



PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

OKLAHOMA LUMBERMEN'S ASSOCIATION

**HEALTH PLAN PLUS
PLAN III**

Restated January 1, 2012

The Benefits and coverages described herein are provided through a Trust Fund, The Health Plan Trust for the Members of the Oklahoma Lumbermen's Association, established by a group of employers, members of the Oklahoma Lumbermen's Association. The Trust Fund is not subject to any insurance guaranty association. Other related financial information is available from your employer or from the Oklahoma Lumbermen's Association. Excess insurance is provided by a licensed insurance company to cover certain claims which exceed certain amounts. This is the only source of funding for these benefits and coverages. The benefits and coverage described herein are funded by contributions from employers and employees who are eligible for coverage.

The Oklahoma Lumbermen’s Association Welcomes You to the Health Plan Plus!

The Oklahoma Lumbermen’s Association is proud to welcome you as a participant in their member-owned, self-funded employee benefit program, the Oklahoma Lumbermen’s Association [O.L.A.] Health Plan Plus [Plan]. Your employer and the Association are committed to providing you benefits that protect you against catastrophic medical expenses and to supporting your preventative care needs.

This is Your Plan Document and Description of Benefits-

We are pleased to provide you with this **Plan Document** and description of benefits for both the health and dental plans. This is your primary source of information defining what claims are eligible for reimbursement and how eligible claims are processed. It is important that you read it carefully and keep it where you can refer to it when needed. To maintain a manageable cost for these benefits, the Plan has certain exclusions and limitations. You may share in the cost of some covered services.

Remember to Practice a Healthy Lifestyle-

Remember, practicing a healthy lifestyle may help lower your medical and dental costs. Maintaining a proper diet, avoiding tobacco, limiting your alcohol consumption and staying physically active are important techniques that you can use to make a difference.

For Benefit Information and Claims Questions-

The Association contracts with a Third Party Administrator, C. L. Frates and Company, for the management of the Plan and its benefits to participants. Please contact their Claims and Utilization Management Administrator at [1-800-850-7166](tel:1-800-850-7166) if you have any questions about Plan benefits.

Thank You!

Thank you for participating in the Oklahoma Lumbermen’s Association Health Plan Plus. By working together the independent lumber and building material dealers and suppliers can maintain excellent benefit programs that meet the needs of the industry and its employees.

TABLE OF CONTENTS

INTRODUCTION	1
EMPLOYER PARTICIPATION PROVISIONS AND CONTRIBUTIONS	3
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS	4
SUMMARY SCHEDULE OF BENEFITS	11
MEDICAL BENEFITS	16
COST MANAGEMENT SERVICES	23
DEFINED TERMS.....	26
PLAN EXCLUSIONS.....	33
CLAIM PROVISIONS	39
COORDINATION OF BENEFITS	43
SUBROGATION, RIGHT OF REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISIONS	46
COBRA CONTINUATION OPTIONS	48
PRIVACY PROVISIONS	51
RESPONSIBILITIES FOR PLAN ADMINISTRATION	53
ERISA DISCLOSURES AND INFORMATION.....	56
ERISA RIGHTS STATEMENT.....	59

INTRODUCTION

This document is a description of the Oklahoma Lumbermen's Association Health Plan Plus Plan III (the Plan). **No oral interpretations can change this Plan.** The Plan described provides benefits for Covered Persons to offset certain health and preventative care expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

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

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

Terms noted with Capitalization have specific meaning in the plan and are identified in the Section "Defined Terms."

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

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

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

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

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

Summary Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Medical Benefits Description. Explains when the medical benefit applies and the types of services covered.

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

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

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

Plan Exclusions. Describes what charges are not covered.

Dental Benefits. Explains the optional dental benefit and the types of services covered. This benefit applies only if elected by your Employer.

Claim Provisions. Explains the requirements for filing claims and the claim appeal process.

Coordination of Benefits. Describes the Plan payment order when a person is covered under more than one plan or other form of coverage.

Subrogation, Right of Reimbursement, and Third Party Recovery Provisions. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries or illness sustained. Describes the participants responsibilities to establish a valid claim when a third party may be liable for covered expenses.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available. ***Applicable only to Qualified Beneficiaries whose eligibility arises from the Employee's employment by an Employer subject to COBRA. An Employer exempt from COBRA and not subject to these provisions is one that normally employed fewer than 20 employees during the preceding calendar year, or as otherwise determined to be exempt.***

Privacy Provisions. Summarizes protection of employee's health information, employee's rights under federal law and how they may control the use of their information.

Responsibilities for Plan Administration. Explains how the Plan is administered and managed by the Plan Sponsor.

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

ERISA Rights Statement. Discloses the Participant's rights under ERISA..

EMPLOYER PARTICIPATION PROVISIONS and CONTRIBUTIONS

Eligible Employer. This Plan is operated and maintained for benefit of Members of the Oklahoma Lumbermen's Association, their Employees and eligible Dependents. An Eligible Member's Employees and their eligible dependents shall be eligible subject to the provisions of the section **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS** and **only** if their Eligible Participating Employer has complied with requirements of participation in the Plan and the provisions of this Section.

An Eligible Employer must meet the following requirements:

- 1) Be a Member of the Oklahoma Lumbermen's Association;
- 2) Have executed the required Employer Application and Agreement for participation in the Plan;
- 3) Have paid all contributions as required herein; and
- 4) Complies with all Plan rules regarding employee eligibility and the Plan's required percentage of Eligible Employee participation as described in the Employer Application and Agreement.

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

Contributions must be paid on or before the first day of the period for which they are due. A 31-day grace period will be granted. If payment is not made during the 31-day grace period the Employer's participation will terminate and coverage will be cancelled for all participants (including dependents) of the Employer. If any claim payments are made during a period of lapse, the Plan shall make every reasonable attempt to recover such payments from the Employer. An Employer will not be considered for reinstatement, nor shall any records or reports be released until such amounts are recovered in full by the Plan.

The contributions required will be determined by the Plan Administrator at its discretion. Contributions may be modified and adjusted upon one calendar month's notice to accommodate any changes in Plan benefits, increased benefit expense, changes in administrative expenses or for the maintenance of reserves. Contributions will be determined in a manner consistent with applicable laws and regulations. The Plan Administrator shall have the ability to surcharge Participating Employers and to maintain, increase, reduce or terminate such surcharges as it deems appropriate.

In the event that contribution levels will be changed Employers will be provided with a minimum of one calendar month notice. It is the responsibility of the Participating Employer to notify its participating employees of any change that will affect employee withholding or contribution amounts. Employee contributions, if any, are the sole discretion of the participating Employer and may be subject to applicable law.

Cancellation by a Participating Employer must be received in writing by the Plan Administrator prior to the beginning of the final calendar month of coverage. Cancellations or terminations are only allowed to be effective the **last day** of the final month of coverage. Partial month termination requests and/or contribution refund requests will not be honored.

