OSEEGIB

Oklahoma State and Education Employees Group Insurance Board

PRE-MEDICARE FORMER EMPLOYEES SURVIVING DEPENDENTS AND COBRA PARTICIPANTS

Option Period Guide

For Plan Year

January 1, 2009 through December 31, 2009

This information is only a brief summary of the plans. All benefits and limitations of these plans are governed in all cases by the relevant plan document, insurance contracts, handbooks, and Rules of the Oklahoma State and Education Employees Group Insurance Board. The Rules of the Oklahoma Administrative Code, Title 360, are controlling in all aspects of Plan benefits. No oral statement of any person shall modify or otherwise affect the benefits, limitations, or exclusions of any plan.

www.sib.ok.gov or www.healthchoiceok.com

You should have already received a schedule of retiree Option Period meetings. If you plan to attend one of these meetings, please bring this Guide with you.

If you are making changes, your Option Period Enrollment/Change Form must be postmarked by November 19, 2008.

If you are not making changes to your coverage, you do not need to return your Option Period Enrollment/Change Form.

Audio CDs and CD versions for PC of the Benefit Guides have been prepared and are available at the Oklahoma Library for the Blind and Physically Handicapped (OLBPH). Contact the OLBPH at 1-405-521-3514, toll-free 1-800-523-0288, and TDD 1-405-521-4672. Text only and pdf versions of the Guide are available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com.

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Oklahoma State and Education Employees Group Insurance Board

Monthly Premiums for Former Employees and Dependents
Plan Year January 1, 2009, through December 31, 2009

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High	$409.12	$587.92	$199.98	$343.10
HealthChoice Basic	$347.96	$503.74	$171.56	$293.44
HealthChoice S-Account	$322.68	$468.90	$162.24	$276.72
Aetna Standard HMO	$668.30	$888.76	$654.90	$654.90
Aetna Alternative HMO	$431.16	$573.40	$422.52	$422.52
CommunityCare Standard HMO	$715.76	$1,023.52	$357.88	$572.60
CommunityCare Alternative HMO	$484.72	$693.14	$242.36	$387.78
GlobalHealth Standard HMO	$333.78	$495.26	$178.98	$285.40
GlobalHealth Alternative HMO	$303.44	$450.28	$162.74	$259.46
PacifiCare Standard HMO	$600.46	$858.64	$300.22	$480.36
PacifiCare Alternative HMO	$388.70	$555.68	$194.20	$310.81
DENTAL PLANS	**MEMBER**	**SPOUSE**	**CHILD**	**CHILDREN**
HealthChoice Dental	$28.58	$28.58	$23.82	$61.84
Assurant Freedom Preferred	$24.84	$24.70	$18.52	$49.80
Assurant Heritage Plus with SBA (Prepaid)	$11.74	$8.86	$7.60	$15.20
Assurant Heritage Secure (Prepaid)	$7.20	$5.98	$5.20	$10.38
CIGNA Dental Care Plan (Prepaid)	$9.26	$6.06	$7.08	$15.32
Delta Dental PPO (POS)	$29.88	$29.90	$26.28	$66.88
Delta's Choice (PPO)	$12.88	$29.48	$29.26	$71.56
VISION PLANS - Voluntary	**MEMBER**	**SPOUSE**	**CHILD**	**CHILDREN**
Humana/CompBenefits VisionCare Plan	$6.76	$5.06	$3.57	$ 4.46
Primary Vision Care Services	$9.25	$8.00	$8.50	$10.75
Superior Vision Services	$6.98	$6.90	$6.60	$ 6.60
UnitedHealthcare Vision	$8.18	$5.79	$4.59	$ 6.98
Vision Service Plan (VSP)	$8.96	$6.00	$5.74	$12.92

LIFE PLAN	PRE-MEDICARE RETIREES/VESTS	
From $5,000 to $40,000	$1.94 Per $1,000	
Age-Rated Life Cost Per $1,000 for $41,000 and Up		
< 30 ---------- $0.05	45 - 49 ------- $0.19	65 - 69 ------- $0.99
30 - 34 ------- $0.05	50 - 54 ------- $0.32	70 - 74 ------- $1.67
35 - 39 ------- $0.08	55 - 59 ------- $0.52	75+ ---------- $2.60
40 - 44 ------- $0.12	60 - 64 ------- $0.60	
DEPENDENT LIFE	$0.97 Per $500 Unit, Per Dependent	

Rates do not reflect any retirement system contribution

By law, the premiums for current employees and pre-Medicare former employees must be the same. For information on how this reduces your premium, see the Frequently Asked Questions section of the HealthChoice website and search for blended rates.

Oklahoma State and Education Employees Group Insurance Board

Monthly Premiums for COBRA Employees and Dependents
Plan Year January 1, 2009, through December 31, 2009

Current and Pre-Medicare Rates				
HEALTH PLANS	**MEMBER**	***SPOUSE**	***CHILD**	***CHILDREN**
HealthChoice High	$417.30	$599.68	$203.98	$349.96
HealthChoice Basic	$354.92	$513.81	$174.99	$299.31
HealthChoice S-Account	$329.13	$478.28	$165.48	$282.25
Aetna Standard HMO	$681.67	$906.54	$668.00	$668.00
Aetna Alternative HMO	$439.78	$584.87	$430.97	$430.97
CommunityCare Standard HMO	$730.08	$1043.99	$365.04	$584.05
CommunityCare Alternative HMO	$494.41	$707.00	$247.21	$395.54
GlobalHealth Standard HMO	$340.46	$505.17	$182.56	$291.11
GlobalHealth Alternative HMO	$309.51	$459.29	$165.99	$264.65
PacifiCare Standard HMO	$612.47	$875.81	$306.22	$489.97
PacifiCare Alternative HMO	$396.47	$566.79	$198.08	$317.03
DENTAL PLANS	**MEMBER**	***SPOUSE**	***CHILD**	***CHILDREN**
HealthChoice Dental	$29.15	$29.15	$24.30	$63.08
Assurant Freedom Preferred	$25.34	$25.19	$18.89	$50.80
Assurant Heritage Plus with SBA (Prepaid)	$11.97	$ 9.04	$ 7.75	$15.50
Assurant Heritage Secure (Prepaid)	$ 7.34	$ 6.10	$ 5.30	$10.59
CIGNA Dental Care Plan (Prepaid)	$ 9.45	$ 6.18	$ 7.22	$15.63
Delta Dental PPO (POS)	$30.48	$30.50	$26.81	$68.22
Delta's Choice (PPO)	$13.14	$30.07	$29.85	$72.99
VISION PLANS	**MEMBER**	***SPOUSE**	***CHILD**	***CHILDREN**
Humana/CompBenefits VisionCare Plan	$6.90	$5.16	$3.64	$ 4.55
Primary Vision Care Services	$9.44	$8.16	$8.67	$10.97
UnitedHealthcare Vision	$8.34	$5.91	$4.68	$ 7.12
Superior Vision Services	$7.12	$7.04	$6.73	$ 6.73
Vision Service Plan (VSP)	$9.14	$6.12	$5.85	$13.18

*** The Rules of the Oklahoma State and Education Employees Group Insurance Board state that for any benefit continued under COBRA, one person must always pay the primary member premium. In cases where a spouse, child, or children are insured under a particular benefit and the member did not retain coverage, one person will always be billed at the primary member rate.**

YOUR OPTION PERIOD ENROLLMENT/CHANGE FORM IS BEING MAILED IN A SEPARATE SECURITY ENVELOPE.

