** apply to a person while Medicare is assuming the role of secondary payor to this Plan based on the rules established by the Social Security Act of 1965 and TEFRA, both as amended from time to time.

A person who is entitled to the benefits provided by Medicare will be considered entitled to have benefits paid whether or not application for such benefits has been made. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

Right of Recovery
Whenever payments have been made by this Plan, at any time, for Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions relating to Coordination, the Plan will have the right to recover these payments, to the extent of the excess, from among one or more of the following:

1. Any individuals to, for or with respect to, whom these payments were made;
2. Any insurance company;
3. Other organizations, including employee welfare benefit plans; and
4. Governmental agencies, organizations and health care funds.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this Coordination provision or any provision of similar purpose of any other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision

SUBROGATION

"Another Party"
"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Participant's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Participant's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery"
"Recovery" shall mean any and all monies paid to the Participant by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation"
"Subrogation" shall mean the Plan's right to pursue the Participant's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement"
"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Participant may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Participant may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Participant may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures or may be entitled to procure regardless of whether the Participant has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Participant agrees that acceptance of benefits is constructive notice of this provision.

The Participant must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Participant's rights to Recovery when this provision applies;

3. Immediately reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

   When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Participant will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. Entering into a settlement or compromise arrangement with a third party without obtaining the Plan's prior written consent shall be deemed to prejudice the Plan's rights.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

When a Participant Retains an Attorney
If the Participant retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Participant's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Participant's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Participant or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Participant or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan,

because the Participant or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Participant is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Participant and to the heir or personal representative of the estate of a deceased Participant, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Participant Does Not Comply
When a Participant does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce this provision, then that Participant agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

PLAN ADMINISTRATION AND GENERAL PROVISIONS

Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Covered Person.

Oklahoma County shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time to time by the Plan Administrator.

The rates for contribution are determined on the basis of amounts of the following types of expenses as determined from time to time by Oklahoma County, to wit:

1. Life insurance premiums;
2. Stop Loss premiums, if any;
3. Cost of conversion privileges, if any;
4. Administrative expenses; and
5. Cost of claims.

Notwithstanding the method of determining rates of contribution and monthly deposits of funds, Oklahoma County is obligated to pay all costs of claims, administrative expenses, and other expenses of the Plan.

In the event that benefits for any Covered Person are increased or decreased because of a change in classification, the adjustment in contribution and the effective date of coverage will commence on the first day of the month following the classification change.

The cost of this Plan is shared between Oklahoma County and Plan Participants. The cost of Coverage, borne by the Plan Participant, will be deducted from their paychecks.

Leave of absence without pay (LWOP). Employee on LOA without pay (LWOP) will pay for both the employee and employer contributions for coverage. The entire cost of coverage for Plan Participants covered under COBRA Continuation of Coverage shall be borne by the Plan Participant. Contributions for Plan Participants on leave of absence and Plan Participants covered under COBRA Continuation of Coverage must be remitted to Oklahoma County, by the date determined by Oklahoma County or coverage will automatically terminate at the end of the month for which contributions were paid. Oklahoma County shall furnish to the Third Party Administrator a listing of Plan Participants that have failed to remit their contribution.

Amending and Terminating The Plan
Oklahoma County expects to maintain this Plan indefinitely; however, as the settlor of the Plan, Oklahoma County, through its directors and officers, may, in its sole discretion, at any time, 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).

Any such amendment, suspension or termination shall be enacted by resolution of Oklahoma County's directors and officers, which shall be acted upon as provided in accordance with applicable federal and state law. Notice shall be provided as required by applicable law.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by Oklahoma County.

Workers' Compensation Not Affected
The benefits provided hereunder are not in lieu of and are not a substitute for any requirements for

coverage of any workers' compensation insurance law or statute.

