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2018 OK 9

IN THE SUPREME COURT OF
THE STATE OF OKLAHOMA

ELIZABETH CATES,	)	
individually and on behalf of	)	
others similarly situated,	)	
Plaintiff/Appellant,	)	No. 114,314
v.	)	FOR OFFICIAL
INTEGRIS HEALTH, INC.,	)	PUBLICATION
an Oklahoma corporation,	)	
Defendant/Appellee.	)	

**ON APPEAL FROM THE DISTRICT COURT
OF OKLAHOMA COUNTY, THE HONORABLE
JUDGE ROGER STUART, PRESIDING**

(Filed Jan. 30, 2018)

¶ 0 Plaintiff/Appellant is a former patient of Defendant/Appellee's medical facility and claims that Defendant/Appellee wrongfully billed her, and others like her, for services. She filed this action in state court, alleging state-law claims for breach of contract, violation of the Oklahoma Consumer Protection Act, and deceit. Defendant/Appellee successfully moved to dismiss these claims on the ground that they are expressly preempted by the federal Employee Retirement Income Security Act. On appeal, we reversed and held that Plaintiff/Appellee's [sic] claims are not pre-empted. We now grant rehearing, vacate our prior

opinion, and issue the following opinion that reaches the same result.¹

**REHEARING GRANTED; OPINION OF
THE COURT ISSUED JUNE 19, 2017,
WITHDRAWN; JUDGMENT OF THE
DISTRICT COURT REVERSED; CASE
REMANDED FOR FURTHER PROCEEDINGS**

Terry W. West, Bradley C. West, Gregg W. Luther, and J. Shawn Spencer, The West Law Firm, Shawnee, Oklahoma, for Plaintiff/Appellant.

Kevin D. Gordon and Alison M. Howard, Crowe & Dunlevy, P.C., Oklahoma City, Oklahoma, for Defendant/Appellee.

Wyrick, J.:

¶ 1 Elizabeth Cates claims that Integris wrongfully billed her for services she received after being admitted to one of Integris's facilities following a car accident. She also claims that Integris has performed the same wrongful billing practice on other patients. The question in this appeal is whether these patients may pursue state-law remedies for their alleged harms.

¶ 2 Cates brought state-law claims for breach of contract, deceit, and violation of the Oklahoma Consumer Protection Act, 15 O.S. §§ 751 *et seq.* But

¹ See *Tomahawk Res., Inc. v. Craven*, 2005 OK 82, ¶ 1, 130 P.3d 222, 224-25 (supp. op. on reh'g) (listing the reasons for granting rehearing).

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Integris argues that Cates's claims are expressly preempted by the federal Employee Retirement Income Security Act² (ERISA). This is so, says Integris, because the claims "relate to" an ERISA plan.³ According to Integris, Cates may vindicate her rights only through pleading a claim under the cause of action established in ERISA.⁴ The district court agreed with Integris and dismissed Cates's claims. We now reverse and hold that Cates's state-law claims are not expressly preempted and may proceed below.

I.

¶ 3 This case arises out of two agreements: one between Cates and Integris, the other between Integris and Cates's health insurance Participating Provider Organization (PPO). The agreement between Cates and Integris is a hospital admission form she signed that provides the promise of healthcare and services in exchange for Cates's promise to comply with hospital rules.⁵ It also specifies that Cates is

² 29 U.S.C. §§ 1001 *et seq.* (2012).

³ *See id.* § 1144(a) ("Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.").

⁴ *See id.* § 1132.

⁵ *See* ROA, Doc. 6, Pl. Class Members' Am. Resp. to Mot. to Dismiss, Ex. 2, at 1 ("In consideration of admission and/or treatment, the patient agrees to abide by the rules of the Hospital."); *see also id.* at 2 ("The patient hereby assigns to Hospital all

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responsible for all charges “that remain after any third party payment . . . unless the Hospital is prohibited by contract between third party and Hospital from billing Patient for these amounts.”⁶ The second agreement at issue, the one between Integris and the PPO, is called a “Participating Hospital Agreement,” and it secures medical services for insurance-plan beneficiaries in exchange for the hospital’s promise to accept pre-arranged, discounted prices.⁷ According to Cates, it also specifies that the hospital may not bill her “except for a copay or deductible or coinsurance, or, in cases where Integris has confirmed the services are not covered, advised the patient the services are not covered prior to delivering the services, and the patient agreed to pay for those services.”⁸

benefits under any insurance policy, health plan, worker’s compensation or other third party payor liable to the patient, in consideration for services rendered by the Hospital.”).

⁶ *Id.* at 2 (“The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Hospital relating to services rendered by the Hospital to the patient that remain after any third party payment (which include, but are not limited to, applicable coinsurance, co-payments, deductibles and amounts for services or treatments that are not covered or for which payment has been denied by any third party) unless the Hospital is prohibited by contract between third party and Hospital from billing Patient for these amounts.”).

⁷ See ROA, Doc. 4, Def.’s Mot. to Dismiss, at 2.

⁸ See ROA, Doc. 10, Tr. of Hr’g on Def.’s Mot. to Dismiss, at 15:4-9 (“[The PPO agreement] prohibits hospital from billing [the patient] except for a copay or deductible or coinsurance, or, in cases where Integris has confirmed the services are not covered, advised the patient the services are not covered prior to delivering

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¶ 4 Cates argues that these two agreements work in tandem to require Integris first to submit all charges to her insurance provider before billing her directly.⁹ She alleges that following her hospital visit, Integris did not submit the charges to her insurer as required, but instead simply filed and asserted a lien against her. She also alleges that Integris has employed the same billing tactic with many of its patients.¹⁰ Accordingly, Cates brought a class action against Integris alleging the following four claims: (1) breach of contract, (2) breach of contract to which Cates is a third-party beneficiary, (3) violation of the Oklahoma Consumer Protection Act, and (4) “deceit.”¹¹

¶ 5 Integris countered that Cates’s claims were “completely” preempted, meaning that they should be treated as federal ERISA claims and could be removed to federal court.¹² Upon removal, however, the federal

the services, and the patient agreed to pay for those services prior.”). The copy of the PPO agreement was filed under seal and was not included as part of the record on appeal.

⁹ ROA, Doc. 3, First Am. Pet., at 3.

¹⁰ *Id.* at 4.

¹¹ *Id.* at 4-5.

¹² See generally *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207-09 (2004) (describing the effect of complete preemption); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) (same).

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courts disagreed and remanded the case back to state court for lack of subject-matter jurisdiction.¹³

¶ 6 Integris now argues that Cates’s state-law claims are “expressly” preempted, meaning that they cannot be brought at all.¹⁴ The Oklahoma district court agreed and granted Integris’s motion to dismiss on that basis. Cates then filed this appeal, which we retained.

¹³ *Cates v. Integris Health, Inc.*, No. 5:12-cv-00763-F, 2014 WL 12493272, at *6 (W.D. Okla. Sept. 30, 2014); *see also Salzer v. SSM Health Care of Okla. Inc.*, 762 F.3d 1130, 1137 (10th Cir. 2014) (opining that the connection between Cates’s claims and her ERISA plan was “too attenuated” to support complete preemption).

¹⁴ *See generally Davila*, 542 U.S. at 208-09 (describing the effect of ERISA’s express preemption provision (29 U.S.C. § 1144(a)) and distinguishing it from complete preemption); *see also* Scott D. Pomfret, *Emerging Theories of Liability for Utilization Review Under ERISA Health Plans*, 34 TORT & INS. L.J. 131, 145 n.83 (1998) (explaining and distinguishing complete and express preemption).

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II.