The Plan may from time to time find it necessary to request certain information, reports, lists, forms, applications or other information including employee and/or employer information from any Participating Employer. It shall be the Participating Employer's responsibility to provide such requested information in a timely manner. Failure of any Participating Employer to supply any such information as requested may result in termination or non-renewal of coverage.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY for PLAN Participation

Eligible Classes of Employees.

Any full time Active Employee (as determined by the Participating Employer and described in the Employer Application and Agreement, but in no case less the required minimum of the Plan) of any Participating Employer shall be eligible for coverage upon completion of the Employer designated waiting period. This Plan does not cover part-time employees or retirees.

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

- (1) Is a Full-Time, Active Employee of the Participating Employer. An Employee shall be considered to be Full-Time if he or she meets his/her Employer's policy for full time employment (subject to the minimum requirement of the Plan.) Owners, Officers, Directors and their family members are required to meet the requirements of the Employer for full time employment requirement to establish eligibility.
- (2) Completes the Waiting Period established by the Employer.

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

- (1) (a) A Spouse.
(b) A Child through age 25.
- (2) A Child of a Participant who is an alternate recipient under a Qualified Medical Child Support Order. If not already enrolled, the Participant must also enroll in the Plan. The Child has a right to coverage with no Pre-Existing Conditions limitation.
- (3) A Child who is: (a) Totally Disabled; (b) not capable of maintaining employment due to mental retardation or physical handicap; (c) dependent upon a Participant for support and maintenance; (d) not married; and, (e) covered under the Plan when age 26 is reached.

At reasonable intervals during the 2 years after Dependent reaches an age limit, the Plan Administrator may require subsequent proof of Total Disability and dependency. After this 2-year period, the Plan Administrator may require subsequent proof once each year. The Plan Administrator reserves the right to have Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, for the existence of incapacity.

The following are excluded as Dependents.

- (1) Other persons that live in the Participant's home, but are not eligible. A child whose parent(s) reside with the Employee or whose parent(s) are covered as dependents is not eligible.
- (2) A divorced former Spouse.
- (3) A person on active duty in military service of any country.
- (4) Or any person who is covered under the Plan as an Employee.

Eligibility Requirements for Dependent Coverage. A Participant's family member becomes eligible for coverage on the first day that the Participant is eligible for coverage and the family member satisfies

the requirements for coverage. The Plan Administrator may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent. The Participant is solely responsible to notify the Plan Administrator of changes in the status of a family member that may affect dependent coverage.

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

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

FUNDING

Contributions to the Plan.

The Employer is responsible for paying all contributions for coverage under this Plan. These contributions may be shared with covered Employees at the discretion of the Employer. The required Employee participation for making contributions is determined by each Eligible Employer and is not governed by this Plan.

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

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan. If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time may be offset if the person has Creditable Coverage from his or her previous plan.

In the event that a Participant, that is 19 or older, is a Late Enrollee as defined herein under Open Enrollment Pre-Existing Conditions are not payable for a period of up to 18 months, subject to any offset for Creditable Coverage of a preceding plan.

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services, supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a physician.

The Pre-Existing Condition exclusion does not apply to pregnancy, Participants through age 18, or to a child who is adopted or placed for adoption before attaining age 19 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan.

ENROLLMENT

If an employee does not enroll when first eligible, the employee may only enroll at a later time according to the Special Enrollment Period provisions or as a late enrollee during Open Enrollment. Please read this section carefully.

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is also required to enroll for Dependent coverage, if Dependent coverage is desired.

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

Any other newborn child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section. There will be no payment from the Plan for the newborn child's claims if the employee does not elect to cover such newborn within 31 days of the date of birth.

TIMELY ENROLLMENT

Timely Enrollment – the enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Individuals losing other coverage. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

- (1) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (2) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other enforce health coverage was the reason for declining enrollment.
- (3) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

- (4) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Employee or Dependent lost other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

A Special Enrollment Period will begin for a Child of a Participant that is an alternate recipient under a Qualified Medical Child Support Order. This Special Enrollment Period will also begin for the applicable Participant if that Participant was not enrolled in the Plan. The Child's eligibility under the Plan is contingent upon the Participant's eligibility under the Plan. The Employer and the Plan must be notified of the Qualified Medical Child Support Order within 60 days of its issuance for this Special Enrollment Period to be available. The Special Enrollment Period will expire 31 days after notification to the Employer or the Plan.

Dependent beneficiaries.

If the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), **and**

A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth if the employee elects to cover the newborn; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

OPEN ENROLLMENT

This Plan has an annual open enrollment opportunity during the month of December. If the employee did not elect to enroll when first eligible or at the time of a Special Enrollment event he or she may enroll during the open enrollment period as a Late Enrollee. As such the employee and any eligible dependents will be subject to all Pre-existing Conditions provisions and exclusions.

Elections made during the open enrollment period will become effective January 1 of the following year.

Insure Oklahoma/O-EPIC Eligibility. An employer may have an open enrollment period during the first full calendar month after qualifying for Insure Oklahoma/Oklahoma's Employer and Employee Partnership for Insurance Coverage (O-EPIC) for employees who are eligible to participate in O-EPIC. Coverage will be effective on the first of the month following the one calendar month O-EPIC enrollment period. Participants enrolling under this O-EPIC provision shall be considered late enrollees.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of 12:01 a.m. on the first day of the month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement, including any waiting period established by the Employer.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee as defined by this Plan for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the 1st day of the following month that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Covered Persons will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates. 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 Options):

- (1) **Plan Discontinuance.** Coverage terminates for all Covered Persons on the date the Plan is terminated.
- (2) **Termination of Employment.** If an Employee terminates or is terminated from employment, coverage ceases for the affected Employee and any Dependents. Coverage ceases on the last day of the month when employment terminated.
- (3) **Loss of Employee Eligibility.** If an Employee loses eligible status as defined, coverage ceases for the affected Employee and any Dependents. Coverage ceases on the last day of the month when eligibility was lost.
- (4) **Military Duty.** If a Covered Person enters the armed forces of any country as a full-time member where active duty is to exceed thirty (30) days, coverage ceases for the Covered Person and all persons covered under that person. Coverage ceases on the last day of the month when military duty began.
- (5) **Non payment of Contribution.** The last day of the month for which the Employer makes the required contributions for coverage.
- (6) **Employer Termination.** When the Employer coverage terminates as described in the Employer Participation Provisions & Contributions section of the Plan.

- (7) **Death.** Coverage terminates on the date of death of the Covered Person.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent 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 Options):

- (1) **Loss of Dependent Status for Child.** Coverage for a Child terminates on the earliest of any of the following:
- (a) The date the Plan or Dependent coverage under the Plan is terminated;
 - (b) The date that the Employee's coverage under the Plan terminated for any reason other than death;
 - (c) On the date which a Dependent child ceases to be a Dependent as defined by the Plan;
 - (d) The date Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days;
 - (e) The last day of the month after the Child becomes age 26.
 - (f) The Last day of the month following the month that the Employee's coverage under the Plan terminated due to death; upon request and payment of any required contributions, dependent coverage may be extended to the end of the month following the month the employee's termination by death.
- (2) **Loss of Dependent Status for Spouse.** Coverage for a Spouse terminates on the date of the following:
- (a) The date the Plan or Dependent coverage under the Plan is terminated;
 - (b) The date that the Employee's coverage under the Plan terminated for any reason other than death;
 - (c) The date Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days;
 - (d) The last day of the month when a divorce decree was granted;
 - (e) The last day of the month when an annulment was granted.
 - (f) The last day of the month following the month that the Employee's coverage under the Plan terminated due to death, and upon payment of any required contributions.