Plan Administrator
The Plan is administered by the Plan Administrator. An individual or entity may be appointed by Oklahoma County to be Plan Administrator and serve at the convenience of Oklahoma County. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, Oklahoma County shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this 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 (including the determination of what services, supplies, care and Treatments are Experimental), 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 as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by applicable law;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by applicable law;

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which 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 PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        Plan Administrator
        Staff designated by Plan Administrator

    ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

    "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to

modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

k. All requirements and agreements of the Plan Sponsor contained in this Plan shall at all times be subject to the applicable provisions of HIPAA relative to the privacy, security and transmission of Protected Health Information.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the HealthSmart Benefit Solutions, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by Reasonable and Customary Security Measures;
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement Reasonable and Customary Security Measures to protect the Electronic PHI; and
- Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined shall have the meanings set forth in the Security Standards.

Nonguarantee of Employment
Nothing contained in the Plan shall be construed as a contract of employment between an Employer and any employee, or as a right of any employee to be continued in the employment of an Employer, or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

Right to Plan Assets
No employee or beneficiary shall have any right to, or interest in, any assets of the Plan upon termination of employment or otherwise, except as provided from time to time under the Plan.

Prior Failure to Enforce Provisions and Waiver
No provision of the Plan shall be waived, or modified or rendered unenforceable at any time as a result of the Plan's prior failure on one or more occasions to insist upon compliance with the provisions. No waiver of provisions of the Plan shall be valid unless made in writing, and signed by the Plan Administrator. No such power extends to or may be delegated to any agent.

Clerical Error
Any clerical error that occurs during the maintaining of eligibility records will not:

1. Continue benefits that should be terminated; or
2. Terminate benefits that should be continued.

If benefits are erroneously paid because of a clerical error, the Plan shall be entitled to a prompt and full refund of any such overpayment from the Plan Participant on whose behalf such benefits were erroneously paid.

Examination
The Plan Administrator shall have the right and opportunity to have examined any individual whose Injury, Illness or Pregnancy is the basis of a claim hereunder when and so often as it may reasonably require during pendency of claim hereunder and also the right and opportunity to request an autopsy in case of death where it is not forbidden by law.

Legal Proceedings
No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within one year after the Plan's claim review procedures have been exhausted.

Genetic Information Nondiscrimination Act of 2008 (GINA)
"GINA" prohibits your Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of genetic information.

2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study so long as the results are not used for underwriting purposes.

3. Requesting, requiring or purchasing genetic information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage. However, if the Plan obtains genetic information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA so long as it is not used for underwriting purposes.

GINA allows your Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA?

Under GINA, the term “genetic information” includes:

a. information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);

b. the manifestation of a disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are dependents, as well as any other first, second, third or fourth degree relative. Further, genetic information includes that information of any fetus or embryo carried by a pregnant woman; and

c. information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic information does <u>not</u> include the sex or age of an individual.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of applicable law, as it applies to employee welfare plans, as well as any other applicable law.

Fraud
The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Gender
The use of masculine pronouns in this Plan Document shall apply to persons of both sexes unless the context clearly indicates otherwise.

Headings
The headings used in this Plan Document are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

Limitation on Actions
No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within one year after the Plan's claim review procedures have been exhausted. Any action with respect to a Named Fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to Injury or Sickness are Incurred or are alleged to have been Incurred.

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Right to Receive and Release Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount.

HEALTH CLAIM PROCEDURES

Introduction
Covered Persons ("claimants") are entitled to full and fair review of any claims made under this Plan. The procedures described herein are intended to provide reasonable procedures governing the filing of claims for Plan benefits, notifications of benefit decisions, and appeal of adverse benefit decisions.

The procedures outlined below must be followed by to obtain payment of health benefits under this Plan.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. No person (including a treating health care professional) will be recognized as an authorized representative until the Plan receives an Appointment of Authorized Representative Form signed by the claimant. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form.

