

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ccok.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ccok.com/pdf/SBC/SBCUniformGlossary-2017.pdf or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 Member /\$4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network \$6,000 Member/\$12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ccok.com/directory or 1-800-777-4890 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 / visit	Not covered	None
	<u>Specialist</u> visit	\$50 / visit	Not covered	None
	<u>Preventive care/ screening/ immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 / visit for x-ray No <u>copayment</u> on blood work	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$200 / visit	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ccok.com or by calling 1-877-293-8628.	Preferred generic drugs	\$15 Preferred retail \$20 Non-Preferred retail \$30 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. Some preferred generic drugs have no charge.
	Preferred brand drugs	\$60 Preferred retail \$70 Non-Preferred retail \$120 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand or generic drugs	\$110 Preferred retail \$135 Non-Preferred retail \$220 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.
	<u>Specialty drugs</u>	\$160 Preferred retail \$200 Non-Preferred retail \$160 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and mail order. The difference between brand and generic pricing is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 / visit	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	Physician/surgeon fees	No charge	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 / visit	\$150 / visit	<u>Copayment</u> is waived if admitted to the hospital.
	<u>Emergency medical transportation</u>	\$50 / transport	\$50 / transport	None
	<u>Urgent care</u>	\$50 / visit <u>Deductible</u> does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200/day not to exceed 1,000	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	Physician/surgeon fees	No <u>copayment</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician office visit - \$30 / visit Other outpatient services - No <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	\$200/day not to exceed \$1,000	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If you are pregnant	Office Visits	No <u>copayment</u>	Not covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No <u>copayment</u>	Not covered	None
	Childbirth/delivery facility services	\$200/day not to exceed \$1,000	Not covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Rehabilitation services</u>	Inpatient - \$100/day. Outpatient - \$50/visit.	Not covered	Up to 60 treatment days per disability, per calendar year. Combination of physical, occupational, and speech therapy. Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	\$25 / day	Not covered	Up to 60 treatment days per disability, per calendar year. Inpatient requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
	<u>Hospice services</u>	No charge	Not covered	Requires <u>preauthorization</u> . Failure to receive <u>preauthorization</u> will result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply	Not covered	Limited to one exam in 365 days.
	Children's glasses	Not covered	Not covered	Not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Bariatric surgery • Children's glasses • Cosmetic surgery • Dental care (Adult)	• Dental care (Child) • Habilitation Services • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

• Acupuncture • Chiropractic care	• Hearing aids (Limited to one for each hearing impaired ear in any 48 month period.)	• Routine eye care (Adult) (limited to 1 visit per year)
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: CommunityCare at or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: CommunityCare at . You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/healthreform, or the Oklahoma Insurance Department at 1-800-522-0071.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al .

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$200
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$80
The total Peg would pay is	\$2,480

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$200
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$700
Copayments	\$1,000
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,860

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$200
■ Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (x-ray)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.



Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de CommunityCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-777-4890.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình CommunityCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-777-4890.
Chinese	本通知有重要的訊息。本通知有關於您透過[插入 SBM 項目的名稱 CommunityCare 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字1-800-777-4890]
Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 CommunityCare 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-777-4890로 전화하십시오.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch CommunityCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-777-4890.
Arabic	يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال CommunityCare. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-800-777-4890
Burmese	ဤစာ၌ အရေးအကြီးသော အချက်အလက် ပါဝင်ပါသည်။ ဤစာ၌ သင့်၏လျှောက်ထားသော သို့မဟုတ် CommunityCare ၏ သင့်သို့ ပေးသော သင့်၏အခွင့်အလမ်းများ ပါဝင်ပါသည်။ အဓိကရက်ကြို ဤစာ၌ အကြောင်းအရာများ သတိထားသော စောင့်ရှောက်မှုများကို မတိုင်မီ ကနဦးစောင့်ရှောက်မှုများ သို့မဟုတ် စရိတ်ခံစားခြင်း ဆက်လက်ဆောင်ရွက်ရန် စောင့်ရှောက်မှုများရှိပါသည့်အားဖြင့် ဤစာ၌ပါရှိပါသည်။ ဤစာ၌ပါရှိသော အချက်အလက်များကို ရရှိရန် ကူညီပေးရန်လိုက်နာရန် မိမိဘာသာစကားဖြင့် အကူအညီရယူပါသည်။ 1-800-777-4890။

Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Hmong	Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm CommunityCare. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 1-800-777-4890.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng CommunityCare. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-777-4890.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de CommunityCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-777-4890.
Laotian	ການແຈ້ງການນີ້ມີຂໍ້ມູນສໍາຄັນ. ການແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບຄໍາຮ້ອງສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ CommunityCare. ເບິ່ງສໍາລັບກໍານົດວັນທີ່ສໍາຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະເປັນຕ້ອງໃຊ້ເວລາດຳເນີນການໂດຍກໍານົດເວລາທີ່ແນ່ນອນ ຈະຮັກສາການຄຸ້ມຄອງສະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-800-777-4890.
Thai	ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอรับประกันสุขภาพของคุณผ่าน CommunityCare ดูกำหนดการในประกาศนี้ คุณจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณคือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือในภาษาของคุณโดยไม่เสียค่าใช้จ่าย โทร 1-800-777-4890
Urdu	اس ایشیاء میں اہم معلومات ہے۔ اس ایشیاء میں CommunityCare سے آپ کے درخواست اور خدمات کے بارے میں اہم معلومات ہے۔ ایشیاء میں اہم تاریخوں کا نظر کریں۔ ہو سکتا ہے کہ آپ کی صحت کی خدمات کو برقرار رکھنے اور اخراجات کی ادائیگی میں مالی مدد ملنے کے لیے، آپ کو خاص تاریخ یا ڈیڈ لائن سے پہلے کچھ کارروائی کرنی پڑے گی۔ آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ 1-800-777-4890 فون کریں۔
Cherokee	O'Wəḡḡi SSZGPT O'ḡḡi. ḡD O'Wəḡḡi RGZḡ4 ḡGWRCT RGḡḡḡV.ḡ O'həḡAWḡḡ ḡḡhVəḡ RGḡ4ḡḡḡḡ CommunityCare SGḡḡḡḡḡḡḡT. CḡRḡḡḡḡḡ ḡVḡḡḡR ḡD SSZGPT. RMḡ ḡḡḡḡ Kḡḡḡḡ Dḡ ḡḡḡḡḡ ḡḡḡḡḡḡ O'ḡḡVB TS ḡḡḡḡḡḡ. Vḡ ḡḡḡ ḡḡḡḡḡḡḡ ḡḡḡ Dḡ ḡḡḡḡḡḡ ḡR O'ḡCBḡḡ ḡḡRḡ ḡḡḡḡ. Dḡḡḡḡḡḡ Dḡḡḡḡḡḡ RGḡḡḡ Zḡ RGZḡ4ḡ ḡSPḡḡ ḡḡḡḡḡḡḡ ḡḡ ḡḡḡ ḡḡḡḡḡḡ ḡḡ Zḡ ḡḡḡḡḡ ḡḡRḡ ḡRT. ḡWZḡḡ ḡḡḡḡ ḡD 1-800-777-4890.
Persian-Farsi	ن اعلیٰ مدیہ حامی ا ا لعات دھیداش این اعلیٰ مدیہ حامی ا ا لعات دم دربارہ فیم تقاضا یوا پوششیدہ ای شمداروبوطب CommunityCare به تارخ های دم درین اعلیٰ متوجعید. شما کهن اینت، طبیعتاریخ های شخصی برای حقظ پوشش دزای ای یا رای کمکبه مخارج دزای لیزوجبانجام کارطیعتاشید. شما حقاین را لوی کهاین ا ا لعات و کمک رله زبان خونب طوایگان ریافت نیلید. 1-800-777-4890



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

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

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

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

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