Continuation During periods of disability. An eligible Employee may remain eligible for a limited time if active, full-time work ceases due to disability. This continuance shall not fulfill any part of any Waiting Period for any reason and shall not exceed 12 weeks from the beginning of the disability.

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.

Continuation During Family and Medical Leave. Applicable to Employers subject to the Family and Medical Leave Act only. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements except for:

- (1) an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period or Pre- Existing Conditions provision;
- (2) an Employee resuming full-time employment no later than 12 months from the commencement of a lay-off or reduction in hours, provided such Employee was a participant in the Plan on the date of the lay-off or reduction in hours. The effective date of such coverage will be the first of the month following the date of rehire; or
- (3) an Employee returning from a Military Leave as outlined below.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

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

SUMMARY SCHEDULE OF BENEFITS

This Summary provides information on benefit levels and limits. Benefits are subject to all other provisions of the Plan as described in this Plan Document.

Verification of Eligibility

Call the numbers listed below to verify eligibility for Plan benefits. Verification of Benefits is not binding on the Plan. All benefits are subject to Plan's provisions at the time treatment is provided.

(800) 842-4351 or (405) 290-5612

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable or within provider contract allowable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

POST-SERVICE notification for the Covered Person is required to make sure the Plan is notified within 2 business days of the beginning of a Covered Person's hospital inpatient stay, Long Term Acute Care Facility stay, skilled nursing facility stay, home health care or purchase or rental of durable medical equipment in excess of \$1,000. Please review this part carefully to avoid a benefit reduction. The telephone number for Post-service notification is (855) 253-7283.

Post-service notification from the Plan is not required for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. Please see the Cost Management section in this booklet for details.

Selecting your Medical Care Professionals and Facilities

This Plan is a plan that has a Participating Provider Organization (PPO) feature. The current PPO for the Plan is First Health. This is subject to change by the Plan with out notice. The PPO has entered into an agreement with certain hospitals, physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Consult "ERISA Disclosures and Information" section or your identification card to identify your PPO.

The Employee is free to choose any provider for their own and their Dependent's care. The benefits provided to reimburse for services are maximized when the Covered Person selects providers in the PPO. The lowest level of benefits applies to services provided by out-of-network providers. Therefore, when a Covered Person uses a PPO provider, that Covered Person may receive a higher payment from the Plan than when an out-of-network provider provides treatment. It is the Covered Person's choice as to which provider to use.

PPO benefits apply only to charges for services performed by providers actively participating in the PPO network on the date services were received. Not all providers at participating hospitals are in the network. Some services during an episode of care, may be covered at the out-of-network level. For example, if a Participant has surgery at a PPO hospital using a participating surgeon, your anesthesiology or pathology, or other services may be from out-of-network providers. If this happens, the anesthesiology and pathology services would be treated as out-of-network benefits.

Additional information about this option, as well as a list of Participating Providers will be made available to Covered Employees and updated as needed.

Medical Emergency Provision. If care is provided in the event of a Medical Emergency as defined by the Plan, benefits will be paid at the in-network level, limited to the in-network Allowable Charge or Usual and Reasonable charge, whichever is lower.

**SUMMARY SCHEDULE OF BENEFITS
OLA Health Plan Plus Plan III**

	PARTICIPATING PROVIDERS (PPO)	OUT OF NETWORK (OON)
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	\$1,250,000	
DEDUCTIBLE PER CALENDAR YEAR *		
Per covered person	\$1,000	\$2,000
Per Family Unit	\$2,000	\$6,000
*The Deductible amounts for each benefit are separate and do not apply to the next higher Deductible. For example, deductible amounts applied to the PPO level do not apply to the out-of network (OON) level deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT (OOP), PER CALENDAR YEAR - Per covered person	\$2,000	\$6,000
The plan will pay the designated percentage of covered charges until the out-of-pocket amounts are reached, at which time the plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise. In-network (PPO) out-of-pocket accumulates to out-of-network (OON) out-of-pocket.		
The following charges do not apply to the out-of-pocket maximum and are never paid at 100%.		
<ul style="list-style-type: none"> • Deductible(s) • Copay amounts • Emergency room care when there is no medical emergency • Cost containment penalties • Out-of network transplant care benefits • Spinal Manipulation/Chiropractic Care • Non-covered charges, such as amounts that exceed Allowable Charge or Usual and Reasonable charge limits 		
Hospital Services		
Inpatient Care (OON room limited to \$500 per day) Intensive Care Unit (OON ICU room limited to \$1,250 per day) Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Admission copay	\$250	\$1,000
Emergency Room Care when there is no medical emergency.	50% copay - does not apply to out-of-pocket maximum	
Physician Services – except as otherwise described in the Summary Schedule of Benefits		
Office Services Visits Surgeries Associated lab and x-ray Urgent care center	\$30 copay Plan pays 100% up to a \$250 per visit maximum; amounts that exceed \$250 are subject to deductible then paid at 80% to OOP max	Plan pays 60% after deductible
Allergy & Hormone Injections - does not include office visit charges	\$5 copay	
Other covered physician services unless limited in this summary	Plan pays 80% after deductible	Plan pays 60% after deductible

**SUMMARY SCHEDULE OF BENEFITS
OLA Health Plan Plus Plan III**

All Other Covered Outpatient Services	Plan pays 80% after deductible	Plan pays 60% after deductible
Total Parenteral Nutrition (TPN)	Plan pays 80% after deductible	Plan pays 60% after deductible

COVERED SERVICES	PARTICIPATING PROVIDERS (PPO)	OUT OF NETWORK (OON)
<p>Well Child Care</p> <p>Services mandated to be covered by the Patient Protection and Affordable Care Act</p>	Plan pays 100%	Not covered
<p>Adult Preventative Care:</p> <p>Services mandated to be covered by the Patient Protection and Affordable Care Act</p>	Plan Pays 100%	Not covered
<p>Prostate cancer screening – limited to for one physician office visit and PSA lab test annually, for participants age 40 and older</p>	Plan pays 100%	Not covered
<p>Prescription Drugs - \$100 Calendar Year deductible (network pharmacies only) per person Retail –30 day maximum supply except for insulin which has a 90 day limit Copayment Generic \$10 Brand Name \$15 All Items exceeding \$40 ingredient & dispensing fee Note: Prescription drugs obtained from a non-network pharmacy are subject to the non-network medical benefit tier.</p>	Plan pays 60%	Plan pays 60% after deductible