An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete the form which can be obtained from the Plan Administrator or the Third Party Administrator. Completed forms must be submitted to:

APPEALS
HealthSmart Benefit Solutions, Inc.
3121 Quail Springs Parkway
Oklahoma City, Oklahoma 73134
405.848.1975 or 800.825.3540

In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Health Claims
All claims and questions regarding health claims should be directed to:

HEALTHSMART BENEFIT SOLUTIONS, INC.
P.O. BOX 42096
OKLAHOMA CITY, OK, 73123-3005

The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred an Eligible Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

   Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   (a) The Plan determines that the course of treatment should be reduced or terminated; or
   (b) The claimant requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Health claims must be filed with the Third Party Administrator within one year **of the date charges for the service were incurred.** Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims.

    a. If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim.
    b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 24 hours, taking into account the medical exigencies, after the earliest of:

        (1) The Plan's receipt of the specified information; or
        (2) The end of the period afforded the claimant to provide the information.

2. Pre-service Non-urgent Care Claims.

    a. If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

3. Concurrent Claims.

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
    b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

4. Post-service Claims.

   a. If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

5. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

6. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

7. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

8. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Initial Adverse Benefit Determination
A decision on a claim is "adverse" if it is a denial, reduction, or termination of a Plan Benefit, including any rescission of coverage or determination of a claimant's eligibility to participate in the Plan, or a failure to provide or make payment (in whole or in part) for a Plan Benefit. In the event of an adverse benefit determination, the Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to identify the claim including date of service, health care provider, **and** claim amount, **as well as a statement that** diagnosis and treatment codes and the corresponding meaning of the codes **shall be made available to the Claimant free of charge upon request**;
2. Specific reason(s) for a denial including any denial codes used with the corresponding meaning of the codes and a description of the standard, if any, used in denying the claim;
3. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
4. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
5. A description of the available internal and/or external review procedures and the time limits applicable to the procedures including information on how to initiate an appeal;

6. A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a final internal adverse benefit determination, and a description of the availability and contact information for a federal health insurance consumer assistance or ombudsman;
7. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
8. A statement that the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice will be provided, upon request;
9. A statement that any rule, guideline, protocol or similar criterion that was relied upon in making the determination will be provided to the claimant, free of charge, upon request;
10. A statement that, in the case of denials based upon a medical judgment (such as whether the treatment is Medically necessary and/or is considered standard of care or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, such explanation will be provided to the claimant, free of charge, upon request; and
11. In a claim involving Urgent Care, a description of the Plan's expedited review process.

Your Right to Appeal an Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Covered Persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Plan Administrator or the Third Party Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which:
    (a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Covered Person; and
    (b) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Covered Person by telephone, facsimile, or other available similarly expeditious method.

How to File an Appeal
These claims procedures provide for two levels of internal appeals and a subsequent external review process. See below for the procedures / timelines that apply to each stage of the appeals process.

First Appeal Level

Requirements for First Appeal

When must the appeal be made? The Covered Person must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. **Any appeal received after expiration of the 180 day period will not be considered and failure to comply with this important deadline may cause the claimant to forfeit any right to further review of an adverse decision under these procedures or in a court of law.**

How should the appeal be submitted? For Pre-service Urgent Care Claims, if the Covered Person chooses to orally appeal, Covered Person may telephone:

APPEALS
HealthSmart Benefit Solutions, Inc.
3121 Quail Springs Parkway
Oklahoma City, Oklahoma 73134
405.848.1975 or 800.825.3540

To file an appeal in writing, the Covered Person's appeal must be addressed as follows and faxed to the following number:

HealthSmart Benefit Solutions, Inc.
Attention: APPEALS
3121 Quail Springs Parkway
Oklahoma City, Oklahoma 73134
Fax # (405) 607-2626

What information must be included in the appeal? It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

How A First Level Appeal Will Be Decided
Upon receipt of the required information, the appeal will be reviewed and decided by The Plan Administrator, the named fiduciary of the Plan. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of

the person who made the initial benefit decision. Notification of a Plan's determination will be provided as shown below. If any new or additional evidence is considered, relied upon, or generated by the Plan in connection with review of the claim or the Plan's decision is based upon any new rationale, the claimant will be provided with a copy of such evidence or rationale sufficiently in advance of the date on which notification of the benefit determination on first appeal is required to be provided in order to give the claimant a reasonable opportunity to respond to the new or additional evidence or rationale prior to that date.