¶ 7 The standard of review for a district court's decision granting a motion to dismiss¹⁵ is *de novo*.¹⁶ The purpose of such a review is to test the law that governs the claim, not the underlying facts.¹⁷ As such, we take all factual allegations in the petition as true and draw all reasonable inferences therefrom.¹⁸ We also do not require the plaintiff to specify a theory of recovery, nor a particular remedy.¹⁹ If relief is possible

¹⁵ There was some confusion below as to whether Integriss's motion to dismiss should have been converted to one for summary judgment in light of the materials attached to the briefs. *See* 12 O.S.2011 § 2012(B) ("If, on a motion asserting the defense numbered 6 of this subsection to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and all parties shall be given reasonable opportunity to present all material made pertinent to the motion by the rules for summary judgment."). Because the motion could have been decided with reference only to the petition and those materials referenced by and integral to the petition, we agree with the district court's decision that the motion need not be converted to one for summary judgment. *See Tucker v. Cochran Firm-Criminal Defense Birmingham L.L.C.*, 2014 OK 112, ¶ 30, 341 P.3d 673, 684-86; *see also KMC Leasing, Inc. v. Rockwell-Standard Corp.*, 2000 OK 51, ¶ 13, 9 P.3d 683, 688-89 ("We will presume the trial court found every special thing necessary to be found to sustain the general finding and conclusion." (internal quotation marks omitted)); *Armstrong v. Gill*, 1964 OK 88, ¶ 8, 392 P.2d 737, 738 ("[T]here [is] a presumption that the court acted properly and did all that was necessary to sustain the proceedings. . . .").

¹⁶ *Dani v. Miller*, 2016 OK 35, ¶ 10, 374 P.3d 779, 785.

¹⁷ *Id.* ¶ 10, 374 P.3d at 785-86.

¹⁸ *Id.* ¶ 10, 374 P.3d at 786.

¹⁹ *Id.*

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under any set of facts that can be gleaned from the petition, the motion to dismiss should be denied.²⁰

¶ 8 The particular law tested in this motion to dismiss is ERISA express preemption – a treacherous “thicket” for any court to navigate.²¹ The basis for ERISA express preemption is found at 29 U.S.C. § 1144(a), which states “[ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any [ERISA] plan.” The key in that standard is the phrase “relate to.”²² The U.S. Supreme Court has said that those words give ERISA a preemption clause that is “conspicuous for its breadth,”²³ preempting anything that “relates to” an ERISA plan in the “normal . . . common sense” meaning of the phrase.²⁴ But the Supreme Court has also said that “relate to” cannot be taken to its logical extreme, lest we find ourselves playing Six Degrees of ERISA, where *everything* eventually relates to an ERISA plan.²⁵ Our job is thus to

²⁰ *Id.* ¶ 11, 374 P.3d at 786.

²¹ See *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182, 1184 (10th Cir. 2003) (“[A]ny court forced to enter the ERISA preemption thicket sets out on a treacherous path.” (alteration in original) (quoting *Gonzales v. Prudential Ins. Co.*, 901 F.2d 446, 451-52 (5th Cir. 1990))).

²² *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990).

²³ *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990).

²⁴ *Ingersoll-Rand Co.*, 498 U.S. at 139.

²⁵ See *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (“If ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for really, universally, relations stop nowhere.” (internal quotation marks and citation omitted)).

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determine whether Cates’s claims fairly “relate to” her ERISA plan, not in the broadest sense of the phrase, but rather in its “normal . . . common sense” meaning.

A.

¶ 9 Integris argues that Cates’s claims “relate to” an ERISA plan because they cannot be decided without reference to her underlying employee benefit plan – a.k.a the ERISA “Plan.”²⁶ Specifically, Integris contends that “any right to have INTEGRIS bill and accept payment from the Plan rather than Plaintiff, applies only to services *covered* under the terms of the Plan,”²⁷ and thus that Cates’s claims cannot be adjudicated without interpretation of what is and is not a “covered” charge under the plan.²⁸ This is especially true, argues Integris, because the real right Cates seeks to vindicate is her right to receive an in-network discount for the services rendered – a discount that applies only to “covered” services under the plan.²⁹ If Integris is correct, it would appear that its express-preemption defense is a strong one.³⁰

²⁶ ROA, Doc. 4, Def.’s Mot. to Dismiss, at 17.

²⁷ *Id.* at 3.

²⁸ *Id.* at 17.

²⁹ *Id.* at 2-3, 17.

³⁰ See *Ingersoll-Rand Co.*, 498 U.S. at 140 (“Because the court’s inquiry must be directed to the plan, this judicially created cause of action ‘relate[s] to’ an ERISA plan.” (alteration in original)).

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¶ 10 Integris’s argument, however, misapprehends the thrust of Cates’s case. Cates isn’t asking for Integris to accept payment from her health insurer for these bills, and she isn’t looking for a discount.³¹ Rather, Cates says that the two contracts she references (the admission form and the PPO agreement) prohibit Integris from billing her at all *if Integris did not first submit those charges for confirmation of coverage and authorization*. In other words, under Cates’s theory, it does not matter whether the charges were “covered,” only whether they were first submitted to the insurer. Accordingly, there would be no need to reference and interpret the ERISA plan in order to ascertain what was and wasn’t “covered” or to itemize her bill into what would or wouldn’t have been discounted. In the words of Plaintiff’s counsel, if Integris failed to first submit the charges to the insurer, Integris “get[s] zero.”³²

¶ 11 An examination of each of Cates’s claims bears this out. First is her claim for breach of contract, the elements of which are (1) the formation of a contract, (2) breach of the contract, and (3) damages as a

³¹ ROA, Doc. 10, Tr. of Hr’g on Def.’s Mot. to Dismiss, at 38:18-24 (“We’re not looking for a discount. [Integris] do[es]n’t get anything. They get zero because they didn’t play by the rules. And so, they keep trying to redraft this to be a discount that’s controlled by the PPO. No, they can’t bill us. Period. Period. They can’t bill us. That’s our argument, no matter how many times [defense counsel] tries to restate it, that’s our argument.”).

³² *Id.*

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result of that breach.³³ Cates alleges she formed a contract with Integris when she signed the hospital admission form³⁴ providing that she would be responsible for payment “*unless* the Hospital is prohibited by contract between third party and Hospital from billing Patient for these amounts.”³⁵ She claims that such a third-party contract exists (the PPO agreement) and that it prohibits Integris from billing her unless it first submits the charges to her insurer for review. She further alleges that Integris billed her without first submitting the charges to her insurer for review, thus breaching both the PPO agreement and the admission form. Cates also alleges that Integris filed and asserted a lien against her for the relevant charges and that she and every other putative class member have suffered damages as a result of Integris’s billing practices.³⁶ Assuming each of these allegations to be true, Cates has stated a colorable claim for relief – and has done so without reference to the ERISA plan.

¶ 12 The same is true of Cates’s claim for breach of a contract to which she is a third-party beneficiary

³³ *Dig. Design Grp., Inc. v. Info. Builders, Inc.*, 2001 OK 21, ¶ 33, 24 P.3d 834, 843.

³⁴ Counsel for Integris also appears to have conceded the contractual nature of this form, stating after the trial court asked whether counsel agreed that Cates has a contract with the hospital: “Well, it’s an admitting form and, yeah, it does – it does look like a contract, yeah, it provides obligations.” ROA, Doc. 10, Tr. of Hr’g on Def.’s Mot. to Dismiss, at 17:25-18:2.

³⁵ ROA, Doc. 6, Pl. Class Members’ Am. Resp. to Mot. to Dismiss, Ex. 2, at 2 (emphasis added).

³⁶ ROA, Doc. 3, First Am. Pet., at 3-4

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(*i.e.*, the PPO agreement), as it was necessarily breached as part of her first claim, and the only additional element she must prove is that the PPO agreement was made expressly for her benefit.³⁷ Cates alleges as much in her petition,³⁸ and we have no trouble inferring that a PPO agreement is made for the express benefit of the insurance beneficiaries receiving services under it.

¶ 13 Cates’s third claim alleges a violation of the Oklahoma Consumer Protection Act, 15 O.S. §§ 751 *et seq.* That law authorizes “a private right of action” whenever a person commits “any act or practice declared to be a violation of the Consumer Protection Act.”³⁹ Cates claims a violation of the provisions that prohibit “[k]nowingly caus[ing] a charge to be made by any billing method to a consumer for services . . . or products which the person knows was not authorized in advance by the consumer.”⁴⁰ Again, based on Cates’s interpretation of the two agreements at issue,⁴¹ there

³⁷ See *Great Plains Fed. Sav. & Loan Ass’n v. Dabney*, 1993 OK 4, ¶ 9, 846 P.2d 1088, 1093.

³⁸ ROA, Doc. 3, First Am. Pet., at 5.

³⁹ 15 O.S.2011 § 761.1(A).

⁴⁰ *Id.* § 753(25)-(26).

⁴¹ See ROA, Doc. 6, Pl. Class Members’ Am. Resp. to Mot. to Dismiss, Ex. 2, at 2 (“The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Hospital relating to services rendered by the Hospital to the patient that remain after any third party payment (which include, but are not limited to, applicable coinsurance, co-payments, deductibles and amounts for services or treatments that are not covered or for which payment has been denied by any third party)

is a conceivable set of facts by which she could establish that she did not consent to the relevant charges and that Integrus knew that when it billed her – and again, she could do all of this without reference to the ERISA plan.

¶ 14 Cates’s last claim is for what she calls “deceit.” In this count, she alleges that Integrus, through filing and asserting its lien against each putative class member, represented that each class member was indebted to Integrus.⁴² She then claims that the representation – in light of her theory of the case – is false, that it is material, that Integrus made it either with knowledge that it was false or with reckless disregard for its truth, that Integrus made it with the intention that each class member act upon it, and that each class member has been harmed as a result.⁴³ This sounds a lot like the basis for a common-law fraud claim,⁴⁴

unless the Hospital is prohibited by contract between third party and Hospital from billing Patient for these amounts.”); ROA Doc. 10, Tr. of Hr’g on Def.’s Mot. to Dismiss, at 15:4-9 (“[The PPO agreement] prohibits the hospital from billing [the patient] except for a copay or deductible or coinsurance, or, in cases where Integrus has confirmed the services are not covered, advised the patient the services are not covered prior to delivering the services, and the patient agreed to pay for those services prior.”).

⁴² ROA, Doc. 3, First Am. Pet., at 4.

⁴³ *Id.* at 4-5.

⁴⁴ See *Bowman v. Presley*, 2009 OK 48, ¶ 13, 212 P.3d 1210, 1217-18 (listing the elements of common-law fraud as: “1) a false material misrepresentation, 2) made as a positive assertion which is either known to be false or is made recklessly without knowledge of the truth, 3) with the intention that it be acted upon,

especially if Cates could establish that class members relied on the lien in paying on the debt or otherwise acting to their detriment. This claim can also be made without any reference to the ERISA plan; the only documents Cates needs are the lien, the two agreements she relies upon to demonstrate that it was wrongfully filed, and whatever evidence she has to demonstrate she acted upon it to her detriment. A set of facts thus exists for which relief would be possible without reference to the ERISA plan.

B.

¶ 15 Because we are applying federal law, we are cognizant of federal court decisions analyzing ERISA preemption. The conclusion we reach today is consistent with those decisions. Most analogous is the Seventh Circuit's decision in *Kolbe & Kolbe Health & Welfare Benefit Plan v. Medical College of Wisconsin, Inc.*⁴⁵ In *Kolbe*, the ERISA plan itself sought to bring state-law, breach-of-contract claims against a hospital, alleging – just as Cates – that the hospital had breached third-party-provider agreements to which the plaintiffs were express beneficiaries.⁴⁶ There, the hospital had requested, accepted, and retained payment from the plan for services rendered to a patient

and 4) which is relied on by the other party to his (or her) own detriment”).

⁴⁵ 657 F.3d 497 (7th Cir. 2011).

⁴⁶ *Id.* at 504.

that was not an insured under the plan.⁴⁷ The plan argued that this was a breach of the network provider agreements because those agreements naturally provided insurance payments only for services provided to insurance beneficiaries.⁴⁸ The district court dismissed the plan's claims as expressly preempted, but the Seventh Circuit reversed, holding that those claims "d[id] not require interpreting or applying the Plan, nor d[id] [they] relate to the Plan in any significant way."⁴⁹ Just as here, the court explained that "plaintiffs' pleadings make it unnecessary to review the Plan," and that the state-law claims could be resolved with reference to only "the member or service agreements and the provider agreements."⁵⁰ The Seventh Circuit then bolstered its decision with the conclusion that "plaintiffs' state law breach of contract action is an area of traditional state regulation that contains allegations which seek to satisfy the statutory objectives of ERISA and is not an alternative enforcement mechanism of ERISA."⁵¹ The same is true here.

¶ 16 We are also persuaded by two other federal appellate decisions in which a healthcare provider was

⁴⁷ *Id.*

⁴⁸ *Id.* at 500-01, 504.

⁴⁹ *Id.* at 504 (citing *Trs. of the AFTRA Health Fund v. Biondi*, 303 F.3d 765, 780 (7th Cir. 2002)).

⁵⁰ *Id.* at 504-05.

⁵¹ *Id.* at 505 (citing *Biondi*, 303 F.3d at 773-82).

the plaintiff seeking to avoid express preemption.⁵² In those cases the healthcare providers treated patients after receiving assurances from the ERISA plan⁵³ that the services were covered, but were then denied payment from the plan once the providers submitted their requests.⁵⁴ In holding that the providers' claims were not preempted, both courts noted that the providers' relevant state-law claims did not seek to recover benefits under the ERISA plans, but rather sought to recover damages that resulted from the providers' reliance on the plans' alleged misrepresentations.⁵⁵ In other words, plaintiffs were – as here – pressing claims that did not rely on an interpretation of the plan in order to secure relief.⁵⁶

⁵² See *Hospice of Metro Denver, Inc. v. Grp. Health Ins. of Okla., Inc.*, 944 F.2d 752 (10th Cir. 1991); *Mem'l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990).

⁵³ In *Memorial Hospital System*, the plaintiff provider received assurance from the plan beneficiary's employer, whom the provider claimed was acting as the ERISA plan's agent. 904 F.2d at 238.

⁵⁴ *Hospice of Metro Denver, Inc.*, 944 F.2d at 753; *Mem'l Hosp. Sys.*, 904 F.2d at 238.

⁵⁵ *Hospice of Metro Denver, Inc.*, 944 F.2d at 754; *Mem'l Hosp. Sys.*, 904 F.2d at 244.

⁵⁶ *Hospice of Metro Denver, Inc.*, 944 F.2d at 754 (“[Plaintiff] does not claim any rights under the plan, and does not claim any breach of the plan contract. The promissory estoppel claim does not seek to enforce or modify the terms of the plan. . . .”); *Mem'l Hosp. Sys.*, 904 F.2d at 250 (“[Plaintiff] has brought this state law action in its independent status as a hospital, and [patient’s] assignment of benefits is irrelevant to [plaintiff’s] right to recover. . . . [Plaintiff] neither seeks benefits from the plan nor claims that the plan acted improperly in processing and denying [plaintiff’s]

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¶ 17 These federal courts also looked to two other factors that support today’s decision. First, the courts also looked to the capacity of the parties as an indication that the claims were not preempted.⁵⁷ The Fifth Circuit in *Memorial Hospital System* explained that “the most important factor for a court to consider in deciding whether a state law affects an employee benefit plan ‘in too tenuous, remote, or peripheral a manner to be preempted’ is whether the state law affects relations among ERISA’s named entities” – i.e., “the employer, the plan, the plan fiduciaries, and the beneficiaries.”⁵⁸ The court then held that because the hospital sued in its capacity as a hospital (rather than in its capacity as the assignee of patient’s benefits) and because the insurer was sued based solely on its promise to pay (rather than on its obligations under the ERISA plan), these claims did not threaten to impact the relations between two ERISA entities, and thus were not what Congress intended to eliminate when it decided to preempt that which might “relate to” an ERISA plan.⁵⁹ The Tenth Circuit cited *Memorial*

claim. The claim is thus independent of the plan’s actual obligations under the terms of the insurance policy and in no way seeks to modify those obligations.”).

⁵⁷ *Hospice of Metro Denver, Inc.*, 944 F.2d at 756; *Mem’l Hosp. Sys.*, 904 F.2d at 249-50.

⁵⁸ 904 F.2d at 249 (quoting *Sommers Drug Stores Co. Emp. Profit Sharing Trust v. Corrigan Enters., Inc.*, 793 F.2d 1456, 1467-68 (5th Cir. 1986)).

⁵⁹ *Id.* at 250.

Hospital System to hold the same in *Hospice of Metro Denver, Inc.*⁶⁰

¶ 18 Second, the federal courts asked whether the plaintiffs would have adequate alternative recourse in the event their state-law claims were preempted – in other words: could they bring federal-law claims under ERISA?⁶¹ In both cases, the plan had denied payment upon its determination that the services rendered were not covered under the express terms of the plan, which, as both courts explained, meant that the provider would not be successful in the event it sought recovery under the ERISA cause of action.⁶² While both courts noted that the lack of a remedy under ERISA does not normally affect a preemption determination, both courts nevertheless found it useful to consider – especially in terms of whether such a result furthered Congress’s intent with ERISA.⁶³ As

⁶⁰ 944 F.2d at 756; *see also* *David P. Coldesina, D.D.S., P.C., v. Estate of Simper*, 407 F.3d 1126, 1136 (10th Cir. 2005) (explaining that the class of “[c]laims that do not affect the relations among the principal ERISA entities” – and thus escape preemption – “[n]ecessarily” includes claims that affect relations between only one ERISA entity and some outside/non-ERISA entity).

⁶¹ *Hospice of Metro Denver, Inc.*, 944 F.2d at 755; *Mem’l Hosp. Sys.*, 904 F.2d at 247-48.

⁶² *Hospice of Metro Denver, Inc.*, 944 F.2d at 753, 755; *Mem’l Hosp. Sys.*, 904 F.2d at 238, 247; *see also* 29 U.S.C. § 1132(a)(1)(B) (2012) (“A civil action may be brought – (1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.”).

⁶³ *Hospice of Metro Denver, Inc.*, 944 F.2d at 755; *Mem’l Hosp. Sys.*, 904 F.2d at 247-48.

the Fifth Circuit explained in *Memorial Hospital System*:

If providers have no recourse under either ERISA or state law in situations such as the one *sub judice* (where there is no coverage under the express terms of the plan, but a provider has relied on assurances that there is such coverage), providers will be understandably reluctant to accept the risk of non-payment, and may require up-front payment by beneficiaries – or impose other inconveniences – before treatment will be offered. This does not serve, but rather directly defeats, the purpose of Congress in enacting ERISA.⁶⁴

¶ 19 Both factors cut in favor of allowing Cates's claims to proceed in this case. First, Cates's claims do not affect the relations between ERISA entities. The healthcare provider in this case (Integris) is not Cates's employer, the ERISA plan, or a plan fiduciary, nor is it acting in the capacity of the beneficiary in this lawsuit. As in the two cases above, Integris is merely acting as a hospital. Moreover, Cates (the plan beneficiary) isn't acting in her capacity as an ERISA principal, as she is not using this action to recover benefits under the terms of her plan. Rather, she is seeking to enforce a promise made outside the ERISA plan, again just like the claimants in the two previously cited cases. Cates is merely a patient suing her hospital – nothing more.

⁶⁴ 904 F.2d at 247-48.

¶ 20 Second, the result of Integriss’s argument is that Cates is left without any legal recourse to challenge its billing practices. While arguably Cates could file an ERISA claim against Integriss to enforce her rights under the plan,⁶⁵ she can prevail only if the services were actually covered by her ERISA plan. If Integriss is right, however, and the services Cates received were *not* covered, then Cates is in the very same position as the hospitals would have been in the two cases above: left holding the bag. “Congress’s primary purpose in enacting ERISA,” however, “was to protect the interests of plan beneficiaries,”⁶⁶ and the Fifth Circuit in *Memorial Hospital System* explained that when providers erect obstacles to those beneficiaries’ procurement of services, the providers “directly defeat” Congress’s purpose.⁶⁷ If Integriss was required to submit Cates’s bill to a third party as part of the bargain struck for healthcare, Integriss’s refusal to do so represents the very kind of obstacle Congress sought to eliminate, and one that we think Congress would want removed even if state law must do the lifting.

* * *

⁶⁵ See *Salzer v. SSM Health Care of Okla. Inc.*, 762 F.3d 1130, 1137-38 (10th Cir. 2014) (permitting a plan beneficiary to bring an ERISA claim against a healthcare provider to enforce rights under his plan). We reiterate, however, that this is not the claim Cates brings in this lawsuit.

⁶⁶ *David P. Coldesina, D.D.S., P.C.*, 407 F.3d at 1136 (citing *Ingersoll-Rand Co.*, 498 U.S. at 137).

⁶⁷ 904 F.2d at 247-48.

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¶ 21 Based on the allegations in Cates’s petition, we hold that she has stated claims for relief that do not “relate to” her ERISA plan as that term has been interpreted by the federal courts. Accordingly, Integris’s motion to dismiss on the ground of express preemption should have been denied. The judgment of the trial court is therefore reversed, and the case is remanded with instructions to proceed in a manner consistent with this opinion.⁶⁸

Combs, C.J., Gurich, V.C.J., Winchester, Edmondson, Reif, and Wyrick, JJ., concur.

Colbert, J., dissents.

Kauger, J., not participating.

⁶⁸ We also note that *all* we have decided is the sufficiency of Cates’s petition at this motion-to-dismiss juncture. Whether the agreements she cites are indeed contracts, what their terms actually require, and all the other elements of her claims remain for the district court to determine on remand.

IN THE SUPREME COURT OF
THE STATE OF OKLAHOMA

ELIZABETH CATES,	)	
Individually and on behalf of	)	
others similarly situated,	)	
Plaintiff/Appellant,	)	No. 114,314
v.	)	FOR OFFICIAL
INTEGRIS HEALTH, INC.,	)	PUBLICATION
an Oklahoma corporation,	)	
Defendant/Appellee.	)	

**ON APPEAL FROM THE DISTRICT COURT
OF OKLAHOMA COUNTY, THE HONORABLE
JUDGE ROGER STUART, PRESIDING.**

(Filed Jun. 19, 2017)

¶0 The plaintiff/appellee [sic], Elizabeth Cates, filed on her behalf and a putative class asserting claims against the defendant/appellee, INTEGRIS Health, Inc., for breach of contract, violation of the Oklahoma Consumer Protection Act, deceit, specific performance, and punitive damages. INTEGRIS successfully moved to dismiss the claims based on the ground that they are all preempted by the Employee Retirement Income Security Act, 29 U.S.C., §§ 1001 *et seq.* Cates appealed. This Court retained the matter for disposition.

REVERSED AND REMANDED.

Terry W. West, Bradley C. West, Gregg W. Luther, J. Shawn Spencer, THE WEST LAW FIRM, Shawnee, Oklahoma; Attorneys for Plaintiff/Appellant.

Kevin D. Gordon, Alison M. Howard, CROWE & DUNLEVY PC, Oklahoma City, Oklahoma; Attorneys for Defendant/Appellee.

¶1 Elizabeth Cates, plaintiff/appellant, filed a lawsuit, individually and on behalf of others similarly situated, against INTEGRIS Health, Inc., defendant/appellee. Her claims include breach of contract, violation of the Oklahoma Consumer Protection Act, deceit, specific performance, and punitive damages.

¶2 INTEGRIS answered that the case fell within the Employee Retirement Income Security Act, 29 U.S.C., §§ 1001 *et seq.* (ERISA), which completely preempts state claims. The case was removed to the federal court from the Oklahoma District Court. After Cates filed a motion to remand to Oklahoma District Court, Judge Joe Heaton of the United States District Court for the Western District, concluded that the claims made by Cates were “completely preempted, creating subject matter jurisdiction in this court.” Judge Heaton denied the motion to remand. *Cates v. INTEGRIS Health, Inc.*, 2012 WL 5456093 (W. D. Okla. 2012) (unpublished).

¶3 Before the Western District decided allegations in the *Cates* case, the Tenth Circuit handed down *Salzer v. SSM Health Care of Oklahoma Inc.*, 762 F.3d 1130 (10th Cir. 2014). That court decided a case factually

similar to the case now before this Court. Both the issues and the facts in *Salzer* are nearly identical to those in this *Cates* case. The holding in *Salzer* concluded that most of Salzer's claims were not preempted, but one claim supported federal question jurisdiction under ERISA and therefore the federal court could assert jurisdiction over all of the claims, including any alleged state-law claims that arose from the same core of operative facts. *Salzer*, 762 F.3d at 1137.

¶4 Richard Salzer's health insurance company had an existing contract with SSM Health Care of Oklahoma, Inc. That contract required SSM to submit covered medical charges to Salzer's insurance company and accept discounted payment from the insurer. *Salzer*, 762 F.3d at 1133. Elizabeth Cates's health insurance company had an existing contract with INTEGRIS Health, Inc. That contract required INTEGRIS to accept a discounted payment and bill the health insurance company for covered charges. These reported facts are the same in both the *Salzer* and *Cates* cases.

¶5 In *Salzer* the 10th Circuit included criticism of the *Cates* case in its opinion based on that court's construction of *Aetna Health Inc. v. Davila*, 542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

“We acknowledge that another decision from the Western District of Oklahoma concluded that an ERISA plan beneficiary's suit against a health care provider for failing to submit claims according to the terms of a provider

agreement was preempted because her “status as a third-party beneficiary is dependent on her participation in the ERISA Plan in the first place.” *Cates v. Integrus Health, Inc.*, No. CIV-12-0763-HE, 2012 WL 5456093, at *3 (W.D.Okla. Nov. 7, 2012) (unpublished). But we find this connection too attenuated to meet the *Davila* standard. See *David P. Coldesina*, 407 F.3d at 1138 (ERISA preemption does not apply if plan is merely “part of the factual backdrop of th[e] case”).

Salzer, 762 F.3d at 1137.

¶6 Like *Salzer*, Judge Heaton cited two elements from *Davila*, in concluding the *Cates* case would not be remanded to the Oklahoma District Court. The first element was whether Cates, at some point, could have brought her claims under ERISA’s civil enforcement provision. The court ruled that interpretation of the terms of the ERISA plan was required to determine whether Cates’s service was entitled to a discounted rate under the hospital’s contract. Therefore the claims fell within ERISA’s civil enforcement scheme. The second element of *Davila* was whether there is “no other independent legal duty” implicated by INTEGRIS’s actions. The court ruled that since plaintiff’s status as a third-party beneficiary is dependent on her participation in the ERISA plan, Cates’s status as a third-party beneficiary was not independent of ERISA. This ruling regarding the second element of *Davila* is what the *Salzer* court concluded as “too attenuated to meet the *Davila* standard.”

¶7 Subsequently, Judge Heaton recused in the *Cates* case and the action was reassigned to Judge Stephen P. Friot. Judge Friot granted Cates’s renewed motion to remand: based on the Tenth Circuit’s *Salzer* case. *Cates v. INTEGRIS Health*, 2014 WL 12493272 (W.D. Okla.).

¶8 Judge Friot acknowledges the close similarity between the facts in the *Salzer* and *Cates* cases. Nevertheless, the court concludes, based on its reading of the *Salzer* case that the decision to retain or remand the ERISA case turns on the difference between the claims in the two cases. If the claims, including that of the in-network discount, “primarily hinge on the provider agreement,” and not Cates’s healthcare plan, then it is a type of claim that does not give rise to preemption jurisdiction. *Cates*, 2014 WL 12493272, *6 (W.D. Okla.). The healthcare plan can be examined to determine if coverage exists, but that reference to the agreement is not dispositive in deciding preemption. *Cates*, 2014 WL 12493272, *6 (W.D. Okla.).

¶9 Instead of the term “relates to” being the test of preemption, the current test, according to *Salzer*, is whether the healthcare plan is merely “part of the factual backdrop” of the case. *Salzer*, 762 F.3d at 1137. Accordingly, Judge Friot has ruled that a reference in the allegations to decide if a certain injury is covered and whether a discount is required in the healthcare plan, are both merely parts of the factual backdrop of an Oklahoma contract case, which is a state issue and not a federal issue. Although both cases seek enforcement of the discount on charges provided in the health

insurance, the Tenth Circuit has drawn a distinction between a claim for tortious interference with a contract, *Salzer*, which is preempted, and a claim by the plaintiff as a third party beneficiary for the enforcement of a discount, *Cates*, which is not preempted.

¶10 Judge Friot's conclusion has decided a rule of federal law in the *Cates* case, which is now before this Court. That decision should continue to govern the same issues in subsequent stages in the same case. *Arizona v. California*, 460 U.S. 605, 618, 103 S.Ct. 1382, 1391, 75 L.Ed.2d 318 (1983).] This is a subsequent stage of the same case.

¶11 We remand to the District Court of Oklahoma County. Based on Judge Friot's ruling, the court can then continue with Oklahoma remedies. We express no opinion on the class action issue.

REVERSED AND REMANDED.

Concur: Combs, C.J., Gurich, V.C.J., Winchester, Edmondson, Colbert and Wyrick,

Dissent: Watt, Reif, JJ. (By separate writing)

Not Participating: Kauger, J.

**IN THE DISTRICT COURT OF
OKLAHOMA COUNTY
STATE OF OKLAHOMA**

ELIZABETH CATES,	)	
Individually, and on behalf	)	
of others similarly situated,	)	
Plaintiff,	)	
v.	)	Case No. CJ-2012-201
	)	Hon. Roger Stuart
INTEGRIS HEALTH, INC.,	)	
an Oklahoma corporation,	)	
Defendant.	)	

**AMENDED ORDER DENYING
PLAINTIFF'S MOTION FOR NEW TRIAL**

(Filed Oct. 6, 2015)

On August 28, 2015, this matter came on for hearing before the Court on the motion (the "Motion") of Plaintiff for new trial to reconsider the order dated July 21, 2015 (the "Order"). The Order dismissed Plaintiffs claims as expressly preempted under 29 U.S.C. § 1144 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). Plaintiff sought reconsideration of the Order on the basis of error of law. 12 Okla. St. § 651. The parties appeared through counsel of record.

Having considered the briefs and heard argument, the Court being fully advised FINDS that the Order was not based upon an error of law. The Court reaffirms that this action's claims, all of which are asserted

under state law, are “related to” an employee benefit plan within the meaning of 29 U.S.C. § 1144; therefore, the claims are expressly preempted by ERISA. As such, the Court DENIES the Motion. Given Plaintiff has not amended the lawsuit within the 30-day time period allowed by the Order, final judgment of dismissal with prejudice is hereby entered, pursuant to 12 Okla. St. § 2012(G).

IT IS SO ORDERED this 6 day of October, 2015.

/s/ Roger Stuart
ROGER STUART
JUDGE OF THE
DISTRICT COURT

APPROVED:

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Bradley C. West,
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**ATTORNEYS FOR
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**ATTORNEYS FOR
DEFENDANT**

**IN THE DISTRICT COURT OF
OKLAHOMA COUNTY
STATE OF OKLAHOMA**

ELIZABETH CATES,	)	
Individually, and on behalf	)	
of others similarly situated,	)	
Plaintiff,	)	
	)	Case No. CJ-2012-201
v.	)	Hon. Roger Stuart
INTEGRIS HEALTH, INC.,	)	
an Oklahoma corporation,	)	
Defendant.	)	

ORDER GRANTING
DEFENDANT'S MOTION TO DISMISS

(Filed Jul. 21, 2015)

On July 13, 2015, this matter came on for hearing before the Court on the motion (the "Motion") of Defendant, INTEGRIS Health, Inc., to dismiss all of the claims as asserted in the First Amended Petition on the ground they are expressly preempted under 29 U.S.C. § 1144 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). The parties appeared through counsel of record.

Having considered the briefs and heard argument, the Court being fully advised FINDS that the action's claims, all of which are asserted under state law, are "related to" an employee benefit plan within the meaning of 29 U.S.C. § 1144; therefore, these claims are

expressly preempted by ERISA. As such, the Court GRANTS the Motion and ORDERS as follows:

1. All of the claims in the First Amended Petition are dismissed with prejudice; and

2. Plaintiff has 30 days within which to amend her petition to assert an ERISA claim under 29 U.S.C. § 1132.

IT IS SO ORDERED this 21 day of July, 2015.

ROGER STUART

ROGER STUART
JUDGE OF THE DISTRICT COURT

APPROVED:

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**ATTORNEYS FOR
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**ATTORNEYS FOR
DEFENDANT**

ELIZABETH CATES,)
Individually, and on behalf)
of others similarly situated,)
Plaintiff,)
vs.) Case No. CJ-2012-201
INTEGRIS HEALTH, INC.,)
An Oklahoma Corporation,)
Defendant.)

(Filed Jan. 30, 2012)

COMES NOW Plaintiff, Elizabeth Cates, Individually and on behalf of others similarly situated, and for her cause of action against Defendant, state as follows:

- 1.** Plaintiff is a citizen of the State of Oklahoma.
- 2.** Defendant is a domestic corporation doing business as a health care provider in the State of Oklahoma, including, but not limited to Oklahoma County.
- 3.** Defendant's service agent is located in Oklahoma County, State of Oklahoma.

CLASS ALLEGATIONS

4. Plaintiff brings this class action pursuant to 12 O.S. §2023 on behalf of herself and all others similarly situated as representative members of the following proposed class:

all residents of Oklahoma from January 1, 2000 to present, who received covered medical care or treatment at the Defendant's facilities as the result of injuries for which a third party was potentially responsible, and who were insured through a health insurance company that maintained a Provider or Participation Agreement with Defendant, but Defendant collected a payment from, or brought a collection action against, or asserted a lien against a patient for a covered charge, other than a co-payment, deductible, or co-insurance. Specifically excluded from this class are: 1) residents whose medical expenses were covered by workers compensation insurance; 2) residents who were insured through Medicare or Medicaid; 3) lawyers, members of the judiciary, and employees of Defendant.

5. Plaintiff is a member of the class she seeks to represent.

6. All of the class members are residents of the State of Oklahoma.

7. **Numerosity (12 O.S. §2023(a)(1)).** The members of the class are so numerous that joinder is impractical and would involve many litigants. Plaintiff

believes that the proposed class definition encompasses in excess of 100 members.

8. Existence of common questions of law and fact (12 O.S. §2023(a)(2)). Common questions of law and fact exist as to all members of the class. These common legal and factual questions include, but are not limited to, the following:

- a. Whether the Defendant breached the agreement with a class member who assigned health insurance benefits to Defendant where Defendant failed to submit the medical bills to the insurance company for payment of a pre-negotiated discounted price, and instead sought an amount in excess of the pre-negotiated discounted price directly from the class member?
- b. Whether the Defendant violated the Oklahoma Consumer Protection Act by committing an “unlawful business practice” by knowingly causing a charge to be made by any billing method to a class member/consumer which Defendant knew was not authorized in advance by the class member/consumer?
- c. Whether the Defendant committed the tort of Deceit by representing that a class member is/was indebted to Defendant in an amount in excess of what Defendant is/was entitled to recover under the Provider or Participation Agreement with

the class member's health insurance company?

- d. Whether the class members are entitled to the remedy of specific performance?
- e. Whether the acts of the Defendant warrant the imposition of punitive damages?
- f. Whether the Plaintiff and class members have sustained damages?
- g. Whether the Defendant concealed its conduct in a manner that tolled the limitations period?

These common issues of law and fact predominate over individual issues.

9. Typicality of claims (12 O.S. §2023(a)(3)).

The claims of the named Plaintiff are typical of the claims of the class in that the named Plaintiff and the members of the class have suffered financial losses due to Defendant's conduct.

10. Adequacy of representation (12 O.S. §2023(a)(4)). Plaintiff and her counsel will fairly and adequately represent and protect the interest of the members of the class. Plaintiff's interests do not conflict with the interests of the members of the class she seeks to represent. Plaintiff has retained counsel competent and experienced in complex mass tort and class action litigation and intends to prosecute this action vigorously for the benefit of the class.

11. Superiority (12 O.S. §2023(b)). A class action is superior to other available methods for the fair

and efficient adjudication to this litigation, since individual joinder of all members of the class is impracticable and would result in a burden on the court.

FACTUAL ALLEGATIONS

12. Plaintiff and all class members received medical care and treatment from Defendant's Facilities for injuries received in an auto collision which was not their fault.

13. Defendant executed a contract ("Agreement") with each class member's health insurance company.

14. The above said Agreement required Defendant's Facilities to submit the covered charges to each class member's health insurance company.

15. The Agreement required Defendant's Facilities to accept the discounted payment from said health insurance company as payment in full, except co-pay or deductible.

16. The Agreement prohibited Defendant's Facilities from seeking any payment for a covered charge from the class member, other than a co-payment, deductible, or co-insurance.

17. In or about May and June 2011, Plaintiff was seen at Defendant's hospital for injuries she received in an automobile collision, which was not her fault. At that time, Plaintiff was insured by virtue of a health insurance policy issued by Oklahoma Lumberman

Association through First Health Network. Plaintiff provided Defendant with her health insurance information at the time of treatment. Rather than submit its bill for services to Plaintiff's health insurance carrier, as it was required to do under the terms of Defendants' Agreement with First Health, Defendant instead filed and asserted a lien upon Plaintiff in November 2011.

18. Defendant's Facilities collected a payment from, and/or brought a collection action against, and/or asserted a lien against the class member for a covered charge, other than a co-payment, deductible, or co-insurance.

19. Defendant concealed its actions in a manner that operates to toll the statute of limitations for the class members, or in the alternative, the class members could not have become aware of Defendant's tortious conduct in the exercise of reasonable diligence.

COUNT ONE – BREACH OF CONTRACT

20. Each class member and Defendant entered into a contract for services. Defendant breached this contract and each class member is entitled to damages.

COUNT TWO – CONSUMER PROTECTION ACT VIOLATION

21. Defendant violated the Oklahoma Consumer Protection Act by committing "unlawful business practice" by knowingly causing a charge to be made by any

billing method to a consumer which the person knows was not authorized in advance by the consumer. Each class member is entitled to recover damages as provided in said Act.

COUNT THREE – DECEIT

22. Defendant represented that each class member is indebted to Defendant in the lien Defendant filed. This representation is material; this representation is false; Defendant knew it was false or made it recklessly, without regard for its truth; Defendant made it with the intention that each class member act upon it; and each class member (and each class member's credit) has been injured as a result. As a result of Defendant's tortious conduct, each class member has been damaged and is entitled to recover against Defendant.

COUNT FOUR – SPECIFIC PERFORMANCE OF A CONTRACT TO WHICH PLAINTIFF IS A THIRD PARTY BENEFICIARY

23. Defendant entered into a contract with each class member's health insurance company known as a Facility Participation Agreement or Provider Agreement ("Agreement").

24. Said Agreement is made for the benefit of insureds/patients such as each class member.

25. Defendant breached this Agreement by failing to submit each class member's medical bills to their

health insurance company so that each class member could receive an in-network discount for said bills, and instead, filed a lien and/or sought payment directly from each class member for the full amount of the bills.

26. Pursuant to Section 29 of Title 15 of the Oklahoma Statutes, each class member seeks an Order of the Court's enforcing the Agreement.

COUNT FIVE – DECLARATORY RELIEF

27. The Agreement requires Defendant to timely submit each class member's medical bills to their health insurance company so that each class member receives an in-network discount for said bills.

28. In the event Defendant fails to timely submit said medical bills then the Agreement prohibits Defendant from collecting a payment from, bringing a collection action against or asserting a lien against each class member.

29. Defendant failed to timely submit each class member's medical bills to their health insurance company for payment as required by the Agreement.

30. As a result of Defendant's failure to timely submit each class member's medical bills to their health insurance company, Defendant is prohibited from collecting a payment from, bringing a collection action against or asserting a lien against each class member.

31. Defendant has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final declaratory relief with respect to the class as a whole, pursuant to Section 2023(B)(2) of Title 12 of the Oklahoma Statutes. Because of this controversy, a declaratory judgment is both necessary and proper in order to set forth and determine the rights, obligations and liabilities that exist among the parties.

COUNT SIX – INJUNCTIVE RELIEF

32. Plaintiff and the class members will suffer irreparable harm without a permanent injunction enjoining Defendant from continuing to file liens where the Defendant should only bill health insurance and accept payment from the health insurance carrier as payment in full. The remedies at law available to Plaintiff and the class members are not adequate. Adequate relief will require Defendant to be enjoined from all such practices in the future.

33. Defendant has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief with respect to the class as a whole, pursuant to Section 2023(B)(2) of Title 12 of the Oklahoma Statutes.

COUNT SEVEN – PUNITIVE DAMAGES

34. Defendant's conduct violated Section 9.1 of Title 23 of the Oklahoma Statutes; therefore, each class member is entitled to recover exemplary damages.

35. Plaintiffs First Amended Petition is proper pursuant to 12 O.S. § 2015 because it has been filed prior to a responsive pleading being served.

WHEREFORE, Plaintiff and each class member prays for a judgment against the Defendant in this action for a sum in excess of the requisite amount for diversity jurisdiction, declaratory relief, injunctive relief, costs incurred, interest, attorney's fees, punitive damages, and for any other relief to which this Court deems appropriate.

Respectfully submitted,

THE WEST LAW FIRM
ATTORNEYS FOR PLAINTIFF

/s/ J. Shawn Spencer
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BRADLEY C. WEST,
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ATTORNEYS' LIEN CLAIMED

[LOGO]

**PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION
OKLAHOMA LUMBERMEN'S ASSOCIATION
HEALTH PLAN PLUS
PLAN IV**

Amended and Restated January 1, 2011

Amended Copy as of February 1, 2011

Amendment Inserted as Last Page

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 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.

* * *

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.

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 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.

* * *

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.

* * *

PLAN EXCLUSIONS

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

* * *

- (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.

* * *

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 [sic] 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 [sic] the following information:

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- 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;

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- (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

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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.

* * *

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.

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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

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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.

* * *

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

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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.

* * *

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:

StarNet Insurance Company
A Berkley Company
2445 Kuser Road, Suite 201
Hamilton Square, NJ 08690

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,

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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.

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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 [sic] 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.

By /s/ Randy Smith
Oklahoma Lumbermen's
Association

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Date 10-27-2010

Witness _____

Date _____

OLA Health Plan Plus Plan IV

* * *

**COVENTRY HEALTH AND
LIFE INSURANCE COMPANY
PARTICIPATING HOSPITAL AGREEMENT**

THIS PARTICIPATING HOSPITAL AGREEMENT (this “**Agreement**”) is made as of this 1st day of July, 2009, (the “**Effective Date**”) by and between INTEGRIS Seminole Medical Center, a duly licensed provider by the State of Oklahoma (hereinafter referred to as “Hospital”), and Coventry Health and Life Insurance Company, (“**Health Plan**”) a Delaware corporation, on behalf of the affiliate companies of Health Plan, First Health Life and Health Insurance Company, and First Health Group Corp. (individually a “**Coventry Company**” collectively “**Coventry Companies**”).

WHEREAS, Health Plan, Coventry Companies, and Payors make available to employers and individuals, or administer on behalf of employers or other entities, various health care benefit programs for the benefit of employees and their eligible dependents or individual participants and their eligible dependents. In addition, Payors provide administrative services and provider network services to third party administrators, insurance companies offering health benefit plans and insurance companies offering workers compensation coverage plans; and

WHEREAS, Health Plan desires to have Hospital as a Participating Provider for Coventry and First Health Products (as defined herein) offered by Health Plan, Coventry Companies and Payors;

WHEREAS, Hospital is duly licensed by the State of Oklahoma and desires to be a Participating Provider for Coventry and First Health Products offered by Health Plan, Coventry Companies, and Payors.

NOW THEREFORE, in consideration for promises and mutual covenants set forth herein and for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Health Plan and Hospital hereby agrees as follows:

1. DEFINITIONS

1.1 Clean Claim. Clean Claim shall have the meaning required by law in the State of Oklahoma and shall include all information required to be submitted in accordance with Section 2.6.

1.2 Covered Services. All of the health care services and supplies: (a) that are Medically Necessary; (b) that are generally available at Hospital; (c) that Hospital is licensed to provide to Members; and (d) that are covered under the terms of the applicable Member Contract.

1.3 Emergency Services. Any health care service provided to a Member after the sudden and at the time, unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity, that would lead a prudent layperson possessing an average knowledge of health and medicine to believe that immediate medical care is required, which may include, but shall not be limited to: (i) placing the Member's health in significant jeopardy, or with respect to a pregnant

woman the health of the woman or unborn child; or, (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part, or (iv) inadequately controlled pain.

1.4 Medically Necessary. Medically Necessary shall mean those services, supplies, equipment and facility charges that are not expressly excluded under the Member Contract and determined by Health Plan or a Payor to be:

1.4.1 Appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury, and improve physiological function and required for a reason other than improving appearance;

1.4.2 In accordance with standards of good medical practice;

1.4.3 Not primarily for the convenience of the enrollee or the enrollee's health care provider, but rendered in the most cost-efficient manner and the appropriate setting;

1.4.4 The most appropriate supply or level of service that can safely be provided to the enrollee; and,

1.4.5 Not experimental or investigational as determined by Health Plan or a Payor under its Experimental Procedures Determination Policy.

1.5 Member. An individual who is eligible to receive Covered Services under a Member Contract. Member includes the subscriber and any of the subscriber's eligible dependents.

1.6 Member Contract. The group or individual Subscription Agreement, Certificate of Insurance, Group Master Agreement, Evidence of Coverage or other contract as amended from time to time between a Payor and an employer, union or Member, which sets forth the terms of the health benefit program.

1.7 Participating Hospital. A Hospital that has entered into a direct or indirect written agreement with a Health Plan to provide Covered Services to Members.

1.8 Participating Provider. A health care provider, including, but not limited to a physician, home health agency, laboratory or other professional, facility, supplier, or vendor that has entered into a direct or indirect written agreement with the Health Plan to provide Covered Services to Members.

1.9 Payor. An entity authorized by a written contract with Health Plan or Coventry Company to access one or more networks of Participating Providers and who or which is liable for funding or underwriting benefit payments under a Member Contract, which entity has a financial responsibility to pay for Covered Services rendered to Members. Payors include Coventry Companies, insurers, employers, unions, associations, corporations, multiple welfare employee arrangements, network, partnerships and third party administrators.

* * *

2. HOSPITAL OBLIGATIONS

2.1 Provision of Covered Services.

2.1.1 Hospital agrees to provide Covered Services to Members of Products on a twenty-four (24) hour per day, seven (7) day per week basis. Hospital shall provide Covered Services in accordance with the Agreement and the bylaws, rules, regulations, policies and procedures of Hospital and its medical staff. Hospital shall not discriminate against a Member on the basis of age, race, color, creed, religion, gender, sexual preference, national origin, health status, use of Covered Services, income level, or on the basis that Member is enrolled in a managed care organization.

* * *

2.6 Claim Submission. Hospital agrees to submit its claims for reimbursement and encounter forms, as required by Health Plan or Payor, on a UB92 Form or Centers for Medicare and Medicaid Services (“CMS”) 1500 forms or successor forms with current CMS coding, current International Classification of Diseases, Ninth Revision (“ICD9”) and Current Procedural Terminology Fourth Edition (“CPT4”) coding in accordance with the then current Medicare guidelines. Hospital shall submit bills within one hundred twenty (120) days of the date of discharge unless coordination of benefit issues exist, or Hospital provides notice to Health Plan or Payor, along with appropriate evidence, of other circumstances outside the control of the Hospital that resulted in the delay.

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Hospital may not bill Health Plan or a Payor for inpatient Covered Services prior to the date of discharge and shall not separate bills for inpatient Covered Services for purposes of additional payments under the Agreement, except when hospitalizations of Member are greater than or equal to sixty (60) days, in which case interim billing is required. Hospital understands and agrees that failure to submit claims in accordance with the requirements of this section may result in the denial of such claims.

* * *

2.9 Permitted Billing of Members. Hospital may bill or charge Members only in the following circumstances: (i) applicable Copayments, Coinsurance, and/or Deductibles not collected at the time that Covered Services are rendered; (ii) Payor, other than Health Plan, becomes insolvent or otherwise fails to pay Hospital in accordance with this Agreement or applicable Federal Law or regulation provided that Hospital has first made all reasonable efforts to obtain payment from Payor; and (iii) services that are not Covered Services only if (a) the Health Plan or Payor confirms that the specific services are not covered, (b) the Member is advised in writing prior to the services being rendered that the specific services may not be Covered Services, and (c) the Member agrees to pay for such services after being so advised. Notwithstanding the foregoing, Hospital may not bill or charge Members enrolled in fully insured products of Health Plan if Health Plan becomes insolvent or otherwise fails to pay Hospital.

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2.9.1 Hospital further agrees that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and a Member or a person acting on Member's behalf.

2.9.2 Any modification, addition, or deletion to the provisions of the Section shall become effective on a date no earlier than sixty (60) days after the State Department of Insurance has received written notice of such change.

2.9.3 Hospital will use best efforts to ensure that all hospital-based physicians, including but not limited to anesthesiologists, radiologists, pathologists and emergency department physicians, agree to accept Health Plan or a Payer's payment as payment in full, subject to applicable copayments, coinsurance and deductibles and to agree to the hold harmless provision contained herein.

* * *

3. HEALTH PLAN/PAYOR OBLIGATIONS

3.1 Payment.

3.1.1 In consideration of Hospital's agreement to perform Covered Services in accordance with the Agreement, Hospital shall be paid for Covered Services performed according to the terms set forth in Exhibit A

attached hereto for Coventry Products and according to the terms set forth in Exhibit B attached hereto for First Health Products. Upon receipt of a Clean Claim, payments shall be made to Hospital in accordance with applicable state law requirements regarding prompt payment. Payor shall pay Hospital in accordance with the terms and conditions of this Agreement and shall pay Clean Claims within the time period permitted by applicable law. Payor acknowledges that under the Provider Agreement, Hospital may refuse to honor the contract rates if Payor does not pay Clean claims within such time frames. In the case of repeated or substantial failure to pay Clean Claims, Hospital may terminate the relationship with the Payor as defined within Section 5.6.

3.1.2 Hospital shall submit its claims for reimbursement, as required by Section 2.6.

3.1.3 Hospital understands and agrees that payment for Covered Services pursuant to the Agreement shall constitute payment in full for all hospital/professional services for which Hospital bills, whether professional or technical in nature.

3.1.4 Health Plan and Payors may reduce or deny payment for services which are not submitted for payment in accordance with the provisions of Section 2.6 or which are not billed or coded in accordance with generally accepted industry standards for hospital billing and coding practices. Health Plan and

Payors may require appropriate documentation and coding to support payment for Covered Services. Hospital shall have the opportunity to correct any billing or coding error within sixty (60) days of denial related to any such claim submission.

* * *

3.2 Identification. With the exception of Worker's Compensation Programs, Health Plan and Payors shall provide an identification card to Members which shall identify whether the Member participates in a Coventry Product or a First Health Product. Set forth in Exhibit C is a listing of the Coventry Product and First Health Product names and logos which will appear on identification cards. In addition the identification card will also identify the Member's benefit plan and the telephone number that Hospital may call to confirm Member's benefit plan, including any limitations or conditions on Covered Services. At such time as Health Plan or a Payor receives an inquiry from Hospital regarding a Member's benefit plan or Covered Services, Health Plan or a Payor shall use information given by Hospital to make preliminary benefit decisions. Health Plan and Payors shall retain the right and sole responsibility to determine whether a service is a Covered Service.

* * *

4. ELIGIBILITY AND AUTHORIZATION.

4.1 Eligibility Determination. Except in the case of provision of Emergency Services, prior to: (i) admitting Members as inpatients; (ii)

performing outpatient services that are included as Covered Services for Members, Hospital shall:

4.1.1 contact Health Plan or a Payor or its designee directly, by phone, and obtain an authorization number during normal business hours, authorizing the performance of Covered Services and confirming the Member's eligibility to receive Covered Services and any limitations or conditions on such Covered Services; and

4.1.2 verify the identity of the Member by requiring the Member to produce his/her Identification Card and another form of identification with a photo whenever possible. If Member is a minor, parent's identification will be acceptable if Member's eligibility is verified with Health Plan or a Payor as set forth in this section. If Member fails to produce an Identification Card, Hospital shall not be penalized for failure to comply with this Section.

4.2 Emergency Services. In cases in which the Hospital determines that Emergency Services are required for a Member, notwithstanding the foregoing, Hospital shall provide such services as are necessary, to evaluate, and if necessary, stabilize the condition of the Member without prior approval from the a [sic] Payor, as required by State and Federal law including EMTALA. Health Plan or a Payor shall pay all reasonably necessary charges associated with the Emergency Services for screening and stabilization; provided that when processing a claim for Emergency Services, a Payor shall consider both

the presenting symptoms and the services provided. If a Member is admitted as an inpatient, Hospital shall notify Health Plan or a Payor of the Emergency Services delivered within twenty-four (24) hours of admission or on the next business day, whichever is later and shall provide, in a timely manner, clinical information relevant to the circumstances of the admission diagnosis and treatment plan. Notwithstanding the foregoing, notification shall be made as promptly as possible upon identification of Health Plan or a Payor as the patient's health insurance.

* * *

6. GENERAL REQUIREMENTS

* * *

6.3 Member Grievances. Hospital agrees to (a) cooperate with and participate in Health Plan's or Payor's applicable appeal, grievance and external review procedures, (b) provide Health Plan or Payor with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees.

* * *

6.8 No Third Party Beneficiaries. Other than as expressly set forth in the Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, without limitation, Members. Nothing in the Agreement shall be construed to create any liability on the part of a Health Plan, Payors, Hospital or their respective directors,

officers, shareholders, employees or agents, as the case may be, to any such third parties for any act or failure to act of any Party hereto.

* * *

6.10 Relationship. None of the provisions of the Agreement is intended to create, nor shall be deemed or construed to create any relationship between the Parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of the Agreement. Neither Hospital nor Health Plan nor any Payor shall be liable to any other Party for any act, or any failure to act, of the other Party to the Agreement. The Parties agree that the Agreement shall be interpreted to be between Hospital and whichever Payor is a party to the Member Contract under which the Member related to the then instant matter in receiving Covered Services.

* * *

INTENDING TO BE BOUND, this Agreement has been duly executed by the authorized representatives of the Parties set forth below as of the date first written above.

App. 87

INTEGRIS Seminole
Medical Center

COVENTRY HEALTH AND
LIFE INSURANCE COMPANY

By: /s/ W. J. Miller

By: /s/ Ann Stoeppelwerth

Print

Print ANN

Name: W. J. Miller

Name: STOEPPELWERTH

Title: CFO

Title: EXECUTIVE
DIRECTOR

Address for Notice:

INTEGRIS Health

5400 N. Independence, Suite 200

Oklahoma City, OK 73112