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YOUR FORM MUST BE POSTMARKED BY NOVEMBER 19, 2008

If you are not making any changes, you do not need to return your Option Period Enrollment/ Change Form.

The participating carriers reviewed and approved the information in this material. There is no guarantee that all providers will remain with the plans or have open patient slots all year long. Please verify your provider is still participating in your plan's network.

2009 PLAN YEAR CHANGES

Health Plan Changes

HealthChoice Plans

- The number of visits allowed without prior authorization for **occupational and speech therapy** is being increased to 20 visits. There will be a limit of 60 visits per year for each type of therapy. The maximum of three services per visit is being removed.
- The number of visits allowed without prior authorization for **physical therapy/physical medicine** is being increased from 15 visits to 20 visits. There will be a limit of 60 visits per year. The maximum of three services per visit is being removed.
- The number of visits allowed without prior authorization for **chiropractic therapy** is being increased from 15 visits to 20 visits. There will be a limit of 60 visits per year. The maximum of three services per visit is being removed.
- The health, dental, and life claims administrator for HealthChoice is changing to EDS Administrative Services, LLC. A new health/dental identification card will be sent to all HealthChoice members.
- The precertification administrator is changing to APS.

HealthChoice Pharmacy Benefit

- Most prescription **antihistamines, decongestants,** and **cough suppressants** will no longer be covered medications. This includes all **non-sedating antihistamines** such as Allegra and Clarinex. Contact HealthChoice for more information, see Help Lines at the back of this Guide.
- Members obtaining **specialty pharmacy medications** through Accredo Health Group will now pay the applicable copay for every 30-day fill.

HMOs

- Some of the HMO service areas will be changing. See the HMO ZIP Code listing on pages 8-10.
- Several of the copays will be changing. Please see the Comparison of Benefits for Health Plans on pages 12-19. **Note:** Changes are in **bold text**.

Dental Plan Changes

HealthChoice Dental Plan

- The coinsurance for Network orthodontia services is being changed to 50%.
- The $50 orthodontia deductible for Network services and the $150 orthodontia deductible for non-Network services is being removed.
- The $1,800 lifetime maximum for orthodontia benefits is being removed.

Vision Plan Changes

- CompBenefits VisionCare Plan's name has changed to Humana/CompBenefits VisionCare Plan. The new web address is www.compbenefits.com/custom/stateofoklahoma.

- Spectera Vision's name has changed to UnitedHealthcare Vision. The new web address is www.myuhcvision.com.

Life Insurance Plan Changes

- The premium rating structure for HealthChoice Life Insurance for former employees is changing. The premium for coverage amounts up to $40,000 will be $1.94 per thousand. The premium for coverage amounts above $40,000 will be age-rated. Please see the premium rate chart at the beginnning of this Guide for age-rated premium amounts.

INTRODUCTION

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) has produced this Option Period Guide to assist you in selecting your benefits for plan year 2009. It is only a summary of the plans available to the following members who are not yet eligible for Medicare:

- Former employees and their dependents
- Surviving dependents
- COBRA participants

Helpful Hints For Option Period

- Review section B of your Option Period Enrollment/Change Form. This section lists the coverage you will have effective January 1, 2009, if you do not make any changes during this Option Period.
- **If you do not want to make any changes to your coverage, no further action is necessary and you do NOT need to return your Option Period Enrollment/Change Form.**
- **If you do not make any changes to your coverage, you will not receive a Confirmation Statement from OSEEGIB.** (Keep a copy of your Option Period Enrollment/Change Form as verification of your insurance coverage.)
- Review the premium rates and plan changes for 2009. Premium rates are listed at the front of this Guide and plan changes are listed on pages 2-3 of this Guide.
- Use the following resources to help you decide what coverage you (and your dependents) wish to carry:
  - This Guide
  - Plan websites
  - Customer Service telephone numbers
  - Provider Directories
  - OSEEGIB Member Services
- Decide on the coverage you want for you (and your dependents) for 2009.
- Check the appropriate box(es) in Section C of your Option Period Enrollment/Change Form for the coverage changes you wish to make effective January 1, 2009.
- Complete your Option Period Enrollment/Change Form and return it to OSEEGIB by November 19, 2008.
- Review your Confirmation Statement when you receive it in the mail to verify your coverage is correct.
- Contact HealthChoice Member Services if your Confirmation Statement is not correct.

HEALTH PLAN HIGHLIGHTS

There are 12 health plans available:

- HealthChoice High Option Plan
- HealthChoice Basic Plan
- HealthChoice S-Account Plan
- HealthChoice USA Plan
- Aetna Standard and Alternative HMO
- CommunityCare Standard and Alternative HMO
- GlobalHealth Standard and Alternative HMO
- PacifiCare Standard and Alternative HMO

See Comparison of Benefits for Health Plans on pages 12-19

- All plans have toll-free numbers for customer service, see Help Lines at the back of this Guide.
- To enroll in the HealthChoice S-Account Plan, you must provide OSEEGIB with proof you have set up a Health Savings Account at a bank or other financial institution. This proof must be submitted to OSEEGIB by December 15, 2008.
- You must live within the HMO's ZIP Code service area to be eligible for an HMO. P.O. Box addresses cannot be used to determine your eligibility for an HMO. See pages 8-10 for the HMO ZIP Code list.
- Check with each health plan if you have benefit questions.

HealthChoice USA Plan

- Pre-Medicare retirees who live outside of Oklahoma and Arkansas may be eligible to enroll in HealthChoice USA which includes a national provider network. Call HealthChoice for details, see Help Lines at the back of this Guide.

DENTAL PLAN HIGHLIGHTS

There are seven dental plans available:

- HealthChoice Dental
- Assurant Freedom Preferred
- Assurant Heritage Plus with SBA (Prepaid)
- Assurant Heritage Secure (Prepaid)
- CIGNA Dental Care Plan (Prepaid)
- Delta Dental PPO (POS)
- Delta's Choice (PPO)

See Comparison of Benefits for Dental Plans on pages 20-21

- All plans have toll-free numbers for customer service. See **Help Lines** at the back of this Guide.
- Check with each dental plan if you have benefit questions.

VISION PLAN HIGHLIGHTS

There are five vision plans available:

- Humana/CompBenefits VisionCare Plan
- Primary Vision Care Services(PVCS)
- Superior Vision Services
- UnitedHealthcare Vision (formerly Spectera)
- Vision Service Plan (VSP)

See Comparison of Benefits for Vision Plans on pages 22-23

- All plans have toll-free numbers for customer service, see Help Lines at the back of this Guide.
- All vision plans have limited coverage for services received from non-participating providers.
- Verify your vision provider is a member of the vision plan's network by calling the toll-free number provided, or check each plan's website for the most up-to-date list of providers.
- Check with each vision plan if you have benefit questions.