Timing of Notification of Benefit Determination on First Appeal
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.

2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

4. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The Plan Administrator shall provide a Covered Person with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. Information sufficient to identify the claim including date of service, health care provider, **and** claim amount, **as well as a statement that** diagnosis and treatment codes with the corresponding meaning of the codes **shall be made available to the Claimant free of charge upon request**;
2. The specific reason or reasons for the denial including denial codes with the corresponding meaning of the codes and a description of the standard, if any, used in denying the claim;
3. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
4. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
5. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
7. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;

8. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
9. A description of the available internal and/or external review procedures and the time limits applicable to the procedures including information on how to initiate a second level appeal;
10. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
11. A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following a final internal adverse benefit determination and a description of the availability and contact information for a federal health insurance consumer assistance or ombudsman ; and
12. The following statement: "You and your 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."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information relevant to the Covered Person's claim for benefits, as may be requested by the Covered Person.

Second Appeal Level
In cases where an appeal of an initial adverse benefit determination is denied, in whole or in part, and the Covered Person believes the appeal was denied wrongly, the Covered Person may seek further review of the claim and review pertinent documents as provided hereunder

GRIEVANCE OKLAHOMA COUNTY BUDGET BOARD
Any Participant feeling aggrieved by a decision of the Claims Administrator has the right to file a written request (or appeal) for consideration with the Oklahoma County Budget Board. The Participant must file any such request within 60 days after the denial under the First Appeal has been made. The written request should specify: the right or benefit allegedly denied, the action which the Participant considers necessary to correct such denial or decision and shall state whether a hearing before the Oklahoma County Budget Board is desired. If a hearing is desired, the matter shall be considered before the Oklahoma County Budget Board, in executive session with the Participant and representatives of the Claims Administrator being eligible to be present. The Oklahoma County Budget Board will review the decision and issues identified in the appeal. The Oklahoma County Budget Board will then make a determination concerning the resolution of the appealed issue within a period of 30 days. The Plan Administrator will then provide written notice to the Participant and Claims Administrator within a period of 30 days following said determination. All decisions of the Plan Administrator shall be final.

In cases where an appeal of an initial adverse benefit determination is denied, in whole or in part, and the Covered Person believes the appeal was denied wrongly, the Covered Person may seek further review of the claim and review pertinent documents as provided for in the procedures for a Second Appeal.

Requirements for Second Appeal

When must the second appeal be made? Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Covered Person has 60 days to file a second appeal of the denial of benefits. **Any appeal received after expiration of the 60 day period will not be considered and failure to comply with this important deadline may cause the claimant to forfeit any right to further review of an adverse decision under these procedures or in a court of law.**

The Covered Person again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Covered Person has the same rights during the second appeal as he or she had during the first appeal.

How should the second appeal be submitted? What must it include? As with the first appeal, the Covered Person's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

How A Second Level Appeal Will Be Decided
Upon receipt of the required information, the appeal will be reviewed and decided by The Plan Administrator, the named fiduciary of the Plan. The person who reviews and decides a second level appeal will be a different individual than the person who made either the initial benefit decision or benefit determination upon first appeal and will not be a subordinate of such person. Notification of a Plan's determination will be provided as shown below. If any new or additional evidence is considered, relied upon, or generated by the Plan in connection with the second level appeal or the Plan's decision is based upon any new rationale, the claimant will be provided with a copy of such evidence or rationale sufficiently in advance of the date on which notification of the benefit determination on second appeal is required to be provided in order to give the claimant a reasonable opportunity to respond to the new or additional evidence or rationale prior to that date.

Timing of Notification of Benefit Determination on Second Appeal
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.

