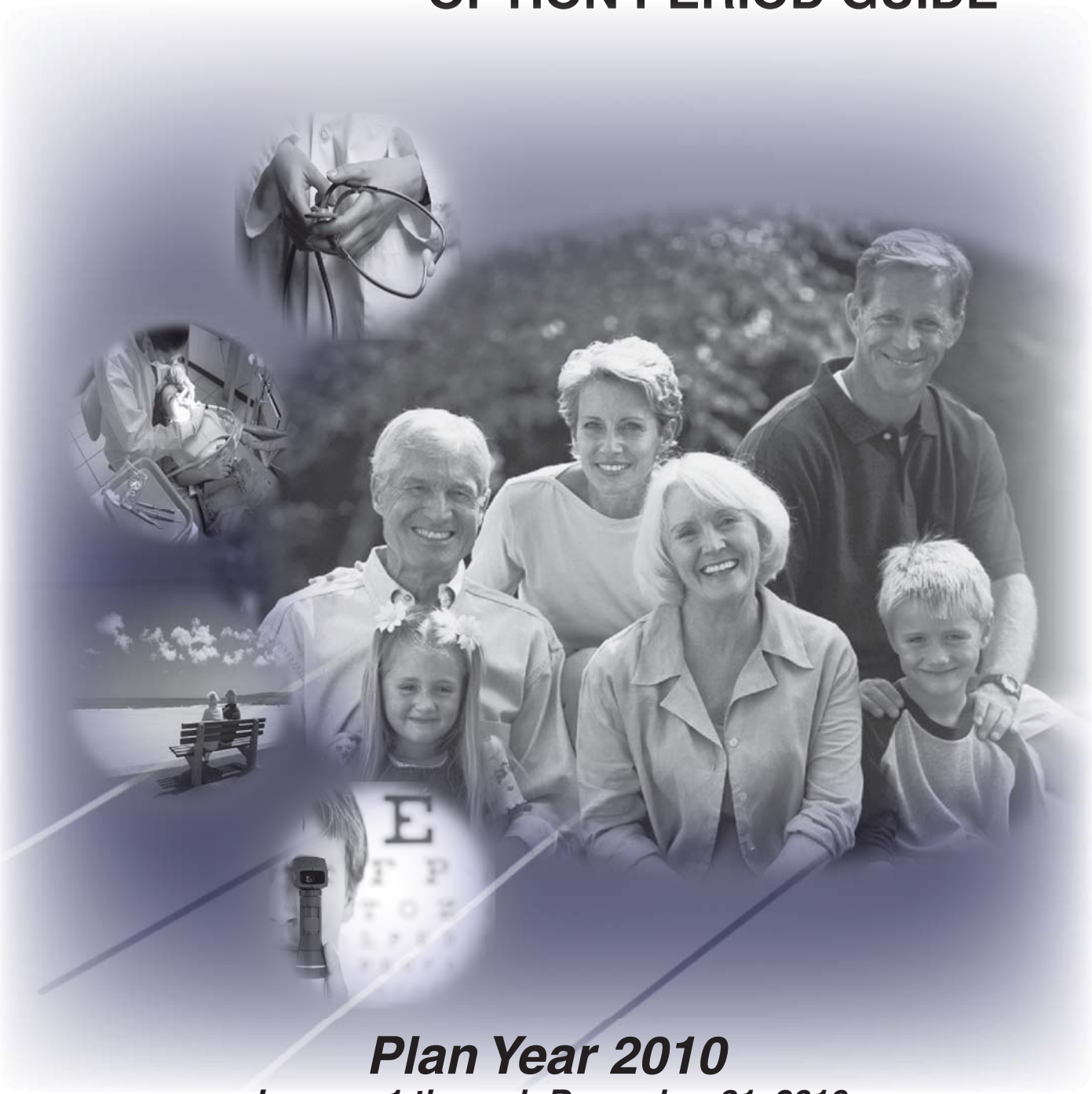
OSEEGIB
Oklahoma State and Education
Employees Group Insurance Board