The loss of your provider on any of the health, dental, or vision plans does not allow a change in plans until the next annual Option Period. You may change providers within your selected plan as needed.

LIFE PLAN OPTIONS

Please take time this Option Period to consider your Life Plan options. Former employees have the following life insurance options:

- Retain your current amount of life insurance
- Reduce your amount of life insurance (in $5,000 increments)
- Reduce your amount of dependent life insurance, if enrolled (in $500 increments)
- Change beneficiaries (not limited to Option Period)

Your Option Period Enrollment/Change Form will indicate the amounts and types of life insurance you currently carry. Please take time to evaluate your coverage for the 2009 plan year. Keep in mind that as a former employee, you cannot reinstate any life insurance that you terminate or decrease.

In the event of your death, life benefits will be paid to your beneficiary(ies); therefore, it is important that you keep your beneficiary designation up to date. You may change your beneficiary designation at any time, but you must file a written request for a change. Beneficiary designation forms are available on our website at www.sib.ok.gov or www.healthchoiceok.com. You may also request this form by calling HealthChoice Member Services, see Help Lines at the back of this Guide. Dependent life proceeds are automatically paid to the member and cannot be assigned or paid to another person.

INSTRUCTIONS AND ELIGIBILITY

Following are the options that former employees (retired, vested, and non-vested), COBRA participants, and surviving dependents have during Option Period:

Former employees and surviving dependents can:

- Change health or dental plans that are already in place
- Drop benefits or dependents
- Decrease life insurance coverage
- Enroll in or change vision plans

COBRA participants can:

- Add dependents and/or change coverage (health, dental, or vision) as long as the former employer participates in that benefit
- Drop benefits or dependents

If you are not making any changes to your coverage, you do NOT need to return your Option Period Enrollment/Change Form. Your current coverage will continue for the 2009 plan year.

The benefits you elect will be in effect from January 1, 2009 through December 31, 2009. Please contact the insurance plans for more information, see Help Lines at the back of this Guide.

After enrollment, the plan(s) you have selected will provide a member handbook or additional material with more information about your benefits. Once enrolled in any of the plans choices, it is your responsibility to review your benefits carefully so you know what is covered and what your plan policies are before you have to use your benefits.

Eligibility for Medicare

If you or one of your dependents will become Medicare eligible on or before January 1, 2009, your plan selections will need to be made from the Option Period guides for Medicare eligible members. For more information or to request a copy of the Guide, contact HealthChoice Member Services, see Help Lines at the back of this Guide.

Dependents

- Dependent children are eligible up to age 25 provided they are unmarried and dependent on you for support. A dependent child may also be covered, regardless of age, if the child is incapable of self-support because of a disability that was diagnosed before the age of 25.
- A dependent who loses eligibility may apply for continuation of coverage under COBRA for a maximum of 36 months. If you have eligibility questions, call HealthChoice Member Services. See the Help Lines pages at the back of this Guide.
- Dropping a dependent from coverage during Option Period is not a COBRA qualifying event.

COBRA Coverage

- COBRA coverage may be available for dependents who become ineligible. Examples of COBRA qualifying events for dependents include:
  - Reaching age 25 (See first bullet under Dependents above)
  - Divorce of a spouse
  - Marriage of a child
  - Death of the covered employee

Don't miss out on important mailings!

Keep your address information up-to-date.

You can use the Change of Address Form available on the HealthChoice website or write a letter advising HealthChoice of your new address including the date of the change, your ID number, and signature.

Mail your completed Change of Address Form or letter to:

OSEEGIB
3545 N.W. 58th Street, Suite 110
Oklahoma City, OK 73112

HMO ZIP Code List

A = Aetna C = CommunityCare G = GlobalHealth P = PacifiCare

HMO ZIP CODE LIST

73002	G P	73058	A C G P	73103	A C G P	73141	A C G P	73193	C G P
73003	A C G P	73059	A G P	73104	A C G P	73142	A C G P	73194	A C G P
73004	A G P	73061	C	73105	A C G P	73143	A C G P	73195	A C G P
73007	A C G P	73063	A C G P	73106	A C G P	73144	A C G P	73196	A C G P
73008	A C G P	73064	A C G P	73107	A C G P	73145	A C G P	73197	A C G P
73010	A G P	73065	A G P	73108	A C G P	73146	A C G P	73198	A C G P
73011	G P	73066	A C G P	73109	A C G P	73147	A C G P	73199	A C G P
73012	A C P	73067	G P	73110	A C G P	73148	A C G P	73432	G
73013	A C G P	73068	A C G P	73111	A C G P	73149	A C G P	73433	G
73014	C G P	73069	A C G P	73112	A C G P	73150	A C G P	73446	G
73016	P	73070	A C G P	73113	A C G P	73151	A C G P	73447	G
73018	G P	73071	A C G P	73114	A C G P	73152	A C G P	73450	G
73019	A C G P	73072	A C G P	73115	A C G P	73153	A C G P	73455	G
73020	A C G P	73073	A C G P	73116	A C G P	73154	A C G P	73460	G
73022	A C G P	73074	G	73117	A C G P	73155	A C G P	73461	G
73023	G	73075	G	73118	A C G P	73156	A C G P	73532	G
73025	A C P	73077	C	73119	A C G P	73157	A C G P	73537	G
73026	A C G P	73078	A C G P	73120	A C G P	73159	A C G P	73544	G
73027	A C G P	73079	G P	73121	A C G P	73160	A C G P	73550	G
73028	A C G P	73080	A G P	73122	A C G P	73162	A C G P	73554	G
73031	A G P	73082	G	73123	A C G P	73163	A C G P	73571	G
73034	A C G P	73083	A C G P	73124	A C G P	73164	C G P	73646	G
73036	A C G P	73084	A C G P	73125	A C G P	73165	A C G P	73658	G
73037	C P	73085	A C G P	73126	A C G P	73167	A C G P	73669	G
73040	G	73089	A G P	73127	A C G P	73169	A C G P	73718	G
73043	G	73090	A C G P	73128	A C G P	73170	A C G P	73724	G
73044	A C G P	73092	G P	73129	A C G P	73172	A C G P	73729	G
73045	A C G P	73093	A G P	73130	A C G P	73173	A C G P	73737	G
73048	G	73095	G P	73131	A C G P	73177	C P	73744	G
73049	A C G P	73096	G	73132	A C G P	73178	A C G P	73747	G
73050	A C G P	73097	A C G P	73134	A C G P	73179	A C G P	73755	G
73051	A C G P	73098	G	73135	A C G P	73180	C P	73757	C
73052	G	73099	A C G P	73136	A C G P	73184	A C G P	73760	G
73054	A C G P	73100	C	73137	A C G P	73185	A C G P	73762	P
73056	A C G P	73101	A C G P	73139	A C G P	73189	A C G P	73763	G
73057	G P	73102	A C G P	73140	A C G P	73190	A C G P	73764	G