2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

4. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Final Internal Adverse Benefit Determination
The Plan Administrator shall provide a Covered Person with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's final internal adverse benefit determination on review, setting forth:

1. Information sufficient to identify the claim including date of service, health care provider, **and** claim amount, **as well as a statement that** diagnosis and treatment codes with the corresponding meaning of the codes **shall be made available to the Claimant free of charge upon request**;
2. The specific reason or reasons for the denial including denial codes with the corresponding meaning of the codes and a description of the standard, if any, used in denying the claim;
3. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
4. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
5. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon

request;

7. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;
8. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
9. A description of the available external review procedures and the time limits applicable to the procedures including information on how to initiate an external appeal including any expedited review procedures that may be applicable;
10. A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following a final internal adverse benefit determination and a description of the availability and contact information for a federal health insurance consumer assistance or ombudsman ; and
11. The following statement: "You and your 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."

Furnishing Documents in the Event of a Final Internal Adverse Benefit Determination
In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information relevant to the Covered Person's claim for benefits as may be requested by the Covered Person.

Exhaustion of Internal Appeals Procedures
All internal claim review procedures provided for in the Plan including a first and second level appeal must be exhausted prior to initiation of any external review or legal action. In the event the Plan fails to strictly adhere to all the requirements of the internal appeals procedures, the claimant shall be deemed to have exhausted all of the internal processes and may initiate any applicable external review or legal action.

Right to External Review
For an adverse benefit determination (other than a determination that a claimant failed to satisfy the eligibility requirements of this Plan), if a claim denial is upheld after a second level appeal, the claimant may request to have the decision reviewed by an independent review organization ("IRO") that has no association with the Plan if such adverse benefit determination involves:

1) medical judgment (including, but not limited to, those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational), as determined by the external reviewer; or

2) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Time for Filing Request for External Review
A request for external review must be made within 4 months after receipt of the Final Internal Adverse Benefit Determination and must be sent to

APPEALS
HealthSmart Benefit Solutions, Inc.
3121 Quail Springs Parkway
Oklahoma City, Oklahoma 73134

For standard external review, a decision will be made within **45 days** of receiving the request. If the claimant has a medical condition that would seriously jeopardize the claimant's life or health or would jeopardize his or her ability to regain maximum function if treatment is delayed, the claimant may be entitled to request an **expedited external review** of the denial.

External Review Procedures

The Plan will comply with the Federal External Review process established by the U.S. Department of Labor which utilizes private accredited IROs and is described in Technical Release 2011-02. Should this process be changed by law, regulations or other applicable guidance, the Plan shall be automatically amended to conform to any new or revised procedures for any request for external review received after the effective date of such change.

1) Request for Standard External Review. A Claimant shall have four (4) months from the receipt of the Final External Adverse Benefit Determination to submit a written request an External Review to the Plan Administrator.

2) Preliminary Determination. Within five (5) business days of receipt of a request for an External Review, the Plan Administrator shall complete a preliminary review of the request to determine whether:

   a. The Claimant is or was covered by the Plan at the time the health care item or service in question was requested or in the case of retrospective review, was covered by the Plan at the time the health care item or service was provided;

   b. The Final Internal Adverse Benefit Determination: i) does not relate to whether the Claimant satisfied the eligibility requirements of the Plan and ii) involves medical judgment or a rescission of coverage as described above in the section "Right to External Review";

   c. The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeal process under 29 C.F.R.§ 2590.715-2719; and

   d. The Claimant has provided all the information and forms required to process an External Review.

3) Preliminary Notice. If a request is not eligible for External Review, the Plan Administrator must issue a written notice to the Claimant within one (1) business day after the Plan Administrator completes the preliminary review, which must include the reasons the requested appeal is not eligible for External Review and contact information for the Employee Benefit Security Administration. If a request is not eligible for External Review because it is incomplete, the notice must include a description of the information necessary to complete the request and permit the Claimant to submit such information by the later of 48 hours after the Claimant receives the notice or by the end of the four (4) month period during which the External Review must be requested.

4) Standard External Review. If a claim is eligible for External Review, the Plan will assign the claim to an IRO that is accredited by URAC or a similar nationally recognized accrediting organization and which is due to receive the claim on the Plan's rotational basis established to prevent bias and ensure independence. The external IRO will conduct a full review of the file, applicable Plan provisions and any material submitted as required by applicable guidance and in compliance with the IRO's contract with the Plan. The IRO will conduct this review on a de novo basis without deference to the Plan's decision.