**SUMMARY SCHEDULE OF BENEFITS
OLA Health Plan Plus Plan III**

COVERED SERVICES	PARTICIPATING PROVIDERS (PPO)	OUT OF NETWORK (OON)
Skilled Nursing Facility 90 days per Calendar Year	Plan pays 80% after deductible	Plan pays 60% after deductible
Home Health Care 40 days per Calendar Year	Plan pays 80% after deductible	Plan pays 60% after deductible
Hospice Care 180 days per Calendar Year	Plan pays 80% after deductible	Plan pays 60% after deductible
Ambulance Services Emergency Only, to nearest facility that can treat	Plan pays 80% after deductible	
Physical Therapy 24 Outpatient visits maximum per Calendar Year	\$30 copay per visit then plan pays 100%	Plan pays 60% after deductible
Spinal Manipulation/Chiropractic – 15 visits per Calendar Year	Plan pays 80% after deductible	Plan pays 60% after deductible
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible
Prosthetics and Orthotics	Plan pays 80% after deductible	Plan pays 60% after deductible
Organ Transplants	Plan pays 80% after deductible	Plan pays 50% after deductible
Acquisition/Procurement Expenses	Plan pays 80% after deductible	Plan pays 50% after deductible
Travel Expenses of the covered person	Not covered	Not Covered
Cost Management Services – Penalty for failure to comply (See the Cost Management Services section in Plan.)	Benefits will be reduced by \$500 per occurrence	

MEDICAL BENEFITS

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Summary Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Summary Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Summary Schedule of Benefits. The rate of payment will vary as indicated for Participating Providers (PPO) and Out-of-Network Providers (OON). No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

IN-NETWORK BENEFITS (PPO)

Benefits for Covered Charges for services provided by a PPO provider will be based on the applicable negotiated rate. In most cases the Covered Person will not be responsible for charge amounts that exceed the negotiated rate, except for required out-of-pocket amounts, or amounts that exceed any specific benefit limits.

OUT-OF-NETWORK BENEFITS (OON)

Benefits for Covered Charges for services provided by an out-of-network provider will be based on the applicable Usual and Reasonable charge for the service provided. Covered Persons are responsible for any amount of charge that exceeds the Usual and Reasonable amount, in addition to any other out-of-pocket amounts, or amounts that exceed any specific benefit limits.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the patient responsibility out-of-pocket limit shown in the Summary Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% based on the applicable negotiated rate or the applicable Usual and Reasonable Charge (except for the charges excluded) for the remainder of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% based on the applicable negotiated rate or the applicable Usual and Reasonable Charge (except for the charges excluded) for the remainder of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Summary Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person. Benefit payments accumulate to this Maximum Benefit Amount for any period of coverage under this Plan, while employed by any Eligible Employer, even when changing to a new Employer from a current employer.

COVERED CHARGES

Covered charges are the Medically Necessary negotiated (in-network) or Usual and Reasonable (out-of-network) charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Summary Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Out-of-network (OON) room is limited to a maximum of \$500 per day. Out-of-network (OON) ICU room is limited to a maximum of \$1,250 per day.

Emergency Room care is subject to limitations described in Summary Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

In the event that coverage is terminated during a pregnancy the Covered Charges will be only those for services actually incurred on or before the termination date.

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).

There is no coverage of Pregnancy for a Dependent child.

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
 - (a) the patient is confined as a bed patient in the facility;
 - (b) the confinement in the Skilled Nursing Facility begins within three days of the Hospital confinement;
 - (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

- (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the day maximums and covered charge limits shown in the Summary Schedule of Benefits.

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

- (a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures. Benefits for each additional procedure that is not incidental are allowed at 50% of the Usual and Customary Charge. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for incidental procedures;
- (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; or
- (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing and therapy services is subject to the Home Health Care limit shown in the Summary Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist.

(6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Summary Schedule of Benefits.

(7) **Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:**

- (a) Local Medically Necessary professional land or air **ambulance** service subject to the limitations in the Summary Schedule of Benefits. A charge for this item will be a

Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided.

- (b) **Anesthetic**; oxygen; intravenous injections, and solutions. Administration of these items is included.
- (c) **Blood and blood derivatives** that are not donated. Administration of these items is included.
- (d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (f) Initial **contact lenses** or glasses required following cataract surgery.
- (g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, if rental would be more costly, but only if agreed to in advance by the Plan Administrator. Replacement of purchased Durable Medical Equipment will be covered when it is no longer functional or repairable. Covered expenses shall exclude any cost for maintenance, repair, alteration or additions to any structure or vehicle. Benefit payment is subject to the Durable Medical Equipment limit shown in the Summary Schedule of Benefits.
- (h) **Foreign Travel.** Charges for emergency medical care outside of the U.S. are covered; assignment of benefits does not apply to such benefits and all charges will be converted to U.S. currency denominations prior to calculation.
- (i) **Laboratory studies.**
- (j) Other **medical supplies** such as colostomy bags, ileostomy supplies, catheters, cervical collars, head halters, or other traction apparatus; glucometers; rental of infusion pumps; initial post-mastectomy breast prosthesis and holding bra. Charges under this category may be subject to the benefit payment maximums as described in the Summary Schedule of Benefits for durable medical equipment, prosthetics or orthotics.
- (k) Treatment of **Mental Disorders and Substance Abuse.** Psychiatrists (M.D.), psychologists (Ph.D.) or licensed professional counselors may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.
- (l) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth. This repair must be made within 180 days from the date of an accident.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Surgical removal of impacted teeth; (medical benefit calculated prior to dental benefit.)

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(m) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(n) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to the following organ or tissue transplants: cornea, artery or vein, bone marrow, heart, heart and lung, heart valve, kidney, implantable prosthetic lenses in connection with cataracts, joint replacement, liver prosthetic bypass or replacement vessels are subject to these limits:

The transplant must be performed to replace an organ or tissue. Organ or tissue transplants must be procured from a human donor.

When both the recipient and the donor are Covered Persons, eligible medical expenses incurred by each person will be treated separately for each person.

When only the recipient is a Covered Person, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. Concerning a donor that is not covered by the Plan; benefits are payable only for covered expenses directly attributable to the procedure to harvest the organ and complications resulting from that procedure are not covered.

Expenses incurred for harvesting organs from a deceased donor are not covered.

If the organ or tissue donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ or tissue charges for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

The Plan will always pay secondary to any other coverage. This includes, but is not limited to, other insurance coverage or any governmental program available to the recipient. No benefits will be provided to the non-Covered Person transplant recipient.

- (o) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Maintenance or replacement of covered orthotic appliances is covered only if the replacement is due to the progression of an Illness or Injury or the growth of a Covered Person. Benefit payment is subject to the Prosthetics and Orthotics limit shown in the Summary Schedule of Benefits.
- (p) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function. Benefit payment is subject to the Physical Therapy limit shown in the Summary Schedule of Benefits.
- (q) **Physicians Assistant.** The professional services of a Physician's Assistant.
- (r) **Prescription Drugs** (as defined in the Summary Schedule of Benefits).
- (s) Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Summary Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (t) The initial purchase, fitting and repair of fitted artificial limbs or other **prosthetic devices** which replace body parts. Maintenance or replacement of covered prosthetic devices is covered only if the replacement is due to the progression of an Illness or Injury or the growth of a Covered Person. Benefit payment is subject to the Prosthetics and Orthotics limit shown in the Summary Schedule of Benefits.
- (u) **Reconstructive Surgery.** Correction of abnormal congenital conditions, surgery to treat an injury that occurred while a Covered Person, and reconstructive mammoplasties will be considered covered charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

Charges for procedures intended to lengthen any portion of the skeletal system are not covered.