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HMO ZIP Code List

A = Aetna C = CommunityCare G = GlobalHealth P = PacifiCare

73768	G	74036	A C G P	74078	C	74136	A C G P	74338	C
73770	G	74037	A C G P	74079	G P	74137	A C G P	74339	C
73772	G	74038	C P	74080	A C G P	74141	A C G P	74340	A C G P
73838	G	74039	A C G P	74081	C P	74145	A C G P	74342	C
74001	C G	74041	C G P	74082	C P	74146	A C G P	74343	C
74002	C G P	74042	C	74083	C	74147	A C G P	74344	C
74003	C	74043	A C G P	74084	C G	74148	A C G P	74345	C
74004	C	74044	C G P	74085	C P	74149	A C G P	74346	C
74005	C	74045	C	74100	C	74150	A C G P	74347	C
74006	C	74046	C G P	74101	A C G P	74152	A C G P	74349	A C G P
74008	A C G P	74047	A C G P	74102	A C G P	74153	A C G P	74350	A C G P
74009	C	74048	C	74103	A C G P	74155	A C G P	74352	A C G P
74010	C G P	74050	A C G P	74104	A C G P	74156	A C G P	74353	C P
74011	A C G P	74051	C	74105	A C G P	74157	A C G P	74354	C
74012	A C G P	74052	C G P	74106	A C G P	74158	A C G P	74355	C
74013	A C G P	74053	A C G P	74107	A C G P	74159	A C G P	74358	C
74014	A C G P	74054	A C G P	74108	A C G P	74169	A C G P	74359	C
74015	A C G P	74055	A C G P	74110	A C G P	74170	A C G P	74360	C
74016	A C G P	74056	C G	74112	A C G P	74171	A C G P	74361	A C G P
74017	A C G P	74058	C	74114	A C G P	74172	A C G P	74362	A C G P
74018	A C G P	74059	C P	74115	A C G P	74182	A C G P	74363	C
74019	A C G P	74060	A C G P	74116	A C G P	74183	A C G P	74364	A C G P
74020	C P	74061	C P	74117	A C G P	74184	A C G	74365	A C G P
74021	A C G P	74062	C P	74119	A C G P	74186	A C G P	74366	A C G P
74022	C	74063	A C G P	74120	A C G P	74187	A C G P	74367	A C G P
74023	C P	74066	A C G P	74121	A C G P	74189	A C G P	74368	C
74026	G P	74067	A C G P	74126	A C G P	74192	A C G P	74369	C
74027	C	74068	C G P	74127	A C G P	74193	A C G P	74370	C
74028	C G P	74070	A C G P	74128	A C G P	74194	A C G P	74401	C
74029	C	74071	C G P	74129	A C G P	74301	C P	74402	C
74030	C G P	74072	C	74130	A C G P	74330	A C G P	74403	C
74031	A C G P	74073	A C G P	74131	A C G P	74331	C	74421	C G P
74032	C P	74074	C P	74132	A C G P	74332	C	74422	C G P
74033	A C G P	74075	C P	74133	A C G P	74333	C	74423	C
74034	C	74076	C P	74134	A C G P	74335	C	74425	C
74035	C G P	74077	C	74135	A C G P	74337	A C G P	74426	C

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HMO ZIP Code List

A = Aetna C = CommunityCare G = GlobalHealth P = PacifiCare

HMO ZIP CODE LIST

74427	C	74468	C	74571	C	74834	G P	74882	P
74428	C	74469	C	74574	C	74835	P	74883	G
74429	A C G P	74470	C	74577	C	74836	G	74884	C G P
74430	C	74471	C	74578	C	74837	C G P	74901	C
74431	C G P	74472	C	74604	C	74838	P	74902	C
74432	C	74477	C G P	74630	C	74839	G	74930	C
74434	C	74501	C	74633	C G	74840	A C G P	74931	C
74435	C	74502	C	74637	C G	74842	G	74932	C
74436	C G P	74521	C	74644	C	74843	G	74935	C
74437	C G P	74522	C	74650	C	74844	G	74936	C
74438	C	74523	C	74651	C	74845	C	74937	C
74439	C	74526	C	74652	C G	74848	G	74939	C
74440	C	74528	C	74727	C	74849	C G P	74940	C
74441	C	74529	C	74735	C	74850	G	74941	C
74442	C	74530	G	74738	C	74851	A C G P	74942	C
74444	C	74531	G	74743	C	74852	A C G P	74943	C
74445	C G P	74536	C	74748	G	74854	A C G P	74944	C
74446	C G P	74543	C	74756	C	74855	A G P	74945	C
74447	C G P	74545	C	74759	C	74856	G	74946	C
74450	C	74546	C	74760	C	74857	A C G P	74947	C
74451	C	74547	C	74761	C	74859	G P	74948	C
74452	C	74548	C	74801	A C G P	74860	P	74949	C
74454	C G P	74549	C	74802	A C G P	74862	P	74951	C
74455	C	74552	C	74804	A C G P	74864	G P	74953	C
74456	C G P	74553	C	74818	C G P	74865	G	74954	C
74457	C	74554	C	74820	G	74866	A C G P	74955	C
74458	C G P	74557	C	74821	G	74867	C G P	74956	C
74459	C	74558	C	74824	G P	74868	C G P	74959	C
74460	C G P	74559	C	74825	G	74869	A G P	74960	C
74461	C	74560	C	74826	A C G P	74871	G	74962	C
74462	C	74561	C	74827	G	74872	G	74964	C
74463	C	74562	C	74829	P	74873	A C G P	74965	C
74464	C	74563	C	74830	C G P	74875	G P	74966	C
74465	C	74565	C	74831	A P	74878	A C G P		
74466	C P	74567	C	74832	G P	74880	G P		
74467	C G P	74570	G	74833	P	74881	A G P		

Summary of Health Plan Deductibles and Out-of-Pocket Amounts

Health Plans	Annual Health Plan Deductible (Network)	Annual Out-of-Pocket
HealthChoice High	$500/Individual	$2,800/Individual – Network $3,300/Individual – Non-Network + amounts above allowed charges
	$1,500/Family	No Family Maximum Out-of-Pocket
HealthChoice Basic	$500/Individual	$5,500/Individual
	$1,000/Family	$11,000/Family
HealthChoice S-Account*	$1,500/Individual (Applies to medical and pharmacy)	$4,000/Individual
	$3,000/Family (Applies to medical and pharmacy)	$8,000/Family
All Standard HMO Plans	$0/Individual	$2,000/Individual
	$0/Family	$4,000/Family
All Alternative HMO Plans	$0/Individual	See the Comparison of Benefits for Health Plans on the next page
	$0/Family	

*** Individual or family deductible must be met before benefits are paid. Also, the individual or family out-of-pocket amount must be met before the plan pays 100% of Allowed Charges for the calendar year.**

