OSEEGIB
Oklahoma State and Education
Employees Group Insurance Board

Employee Benefit Options Guide

Plan Year 2010

January 1 through December 31, 2010

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

#2221

Update to Printed Version of This Guide

Update to the Health Plan Changes on page ii:

- The new local number for GlobalHealth is 1-405-280-5600.

Basic Life...For You on page 3 - first bullet

- You may enroll in Basic Life during Option Period without a *Life Insurance Application*. Mark the appropriate box on your *Option Period Enrollment/Change Form*.

The following ZIP Codes were not available from GlobalHealth HMO when this guide went to print. There are five additional ZIP Codes in the GlobalHealth service area. They are:

- 73401
- 73402
- 73403
- 74401
- 74402

Oklahoma State and Education Employees Group Insurance Board

Monthly Premiums for Current Employees

Plan Year January 1, 2010 - December 31, 2010

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High	$442.80	$625.88	$228.32	$342.44
HealthChoice Basic	$384.22	$546.84	$200.36	$300.88
HealthChoice S-Account	$365.80	$513.68	$190.32	$283.98
HealthChoice USA	$678.57	$678.57	$226.33	$339.31
Aetna Standard HMO	$715.40	$951.38	$488.78	$782.04
Aetna Alternative HMO	$502.32	$668.02	$343.20	$549.12
CommunityCare Standard HMO	$775.08	$1,108.34	$387.54	$620.06
CommunityCare Alternative HMO	$534.54	$764.38	$267.28	$427.64
GlobalHealth Standard HMO	$344.18	$510.70	$184.56	$294.30
GlobalHealth Alternative HMO	$312.90	$464.30	$167.82	$267.54
PacifiCare Standard HMO	$605.20	$870.16	$302.38	$483.92
PacifiCare Alternative HMO	$417.38	$600.10	$208.52	$333.72
DISABILITY (Employee only)		$9.10 (Limited county participation only)		

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice Dental	$30.28	$30.28	$25.24	$65.50
Assurant Freedom Preferred	$26.33	$26.18	$19.63	$52.79
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)	$30.48	$30.50	$26.80	$68.22
Delta's Choice (PPO)	$13.40	$30.44	$30.68	$74.46

VISION PLANS - Employee Paid	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 Plan	$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		
HealthChoice Basic Life ($20,000) $4.56	First $20,000 of Supplemental Life $4.56	
Age-Rated Supplemental Life – Cost Per $20,000		
< 30 ---------- $1.00	45 - 49 ------- $ 3.80	65 - 69 ------- $19.80
30 - 34 ------- $1.00	50 - 54 ------- $ 6.40	70 - 74 ------- $33.40
35 - 39 ------- $1.60	55 - 59 ------- $10.40	75+ ---------- $52.00
40 - 44 ------- $2.40	60 - 64 ------- $12.00	

DEPENDENT	Low Option $2.60	Standard Option $4.32	Premier Option $8.64
Spouse	$6,000	$10,000	$20,000
Child (age 6 months to 25)	$3,000	$5,000	$10,000
Child (live birth to 6 months)	$1,000	$1,000	$1,000

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If you have questions concerning anything in this guide, please see Help Lines for contact information for each plan.

The participating carriers reviewed and approved the information in this Guide. There is no guarantee that a provider will remain within a plan's network or have open patient slots throughout the year. Please verify your providers' participation in your plan's network.

A searchable text version of the Employee Benefit Options Guide is available on the OSEEGIB website at www.sib.ok.gov or www.healthchoiceok.com. This Guide is also available in CD format 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.

This publication was printed by the Oklahoma State and Education Employees Group Insurance Board as authorized by 74 O.S. Section 1301, et seq. 109,000 copies have been printed at a cost of $0.322 each. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

2010 PLAN CHANGES

Health Plan Changes

HealthChoice Plans

- Copays are being increased from $25 to $50. Changes are indicated by bold text in the *Comparison of Benefits for Health Plans* on pages 10-17.

HealthChoice Pharmacy Benefit

- Pharmacy copays are being increased. Changes are indicated by bold text in the *Comparison of Benefits for Health Plans* on page 16.
- Brand-name triptans, which are used to treat migraine headaches, are non-Preferred medications. Sumatriptan, the generic for Imitrex, is the Preferred medication in this category.

HMOs

- Several of the out-of-pocket maximums, copays, and pharmacy copays are changing. These changes are indicated by bold text in the *Comparison of Benefits for Health Plans* on pages 10-17.
- Some HMO service areas are changing. See the *HMO ZIP Code List* on pages 8-9 to check your eligibility.
- GlobalHealth has new phone numbers. The new local number is 1-405-280-5600 and the new toll-free number is 1-877-280-5600.

Dental Plan Changes

The Comparison of Benefits for Dental Plans on pages 18-19 has been redesigned to show your costs for Network services instead of what the plans pay.

HealthChoice Dental Plan

- Topical fluoride treatments will be covered only for children through age 12.

DMOs/Prepaid Dental

- CIGNA Dental Care Plan has a new phone number. The new toll-free number is 1-800-244-6224. Also, their customer service hours have been extended to 24 hours a day, seven days a week.

Life Plan Changes

HealthChoice Life Plan

- If you are enrolled in one of the health plans offered through OSEEGIB, you may purchase one $20,000 unit of life insurance during Option Period without completing a Life Insurance Application. You cannot apply for supplemental life coverage that exceeds the Plan maximum of five times your annual salary or $300,000, whichever is less. You must complete a Life Insurance Application to apply for more than $20,000 of coverage.