   Within five business (5) days after the Plan has assigned an IRO to review the claim, the Plan shall provide the documents and information considered by the Plan in making its Final Internal Adverse Benefit Determination. If the IRO receives any new evidence or information, it shall provide such information to the Plan and the Plan may reconsider its decision. If the Plan changes its decision upon reconsideration, it must notify the Claimant and the IRO of its new decision within one (1) business day of making such decision. The IRO must then terminate its review.

The IRO shall provide the Claimant and the Plan with a written notice of its decision within 45 days of the date on which the IRO received the request for External Review. Such notice shall include all information required by applicable guidance.

Upon receipt of the IRO's final determination reversing the Plan's determination, the Plan shall immediately provide coverage or payment for the claim.

5) Expedited External Review. A Claimant may make a request for an expedited external review with the Plan at the time the Claimant receives:

   a. An Adverse Benefit Determination that involves a medical condition of the Claimant where the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or If the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged since receiving such emergency services.

   Upon receipt of a request for an expedited External Review, the Plan shall determine if the request satisfies the requirements to be eligible for a standard External Review. The Plan must immediately send the Claimant notice of such preliminary determination of eligibility.

   If a claim is eligible for expedited External Review, the Plan shall assign the claim to an IRO. The IRO shall provide the Claimant and the Plan with a written notice of its decision as soon as possible, but in no event more than 72 hours after the IRO received the request for an expedited External Review. If the notice is not in writing, within 48 hours of the date the notice is provided, the IRO must provide a written confirmation of its decision to the Claimant and the Plan.

Effect of Decisions by Plan Administrator
Any decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be afforded the maximum deference permitted by law.

Limitations Period
Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures, including any applicable external review procedures, have been exhausted.

Additional Information
Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment of a benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Plan may make payments to such person or legal representative or to a relative or friend of such person for such person's benefit, or the Plan Administrator may apply the payment for benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a benefit or installment thereof in accordance with the provisions of this section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

All claims and appeals will be adjudicated and decided in a fair and impartial manner, and financial considerations or implications to the Plan Administrator will NOT be taken into account when claims and/or appeals are adjudicated/decided.

GENERAL PLAN INFORMATION

Name Of Plan:	Oklahoma County Health Benefit Plan
Employer/Plan Sponsor:	Oklahoma County 320 Robert S. Kerr Oklahoma City, OK 73102
Plan Administrator: (Named Fiduciary)	Oklahoma County 320 Robert S. Kerr Oklahoma City, OK 73102
Employer Identification Number:	73-6006400
Plan Effective Date:	July 1, 1985
Amended and Restated Date	January 1, 2015
Plan Year:	January 1 through December 31
Plan Type:	Medical Prescription Drug
Third Party Administrator For Claims Service:	HealthSmart Benefit Solutions, Inc. 3121 Quail Springs Parkway Oklahoma City, Oklahoma 73134 405.848.1975 or 800.825.3540
Participating Employer(s):	A complete list of all Employers may be obtained upon written request to the Plan Administrator.
Agent for Service of Process:	Oklahoma County Clerk Plan Administrator 320 Robert S. Kerr Oklahoma City, OK 73102

Type of Administration
The Plan Administrator, Oklahoma County, administers the Plan. HealthSmart Benefit Solutions, Inc. is a Third Party Administrator that has been retained by the Plan Administrator to provide clerical services to the Plan.

Funding and Source of Contributions
The Plan is self-funded from the contributions of the Employer and Plan Participants.

Provisions Limiting Benefits
The following provisions can limit the benefits that you receive under this Plan: Deductibles, Reasonable and Customary Charges, Medical Necessity, exclusions and limitations, Coordination of Benefits, effect of Medicare, limits on certain benefits and subrogation.