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Calendar Year Deductibles	$500 individual $1,500 family	$500 individual $1,000 family Deductible applied after Plan pays first $500 of Allowed Charges	The combined medical and pharmacy deductible must be met before benefits are paid. $1,500 individual $3,000 family	No deductible
Calendar Year Out-of-Pocket Maximum	$2,800 Network, individual $3,300 + amounts over Allowed Charges non-Network, individual	$5,500 individual $11,000 family	$4,000 individual $8,000 family Non-Network charges do not apply	**$2,000 individual** **$4,000 family**
Office Visit (Professional Services)	$25 copay	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan **For Network services:** •$0 of Allowed Charges through first $500 •100% through next $500 of deductible (only Allowed Charges apply to the deductible) •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $11,000 •You may use non-Network providers, but it will be more costly	Member pays 100% of Allowed Charges until deductible is met $25 copay applies after deductible	**$25 copay/PCP** $35 copay/specialist
Diagnostic X-ray and Lab	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	No copay/laboratory services or outpatient radiology $100 copay per MRI, CAT, MRA, or PET scan
Hospital Inpatient Admission	20% of Allowed Charges after deductible Additional $300 non-Network deductible per admission		20% of Allowed Charges after deductible Additional $300 non-Network deductible per admission	**$250 copay** Preauthorization required
Hospital Outpatient Visit	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	**$175 copay** Preauthorization required
Skilled Nursing Facility	20% of Allowed Charges after deductible Precertification required Limit: 100 days per year		20% of Allowed Charges after deductible Precertification required Limit: 100 days per year	No copay Limit: 100 days per year
Immunizations	No charge for well-baby and adult immunizations $25 office visit copay and/or administration fee may apply		No charge for well-baby and adult immunizations $25 office visit copay and/or administration fee may apply	$0 copay/birth through age 18 $10 copay/ages 19 and over

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See Help Lines at the back of this Guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
No deductible	No deductible	No deductible	No deductible	Calendar Year Deductibles
$3,000 individual **$6,000** family	**$2,500** individual **$5,000** family	**$3,000** individual **$5,000** family	$2,000 individual $4,000 family	Calendar Year Out-of-Pocket Maximum
$30 copay/PCP **$45 copay**/specialist	**$30 copay**/PCP **$45 copay**/specialist	$25 copay/PCP **$50 copay**/specialist	**$30 copay**/PCP $50 copay/specialist	Office Visit (Professional Services)
$45 copay	No additional copay/ laboratory services or outpatient radiology $100 copay per MRI, CAT, MRA, or PET scan	$0 copay Specialty scans (MRI, CAT, PET, etc.) $250 copay per scan	$0 copay/standard lab and radiology **$300 copay** per MRI, MRA, PET, or CAT	Diagnostic X-ray and Lab
$500 copay Preauthorization required	**$350 copay**	$250 copay per day **$750 maximum per admission**	**$1,000 copay**/ admission	Hospital Inpatient Admission
$300 copay	**$200 copay**	**$250 copay**	$500 copay	Hospital Outpatient Visit
$0 copay Limit: 100 days per year	No copay Limit: 60 days per disability	No copay Limit: 100 days	$500 copay per day $1,500 maximum per admission Limit: 100 consecutive days	Skilled Nursing Facility
$0 copay/birth through age 18 $10 copay/ages 19 and over	$0 copay/ages birth through 18 years $25 copay/ages 19 and over	$0 copay/birth to age 18 $25 copay/PCP office visit for adults Standard copays may apply in conjunction with office visit	$0 copay/birth through age 18 (if no other service is rendered) **$30 copay**/PCP **$50 copay**/specialist ages 19 and over	Immunizations

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See Help Lines at the back of this Guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Periodic Health Exams	$25 copay per exam 1 mammogram at no charge for women age 40 and over	1 mammogram at no charge for women age 40 and over Women under 40 pay $25 copay •Office visit copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan **For Network services:** •$0 of Allowed Charges through first $500 •100% through next $500 of deductible (only Allowed Charges apply to the deductible) •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $11,000 •You may use non-Network providers, but it will be more costly	20% of Allowed Charges after deductible 1 mammogram at no charge for women age 40 and over	$10 copay per visit for routine physicals
Allergy Treatment and Testing	20% of Allowed Charges after deductible Limit: 60 tests every 24 months		20% of Allowed Charges after deductible Limit: 60 tests every 24 months	**$25 copay/PCP** $35 copay/specialist **$25 for 6 week supply of antigen (including shots)**
Emergency Health Care Facility Visit	20% of Allowed Charges after deductible Additional $100 ER deductible; waived if admitted		20% of Allowed Charges after deductible Additional $100 ER deductible; waived if admitted	**$125 copay**; waived if admitted
After Hours Urgent Care	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	**$35 copay**
Mental Health or Substance Abuse Inpatient Admission*	20% of Allowed Charges after deductible Limit: 30 days per year		20% of Allowed Charges after deductible Limit: 30 days per year	**$250 copay** Limit: 30 days per year
Mental Health or Substance Abuse Outpatient Visit*	20% of Allowed Charges after deductible Limit: 26 visits per year		20% of Allowed Charges after deductible Limit: 26 visits per year	**$25 copay**/PCP $35 copay/specialist Limit: 26 visits per year
Durable Medical Equipment (DME)	20% of Allowed Charges after deductible For purchase, rental, repair, or replacement		20% of Allowed Charges after deductible For purchase, rental, repair, or replacement	20% coinsurance initial device 20% coinsurance repair and replacement

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See Help Lines at the back of this Guide for contact information.

*Mental Health Parity provides that certain biological conditions for severe mental illness are not limited as other mental health conditions. This does not apply to substance abuse.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
$10 copay for adults	$25 copay	$25 copay/PCP Limit: 1 per year	**$30 copay/PCP** $50 copay/specialist	Periodic Health Exams
$20 copay per visit $20 copay for 6 week supply of antigen (including shots)	**$30 copay**/PCP visit **$45 copay**/specialist visit **$30 copay** for 6 week supply of serum (including shots)	$25 copay/PCP visit **$50 copay**/specialist **$30 copay** for 6 week supply of antigen (including shots)	**$30 copay/PCP** $50 copay/specialist	Allergy Treatment and Testing
$150 copay	**$150 copay; waived if admitted**	**$150 copay; waived if admitted**	**$200 copay; waived if admitted**	Emergency Health Care Facility Visit
$75 copay	**$35 copay** per visit	$25 copay/PCP **$50 copay**/all others	**$30 copay**/PCP $50 copay/specialist	After Hours Urgent Care
$500 copay Limit: 30 days per calendar year	$400 copay Limit: 30 days per year	$250 per day **$750 maximum per admission** Limit: 30 days per year	**$1,000 copay**/admission Limit: 30 consecutive days per year	Mental Health or Substance Abuse Inpatient Admission*
$45 copay Limit: 26 visits per calendar year	**$30 copay**/PCP **$45 copay**/specialist Limit: 26 visits per year	**$50 copay** Limit: 26 visits per year	**$30 copay/PCP** $50 copay/specialist Limit: 26 visits per year	Mental Health or Substance Abuse Outpatient Visit*
20% of contracted rate	20% coinsurance	20% coinsurance $5,000 annual maximum	20% coinsurance Limit: $10,000 per year	Durable Medical Equipment (DME)

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See Help Lines at the back of this Guide for contact information.

*Mental Health Parity provides that certain biological conditions for severe mental illness are not limited as other mental health conditions. This does not apply to substance abuse.

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Occupational or Speech Therapy Visit	20% of Allowed Charges after deductible Each service limited to 20 visits per year without prior authorization Each service limited to 60 visits per year	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan **For Network services:** •$0 of Allowed Charges through first $500 •100% through next $500 of deductible (only Allowed Charges apply to the deductible) •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $11,000 •You may use non-Network providers, but it will be more costly	20% of Allowed Charges after deductible Each service limited to 20 visits per year without prior authorization Each service limited to 60 visits per year	No copay inpatient **$25 copay**/PCP $35 copay/specialist Limit: 60 treatment days per course of therapy
Physical Therapy/ Physical Medicine Visit	20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Limited to 60 visits per year		20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Limited to 60 visits per year	No copay inpatient **$25 copay**/PCP $35 copay/specialist Limit: 60 treatment days per course of therapy
Chiropractic and Manipulative Therapy Visit	**Chiropractic services only**: 20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization; **for manipulative therapy, see Physical Therapy/ Physical Medicine** Limited to 60 visits per year		**Chiropractic services only**: 20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization; **for manipulative therapy, see Physical Therapy/ Physical Medicine** Limited to 60 visits per year	$35 copay Limit: 15 visits per year PCP referral required
Hospice	20% of Allowed Charges after deductible for terminal illness of 6 months or less Requires prior authorization or penalty applies		20% of Allowed Charges for terminal illness of 6 months or less Requires prior authorization or penalty applies	No copay
Hearing Screening and Hearing Aids	$25 copay/basic hearing screening Limit: 1 per year Hearing aids covered for children up to age 18 as durable medical equipment		$25 copay after deductible/basic hearing screening Limit: 1 per year Hearing aids covered for children up to age 18 as durable medical equipment	**$25 copay** Limit: 1 per year Hearing aids – 20% coinsurance for children up to age 18

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See Help Lines at the back of this Guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
No copay/inpatient **$45 copay**/outpatient therapy Limit: 60 consecutive days per course of therapy	No copay/inpatient **$45 copay** outpatient therapy Limit: 60 days per disability	No copay/inpatient **$50 copay** per outpatient visit Limit: 60 consecutive days per illness or injury	**$1,000 copay inpatient** Outpatient - **$30 copay/PCP** $50 copay/ specialist Limit: 60 days per episode	Occupational or Speech Therapy Visit
$45 copay/outpatient therapy Limit: 60 consecutive days per course of therapy	No copay/inpatient **$45 copay** outpatient therapy Limit: 60 days per disability	No copay/inpatient **$50 copay** per outpatient visit Limit: 60 consecutive days per illness or injury	**$1,000 copay inpatient** Outpatient - **$30 copay/PCP** $50 copay/ specialist Limit: 60 days per episode	Physical Therapy/ Physical Medicine Visit
$45 per visit Limit: 15 visits per calendar year	**$45 copay** Limit: 15 visits per year	**$50 copay** Limit: 15 visits per year – referral required	$20 copay Limit: 15 visits per year - referral required Limited to treatment of neurological and orthopedic conditions	Chiropractic and Manipulative Therapy Visit
No copay	No copay	No copay For terminal illness of 6 months or less Preapproval required	$50 copay per visit	Hospice
$10 copay Hearing aids covered for children up to age 18; limit 1 per ear every 48 months	**$30 copay** Limit: 1 per year Hearing aids – 20% coinsurance for children up to age 18	$25 copay per visit Limit: 1 visit per year Hearing aids – 20% coinsurance Limit: $5,000 combined DME, orthotics, and prosthetics Covered for children up to age 18	**$30 copay/PCP** $50 copay/specialist Hearing aids – covered for children up to age 18	Hearing Screening and Hearing Aids

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See Help Lines at the back of this Guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option and HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Pharmacy Benefits	**NETWORK:** **Generic Mandate** **Preferred Medication:** ♦ The cost of medication is $100 or less - You pay up to $25 or actual cost if less ♦ The cost of medication is more than $100 - You pay 25% up to a $50 maximum ♦ Out-of-pocket maximum - $2,500 per person using Preferred products at Network pharmacies, then you pay $0 **Non-Preferred Medication:** ♦ The cost of medication is $100 or less - You pay up to $50 or actual cost if less ♦ The cost of medication is more than $100 - You pay 50% up to a $100 maximum ♦ Out-of-pocket maximums do not apply to non-Preferred medications **NOTE**: ♦ Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater. ♦ Some medications may have a limit on quantity and/or duration of therapy. ♦ Some medications require prior authorization. Specialty medications are covered when ordered through Accredo Health Group. ♦ HealthChoice Health Plans offer each covered individual a lifetime pharmacy benefit of $2,000,000. If you choose a brand-name medication when a generic is available, you will be responsible for the difference in cost, **plus** the copay **NON-NETWORK:** **Preferred Medication:** ♦ You pay the cost of medication up to a $75 maximum plus a dispensing fee **Non-Preferred Medication:** ♦ You pay the cost of medication up to a $125 maximum plus a dispensing fee	After the combined medical and pharmacy $1,500 individual and/or $3,000 family deductible has been met, the pharmacy benefits are: **NETWORK:** **Generic Mandate** **Preferred Medication:** ♦ The cost of medication is $100 or less - You pay up to $25 or actual cost if less ♦ The cost of medication is more than $100 - You pay 25% up to a $50 maximum **Non-Preferred Medication:** ♦ The cost of medication is $100 or less - You pay up to $50 or actual cost if less ♦ The cost of medication is more than $100 - You pay 50% up to a $100 maximum **NOTE**: ♦ Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater. ♦ Some medications may have a limit on quantity and/or duration of therapy. ♦ Some medications require prior authorization. Specialty medications are covered when ordered through Accredo Health Group. ♦ HealthChoice Health Plans offer each covered individual a lifetime pharmacy benefit of $2,000,000. If you choose a brand-name medication when a generic is available, you will be responsible for the difference in cost, **plus** the copay **NON-NETWORK:** **Preferred Medication:** ♦ You pay the cost of medication up to a $75 maximum plus a dispensing fee **Non-Preferred Medication:** ♦ You pay the cost of medication up to a $125 maximum plus a dispensing fee	Up to $10 generic formulary **Up to $30 brand formulary (when no generic is available)** **Up to $50 brand formulary (when generic is available)** Greater of a 30-day supply or 100 units Certain medications have restricted quantities Mail order may be available, see Plans for details **Please note:** Tier categories will be determined by each HMO based on their own formulary design

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
Tier 1: $20 **Tier 2: $40** **Tier 3: $70** Mail order 90-day supply: **$40 copay** for formulary generic drugs **$80 copay** for formulary drugs **$140 copay** for non-formulary brand name and non-formulary generic drugs Greater of a 30-day supply or 100 units Certain medications have restricted quantities	Tier 1: $10 **Tier 2: $40** **Tier 3: $65** Greater of a 30-day supply or 100 units Certain medications may have restricted quantities These copays do not apply to the maximum out-of-pocket	Tier 1: $10 **Tier 2: $50** **Tier 3: $75** Greater of a 30-day supply or 100 units Certain medications may have restricted quantities These copays do not apply to the maximum out-of-pocket	**$10 copay** for formulary generic drugs **$30 copay** for formulary brand-name drugs **$50 copay** for non-formulary generic and non-formulary brand drugs 30-day supply or 100 units Certain medications have restricted quantities	**Pharmacy Benefits**

PHARMACY

COMPARISON OF BENEFITS FOR DENTAL PLANS

	HEALTHCHOICE DENTAL	CIGNA DENTAL CARE PLAN (PREPAID)	ASSURANT FREEDOM PREFERRED
ANNUAL DEDUCTIBLE	♦ Network: $25 Basic and Major ♦ Non-Network: $25 Preventive, Basic, and Major	♦ No deductibles or plan maximums ♦ $5 office copay applies	♦ $25 per person, per calendar year, waived for preventive services in-network
PREVENTIVE CARE Allowed Charges apply	♦ Network: 100% ♦ Non-Network: 100% of Allowed Charges after deductible ♦ No charge for topical fluoride application (up to age 16)	♦ Sealant: $15 per tooth ♦ No charge for routine cleaning once every 6 months ♦No charge for topical fluoride application (through age 18) ♦No charge for periodic oral evaluations	100% of usual and customary with no deductible when in-network
BASIC CARE Allowed Charges apply	♦ Network: 85% ♦ Non-Network: 70% Deductible applies	♦ Amalgam: 1 surface, permanent teeth $20	♦ Network: 85% ♦ Non-Network: 70% Plan pays 85% of usual and customary when in-network, deductible applies
MAJOR CARE Allowed Charges apply	♦ Network: 60% ♦ Non-Network: 50% Deductible applies	♦ Root canal, anterior: $325 ♦ Periodontal/scaling/root planing 1-3 teeth (per quadrant): $65	♦ Network: 60% ♦ Non-Network: 50% Plan pays 60% of usual and customary when in-network, deductible applies
ORTHODONTIC CARE Allowed Charges apply	♦ Network: 50% ♦ Non-Network: 50% ♦12 month waiting period ♦No lifetime maximum for Network or non-Network	♦ $2,100 out-of-pocket for child through age 18 ♦ $2,900 out-of-pocket for adult 24 month treatment excludes orthodontic treatment plan and banding	♦ Network: 60% ♦ Non-Network: 50% Up to $1,800 lifetime maximum for members under age 19
PLAN YEAR MAXIMUM	♦ Network and non-Network $2,000	♦ No calendar year maximum	♦ $2,000
FILING CLAIMS	♦ Network: No claims to file ♦ Non-Network: You file claims	♦ No claims to file	♦ Member/provider must file claims

COMPARISON OF BENEFITS FOR DENTAL PLANS

Assurant Prepaid Plans Heritage Plus with SBA and Heritage Secure	Delta Dental PPO – *"Point of Service"*		Delta's Choice – PPO
	PPO Network	Premier Network and Non-Network	PPO Network
♦ No deductibles	♦ $25 per person, per calendar year applies to Basic and Major Care only	♦ $100 per person, per calendar year applies to all care except Orthodontic Care (Level 4)	♦ $100 per person, per calendar year applies to Major Care (Level 4) only
♦ No charge for routine cleaning (once every 6 months) ♦No charge for topical fluoride application (up to age 18) ♦No charge for periodic oral evaluations	♦ Plan pays 100% of allowable amounts	♦ Plan pays 100% of allowable amounts after deductible	Schedule of covered services and enrollee copays. Copay examples: ♦ Routine cleaning: $5 ♦ Periodic oral evaluations: $5 ♦ Topical fluoride application (up to age 19): $5
♦ Fillings ♦ Minor oral surgery Refer to the copayment schedule for each plan	♦ Plan pays 85% of allowable amounts after deductible	♦ Plan pays 70% of allowable amounts after deductible	Schedule of covered services and enrollee copays. Copay examples: ♦ Amalgam: 1 surface, permanent teeth $12
♦ Root canal ♦ Periodontal ♦ Crowns Refer to the copayment schedule for each plan	♦ Plan pays 60% of allowable amounts after deductible	♦ Plan pays 50% of allowable amounts after deductible	Schedule of covered services and enrollee copays. Copay examples: ♦ Crown: porcelain/ceramic substrate $241 ♦ Complete denture: maxillary $320
♦ 25% discount ♦ Adults and Children	♦ Plan pays 60% of allowable amounts, up to lifetime maximum of $1,800	♦ Plan pays 60% of allowable amounts, up to lifetime maximum of $1,800	♦ You pay amounts in excess of $50 per month ♦ Lifetime maximum of $1,800
♦No annual maximum for general dentist	♦ $2,000 per person, per calendar year	♦ $2,000 per person, per calendar year	♦ $2,000 per person, per calendar year
♦ No claims to file	♦ Claims are filed by participating dentists	♦ Claims are filed by participating dentists	♦ Claims are filed by participating dentists

COMPARISON OF BENEFITS FOR VISION PLANS

	Humana/CompBenefits VisionCare Plan		Primary Vision Care Services, Inc.	
Covered Services	In-Network	Out-of-Network	In-Network	Out-of-Network*
Eye Exams	$10 copay One exam for eyeglasses or contacts every calendar year	Copays do not apply Plan pays up to $35; One exam every calendar year	$0 copay No limit on exams per year	Exam fee reimbursed up to $40 One exam every calendar year
Lenses Each Pair	$25 material copay applies to lenses and/or frames (single, lined bifocal, trifocal, lenticular covered at 100%). Progressive at wholesale cost. One pair of lenses every calendar year	Plan pays up to: $25 single $40 bifocals $60 trifocals $100 lenticular One pair of lenses every calendar year	You pay wholesale cost with no limit on number of pairs	Fees reimbursed up to $40-$60 for one set of lenses and frames
Frames	$25 material copay applies to lenses and/or frames. $45 wholesale frame allowance. One set of frames every calendar year	Copay does not apply Plan pays up to $45 One set of frames every calendar year	You pay wholesale cost with no limit on number of pairs	Fees reimbursed up to $40-$60 for one set of lenses and frames
Contact Lenses	$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits Medically necessary, Plan pays 100% One set of contacts every calendar year	$130 allowance for exam, contacts, and fitting fee in lieu of all other benefits Medically necessary, Plan pays $210 One set of contacts every calendar year	You pay wholesale cost for an annual supply of contacts. For 1st time fittings, $50 copay on soft lens and $75 copay on all rigid gas permeable lenses	Fees reimbursed up to $60 One set annually (in lieu of glasses)
Laser Vision Correction	$895 copay conventional $1,295 copay custom $1,895 copay custom plus bladeless when services are rendered by a TLC Network Provider	No benefit	Discounted laser refractive surgery at multiple state locations	No benefit

All vision plan benefits are based on a calendar year instead of a 12-month basis

***Out-of-Network limited to one eye exam and one set of eyeglasses or contact lenses annually. Cannot be used with In-Network services.**

COMPARISON OF BENEFITS FOR VISION PLANS

Superior Vision Services		UnitedHealthcare Vision		Vision Service Plan (VSP)	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
$10 copay One exam every calendar year	OD-$26 max MD-$34 max	$10 copay One exam every calendar year	Plan pays up to $40	$10 copay One exam every calendar year	$10 copay Plan pays up to $35
$25 copay One pair of lenses every calendar year	Plan pays up to: $26 single $39 bifocals $49 trifocals $78 lenticular	$25 copay One pair of lenses every calendar year	Plan pays up to: $40 single $60 bifocals $80 trifocals $80 lenticular	$25 copay* One set of lenses every calendar year Polycarbonate lenses covered in full for dependent children	$25 copay* Plan pays up to: $25 single $40 bifocals $55 trifocals $80 lenticular
$25 copay Plan pays up to $125 One set of frames every calendar year	Plan pays up to $68	$25 copay One set of frames every calendar year	Plan pays up to $45	$25 copay* One frame per calendar year, $120 allowance. 20% off any out-of-pocket costs above the allowance	$25 copay* Plan pays up to $45
$0 copay Plan pays up to $120 Medically necessary contacts are covered in full (in lieu of glasses)	$0 copay Plan pays up to $100 For medically necessary contacts, Plan pays up to $210 (in lieu of glasses)	$25 copay covers fitting/evaluation fees, contacts (including disposables) and up to 2 follow-up visits (in lieu of glasses)	Plan pays up to $150 For medically necessary contacts, Plan pays up to $210 (in lieu of glasses)	$0 copay $120 allowance applied to the cost of your contact lens exam and the contact lenses. 15% discount on contact lens exam (in lieu of glasses)	$0 copay Plan pays up to $105 for disposable or conventional contact lenses (in lieu of glasses)
20% off retail price	No benefit	Members have access to discounted refractive eye surgery from numerous provider locations throughout the U.S.	No benefit	Laser vision correction services (PRK, LASIK, and Custom LASIK) are provided at a reduced cost through VSP's contracted laser surgery centers	No benefit

All vision plan benefits are based on a calendar year instead of a 12-month basis

***Benefit includes an annual $25 materials copay on lenses or frames, but not both. Contact VSP for information on the added value discounts. See the Help Lines.**

NOTICE OF CREDITABLE COVERAGE

What You Should Know About Creditable Coverage

If you're a former employee who is already eligible or who will soon become eligible for Medicare, you may be hearing a lot about Medicare Part D prescription drug plans and Creditable Coverage.

The term Creditable Coverage simply means that the prescription drug benefits of an insurance plan meet certain standards that have been set by the Centers for Medicare and Medicaid Services (CMS).

HealthChoice is federally contracted to provide Medicare Part D prescription drug benefits through our Medicare Supplement Plans. All HealthChoice prescription drug benefits meet or exceed the standards set by CMS; therefore, the HealthChoice plans provide our members with Creditable Coverage.

All the HMOs and alternate Medicare plans offered through the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), such as the Medicare Advantage-Prescription Drug Plans (MA-PD) provide Creditable Coverage.

Since you have Creditable Coverage through HealthChoice, or through one of the alternative plans offered through the Oklahoma State and Education Employees Group Insurance Board, you will not be subject to Medicare's late enrollment penalty if you decide to drop your coverage through OSEEGIB and enroll in another Medicare Part D prescription drug plan.

For more information about Creditable Coverage, contact HealthChoice Member Services, see Help Lines at the back of this Guide.

Nearing Medicare Eligibility

About two months before you or one of your eligible dependents turns 65, OSEEGIB will send you a letter that explains the Medicare plan options available to you.

The letter will also include instructions on how to enroll with a Medicare Supplement or Medicare Advantage Prescription Drug plan. If you or one of your dependents is soon becoming Medicare eligible, watch your mail for important information about enrollment.

HELP LINES

HEALTHCHOICE HELP LINES

Health, Dental, and Life Claims, Benefits, Verification of Coverage, and ID Cards

Oklahoma City Area 1-405-416-1800

All Other Areas 1-800-782-5218

TDD Oklahoma City Area 1-405-416-1525

TDD All Other Areas 1-800-941-2160

Website www.sib.ok.gov or www.healthchoiceok.com

Pharmacy Claims/Pharmacy ID Cards

All Areas 1-800-903-8113

TDD All Areas 1-800-825-1230

Precertification

All Areas 1-800-848-8121

TDD All Areas 1-877-267-6367

Member Services/Provider Directory

Oklahoma City Area 1-405-717-8780

All Other Areas 1-800-752-9475

TDD 1-405-949-2281

TDD All Areas 1-866-447-0436

HealthChoice USA

Customer Service and Claims 1-800-782-5218

Provider Information 1-877-877-0715 ext. 4059

TDD All Areas 1-800-941-2160

Website www.choicecarenetwork.com

HELP LINES

HMO PLANS' HELP LINES

Aetna

All Areas 1-800-949-3104

TDD All Areas 1-800-628-3323

Website www.aetna.com/okstateemployees/

CommunityCare

All Areas 1-800-777-4890

TDD All Areas 1-800-722-0353

Website www.ccok.com

GlobalHealth, Inc.

Oklahoma City Area 1-405-280-2990

All Other Areas 1-877-280-2990

TDD All Areas 1-800-522-8506

Website www.globalhealth.cc

PacifiCare

All Areas 1-800-825-9355

TDD All Areas 1-800-557-7595

Website www.pacificare.com

DENTAL PLANS' HELP LINES

Assurant, Inc. Dental

Prepaid Plan 1-800-443-2995

Indemnity Plan 1-800-442-7742

Website www.assurantemployeebenefits.com

CIGNA Prepaid Dental

All Areas 1-800-367-1037

Hearing Impaired Relay Svc 1-405-948-3303

Website www.cigna.com

Delta Dental

Oklahoma City Area 1-405-607-2100

All Other Areas 1-800-522-0188

Website www.deltadentalok.org/state_employees/

HELP LINES

VISION PLANS' HELP LINES

Humana/CompBenefits

All Areas 1-800-865-3676

TDD All Areas 1-877-553-4327

Website www.compbenefits.com/custom/stateofoklahoma

Primary Vision Care Services

All Areas 1-888-357-6912

TDD All Areas 1-800-722-0353

Website www.pvcs-usa.com

Superior Vision Services

All Areas 1-800-507-3800

TDD 1-916-852-2382

Website www.superiorvision.com

UnitedHealthcare Vision

All Areas 1-800-638-3120

TDD All Areas 1-800-524-3157

Website www.myuhcvision.com

Vision Service Plan (VSP)

All Areas 1-800-877-7195

TDD All Areas 1-800-428-4833

Website www.vsp.com

HealthChoice

3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112
www.sib.ok.gov or www.healthchoiceok.com
Phone Number - 405-717-8780
Toll Free - 1-800-752-9475
Hearing Impaired - 405-949-2281
Toll Free Hearing Impaired - 1-866-447-0436

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