Vision Plan Changes

- Humana/CompBenefits will apply a $25 copay for frames purchased out-of-network. This change is indicated by bold text in the Comparison of Benefits for Vision Plans on page 20.

If you have questions about any of the plans, use the contact information on the *Help Lines* page on the inside back cover of this Benefit Options Guide.

INTRODUCTION

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) produced this Employee Benefit Options Guide to help you select your benefits. It is a summary of the available plans. The insurance benefits explained in this Guide are:

- Health
- Dental
- Life
- Disability
- Vision

See the plan comparison charts to determine your costs under each plan.

Helpful Hints For Option Period

- Review Section B of your pre-printed *Option Period Enrollment/Change Form.* This is the coverage you will have effective January 1, 2010, if you do not make changes during Option Period.
- Contact your Insurance Coordinator immediately if you have questions about your current coverage.
- Review plan changes for 2010 on page ii of this Guide.
- **Ask your Insurance Coordinator about the need to return your form even if you are not making any changes.**
- Use the following resources to help you decide on coverage for you and your dependents:

  - This Guide
  - Plan Websites
  - Customer Service Telephone Numbers
  - Provider Directories
  - OSEEGIB Member Services
  - Your Insurance Coordinator

- Decide on coverage for yourself (and your dependents) for 2010.
- Complete your *Option Period Enrollment/Change Form* and return it to your Insurance Coordinator by the designated deadline.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact your Insurance Coordinator if your *Confirmation Statement* is not correct. **If you do not make 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.

Helpful Hints For New Employees

- Use the following resources to help you decide on coverage for you and your dependents:

  - This Guide
  - Plan Websites
  - Customer Service Telephone Numbers
  - Provider Directories
  - OSEEGIB Member Services
  - Your Insurance Coordinator

- Decide on coverage for yourself (and your dependents) for 2010.
- Complete your *Insurance Enrollment Form* and return it to your Insurance Coordinator by the designated deadline.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact your Insurance Coordinator immediately 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 10-17 to determine your costs under each plan.

- All health plans coordinate benefits with other group insurance plans you have in force. For more information, check with each health plan.
- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- All plans have toll-free numbers for customer service. See *Help Lines* on the inside back cover.
- 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 by December 15, 2009. Without proof, your health plan will default to the HealthChoice Basic Plan.
- You must live or work within the HMO's ZIP Code service area to be eligible for that HMO. Post Office Box addresses cannot be used to determine your eligibility for an HMO. See pages 8-9 for the *HMO ZIP Code List*.
- Check with each health plan if you have benefit questions.

*The HealthChoice USA Plan is designed for employees who receive an assignment of more than 90 consecutive days outside of Oklahoma and Arkansas. Call HealthChoice Member Services for more details.

DENTAL PLAN HIGHLIGHTS

Verify your employer offers dental coverage through OSEEGIB.

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 18-19 to determine your costs under each plan.

- All dental plans have toll-free numbers for customer service. See *Help Lines* on the inside back cover.
- Check with each dental plan if you have benefit questions.

VISION PLAN HIGHLIGHTS

Verify your employer offers vision coverage through OSEEGIB.

There are five vision plans available:

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

See *Comparison of Benefits for Vision Plans* on pages 20-21 to determine your costs under each plan.

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

If your provider leaves your health, dental, or vision plan, you cannot change plans until the next annual Option Period. You may change providers within your plan as needed.

Thinking About Retirement?

If you are a current employee who will be retiring **before** January 1, 2010, please contact OSEEGIB Member Services and request the appropriate materials. You will select your benefits from either the Former Pre-Medicare or Medicare Option Period Guide, not this Guide. To contact Member Services, refer to *Help Lines* on the inside back cover.

HEALTHCHOICE LIFE INSURANCE

Verify your employer offers HealthChoice Life Insurance.

- As a **new employee**, you may elect life insurance coverage within 30 days of your employment date or the date you become eligible. You can enroll in a limited amount of coverage, **Guaranteed Issue**, without an approved *Life Insurance Application*.
- As a **current employee**, if you did not enroll when first eligible, you may enroll:
  - During the annual Option Period. If you are enrolled in one of the health plans offered through OSEEGIB, an approved Life Insurance Application is required only if you apply for more than $20,000 in coverage.
  - Within 30 days of a midyear qualifying event. An approved Life Insurance Application is required.
  - Within 30 days of the loss of other group life coverage. You can enroll in the amount of coverage you lost rounded up to the next $20,000 unit without a *Life Insurance Application*.

Basic Life . . . For You

- You may enroll in Basic Life during Option Period without a *Life Insurance Application* if you are enrolled in one of the health plans offered through OSEEGIB. Mark the appropriate box on your *Option Period Enrollment/Change Form*.
- Basic Life pays a benefit of $20,000 to your beneficiary(ies) in the event of your death.
- Basic Life coverage includes Accidental Death and Dismemberment (AD&D) coverage. This coverage pays an additional $20,000 to your beneficiary(ies) if your death is due to an accident, or it pays you a reduced benefit if you lose your sight or a limb due to an accident.

Supplemental Life Insurance . . . For You

- At the time of your initial enrollment, you can purchase Supplemental Life coverage in an amount equal to two times your annual salary, rounded up to the next $20,000. This amount, known as Guaranteed Issue, is available without providing a *Life Insurance Application*.
- You may purchase Supplemental Life coverage in units of $20,000. One $20,000 unit of life insurance may be purchased during Option Period without a *Life Insurance Application* as long as you are already enrolled in Basic Life and one of the health plans offered through OSEEGIB. You cannot apply for supplemental life coverage that exceeds the Plan maximum of five times your annual salary or $300,000, whichever is less. You must complete a *Life Insurance Application* to apply for additional coverage above $20,000.
- The first $20,000 unit of Supplemental Life provides an additional $20,000 of AD&D insurance.
- A *Life Insurance Application* is available from your Insurance Coordinator.