ATTACHMENTS

PRESCRIPTION DRUG BENEFIT

OUTPATIENT PRESCRIPTION CARD BENEFIT:			
Prescription Plan Out of Pocket Annual Maximum	Single: $3,600 Family: $4,200		
Covered Prescription Drug Expenses	RETAIL	RETAIL 90	MAIL
Per Prescription Limit:	34 day supply	90 days	90 days
Generic:	$5	$15	$10
Formulary Brand:	20% with $20 min. and $60 max.	20% with $60 min. and $180 max.	$55
Brand Name: (if a generic or formulary brand is available and the member chooses the brand name drug, then the member will pay the entire cost; unless deemed medically necessary by medical review)	30% with $40 min. and $80 max.	30% with $120 min. and $240 max.	$75

The Retail 90 is available only at participating pharmacies. For a complete list of these pharmacies, please visit the Oklahoma County Clerk's website at: http://countyclerk.oklahomacounty.org/hr/forms

Generic Drugs
Generic drugs are prescription drugs that have the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Formulary Drugs
Preferred drugs are certain generic and brand name drugs that can meet a patient's clinical needs at a lower cost than other brand name drugs. Preferred brand medications are selected according to their: safety, efficacy (how well the drug works), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice and cost.

Brand Name Drugs
If a brand name drug has a preferred equivalent, but you or your Physician choose an alternate, brand name drug for your prescription, you will pay a higher copayment. If your Physician prescribes a brand name drug, ask your network pharmacist to consult with your Physician to discuss whether a formulary drug may be substituted.

Covered Drugs
(The following list is intended as an example and is neither exhaustive nor all inclusive.)

1. Legend drugs. Exceptions: See Exclusion list below;
2. Insulin;
3. Disposable insulin needles/syringes;
4. Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes-Tape);
5. Compounded medication of which at least one ingredient is a legend drug;
6. Smoking Deterrent Medications containing nicotine or any other smoking cessation aids, all dosage forms;
7. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.
8. Sildenifil citrate (Viagra) or drugs designed to improve sexual performance;
9. Generic Tamoxifen and Generic Raloxifene covered at No copay.

Drug Exclusions
(The following list is intended as an example and is neither exhaustive nor all inclusive.)

1. Anorectics (any drugs used for the purpose of weight loss **unless authorized by Case Management**);
2. Anti-wrinkle agents (e.g. Renova®, Retina-A®);
3. Dermatologicals, hair growth stimulants;
4. Charges for the administration or injection of any drug;
5. Infertility medications;
6. Injectible contraceptives;
7. Immunization agents, blood or blood plasma;
8. Growth Hormones;
9. Non-legend drugs other than those listed above;
10. Charges for the prescription drug, Gleevec;
11. Drugs labeled "Caution-limited by federal law to investigational use" or Experimental drugs, even though a charge is made to the individual;
12. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, skilled nursing facility, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
13. Any drug or medication that is not a Covered Drug;
14. Any Covered Drug prescribed for use by other than a Covered Person;
15. The amount of any Covered Drug per prescription or refill in excess of a 30 day supply unless covered by the Mail Order Program, whichever is applicable; (If your drug is listed on the FDA list of maintenance drugs, you may purchase up to a 90 day supply.);
16. Any Covered Drug provided or administered by the prescriber or provider to a patient while in a Hospital, Skilled Nursing Facility or similar institution;
17. Any prescription refill of a Covered Drug in excess of the number specified by the doctor or dispensed more than one year after ordered by the doctor;
18. Any Covered Drug, which may be properly received without charge under any local, state, or federal government program; and
19. Any Covered Drug prescribed for an Injury or Illness which would entitle the patient to benefits under a Workers' Compensation Act or similar legislation if the person made timely claim for those benefits.

Prescription Card Service

The procedures for obtaining prescription drugs through this service are as follows:

A Covered Person may obtain a Covered Drug from a participating pharmacy by paying the prescription drug services Deductible for each prescription filled.

If a Covered Person purchases a Covered Drug from a non-participating pharmacy, the amount of Prescription Drug Benefits payable for each prescription filled will be the sum of the drug's ingredient cost, the dispensing fee that would be payable to a participating pharmacy and any sales tax, less the Deductible, or, if less, the actual charge.