- (v) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (w) **Spinal Manipulation/Chiropractic** services only to limitations in the Summary Schedule of Benefits by a licensed M.D., D.O. or D.C.
- (x) **Sterilization** procedures.
- (y) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (z) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge.

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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).

- (aa) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Post-service Notification is Required for Certain Services

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

Post-service Notification & Cost Management Services Phone Number

C. L. Frates and Company Post-Service Notification
(855) 253-7283

The Employee ID card also contains the Post-Service Notification phone number.

The **patient or family member** must call this number to provide Post-service Notification. This call must be made within 2 business days of services being rendered.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION MANAGEMENT

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

The program consists of:

- a) The Plan being notified within 2 business days of the beginning of a Covered Person's hospital inpatient stay, Long Term Acute Care Facility stay, skilled nursing facility stay, home health care or purchase or rental of durable medical equipment in excess of \$1,000. Please review this part carefully to avoid a benefit reduction;
- b) Retrospective review of the Medical Necessity of services for which claims have been made;
- c) Concurrent review, based on the admitting diagnosis, of the services requested by the attending Physician; and
- d) Review of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

Mothers and Newborns Provision - Post-service Notification is not required by the Plan for a maternity length of stay that is 48 hours or less for a vaginal delivery, or 96 hours or less for a cesarean delivery. In the event that newborn dependents are inpatients for longer than 48 hours, Post-service Notification is required. If any Covered Person, including a newborn dependent, is not discharged within the time period provisions of this paragraph, Post-service Notification is required.

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

Contact the Utilization Management Administrator at:

*C. L. Frates and Company
(855) 253-7283*

with the following information:

- The name of the patient and relationship to the covered Employee
- The name, identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

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

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

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting - even to his or her home.

Case Management is a program whereby a case manager monitors these patients, and explores and discusses alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and alternative treatment plans.

The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan to extend plan benefits.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. Treatment decisions are distinct from Plan Benefit decisions and are the responsibility of the Covered Person and their Physician.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is 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 as described in the Employer application and agreement, but not less than the Plan minimum of 30 hours per week.

Allowable Charge is an amount that is charged for a procedure, service, drug or device that is negotiated by the Plan or the Plan's PPO or is the amount of any non-negotiated charge that does not exceed the Usual and Reasonable charge under the terms of the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Association is the Oklahoma Lumbermen's Association.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the Jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Child (Children) The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Stepchildren who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of twenty six (26) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

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

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

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

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent Those persons specified in Eligibility, Funding, Effective Date and Termination Provisions section are eligible for coverage.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Eligible Employer is an employer member of the Association as described in the Section "EMPLOYER PARTICIPATION PROVISIONS & CONTRIBUTIONS."

Employee means a person who is an Active Employee (Full-time) of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is an Eligible Employer who has made application to the Plan Administrator and has been accepted into the Plan.

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

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

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going 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) if 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.

If any one of the above factors is confirmed, or the patient is required to sign a consent form which indicates that the proposed treatment or procedure is part of a scientific study or medical research to determine efficacy or safety, the services, supplies, care and treatment will be considered Experimental and/or Investigational.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

The Plan Administrator has final discretion to determine whether or not a particular service, device, drug, procedure or protocol is experimental and/or investigational.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Filing Deadline. One year from the date the service is incurred.

Generic Drug means a Prescription Drug which has 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.

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

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

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

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations and/or it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff, and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy. A genetic indication for increased risk of a disease is not an Illness.

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

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

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Lifetime benefits terminate when coverage under this Plan terminates.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

Member Any person or business that is accorded membership status in the Association for the current year.

Mental Disorder means 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.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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

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

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), and for the purpose of this document, Doctor of Optometry (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Registered Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Physiotherapist, Psychologist (Ph.D.), Speech Language Pathologist, Physician's Assistant (P.A.) 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 means the Oklahoma Lumbermen's Association Health Plan Plus, which is a benefits plan for certain Employees of Eligible Employers and is described in this document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months of the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations,

diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child, or to a child who is adopted or placed for adoption before attaining age 26 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan, a Covered Person through age 18. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

A **Qualified Medical Child Support Order** is any judgment, decree or order (including approval of a settlement agreement) which provides for child support with respect to a Child of a Participant or provides for health benefit coverage to such a Child, is made pursuant to a state domestic relations law (including a community property law, and related to benefits under the Plan, or is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act with respect to the Plan) if such judgment, decree or order is issued by a court of competent jurisdiction or is issued through an administrative process established under state law and has the force and effect of law under applicable state law, and which creates or recognizes the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to receive benefits for which a Participant is eligible under the Plan.

Sickness is for all persons but a covered Dependent daughter: Illness, disease or Pregnancy.

For a covered Dependent daughter: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.

- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

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

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse The term "Spouse" shall mean the person of the opposite gender recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Total Parenteral Nutrition (TPN): nutritional formulas that contain nutrients such as salts, glucose, amino acids, lipids, electrolytes, and added vitamins which are administered as a sole means of nutritional support/intake, when food can not be given by other routes. TPN must be prescribed by a Physician as a result of a Sickness or Injury and be Medically Necessary.

Usual and Reasonable Charge is a charge that is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan calculates benefits based on the actual charge billed if it is lesser than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Waiting Period. The period of time that must pass after the Enrollment Date before coverage in the Plan becomes effective for an Employee or Covered Person. No leave of absence for any reason shall fulfill any part of the Waiting Period. This period of time is defined by the Employer Participation Agreement.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Summary Schedule of Benefits, a charge for the following is not covered:

- (1) **Academic/Ability Testing.** Charges for learning disorders academic or ability testing.
- (2) **Administrative expense** including overhead, missed appointment fees, and insurance surcharges.
- (3) **Alternative therapies.** Charges for alternate therapies, including, but not limited to, acupuncture, biofeedback, holistic medicine, hypnotherapy, massage therapy, music therapy, nutritional consultation, psychosurgery, recreational therapies, reflexology, sexual issues therapies and physical and meditative therapies including, but not limited to, yoga.
- (4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol unless the result of an act of domestic violence or a medical condition (including both physical and mental health conditions). The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol.
- (5) **Bone Growth.** Stimulators whose intended effect is to enhance growth of bone or the spinal cord.
- (6) **Complications and reversals of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
- (7) **Corrective appliances and/or shoes.** Orthopedic or corrective shoes, shoe lifts or heels (i.e. orthotics or appliances/supplies), wedges.
- (8) **Cosmetic care.** Charges incurred as a result of any surgery, procedure or treatment to enhance or change the external appearance, or complications of such surgery, procedure or treatment; unless such treatment is rendered to correct a condition resulting from Injury or to correct a congenital anomaly of a Dependent child. Treatment rendered to correct a condition resulting from Injury must be incurred within the one-year period following the date of Injury. Charges for procedures to lengthen limbs are not covered for any diagnosis, including congenital anomaly.
- (9) **Counseling services.** Sexual, marital or family counseling, therapy or training, pastoral or academic.
- (10) **Court ordered services.** Charges for services, testing, therapy or treatment when it is court ordered, as a condition of parole or probation, when ordered by a governmental agency, or in lieu of incarceration.
- (11) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (12) **Dental care.** Charges for dental services or supplies. However, benefits will be payable for charges incurred for treatment required because of Injury to natural teeth or jaw sustained while covered. Such expenses must be incurred within twelve (12) months of the date of the

- accident. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture.
- (13) **Erectile Dysfunction.** Charges for procedures, supplies or devices for erectile dysfunction.
 - (14) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
 - (15) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
 - (16) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
 - (17) **Eye care.** Radial keratotomy or any other eye surgery to correct vision. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. Charges for orthometric vision therapy and orthoptics. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
 - (18) **Food.** Charges for food or food supplements required due to treatment.
 - (19) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services. Charges for emergency medical care outside of the U.S. are covered; assignment of benefits does not apply to such benefits and all charges will be converted to U.S. currency denominations prior to calculation.
 - (20) **Foot Care.** Any treatment for weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; corns, calluses or toenails, except removal of nail roots and medically necessary required services in the treatment of metabolic and peripheral vascular disease.
 - (21) **Genetic Analysis.** Charges for genetic analysis. Charges for studies done for the therapeutic evaluation of a response or expected response to Medically Necessary medication or treatment of a disease process will be allowed.
 - (22) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
 - (23) **Growth hormones.** Charges for the provision of human or synthetic growth hormones.
 - (24) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as otherwise covered under the Medical Benefits Section.
 - (25) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting. Examinations required as the result of a non-occupational accidental injury occurring while covered under this Plan are eligible. Exception – Charges for a Covered Person under the age of 13 for hearing examinations and aids are covered.
 - (26) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

- (27) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance unless the actions giving rise to the injuries result from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- (28) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician unless the result of an act of domestic violence or a medical condition (including both physical and mental health conditions). Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply to substance abuse treatment services explicitly covered under this Plan.
- (29) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (30) **Incomplete statements.** Charges contained in statements that are incomplete. The documentation submitted by a Covered Person must include itemized statements identifying the patient, date of treatment, diagnosis and type of service provided, and charge for each service. Examples of unacceptable statements are photocopies, cash register receipts, canceled checks and similar documents.
- (31) **Infertility.** Diagnosis, care, treatment and procedures to correct for infertility; artificial insemination or in vitro fertilization, or any other treatment, service, device or medication intended to enhance fertility or induce pregnancy, including surrogate expenses.
- (32) **Learning disorders or deficiencies and related non-illness related behavioral problems.** Expenses for education, counseling, job training, or care, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.
- (33) **Lipectomy.** Charges for services or supplies for a lipectomy, including any surgical or suction lipectomy.
- (34) **Miscellaneous fees.** Miscellaneous fee charges for, including but not limited to, after hour, data analysis, handling and conveyance, lab stat charges, interpretation and report preparation, shipping and handling, and telephone consultation.
- (35) **Motorized Vehicle Contests.** Care and treatment of an Injury or Sickness that results from engaging as a participant in any motorized vehicle speed, maneuvering or rally contest or event. This exclusion applies to organized, informal and illegal activities.
- (36) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (37) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (38) **Non-medical equipment and therapies.** Charges to buy or rent air conditioners, air purifiers, breast pumps, humidifiers, motorized transportation equipment, vehicles and accessories, escalators or elevators in private homes. Also, charges for swimming pools,

- waterbeds, whirlpools and hot tubs or supplies, general exercise programs and equipment, challenge courses and similar outings, nonprescription items, drugs, supplies and equipment.
- (39) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
 - (40) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
 - (41) **Not accepted practice.** Charges for or in connection with experimental procedures or treatment methods not provided in accordance with accepted standards of medical, dental, psychiatric or other specialty practice.
 - (42) **Not Medically Necessary.** Charges for services, treatments and supplies that are not Medically Necessary.
 - (43) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
 - (44) **Nursing services.** Charges for professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's life and such care is specified as covered under the Plan.
 - (45) **Obesity.** Care and treatment of obesity by any method including surgery, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.
 - (46) **Occupational.** Care and treatment of an Injury or Sickness that is Occupational - that is, arises from work for wage or profit including self-employment, whether or not the injured person is required to be covered under any law for compensation for such injuries. The Plan Administrator has sole discretion to determine if an Injury or Sickness is Occupational.
 - (47) **Office Fees.** Any charges resulting from the failure to keep a scheduled visit with a Physician or other provider, completion of any insurance forms.
 - (48) **Orthognathic.** Care, services, procedures or treatment for procedures to change the length of the jaw.
 - (49) **Orthotripsy.** Care or procedures commonly referred to as "orthotripsy", utilizing shock or sound waves, to improve the function of joints or any other part of the body.
 - (50) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.
 - (51) **Physicals.** Charges for employment, camp, school, flight or insurance physicals.
 - (52) **Physicians' fees.** Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician.
 - (53) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

- (54) **Pre-existing Conditions.** Care or treatment of Pre-existing Conditions, except as specifically identified as covered under this Plan.
- (55) **Pregnancy of Dependent child.** Care and treatment of Pregnancy and Complications of Pregnancy for a Dependent child only.
- (56) **Prescription Drugs.** The following drugs, treatments, devices, or supplies:
- Drugs determined to be “less than effective” by the Drug Efficacy Study Implementation (DESI) Program
 - Over the counter drugs and products
 - Retin-A (except for covered dependent children up to age 18)
 - Fertility agents
 - Growth hormone
 - Vitamins that require a prescription, except those prescribed for pre-natal health
 - Diet aids
 - Anti-smoking aids or devices, except for Zyban and Chantix, which are covered as any other prescription.
 - Drugs used to treat or cure baldness
 - Anabolic steroids used for body building
 - Products used for cosmetic indications
 - Therapeutic devices or appliances, support garments and other non-medical substances regardless of intended use
 - Immunization agents, biological sera, blood or blood products administered on an out-patient basis
 - Drugs labeled “Caution – limited by federal law to investigational use” or experimental drugs, even though a charge is made to the individual
 - Any charge for the administration of prescription legend drugs or injectable insulin
 - Drugs covered under Workers’ Compensation
- (57) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.
- (58) **Relative providing services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, grandparent or grandchild whether the relationship is by blood or exists in law.
- (59) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (60) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Summary Schedule of Benefits.

- (61) **Sales Taxes, shipping and mailing charges.**
- (62) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or attempted suicide while sane unless the result of an act of domestic violence or a medical condition (including both physical and mental health conditions).
- (63) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (64) **Sex changes.** Care, services or treatment for non-congenital trans-sexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (65) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (66) **Supportive or Maintenance Therapies (PT, OT, Speech).** Charges for non-corrective care or treatment. Charges for care or treatment which evidence of improvement or recovery within a reasonable and generally predictable period of time is not established.
- (67) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (68) **Termination of Pregnancy.** Services, supplies, care or treatment in connection with an abortion unless the life of the Participant or Spouse is endangered by the continued Pregnancy.
- (69) **Telephone consultations, internet consultations, missed appointments** or the completion of a claim form.
- (70) **Temporomandibular Joint Syndrome.** Services, supplies, care or treatment of Temporomandibular Joint Syndrome
- (71) **Third Party Liability.** Care for Injury or Sickness that results from the actions of a third party, whether or not such third party is able to reimburse the Covered Person for such care. Upon compliance by the Covered Person with requirements of the Section "Subrogation, Right of Reimbursement, and Third Party Recovery Provisions" in this Document the Plan Administrator may provide benefits for such charges subject to the Plan's right of recovery.
- (72) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (73) **Treatment before onset.** Charges, whether or not recommended by a Physician, for treatment for genetically predisposed diseases, disorders or conditions prior to onset of the disease, disorder or condition.
- (74) **War.** Any loss, whether as a member of the armed forces or as a civilian, that is due to a declared or undeclared act of war.

CLAIM PROVISIONS

Filing claims properly and in a timely manner will help avoid delays in adjudication and facilitate prompt payment of any benefits due. Using a participating provider will help reduce claim filing issues. These providers will normally file claims for participants for covered services. Although a provider may file your claim, it is the Covered Person's responsibility to make sure that a proper claim has been filed. In the event that additional information is requested to complete a claim, it is the Covered Person's responsibility to make sure that a response is provided.

Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan Administrator has the final and ultimate responsibility for claim decisions and payment of Plan benefits.

A **properly filed claim** is a written statement or claim form regarding medical or dental services which provides sufficient information substantiating the claim to allow the Plan to accurately and promptly determine available benefits for covered services. Claims from providers must be submitted on a CMS 1500, UB04, their successors, or other forms as approved by the Plan. Electronic claims may accepted by the Plan from providers of services if they meet the requirements of federal law under the Health Insurance Portability and Accountability Act (HIPAA.) A properly filed claim would also include an itemized statement of services from the provider and additional information including medical records and other appropriate information when requested by the Plan.

When a Covered Person is submitting a claim instead of the provider of services they must included the following information:

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

Forward claims to the Claims Administrator at this address:

C. L. Frates and Company
P. O. Box 269001
Oklahoma City, Oklahoma 73126-9001
(405) 290-5696 or (800) 850-7166

Providers may find additional electronic claim filing information at www.clfrates.com/edipayor.stm.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator as soon as possible after services are incurred. Claims must be submitted within 12 months from the date of service in order to receive consideration for payment. At the sole discretion of the Plan Administrator this requirement may be waived when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant, provider and other appropriate entities.

MEDICAL EXAMINATIONS AND SECOND OPINIONS

In determining benefits, the Plan reserves the right to have a Covered Person seek an independent medical evaluation. The Plan also reserves the right to have a Covered Person seek a second medical opinion.

CLAIM ADJUDICATION, DECISION NOTIFICATION and PAYMENT of BENEFITS

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Covered Person with a written notice of this denial. This written notice will be provided within 30 days after receipt of the complete and properly filed claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Covered Person wishes to submit the claim for review.

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

If special circumstances beyond the control of the Plan Administrator require a 15-day extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Covered Person. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim.

Payment of Benefits

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

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

Facility of Payment of Benefits

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

Legal Action

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

CLAIMS REVIEW PROCEDURE

A Covered Person or the Participant's authorized representative, provided that such authorization has been made in writing and provided to the Plan, has the right to request a review ("Appeal") of any adverse benefit determination regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) medical necessity, propriety, effectiveness or efficiency. The Plan's appeal process must be exhausted before seeking other available remedies in the event of a disputed claim.

The Plan offers two internal review levels. The first review level is an evaluation by an appropriately qualified person who was uninvolved with the adverse benefit determination (a "Level-One Appeal"). The second review level is an evaluation by the Plan Administrator or their representative, who was uninvolved in either the adverse benefit determination or the Level-One Appeal decision (a "Level-Two Appeal"). An Employee or the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and/or the State insurance regulatory agency. Finally, a Covered Person always has a right to bring a civil action under the appropriate state or federal law after exhausting the Plan's appeal process.

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

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

To begin the Appeal process a Covered Person must do the following:

1. Make an oral or written Appeal request at the telephone number or address provided below within 180 days of the Appealed decision's adverse benefit determination. Covered Persons making oral requests will be sent an Appeal Form to complete and return.
2. An appeal coordinator will evaluate all requests regarding **contractual relationships, coverage, payment or reimbursement for health care services**. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding **medical necessity, propriety, effectiveness or efficiency**.
3. A Covered Person is responsible for providing all documentation supporting the Appeal request at the time of the request. The Plan will evaluate a request based on the information in its possession.
4. The Plan will provide the Covered Person and the Covered Person's requesting provider a written notification of its decision within thirty (30) days of receiving a written Appeal request or a completed Appeal form.

Contact Information:

C. L. Frates and Company:

Appeal Coordinator

P.O. Box 269001

Oklahoma City, Oklahoma 73126-9001

Telephone: (405) 290-5696

FAX: (405) 290-5798

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare - are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. All other plan provisions, exclusions and limitations will apply. Any part of an Allowable Charge that is paid or contractually reduced by a plan that is primary to this Plan will not be covered.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Any plan of prescription drug coverage
- (3) Blue Cross and Blue Shield group plans.
- (4) Group practice and other group prepayment plans.
- (5) Federal government plans or programs. This includes Medicare.
- (6) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (7) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Medicare Provisions, Working Aged. This Plan has elected to determine coordination with Medicare with respect to the working aged or dependents of the working aged on the basis of the size of the Employer that provides the Covered Person's eligibility. The Plan will treat such Covered Person, whose eligibility is established by an Employer with fewer than 20 Employees as determined by the Social

Security Act, as a participant in "small employer" group health plan. As such benefits will be determined according to the provisions of this Section, with Medicare as the Primary Plan. Covered Persons whose eligibility is established on the basis of the Employee's employment with an Employer with 20 or more Employees, will have their claims processed by this Plan as the Primary Plan.

Prescription Drug Plans. This plan will not coordinate any benefits for services covered under the Prescription Benefits of this Plan. In the event that another prescription plan is used for a primary payment no benefit is payable under this Plan.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special rule. If the person covered directly is a Medicare beneficiary, and Medicare is secondary to Plan B, and Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:

- (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination as outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
 - (4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person is requested to give this Plan the information it asks for about other plans and their payment of Allowable Charges.

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

Right of recovery when Coordination of Benefits exists. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

SUBROGATION, RIGHT OF REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

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

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

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

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

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

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

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

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

COBRA CONTINUATION OPTIONS

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

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

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

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "Dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (under part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

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

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage,

for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

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

If you have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Oklahoma Lumbermen's Association
2801 Lincoln Blvd., Suite 237
Oklahoma City, OK 73105
(405) 602-5384

PRIVACY PROVISIONS

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

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

We will provide you with the Plan's "Notice of Privacy Practices" as one component of compliance with new federal and state guidelines, which the Plan must comply with by April 14, 2004. This information will explain to you special procedures that will be instituted to allow you to control and manage your health information and also describe to you any policies regarding disclosure of information to the Plan Sponsor.

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

Protected Health Information (PHI). Effective April 14, 2004, the Plan shall conform with the requirements of Section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule") by establishing the extent to which the Employer will receive, use, and/or disclose PHI.

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

- (1) use or disclose PHI only as permitted by the Plan documents or as required by law;
- (2) ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (4) report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- (5) make available to Covered Persons their PHI in accordance with 45 CFR § 164.524;
- (6) make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.524;

- (7) make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- (8) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request for purposes of determining compliance by the Plan with applicable regulations regarding use and disclosure of PHI; and
- (9) if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purposes for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) ensure that adequate separation between Plan and the Plan Sponsor is established.

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

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

D. Designation of Privacy Officer. The Executive Vice President of the Plan Sponsor is designated as the Privacy Official for the Plan, and the Privacy Official shall be responsible for the development and implementation of policies and procedures of the Plan necessary to comply with the Privacy Rules and shall provide further information about matters covered by the Notice of Privacy Practices that is provided to participants in the Plan.

E. Designation of Contact Person. The Executive Vice President of the Plan Sponsor is designated as the Contact Person for the Plan, and the Contact Person shall be responsible for receiving complaints from participants in the Plan.

F. Required Separation between the Plan and the Employer. In accordance with the Privacy Rule, the Oklahoma Lumbermen's Association Privacy Policy provides a description of the employees, classes of employees, or workforce members under the control of the Employer who may be given access to individuals' PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan. Such list reflects the employees, classes of employees, or other workforce members of the Employer who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Employer provides for the Plan. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions of this section.

The Employer will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Oklahoma Lumbermen's Association Health Plan Plus is the benefit plan of Oklahoma Lumbermen's Association, also called the Plan Sponsor. It is administered by the Plan Administrator, the Employee Benefits Committee of the Oklahoma Lumbermen's Association, in accordance with the provisions of ERISA. The Plan Administrator is appointed by the President of the Board of Directors of the Plan Sponsor.

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 or the amount, manner and time of payment of any Plan benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

DUTIES OF THE PLAN ADMINISTRATOR

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

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

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

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

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

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

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

GENDER AND NUMBER. As used in this Plan Document the masculine reference shall include the feminine and the singular shall include the plural.

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

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

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

ENTIRE CONTRACT. The Plan (as amended) and any individual enrollment applications shall constitute the entire contract of coverage. Any statement made by the Plan Administrator and its designees, including the Claims Administrator, are deemed to be representation and not warranties. Such statements will not invalidate the Plan as stated in the Plan Document unless contained in a written statement signed by the Plan Administrator and the Participant.

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

AMENDING AND TERMINATING THE PLAN

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

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

RENEWABILITY

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

- (1) for nonpayment of contributions;
- (2) for fraud or other intentional misrepresentation of material fact by the Employer;
- (3) for noncompliance with material provisions of the Plan;
- (4) because the Plan is ceasing to offer coverage in a geographic area; or
- (5) in the case of benefits offered through a network, there is no longer any Covered Person enrolled through the Employer who lives, resides or works in the service area of the network and the Plan applies to this paragraph uniformly without regard to the claims experience of Employers or any health status-related factor in relation to Covered Persons.

ERISA DISCLOSURES AND INFORMATION

PLAN NAME, NUMBER AND TYPE:

Plan Name – Oklahoma Lumbermen’s Association Health Plan Plus (the “Plan”)

Plan Number – 501

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

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

Oklahoma Lumbermen’s Association
2801 Lincoln Blvd. Ste 237
Oklahoma City, OK 73105
(405) 602-5384
EIN: 73-1298666

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR:

The Employee Benefits Committee of the Oklahoma Lumbermen’s Association
2801 Lincoln Blvd Ste 237
Oklahoma City, OK 73105
(405) 602-5384

PARTICIPATING EMPLOYERS:

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

NAMED FIDUCIARY:

Oklahoma Lumbermen’s Association
2801 Lincoln Blvd Ste 237
Oklahoma City, OK 73105
(405) 602-5384

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

Oklahoma Lumbermen’s Association
2801 Lincoln Blvd Ste 237
Oklahoma City, OK 73105

SOURCE OF CONTRIBUTIONS AND PLAN FUNDING:

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

The name and address of the insurance company providing the excess insurance is as follows:

American Fidelity Assurance Company
2000 North Classen Boulevard
Oklahoma City, Oklahoma 73106

PLAN YEAR:

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

TYPE OF ADMINISTRATION:

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

C.L. Frates and Company
P.O. Box 269001
Oklahoma City, Oklahoma 73126-9001
405-290-5696 or 800-850-7166

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

ELIGIBILITY:

The Plan's provisions relating to eligibility are described in detail in the section entitled "Eligibility, Funding, Effective Date and Termination Provisions".

DESCRIPTION OF BENEFITS:

The Plan provides Covered Persons with the payment of or reimbursement of certain eligible medical expenses, which are described in detail in the section entitled "Medical Benefits".

PREFERRED PROVIDER ORGANIZATION (PPO)

First Health is the designated PPO network. (www.myfirsthealth.com) 1-800-226-5116

PROVISIONS LIMITING BENEFITS (Summary Only):

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

- deductibles, maximum Lifetime limits, and maximum annual limits;
- exclusions and limitations;
- subrogation, right of reimbursement and third party recovery rights of the Plan;
- coordination of benefits when a Covered Person is enrolled in more than one plan and this Plan is not the primary plan;
- effects of Medicare;
- possible reductions when private hospital rooms are used and for certain multiple surgical procedures;
- reductions due to charges that exceed Usual and Reasonable charges;

- reductions or denials due to services that are not generally accepted as appropriate, and/or which are not medically necessary, and/or which are considered as over-utilization;
- treatment, services and supplies that are excluded from coverage by the Plan, whether or not medically necessary;
- non-compliance with the Plan's claims filing deadlines.

These provisions are described in greater detail throughout this document.

ERISA RIGHTS STATEMENT

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

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

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

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

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

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

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

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

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

BY THIS AGREEMENT, the Oklahoma Lumbermen's Association Health Plan Plus is hereby adopted and amended as shown.

IN WITNESS WHEREOF, this instrument is executed for the Oklahoma Lumbermen's Association on or as of the day and year first below written.

OLA Health Plan Plus Plan III