The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.ccok.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ccok.com/pdf/SBC/SBCUniformGlossary-2017.pdf or call 1-800-777-4890 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 member/$1,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and physician office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network $3,500 Member/$7,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.ccok.com/directory or 1-800-777-4890 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with you provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit Deductible does not apply	Not covered	None
	Specialist visit	$35 / visit Deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.ccok.com** or by calling 1-877-293-8628.	Preferred generic drugs	$15 Preferred retail $20 Non-Preferred retail $30 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. Some preferred generic drugs have no charge.
	Preferred brand drugs	$40 Preferred retail $50 Non-Preferred retail $80 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand or generic drugs	$70 Preferred retail $90 Non-Preferred retail $140 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and a 90 day supply for mail order. The difference between brand and generic pricing is not covered.
	Specialty drugs	$160 Preferred retail $200 Non-Preferred retail $160 mail order per prescription	Not covered	Covers up to a 30 day supply for retail and mail order. The difference between brand and generic pricing is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 / visit Deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% coinsurance Deductible does not apply	Not covered	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam	No charge Deductible does not apply	Not covered	Limited to one exam in 365 days.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation Services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids (Limited to one for each hearing impaired ear in any 48 month period.)
- Routine eye care (Adult) (limited to 1 visit per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: CommunityCare at 1-800-777-4890 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: CommunityCare at 1-800-777-4890. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/healthreform, or the Oklahoma Insurance Department at 1-800-522-0071.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

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

Language Access Services:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-777-4890.

About these Coverage Examples:

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

Peg is Having a Baby

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

The plan's overall deductible	$500
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$2,790**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$500
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,360**

Mia's Simple Fracture

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

The plan's overall deductible	$500
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$840**

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

Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de CommunityCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-777-4890.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình CommunityCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-777-4890.
Chinese	本通知有重要的訊息。本通知有關於您透過[插入 SBM 項目的名稱 CommunityCare 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。 您可能需要在截止日期之前採取行動，以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入数字1-800-777-4890
Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 CommunityCare 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-777-4890로 전화하십시오.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch CommunityCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-777-4890.
Arabic	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال CommunityCare. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-800-777-4890
Burmese	ဤစာရွက် အေရးႀကီးေသာ အခ်က္အလက္ ပါဝင္ပါသည္။ ဤစာရြက္ သင့္၏ေလွ်ာက္လာ သို႔မဟုတ္ CommunityCare ႏွင့္ သက္ဆိုင္ေသာ သင့္ ခံစားခြင့္ အခ်က္အလက္မ်ား ပါဝင္ပါသည္။ အဓိကရက္စြဲမ်ားကို ဤစာရြက္ရွာေဖြပါ။ သတ္မွတ္ထားေသာ ေနာက္ဆံုးရက္ မတိုင္မီ က်န္းမာေရးခံစားခြင့္ သို႔မဟုတ္ ဈေရိတ္ခံစားခြင့္ ဆက္လက္ရရွိေနေစရန္ ေဆာင္ရြက္ရန္လိုအပ္သည္ကို ေဆာင္ရြက္ပါ။ ဤကိစၥႏွင့္ ပတ္သက္၍ မွန္ကန္ေသာအခ်က္အလက္မ်ားရရွိရန္ ကုန္က်စရိတ္ ေပးရန္မလိုဘဲ မိမိဘာသာစကားျဖင့္ အကူအညီရယူႏိုင္သည္။ 1-800-777-4890။

Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Hmong	**Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm CommunityCare. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 1-800-777-4890.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng CommunityCare. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-777-4890.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de CommunityCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-777-4890.
Laotian	ການແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ການແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບຄຳຮ້ອງຂະ ໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ CommunityCare. ເບິ່ງສາວັນກຳນົດວັນທີ່ສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈຳເປັນຕ້ອງໃຊ້ເວລາດຳເນີນການໂດຍກຳນົດເວລາທີ່ແນ່ນອນ ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-800-777-4890.
Thai	ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน CommunityCare ดูกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-800-777-4890
Urdu	اس اشتہار میں اہم معلومات ہے۔ اس اشتہار میں CommunityCare سے اپ کے درخواست اور خدمات کے بارے میں اہم معلومات ہے۔ اشتہار میں اہم تاریخوں کا نظر کریں۔ ہو سکتا ہے کی صحت کی خدمات کو برقرار رکھنے اور اخراجات کی ادائگی میں مالی مدد ملنے کے لیے، اپ کو خاص تاریخ یا ڈیڈ لائن سے پہلے کچھ کارروائی کرنی پڑے گی۔ اپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ 1-800-777-4890 فون کریں۔
Cherokee	**ᎤᏬᏪᎳᏅᎯ ᏕᏍᏃᏣᏢ ᎤᎾᏫᏍᏗ.** ᎯᎠ ᎤᏬᏪᎳᏅᎯ ᎡᏣᏃᏁᎩ ᏥᏣᏔᎦᏟ ᎡᏣᏠᏯᏍᏛᏗ ᎤᏂᏍᎪᎳᏁᎸ ᎯᏍᏂᏙᏍ ᎡᏣᏎᎩᏍᏛᏍᎩ CommunityCare ᏕᏣᏛᏍᏓᏁᏗᏍᎬ. ᏣᏍᏆᏍᏚᏍᏗ ᏓᏙᏓᏆᏒ ᎯᎠ ᏕᏍᏃᏣᏢ. ᎡᎷᏯ ᎠᏆᏍᏗ ᏦᏥᎦᏗ ᎠᏍ ᏩᎵᏄᏗ ᏍᏂᎬᏪᏍᏓ ᎤᏍᏗᏰᏍ ᏔᏍ ᏥᏍᎠᏍᏆ. ᏙᎯ ᏩᏍᏗ ᎠᏂᎠᏛᏍᏍ ᏩᏍᏗ ᎠᏍ ᏧᎦᏪᎳᏛ ᏢᏒ ᎤᎾᏓᏟᏴᏍᏗ ᏂᏢᏒᎾ ᏩᏰᏪᏗ. ᎠᎴᏍᏓᏪᎳᏅ ᎠᎴᏍᏕᏯᏗ ᎡᏩᏂᏗ ᏃᏊ ᎡᏣᏃᏁᎩᏍᏗ ᏩᏍᏆᏍᏇ ᏩᏍᏔᏂᎯᏍᏗᏍ ᏩᏂᏈ ᏕᏫᏂᎯᏍᏗ ᎡᏢ ᏃᏊ ᏧᎦᏪᏗ ᏂᏢᏒᎾ ᏢᏆᎢ. ᏗᏔᏃᎮᏗ ᏗᎰᏍᏗ ᎯᎠ 1-800-777-4890.
Persian-Farsi	ن اعلامیه حاوی اطلاعات مهم است. این اعلامیه حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق CommunityCare است. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه ای یا کمک در پرداخت هزینه ها نیاز به انجام کارهایی در مهلت مقرر داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. 1-800-777-4890

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

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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

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

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

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