Dependent Life Insurance . . . For Your Family

DEPENDENT	LOW OPTION	STANDARD OPTION	PREMIER OPTION
Spouse	$6,000	$10,000	$20,000
Child (age 6 months to 25)	$3,000	$5,000	$10,000
Child (live birth to 6 months)	$1,000	$1,000	$1,000

- If you enroll in Basic Life insurance, you may purchase Dependent Life insurance for your spouse and dependents at your initial enrollment, during the annual Option Period, or within 30 days of a loss of other group life insurance or midyear qualifying event.
- Dependent Life does not include AD&D coverage.
- There are three options for Dependent Life coverage: Low Option, Standard Option, or the Premier Option. Regardless of your number of dependents, the monthly premium is the same.
- A *Life Insurance Application* is not required for Dependent Life coverage.

Beneficiary Designation

Benefits are paid to your beneficiary(ies) in a lump sum. You must name your beneficiary(ies) when you enroll. Your beneficiary designation may be changed at any time. For a *Beneficiary Designation Form* or more information, contact your Insurance Coordinator. *Beneficiary Designation Forms* are also available on the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**. Be aware that life insurance benefits for covered dependents are always paid to the member.

HEALTHCHOICE DISABILITY INSURANCE

Verify your employer offers HealthChoice Disability Insurance (limited county participation only).

The HealthChoice Disability Insurance Plan provides **partial** replacement income if you are unable to work due to an illness or injury. Disability coverage is not available to dependents.

Eligibility

Your enrollment in the Plan begins the first day of the month following your employment date or the date you become eligible. You become eligible for disability benefits after 31 consecutive days of employment. During that time, you must have continuously performed all of the material duties of your regular occupation. Any claim for disability benefits must be filed within one year of the beginning of your disability.

GENERAL ENROLLMENT INFORMATION

Your employer determines which benefits are available to you and may not participate in all the benefits explained in this Guide. Ask your Insurance Coordinator which benefits are available under your employer's Employee Benefit Plan.

The benefits you select will be in effect from January 1, 2010, or the effective date of your coverage, through December 31, 2010. Please contact the insurance plan(s) at the phone number(s) or website(s) listed in *Help Lines* on the inside back cover for more information on any of the plans.

After enrollment, the plan(s) you have selected will provide a member handbook or additional materials with more information about your benefits.

Once enrolled in any of the plans, it is your responsibility to review your benefits carefully so you know what is covered, as well as the plan's policies and procedures, before you use your benefits.

Option Period Enrollment

This is the time when eligible employees may:

- Enroll in plans
- Change plans or drop coverage
- Increase or decrease life insurance coverage
- Add eligible family members to or drop them from coverage

- You may enroll in health, dental, life, and/or vision coverage for yourself and/or your dependent(s) during the annual Option Period, as long as you have not dropped that coverage within the past 12 months. If you have dropped coverage, limitations and/or exceptions may apply.

Initial Enrollment

This is the time when new employees are eligible to:

- Enroll in insurance plans
- Enroll eligible dependents
- Apply for life insurance coverage above Guaranteed Issue

- As a new employee, you have 30 days from your employment date, or the date you become eligible, to make your benefit selections. If you do not enroll within 30 days, you will not be able to enroll until the next annual Option Period unless you experience a qualifying event during the plan year. Your employer's Section 125 Plan (if applicable) determines any exceptions to this rule. Check with your Insurance Coordinator for more information.
- If you request life insurance coverage in an amount greater than two times your annual salary, Guaranteed Issue, you must complete and submit a *Life Insurance Application* for approval. See your Insurance Coordinator for an application.
- Keep a copy of your *Insurance Enrollment Form* for your records.

ELIGIBILITY

Members

- Your employer must participate in the plans offered through OSEEGIB.
- You must be a current Education employee eligible to participate in the Oklahoma Teachers' Retirement System working a minimum of four hours per day or 20 hours per week, or a current State of Oklahoma or Local Government employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.
- You must be enrolled in a group health plan in order to enroll in dental or life insurance.

Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. Eligible dependents include:
  - Your legal spouse (including common-law).
  - Your unmarried children up to age 25, including your natural child or stepchild, provided you are primarily responsible for their support, and your natural child or stepchild, regardless of residence, if ordered by the court; court documentation is required.
  - A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 25. Subject to medical review and approval.

- Other dependent children with an approved Declaration of Dependency form. This form is required when the member has not been granted custody, adoption, or guardianship by a court, and the member's most recent income tax return does not list the child as a dependent for income tax purposes.

- If your spouse is enrolled separately in one of the OSEEGIB plans, your dependents may be covered under one parent's health, dental, or vision plan (but not both); however, dependents may be covered by both parents for dependent life insurance.
- Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage, or loss of other group coverage occurs. If eligible dependents are dropped from coverage, you cannot re-enroll them for a minimum of 12 months. The 12-month requirement does not apply when dependents lose other group health, dental, vision, and/or life insurance coverage and are seeking reinstatement.
- Dependents may only be enrolled in the same types of coverage and in the same plans you have as the primary member.
- To enroll your newborn, a change form must be provided to your Insurance Coordinator within 30 days of the birth. If you do not enroll your newborn during this 30-day period, you will not be able to do so until the next annual Option Period. Direct notification to an HMO will not enroll your newborn, or any other dependents. The newborn's Social Security Number is not required at the time of initial enrollment, but must be provided once it is received from the Social Security Administration. Insurance premiums for the month the child was born must be paid, and deductible and coinsurance may apply.
- Without enrollment, newborns will be covered only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Deductible and coinsurance may apply.
- Dependents who lose eligibility may apply for continuation of health, dental, or vision coverage under COBRA for a maximum of 36 months. Dropping dependents during Option Period is not a COBRA qualifying event. See your Insurance Coordinator for more information.

EXCLUDING DEPENDENTS FROM COVERAGE

- You can exclude your spouse from health and/or dental coverage. Contact your Insurance Coordinator for details. Your spouse must sign the Spouse Exclusion Certification section of the *Insurance Enrollment Form* or the *Option Period Enrollment/Change Form*.
- You can also exclude your spouse or other dependents if they are covered under another group health or dental plan, or are eligible for Indian or military health benefits.

Note: Your spouse cannot be excluded from vision coverage if your other dependents are covered unless your spouse has proof of other group vision coverage.

EFFECTIVE DATE OF COVERAGE

- **Option Period** elections become effective on January 1, 2010, the beginning of the new plan year.
- **New employee** coverage is effective the first day of the month following your employment date or the date you become eligible through your employer.
- **Midyear changes** become effective the first of the month following a qualifying event. Adopted children are eligible the first day of the month you obtain physical custody of the child.

CHANGES TO COVERAGE

Initial Enrollment

- As a new employee, you have 30 days following the date you become eligible to make changes to your original benefit selections. These changes are effective the first day of the month following the date the change in coverage is made.

Midyear Changes

- Midyear plan changes are allowed only if a qualifying event such as birth, marriage, or loss of other group coverage occurs. You must complete an *Insurance Change Form* within 30 days of the event. See your Insurance Coordinator for more information.

CONFIRMATION STATEMENT

- You will be mailed a *Confirmation Statement* (CS) when you enroll or make changes to your coverage. Your CS lists the coverage you are enrolled in, the effective date of your coverage, and the premium amounts for your coverage.
- Always review your CS to verify your coverage is correct. Corrections to your coverage must be submitted to your Insurance Coordinator within 60 days of your election. Corrections reported after 60 days will be effective the first of the month following notification.
- Section B of your *Option Period Enrollment/Change Form* lists the coverage you will have effective January 1, 2010, if you do not make changes to your coverage during Option Period. If you don't make changes, you will not receive a CS from OSEEGIB. Keep a copy of your *Option Period Enrollment/Change Form* as verification of your coverage.

TRANSFER EMPLOYEE

- You can keep your coverage continuous when moving from one participating employer to another as long as there is no break in coverage that lasts more than 30 days. Premiums must be paid upon reporting to work.
- Benefit options may vary from employer to employer. Changes to your coverage must be made within the first 30 days of your transfer. See your Insurance Coordinator for more information.

TERMINATION OF COVERAGE

- Coverage will end the last day of the month in which a termination event occurs. Examples of termination events include:
  - Loss of employment
  - Loss of dependent eligibility
  - Non-payment of premiums
  - Death

COBRA

Temporary Continuation of Coverage

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and/or your dependents to continue health, dental, and/or vision insurance coverage after your employment terminates or after your dependent loses eligibility. Certain time limits apply to enrollment. An additional two percent administration fee is added to COBRA insurance premiums. Contact your Insurance Coordinator immediately upon termination of your employment, or when changes to your family status occur, to find out more about your COBRA rights. Your Insurance Coordinator will provide the necessary enrollment information and premiums for COBRA. COBRA enrollment is limited to 18 months for eligible employees; 29 months for eligible disabilities; and 36 months for dependents.

HMO ZIP Code List

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

73002	G P	73067	G P	73120	A C G P	73177	C P	73754	G	74039	A C G P
73003	A C G P	73068	A C G P	73121	A C G P	73178	A C G P	73755	G	74041	C P G
73004	A G P	73069	A C G P	73122	A C G P	73179	A C G P	73757	C	74042	C
73007	A C G P	73070	A C G P	73123	A C G P	73180	C P	73760	G	74043	A C G P
73008	A C G P	73071	A C G P	73124	A C G P	73184	A C G P	73762	G P	74044	C P G
73010	A G P	73072	A C G P	73125	A C G P	73185	A C G P	73763	G	74045	C
73011	G P	73073	A C G P	73126	A C G P	73189	A C G P	73764	G	74046	C P G
73012	A C G P	73074	G	73127	A C G P	73190	A C G P	73768	G	74047	A C G P
73013	A C G P	73075	G	73128	A C G P	73193	C P	73770	G	74048	C G
73014	C P G	73077	C	73129	A C G P	73194	A C G P	73772	G	74050	A C G P
73016	G P	73078	A C G P	73130	A C G P	73195	A C G P	73838	G	74051	C G
73017	G	73079	G P	73131	A C G P	73196	A C G P	73860	G	74052	C P G
73018	G P	73080	A G P	73132	A C G P	73197	A C P	74001	C G	74053	A C G P
73019	A C G P	73082	G	73134	A C G P	73198	A C G P	74002	C G P	74054	A C G P
73020	A C G P	73083	A C G P	73135	A C G P	73199	A C P	74003	C G	74055	A C G P
73022	A C G P	73084	A C G P	73136	A C G P	73401	G	74004	C	74056	C G
73023	G	73085	A C G P	73137	A C G P	73402	G	74005	C	74058	C
73025	A C G P	73089	A G P	73139	A C G P	73403	G	74006	C	74059	C G P
73026	A C G P	73090	A C G P	73140	A C G P	73432	G	74008	A C G P	74060	A C G P
73027	A C G P	73091	G	73141	A C G P	73433	G	74009	C	74061	C G P
73028	A C G P	73092	G P	73142	A C G P	73434	G	74010	C P G	74062	C P
73030	G	73093	A G P	73143	A C G P	73444	G	74011	A C G P	74063	A C G P
73031	A G P	73095	G P	73144	A C G P	73446	G	74012	A C G P	74066	A C G P
73034	A C G P	73096	G	73145	A C G P	73447	G	74013	A C G P	74067	A C G P
73036	A C G P	73097	A C G P	73146	A C G P	73450	G	74014	A C G P	74068	C P G
73037	C P	73098	G	73147	A C G P	73455	G	74015	A C G P	74070	A C G P
73040	G	73099	A C G P	73148	A C G P	73460	G	74016	A C G P	74071	C P G
73043	G	73100	C	73149	A C G P	73461	G	74017	A C G P	74072	C
73044	A C G P	73101	A C G P	73150	A C G P	73481	G	74018	A C G P	74073	A C G P
73045	A C G P	73102	A C G P	73151	A C G P	73488	G	74019	A C G P	74074	C P
73047	G	73103	A C G P	73152	A C G P	73532	G	74020	C P	74075	C P
73048	G	73104	A C G P	73153	A C G P	73537	G	74021	A C G P	74076	C P
73049	A C G P	73105	A C G P	73154	A C G P	73544	G	74022	C G	74077	C
73050	A C G P	73106	A C G P	73155	A C G P	73550	G	74023	C G P	74078	C
73051	A C G P	73107	A C G P	73156	A C G P	73554	G	74026	G P	74079	G P
73052	G	73108	A C G P	73157	A C G P	73571	G	74027	C	74080	A C G P
73054	A C G P	73109	A C G P	73159	A C G P	73646	G	74028	C P G	74081	C G P
73055	G	73110	A C G P	73160	A C G P	73658	G	74029	C	74082	C P
73056	A C G P	73111	A C G P	73162	A C G P	73669	G	74030	C P G	74083	C
73057	G P	73112	A C G P	73163	A C G P	73716	G	74031	A C G P	74084	C G
73058	A C G P	73113	A C G P	73164	C G P	73718	G	74032	C P	74085	C G P
73059	A G P	73114	A C G P	73165	A C G P	73724	G	74033	A C G P	74100	C
73061	C	73115	A C G P	73167	A C G P	73729	G	74034	C	74101	A C G P
73063	A C G P	73116	A C G P	73169	A C G P	73735	G	74035	C G P	74102	A C G P
73064	A C G P	73117	A C G P	73170	A C G P	73737	G	74036	A C G P	74103	A C G P
73065	A G P	73118	A C G P	73172	A C G P	73744	G	74037	A C G P	74104	A C G P
73066	A C G P	73119	A C G P	73173	A C G P	73747	G	74038	C P G	74105	A C G P

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HMO ZIP Code List

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

74106	A C G P	74189	A C P	74427	C	74526	C	74802	A C G P	74878	A C G P
74107	A C G P	74192	A C G P	74428	C	74528	C	74804	A C G P	74880	G P
74108	A C G P	74193	A C G P	74429	A C G P	74529	C	74818	C G P	74881	A G P
74110	A C G P	74194	A C P	74430	C	74530	G	74820	G	74881	A G P
74112	A C G P	74301	C P	74431	C G P	74531	G	74821	G	74882	P
74114	A C G P	74330	A C G P	74432	C	74536	C	74824	G P	74883	G
74115	A C G P	74331	C	74434	C G	74543	C	74825	G	74884	C G P
74116	A C G P	74332	C G	74435	C	74545	C	74826	A C G P	74901	C
74117	A C G P	74333	C	74436	C P G	74546	C	74827	G	74902	C
74119	A C G P	74335	C	74437	C G P	74547	C	74829	P	74930	C
74120	A C G P	74337	A C G P	74438	C	74548	C	74830	C G P	74931	C
74121	A C G P	74338	C	74439	C	74549	C	74831	A G P	74932	C
74126	A C G P	74339	C	74440	C	74552	C	74832	G P	74935	C
74127	A C G P	74340	A C G P	74441	C	74553	C	74833	P	74936	C
74128	A C G P	74342	C	74442	C	74554	C	74834	G P	74937	C
74129	A C G P	74343	C	74444	C	74557	C	74835	P	74939	C
74130	A C G P	74344	C	74445	C G P	74558	C	74836	G	74940	C
74131	A C G P	74345	C	74446	C P G	74559	C	74837	C G P	74941	C
74132	A C G P	74346	C	74447	C G P	74560	C	74838	P	74942	C
74133	A C G P	74347	C	74450	C	74561	C	74839	G	74943	C
74134	A C G P	74349	A C G P	74451	C	74562	C	74840	A C G P	74944	C
74135	A C G P	74350	A C G P	74452	C G	74563	C	74842	G	74945	C
74136	A C G P	74352	A C G P	74454	C P G	74565	C	74843	G	74946	C
74137	A C G P	74353	C P	74455	C	74567	C	74844	G	74947	C
74141	A C G P	74354	C	74456	C G P	74570	G	74845	C	74948	C
74145	A C G P	74355	C	74457	C	74571	C	74848	G	74949	C
74146	A C G P	74358	C	74458	C P G	74574	C	74849	C G P	74951	C
74147	A C G P	74359	C	74459	C	74577	C	74850	G	74953	C
74148	A C G P	74360	C	74460	C G P	74578	C	74851	A C G P	74954	C
74149	A C G P	74361	A C G P	74461	C	74604	C G	74852	A C G P	74955	C
74150	A C G P	74362	A C G P	74462	C	74630	C	74854	A C G P	74956	C
74152	A C G P	74363	C	74463	C	74633	C G	74855	A G P	74959	C
74153	A C G P	74364	A C G P	74464	C	74637	C G	74856	G	74960	C
74155	A C G P	74365	A C G P	74465	C	74644	C	74857	A C G P	74962	C
74156	A C G P	74366	A C G P	74466	C P	74650	C G	74859	G P	74964	C
74157	A C G P	74367	A C G P	74467	C P G	74651	C	74860	G P	74965	C
74158	A C G P	74368	C	74468	C	74652	C G	74862	P	74966	C
74159	A C G P	74369	C	74469	C	74727	C	74864	G P		
74169	A C G P	74370	C	74470	C	74735	C	74865	G		
74170	A C G P	74401	C G	74471	C	74738	C	74866	A C G P		
74171	A C G P	74402	C G	74472	C	74743	C	74867	C G P		
74172	A C G P	74403	C G	74477	C P G	74748	G	74868	C G P		
74182	A C G P	74421	C G P	74501	C	74756	C	74869	A G P		
74183	A C P	74422	C G P	74502	C	74759	C	74871	G		
74184	A C	74423	C	74521	C	74760	C	74872	G		
74186	A C G P	74425	C	74522	C	74761	C	74873	A C G P		
74187	A C G P	74426	C	74523	C	74801	A C G P	74875	G P		

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for 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 applies after Plan pays first $500 of Allowed Charges	$1,500 individual $3,000 family The combined medical and pharmacy deductible must be met before benefits are paid	No deductible
Calendar Year Out-of-Pocket Maximum	$2,800 Network individual $3,300 non-Network individual, plus amounts over Allowed Charges	$5,500 individual $11,000 family	$4,000 individual $8,000 family Non-Network charges do not apply	**$2,500 individual** **$5,000 family**
Office Visit (Professional Services)	**$50 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 **$50 copay** applies after deductible	**$30 copay/PCP** **$40 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 **$150 copay** per MRI, CAT, MRA, or PET scan
Hospital Inpatient Admission	20% of Allowed Charges after deductible $300 deductible per non-Network admission		20% of Allowed Charges after deductible $300 deductible per non-Network admission	**$350 copay** Preauthorization required
Hospital Outpatient Visit	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	**$250 copay** Preauthorization required
Well Baby Care Visit	**$50 copay**; no deductible applies		**$50 copay**; no deductible applies	$0 copay
Immunizations	No charge for well baby and adult immunizations **$50 office visit copay** and/or administration fee may apply		No charge for well baby and adult immunizations **$50 office visit copay** and/or administration fee may apply	$0 copay/ages 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 each plan. See *Help Lines* on the inside back cover of this guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
No deductible	No deductible	No deductible	No deductible	**Calendar Year Deductibles**
$3,000 individual $6,000 family	**$3,000 individual** **$6,000 family**	$3,000 individual $5,000 family	**$2,500 individual** **$5,000 family**	**Calendar Year Out-of-Pocket Maximum**
$55 copay/PCP **$65 copay/specialist**	**$35 copay/PCP** **$50 copay/specialist**	$25 copay/PCP $50 copay/specialist	**$35 copay/PCP** $50 copay/specialist	**Office Visit (Professional Services)**
$65 copay per visit Per scan for : MRI,CT, MRA, and PET scan	No additional copay/ laboratory services or outpatient radiology **$200 copay** per MRI, CAT, MRA, or PET scan	$0 copay $250 copay per MRI, MRA, PET, or CAT	$0 copay/standard lab and radiology **$200 copay** per MRI, MRA, PET, or CAT	**Diagnostic X-ray and Lab**
$1,000 copay Preauthorization required	**$500 copay**	$250 copay per day $750 maximum per admission	$1,000 copay/admission	**Hospital Inpatient Admission**
$500 per visit copay Must be preauthorized	**$300 copay**	$250 copay	$500 copay	**Hospital Outpatient Visit**
$0 copay up to age 2	$0 copay up to age 2	$0 copay up to age 2 $25 copay PCP over age 2	$0 copay	**Well Baby Care Visit**
$0 copay/ages 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/ages 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) **$10 copay** ages 19 and over	**Immunizations**

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COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Periodic Health Exams	**$50 copay** per exam One mammogram per year at no charge for women age 40 and over	One mammogram per year at no charge for women age 40 and over •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*	**$50 copay** per exam One 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	**$30 copay**/PCP **$40 copay**/specialist **$30 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	**$150 copay**; waived if admitted
After Hours Urgent Care	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	**$40 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*	**$350 copay**
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*	**$30 copay**/PCP **$40 copay**/specialist
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

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*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	Your Costs for Network Services
$10 copay for ages 19 and over	$25 copay	$25 copay/PCP Limit: One per year	**$35 copay**/PCP $50 copay/specialist	Periodic Health Exams
$20 copay per visit $20 copay for 6-week supply of antigen (including shots)	**$35 copay**/PCP visit **$50 copay**/specialist visit $30 copay for 6-week supply of antigen (including shots)	$25 copay/PCP visit $50 copay/specialist $30 copay for 6-week supply of antigen (including shots)	**$35 copay**/PCP $50 copay/specialist **$35 serum and shots including a 6-week supply of antigen**	Allergy Treatment and Testing
$200 per visit copay (waived if admitted)	**$200 copay**; waived if admitted	$150 copay; waived if admitted	$200 copay; waived if admitted	Emergency Health Care Facility Visit
$75 per visit copay	**$50 copay** per visit	$25 copay/PCP $50 copay/all others	**$50 copay** per visit	After Hours Urgent Care
$1,000 copay Must be preauthorized	**$500 copay** **Must be preauthorized and approved through CCOK Behavioral Health Services**	$250 per day $750 maximum per admission	$1,000 copay/admission	Mental Health or Substance Abuse Inpatient Admission
$55 copay/PCP **$65 copay**/Specialist Single or group therapy except for the biologically-based diagnoses treated as other illnesses	**$35 copay**/PCP **$50 copay**/specialist **Must be preauthorized and approved through CCOK Behavioral Health Services**	$50 copay Must be preauthorized	**$35 copay**/PCP $50 copay/specialist	Mental Health or Substance Abuse Outpatient Visit
20% of contracted rate	20% coinsurance initial device 20% coinsurance repair and replacement	20% coinsurance $5,000 annual maximum	20% coinsurance $10,000 annual maximum	Durable Medical Equipment (DME)

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COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Occupational and Speech Therapy Visits	20% of Allowed Charges after deductible **For each service** Limit: 20 visits per year without prior authorization Maximum of 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 **For each service** Limit: 20 visits per year without prior authorization Maximum of 60 visits per year	No copay inpatient **$30 copay**/PCP **$40 copay**/specialist Limit: 60 treatment days per illness
Physical Therapy/ Physical Medicine Visit	20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Maximum of 60 visits per year		20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Maximum of 60 visits per year	No copay inpatient **$30 copay**/PCP **$40 copay**/specialist Limit: 60 treatment days per illness
Chiropractic and Manipulative Therapy Visit	**Chiropractic services**: 20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Maximum of 60 visits per year **For manipulative therapy, see Physical Therapy/Physical Medicine**		**Chiropractic services**: 20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Maximum of 60 visits per year **For manipulative therapy, see Physical Therapy/Physical Medicine**	**$40 copay** Limit: 15 visits per year PCP referral required
Maternity Pre and Post Natal Care	20% of Allowed Charges after deductible Includes One postpartum home visit - criteria must be met		20% of Allowed Charges after deductible Includes One postpartum home visit - criteria must be met	**$30 copay** for initial visit **$350 copay** per hospital admission
Hearing Screening and Hearing Aids	**$50 copay**/basic hearing screening Limit: one per year Hearing aids are covered as durable medical equipment for children up to age 18		**$50 copay** after deductible/basic hearing screening Limit: one per year Hearing aids are covered as durable medical equipment for children up to age 18	**$30 copay** Limit: One 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 each plan. See *Help Lines* on the inside back cover of this guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
No copay inpatient **$65 copay**/outpatient therapy Limit: 60 consecutive days per illness	No copay inpatient **$50 copay** outpatient therapy Limit: 60 days per illness	No copay inpatient $50 copay per outpatient visit Limit: 60 consecutive days per illness	$1,000 copay inpatient Outpatient - **$35 copay**/PCP $50 copay/ specialist Limit: 60 days per illness	Occupational or Speech Therapy Visit
$65 copay outpatient therapy Limit: 60 consecutive days per illness	No copay inpatient **$50 copay** outpatient therapy Limit: 60 days per illness	No copay inpatient $50 copay per outpatient visit Limit: 60 consecutive days per illness	$1,000 copay inpatient Outpatient - **$35 copay**/PCP $50 copay/ specialist Limit: 60 days per illness	Physical Therapy/ Physical Medicine Visit
$65 copay Limit: 15 visits per calendar year	**$50 copay** Limit: 15 visits per year	$50 copay Limit: 15 visits per year – referral required	**$50 copay** Limit: 15 visits per year - referral required Limited to treatment of neurological and orthopedic conditions	Chiropractic and Manipulative Therapy Visit
$65 copay for initial visit; thereafter covered at 100% **$1,000** copay per hospital admission	**$35 copay** for initial visit **$500 copay** per hospital admission	$25 copay initial visit only $250 copay per hospital admission per day $750 maximum per admission	**$35 copay**/PCP $50 copay/specialist for initial visit once diagnosis of pregnancy is confirmed $1,000 copay per hospital admission	Maternity Pre and Post Natal Care
$10 copay Limit: One per ear every 48 months Hearing aids covered for children up to age 18;	**$35 copay** Limit: One per year Hearing aids – 20% coinsurance for children up to age 18	$25 copay per visit Limit: One per year Hearing aids – 20% coinsurance Covered for children up to age 18 Limit: $5,000 combined DME, orthotics, and prosthetics	**$35 copay**/PCP 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 each plan. See *Help Lines* on the inside back cover of this guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

PHARMACY

Your Costs for 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 $30** or actual cost if less •The cost of medication is more than $100 - You pay 25% **up to a $60 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 $60** or actual cost if less •The cost of medication is more than $100 - **You pay 50% up to a $120 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 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 $30** or actual cost if less •The cost of medication is more than $100 - **You pay 25% up to a $60 maximum** **Non-Preferred Medication:** •The cost of medication is $100 or less - **You pay up to $60** or actual cost if less •The cost of medication is more than $100 - **You pay 50% up to a $120 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 $5 generic formulary** **Up to $30 brand formulary (when no generic is available)** **Up to $60 brand formulary (when generic is available)** The lesser of 30-day supply or 100 units Certain medications have restricted quantities Mail order may be available, contact Plans for details Please note: Tier categories will be determined by each HMO based on its formulary design

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for 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 30-day supply or 100 units Certain medications have restricted quantities	Tier 1: $10 Tier 2: $40 Tier 3: $65 Up to $65 non-formulary The lesser of 30-day supply or 100 units. Selected medications may have restricted quantities.	Tier 1: $10 Tier 2: $50 Tier 3: $75 The lesser of 30-day supply or 100 units. Certain medications may have restricted quantities These copays do not apply to the maximum out-of-pocket	**$5 copay** for formulary generic drugs $30 copay for formulary brand-name drugs **$60 copay** 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

Your Costs for Network Services	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 deductible or plan maximum $5 office copay apply	$25 per person, per calendar year, waived for preventive services in-network
Preventive Care Allowed Charges apply	Network: $0 Non-Network: $0 of Allowed Charges after deductible	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	$0 with no deductible when in-network
Basic Care Allowed Charges apply	Network: 15% Non-Network: 30% Deductible applies	Amalgam: One surface, permanent teeth $20	Network: 15% Non-Network: 30% Plan pays 85% of usual and customary when in-network, Deductible applies
Major Care Allowed Charges apply	Network: 40% Non-Network: 50% Deductible applies	Root canal, anterior: $325 Periodontal/scaling/root planing 1-3 teeth (per quadrant): $65	Network: 40% 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 may apply No lifetime orthodontic maximum for Network or non-Network Covered for members under age 19 and members over age 19 with TMD	$2,100 out-of-pocket for children through age 18 $2,900 out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding	Network: 40% Non-Network: 50% Up to $1,800 lifetime maximum for members under age 19 24-month waiting period may apply
Plan Year Maximum	Network and non-Network $2,000 per person per year	No 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 year applies to Basic and Major Care only	$100 per person per year	$100 per person per year applies to Major Care only (Level 4)
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	$0 of allowable amounts No deductible applies	$0 of allowable amounts after deductible	Schedule of covered services and copays. Copay examples: Routine cleaning $5 Periodic oral evaluation $5 Topical fluoride application (up to age 19) $5
Fillings Minor oral surgery Refer to the copayment schedule for each plan	15% of allowable amounts after deductible	30% of allowable amounts after deductible	Schedule of covered services and copays. Copay example: Amalgam - One surface, primary or permanent tooth $12
Root canal Periodontal Crowns Refer to the copayment schedule for each plan	40% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of covered services and copays. Copay examples: Crown - porcelain/ceramic substrate $241 Complete denture - maxillary $320
25% discount Adults and children	40% of allowable amounts, up to lifetime maximum of $1,800 No deductible applies No waiting period	40% of allowable amounts, up to lifetime maximum of $1,800 No deductible applies No waiting period	You pay amounts in excess of $50 per month Lifetime maximum up to $1,800 No deductible applies No waiting period
No annual maximum for general dentist	$2,000 per person per year	$2,000 per person per year	$2,000 per person per 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 per year	Copays do not apply Plan pays up to $35; One exam per year	$0 copay No limit on exams per year	Exam fee reimbursed up to $40 One exam per year
Lenses Each Pair	$25 material copay applies to lenses and/or frames (single, lined bifocal, trifocal, lenticular are covered at 100%). A discount applies to progressive lenses One pair of lenses per year	Plan pays up to: $25 single $40 bifocals $60 trifocals $100 lenticular One pair of lenses per 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 per year	**$25 copay** Plan pays up to $45 One set of frames per 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 per year	$130 allowance for exam, contacts, and fitting fee in lieu of all other benefits Medically necessary, Plan pays $210 One set of contacts per year	You pay wholesale cost for an annual supply of contacts. For first time fittings, $50 copay on soft lenses 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
Vision benefits apply from January 1 through December 31, 2010			*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 Plan		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 per year	OD-$26 max MD-$34 max	$10 copay One exam per year	Plan pays up to $40	$10 copay One exam per year	$10 copay Plan pays up to $35
$25 copay One pair of lenses per year	Plan pays up to: $26 single $39 bifocals $49 trifocals $78 lenticular	$25 copay One pair of lenses per year	Plan pays up to: $40 single $60 bifocals $80 trifocals $80 lenticular	$25 copay* One set of lenses per year Polycarbonate lenses covered in full for dependent children Average 35-40% savings on all non-covered lens options	$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 per year	Plan pays up to $68	$25 copay One set of frames per year	Plan pays up to $45	$25 copay* One frame per 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
Vision benefits apply from January 1 through December 31, 2010				*Benefit includes an annual $25 materials copay for lenses or frames, but not both. Contact VSP at 1-800-877-7195 for additional information regarding in-network added value discounts.	

Notes

HealthChoice (OSEEGIB) 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 Areas	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

Certification

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 or All Areas 1-866-447-0436

Disability Plan

Oklahoma City Area	1-405-841-9686
All Areas	1-800-722-2567
TDD All Areas	1-800-863-5488

HealthChoice USA

Customer Service & Claims	1-800-782-5218
Provider Information	1-877-877-0715 ext. 4059
TDD All Areas	1-800-941-2160
Website	www.choicecarenetwork.com

HMO Plans' Help Lines

Aetna

All Areas	1-800-949-3104
TDD All Areas	1-800-628-3323
Website	www.aetnaokstateemployees.com

CommunityCare

All Areas	1-800-777-4890
TDD All Areas	1-800-722-0353
Website	www.ccok.com

GlobalHealth, Inc.

Oklahoma City Area	1-405-280-5600
All Other Areas	1-877-280-5600
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	1-800-244-6224
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/

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 (PVCS)

All Areas	1-888-357-6912
TDD All Areas	1-800-722-0353
Website	www.pvcs-usa.com

Superior Vision Plan

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

Oklahoma State and Education
Employees Group Insurance Board
3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112

OPTION PERIOD GUIDE
PLAN YEAR 2010