The procedures for charges for Mail Order Service prescriptions are as follows:

1. Complete any applicable forms for the first mail service order or to report any changes to the initial profile form.

2. Send the original prescription and any applicable forms to the Pharmacy Benefit Manager.

EMPLOYEE ACKNOWLEDGMENT

This shall acknowledge that I have received a copy of Oklahoma County Health Benefit Plan. I understand that the information in this document is a complete description of the benefits provided by the Plan. I recognize that it is my responsibility to read and maintain this document, as it has been provided by the Plan Administrator to inform Participants of their rights and benefits provided herein.

I understand that the information in this document is intended to acquaint Participants with general benefits and procedures, however Oklahoma County remains free to act according to prudent business judgment, and to change the benefits and procedures described herein at any time.

I further understand that I will be responsible for complying with future changes in such benefits and procedures communicated to Participants from time to time.

Date: ______________________________

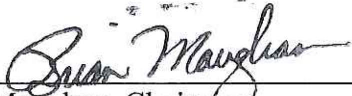
____
Employee Signature

____
Printed Name

To approve the Oklahoma County Health Benefit Plan Document and Summary Plan Description. This item was approved by the Budget Board on April 16, 2015.

Approved on April 22, 2015.

By Board of County Commissioners



Brian Maughan, Chairman

Raymond L. Vaughn Jr., Vice-Chairman

Willa Johnson, Member

ATTEST:

Carolynn Caudill, Oklahoma County Clerk

#171

REQUEST FOR DISTRICT ATTORNEY LEGAL SERVICES

THIS FORM IS TO BE USED TO REQUEST ADVICE AND/OR REPRESENTATION FROM THE DISTRICT ATTORNEY'S OFFICE REGARDING THE COUNTY OF OKLAHOMA, COUNTY OFFICIALS AND EMPLOYEES AS REQUIRED BY SECTIONS 215.4, 215.5, 215.25 AND 215.26 OF TITLE 19 OF THE OKLAHOMA STATUTES.

IF ADVICE IS SOUGHT, THE REQUEST MUST BE SIGNED BY AN ELECTED COUNTY OFFICER. THIS FORM MUST BE FILLED OUT AND SUBMITTED TO THE CIVIL DIVISION OF THE OKLAHOMA COUNTY DISTRICT ATTORNEY'S OFFICE IN A TIMELY MANNER. ALL RESPONSES TO REQUESTS FOR ADVICE WILL BE IN WRITING.

IF THE REQUEST IS FOR LEGAL REPRESENTATION UNDER 19 O. S. SECTION 215.25, THE REQUEST MUST BE SUBMITTED IN WRITING EARLY ENOUGH TO PERMIT THE DISTRICT ATTORNEY'S OFFICE ADEQUATE TIME TO COMPLETE A THOROUGH "GOOD-FAITH-AND-COURSE-OF-EMPLOYMENT" INVESTIGATION AS CONTEMPLATED BY 19 O.S. SECTION 215.26.

DATE OF REQUEST: **03/26/2015.**
COUNTY DEPARTMENT MAKING REQUEST: **County Clerk's HR/Benefits Department**

STATE WITH SPECIFICITY, WHAT THE REQUEST IS AND WHY THE ASSISTANCE OF THE DISTRICT ATTORNEY'S OFFICE IS NEEDED: **Please review the Oklahoma County Health Benefit Plan Document and Summary Plan Description as to form and legality.**

ATTACH ADDITIONAL DOCUMENTS AS APPROPRIATE. (**NOTE:** Advice, reviews and approvals as to "form and legality" are based on the documentation and information provided to the District Attorney's Office. Please provide all relevant information when requesting an opinion or review from the District Attorney's Office).

Jon Wilkerson, in the office of
Carolynn Caudill, County Clerk
COUNTY OFFICER

....

DATE RECEIVED BY DISTRICT ATTORNEY: ______________________

REPLY BY DISTRICT ATTORNEY: ______________________

OK 3/30/15

DAVID PRATER,
DISTRICT ATTORNEY

By: