

Summary of Coverage

Employer: Choctaw Enterprises

Group Policy: GP-819977

SOC: 1A

Issue Date: November 20, 2007

Effective Date: October 1, 2007

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

This Summary of Coverage may be an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time employee working 32 hours or more per week and your Employer has determined that your place of residence is within the Service Area covered under this Plan.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date you complete a probationary period of 30 days of continuous service for your Employer or, if later, the date you enter the Eligible Class.

Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 19 years of age.

Any other unmarried child under age 24 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent.

Open Access Managed Choice - CMSE, CAE, CPRE

Your children include:

- Your biological children.
- Your adopted children.
- Your stepchildren.
- Any other child you support who lives with you in a parent-child relationship.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

Enrollment Procedure

Initial Enrollment

To become covered under this Plan, you must request enrollment during the Initial Enrollment Period for yourself and any eligible dependents you wish to cover. The Initial Enrollment Period starts on your Eligibility Date and ends 31 days later.

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll before the end of the Initial Enrollment Period. Otherwise, you may be considered a **Late Enrollee**.

Your contributions, if any, toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Late Enrollment

If you do not sign and return your enrollment form during the Initial Enrollment Period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next late entrant enrollment period. If at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must sign and return your enrollment form before the end of the next late entrant enrollment period.

Late Enrollees are subject to the Preexisting Condition Limitation.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Special Enrollment Periods

A person, including yourself, will not be considered to be a **Late Enrollee** if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
 - i. the person was covered under another group health plan or other health insurance coverage; and
 - ii. you stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if your Employer requires the statement and gives you notice of the requirement; and

the person loses such coverage because:

- i. it was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
- ii. it was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
 - legal separation or divorce;
 - death;
 - termination of employment;
 - reduction in the number of hours of employment;
 - the employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
 - cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - the operation of another Plan's lifetime maximum on all benefits, if applicable; or
- iii. employer contributions toward the coverage were terminated.

- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you and any eligible dependents will not be considered to be **Late Enrollees** if your Employer offers multiple health benefit plans and you elect a different plan during the open enrollment period.

Also, the following persons will not be considered to be **Late Enrollees** given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the marriage, birth, adoption, or placement for adoption.
- Your spouse from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within 31 days of the court order.

Coverage will be effective:

- i. in the case of marriage, on the date the completed request for enrollment is received;
- ii. in the case of a newborn, on the date of birth;
- iii. in the case of adoption, on the date of the child's adoption or placement for adoption;
- iv. in the case of court ordered coverage of a spouse or child, on the date of the court order;
- v. in the case of loss of coverage under COBRA continuation, on the date COBRA continuation ended; and
- vi. in the case of loss of coverage for other reasons, the date on which the applicable event occurred.

Effective Date of Coverage

Employees

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed enrollment form.

If you are considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage.

You should report any newly acquired dependents. This may affect your contributions. Coverage will take effect as described in the section entitled, "Special Enrollment Periods".

If any dependent is considered a **Late Enrollee**, coverage will take effect on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for such dependent.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

The following expenses incurred for Preferred Care:

- Fees of a physician for non-surgical office visits
- Emergency Use of the Emergency Room
- Urgent Care Expenses
- Routine Physical Exam Expenses
- Immunization expenses for child to age 19
- Routine Eye Exam Expenses
- Routine Hearing Exam Expenses
- Covered Medical Expenses incurred for a routine mammogram
- Colorectal Mandate Expenses
- Routine screening for cancer of the prostate, including a digital rectal exam (DRE) and a prostate specific antigen (PSA) test
- Routine OB/GYN exam, including pap smear
- Short-Term Rehabilitation Expenses
- Spinal Disorder Expenses

The following expenses incurred for Non-Preferred Care:

- Emergency Use of the Emergency Room
- Immunization expenses for child to age 19

Preferred Family Deductible Limit \$ 750
Non- Preferred Family Deductible Limit \$ 1,500

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal \$ 750, the Calendar Year Deductible will not apply to expenses incurred for preferred and other health care during the rest of that calendar year for you and your dependents.

Emergency Room Deductible \$ 50 per visit

This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a Non-Preferred Care Provider and for care for dependents who permanently reside outside the Service Area covered under this Plan. This amount is waived if a person becomes confined in a hospital.

Emergency Room Copay \$ 50 per visit

This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred Care Provider. This amount is waived if the person becomes confined in a hospital.

Urgent Care Copay 100% after \$ 25 per visit

This Urgent Care Copay applies to expenses incurred for urgent care provided by a Preferred Care Provider. This amount is waived if the person becomes confined in a **hospital**.

Inpatient Hospital Deductible \$ 250

This Inpatient Hospital Deductible applies to Inpatient Hospital Expenses incurred for Non-Preferred Care and for care for dependents who permanently reside outside the Service Area covered under this Plan, except for Hospice and Skilled Nursing Facility.

However, for a confinement of a well newborn child that starts on the day of birth, the Inpatient Hospital Deductible will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

The Benefits Payable

After any applicable deductible or copay amount, the Health Expense Benefits paid under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet-Certificate.

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

Payment Percentage

The Payment Percentage applies after any deductible or copay amounts.

	Preferred Care	Non-Preferred Care
<i>Hospital Expenses</i>		
Emergency Room Treatment		
Emergency Care	100%	100%
Other Hospital Expenses	90%	70%
<i>Physician Fees</i>		
Office Care	100% after a \$ 20 copay	70%
Routine Physical Exam Expenses	100% after a \$ 20 copay	70%
Routine Eye Exam Expenses	100% after a \$ 20 copay	70%
Routine Hearing Exam Expenses	100% after a \$ 20 copay	70%
Immunization Expenses	100%	100%
Other Physician Services	90%	70%
Covered Medical Expenses incurred in connection with a mammogram	100%	70%
Covered Medical Expenses for Durable Medical and Surgical Equipment	90%	70%
<i>Short Term Rehabilitation Expenses</i>		
Payment Percentage	100% after a \$20 Per Visit Copay	70%
<i>Spinal Disorder Expenses</i>		
Payment Percentage	100% after a \$20 Per Visit Copay	70%

Other Covered Medical Expenses

Convalescent Facility Expenses	90%	70%
Home Health Care Expenses	100%	70%
Skilled Nursing Care Expenses	90%	70%
Hospice Care Expenses		
Inpatient Care	90%	70%
Outpatient Care	90%	70%

For Comprehensive Infertility Expenses

	Preferred Care	Non-Preferred Care
Payment Percentage	90%	70%
All Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown	90%	70%

Coverage for Dependents Who Permanently Reside Outside the Service Area

Covered Medical Expenses for dependents who permanently reside outside the Service Area covered under this Plan include the types of expenses listed under Non-Preferred Care. Benefits will be paid at 80%.

Payment Percentage and Special Maximums

National Medical Excellence		
Travel and Lodging Expenses		100%
	Preferred Care	Non-Preferred Care

Alcoholism and Drug Abuse

Inpatient Treatment	90%	70%
Outpatient Treatment	90% after a \$ 20 per visit copay	70%

Special Inpatient	
Calendar Year	
Maximum Days	30

Special Outpatient	
Calendar Year	
Maximum Visits	20

Payment Limits

These limits apply to Covered Medical Expenses except:

Expenses applied against any deductible, copay or penalty amount.

Payment Limit which Applies to Expenses for a Person

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 1,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches \$ 2,000, then benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Payment Limit which Applies to Expenses for a Family

When a family's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 2,000 in a calendar year, benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, except those for Non-Preferred Care. When the amount reaches \$ 4,000, then benefits will be payable at 100% for all of their Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year, including those for Non-Preferred Care.

Benefit Maximums

(Read the coverage section in your Booklet Certificate for a complete description of the benefits available.)

Convalescent Days	90 per calendar year
Private Duty Nursing Care Maximum Shifts	70 per calendar year
Home Health Care Maximum Visits	100 per calendar year
Hospice Care Maximum Number of Days	30
Outpatient Maximum	\$ 5,000
Short-Term Rehabilitation Maximum Visits	60 per calendar year
Durable Medical and Surgical Equipment Calendar Year Maximum	\$ 2,500
National Medical Excellence Lodging Expenses Maximum	\$ 50
Travel and Lodging Maximum	\$ 10,000
Private Room Limit	The institution's semiprivate rate.
Lifetime Maximum Benefit	\$ 2,000,000

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE
WITH YOUR BOOKLET-CERTIFICATE**

Additional Information Provided by Choctaw Enterprises

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Employer Identification Number:

73-1531149

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Choctaw Enterprises
2101 W. Arkansas Street
Durant, OK 74701

Agent For Service of Legal Process:

Choctaw Enterprises
2101 W. Arkansas Street
Durant, OK 74701

End of Plan Year:

December 31

Source of Contributions:

Employer/Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the HR Manager.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan 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 and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your 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 documents governing the Plan for 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 after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon 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 your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 materials 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 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a 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 is 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, 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.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.