FORMER EMPLOYEES SURVIVING DEPENDENTS AND COBRA PARTICIPANTS

OPTION PERIOD GUIDE



Plan Year 2010

January 1 through December 31, 2010

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

#2228

Update to Printed Version of This Guide

The following ZIP Codes were not available from GlobalHealth HMO when this guide went to print. There are 133 additional ZIP Codes in the GlobalHealth service area. They are:

♦ 73001	♦ 73094	♦ 73463	♦ 73566	♦ 73736	♦ 74072	♦ 74441	♦ 74651
♦ 73005	♦ 73401	♦ 73487	♦ 73601	♦ 73738	♦ 74074	♦ 74444	♦ 74829
♦ 73006	♦ 73402	♦ 73491	♦ 73620	♦ 73742	♦ 74075	♦ 74450	♦ 74833
♦ 73009	♦ 73403	♦ 73521	♦ 73625	♦ 73743	♦ 74076	♦ 74451	♦ 74845
♦ 73015	♦ 73425	♦ 73522	♦ 73639	♦ 73750	♦ 74077	♦ 74455	♦ 74859
♦ 73029	♦ 73430	♦ 73523	♦ 73651	♦ 73753	♦ 74078	♦ 74459	♦ 74860
♦ 73032	♦ 73435	♦ 73526	♦ 73655	♦ 73756	♦ 74083	♦ 74461	♦ 74880
♦ 73033	♦ 73436	♦ 73529	♦ 73701	♦ 73757	♦ 74401	♦ 74463	♦ 74936
♦ 73038	♦ 73437	♦ 73533	♦ 73702	♦ 73773	♦ 74402	♦ 74464	♦ 74945
♦ 73039	♦ 73438	♦ 73534	♦ 73703	♦ 74020	♦ 74423	♦ 74465	♦ 74946
♦ 73041	♦ 73441	♦ 73536	♦ 73705	♦ 74027	♦ 74426	♦ 74468	♦ 74948
♦ 73042	♦ 73442	♦ 73539	♦ 73706	♦ 74032	♦ 74427	♦ 74469	♦ 74954
♦ 73053	♦ 73443	♦ 73549	♦ 73720	♦ 74034	♦ 74428	♦ 74470	♦ 74955
♦ 73061	♦ 73448	♦ 73556	♦ 73727	♦ 74042	♦ 74432	♦ 74471	♦ 74962
♦ 73062	♦ 73453	♦ 73559	♦ 73730	♦ 74045	♦ 74435	♦ 74630	
♦ 73077	♦ 73458	♦ 73560	♦ 73733	♦ 74058	♦ 74438	♦ 74640	
♦ 73086	♦ 73459	♦ 73564	♦ 73734	♦ 74062	♦ 74439	♦ 74644	

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 to your coverage, your *Option Period Enrollment/Change Form* must be postmarked by December 4, 2009.

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

Keep your *Option Period Enrollment/Change Form* as verification of your coverage.

A searchable text version of this Option Period 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. 14,000 copies have been printed at a cost of $0.417 each. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

Oklahoma State and Education Employees Group Insurance Board

Monthly Premiums for Former Employees and Surviving Dependents

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	$1108.34	$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
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	**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 PLAN*	PRE-MEDICARE RETIREE/VESTS	
From $5,000 to $40,000	$1.94 Per $1,000	
Age-Rated Supplemental 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.

*** Life insurance premiums for surviving dependents can be found on the next page.**

Oklahoma State and Education Employees Group Insurance Board

Plan Year January 1, 2010 - December 31, 2010

Monthly Life Insurance Premiums for Surviving Dependents

SURVIVING DEPENDENTS OF CURRENT EMPLOYEES	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
SURVIVING DEPENDENTS OF FORMER EMPLOYEES	$0.97 Per $500 Unit, Per Dependent		

Monthly Premiums for COBRA Employees and Dependents
Current and Pre-Medicare Rates

HEALTH PLANS	MEMBER	*SPOUSE	*CHILD	*CHILDREN
HealthChoice High	$451.66	$638.40	$232.89	$349.29
HealthChoice Basic	$391.90	$557.78	$204.37	$306.90
HealthChoice S-Account	$373.12	$523.95	$194.13	$289.66
HealthChoice USA	$692.14	$692.14	$230.86	$346.10
Aetna Standard HMO	$729.71	$970.41	$498.56	$797.68
Aetna Alternative HMO	$512.37	$681.38	$350.06	$560.10
CommunityCare Standard HMO	$790.58	$1130.51	$395.29	$632.46
CommunityCare Alternative HMO	$545.23	$779.67	$272.63	$436.19
GlobalHealth Standard HMO	$351.06	$520.91	$188.25	$300.19
GlobalHealth Alternative HMO	$319.16	$473.59	$171.18	$272.89
PacifiCare Standard HMO	$617.30	$887.56	$308.43	$493.60
PacifiCare Alternative HMO	$425.73	$612.10	$212.69	$340.39
DENTAL PLANS	**MEMBER**	***SPOUSE**	***CHILD**	***CHILDREN**
HealthChoice Dental	$30.89	$30.89	$25.74	$66.81
Assurant Freedom Preferred	$26.86	$26.70	$20.02	$53.85
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)	$31.09	$31.11	$27.34	$69.58
Delta's Choice (PPO)	$13.67	$31.05	$31.29	$75.95
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
Superior Vision Services	$7.12	$7.04	$6.73	$6.73
UnitedHealthcare Vision	$8.34	$5.91	$4.68	$7.12
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 DECEMBER 4, 2009

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 Guide. There is no guarantee that all providers will remain with the plans or have open patient slots throughout the year. Please verify your providers' participation in your plan's network.

2010 PLAN CHANGES

Health Plan Changes

HealthChoice Plans

- Copays are being increased from $25 to $50. All plan changes are indicated by bold text in the *Comparison of Benefits for Health Plans* on pages 12-19.

HealthChoice Pharmacy Benefit

- Pharmacy copays are being increased. Changes are indicated by bold text in the *Comparison of Benefits for Health Plans* on page 18.
- 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 12-19.
- Some HMO service areas are changing. See the *HMO ZIP Code List* on pages 8-10 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 20-21 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.

Vision Plan Changes

- Humana/CompBenefits will apply a $25 copay for frames purchased out-of-network. This change is indicated in bold text in the *Comparison of Benefits for Vision Plans* on page 22.

If you have questions about any of the plans, see *Help Lines* located on pages 25-26 of this Option Period Guide.

INTRODUCTION

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) produced this Option Period Guide to help you select your benefits. It is a summary of the available plans for 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 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.
- 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 your *Option Period Enrollment/Change Form* as verification of your insurance coverage.
- Review premium rates and plan changes for 2010. Premium rates are listed at the front of this Guide and plan changes are listed on page 2 of this Guide.
- Use the following resources to help you decide on coverage for yourself and your dependents:

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

- Decide on coverage for yourself (and your dependents) for 2010.
- 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.
- Complete your *Option Period Enrollment/Change Form* and return it to OSEEGIB by December 4, 2009.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact OSEEGIB Member Services if your *Confirmation Statement* is incorrect.

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 informing 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

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 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 pages 25-26 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 by December 15, 2009. Without proof, your health plan will default to the HealthChoice Basic Plan.
- You must live within the HMO's ZIP Code service area to be eligible for an HMO. Post Office 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* on pages 25-26 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 to determine your costs under each plan.

- All dental plans have toll-free numbers for customer service. See *Help Lines* on pages 25-26 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 Plan
- UnitedHealthcare Vision
- Vision Service Plan (VSP)

See *Comparison of Benefits for Vision Plans* on pages 22-23 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 pages 25-26 of this Guide.
- Verify your vision provider is a member of the vision plan's network by calling the toll-free numbers 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.

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.

HEALTHCHOICE LIFE INSURANCE

Please take time this Option Period to consider your life insurance needs. Former employees and surviving dependents have the following life insurance options:

- Retain your current amount of life insurance
- Reduce your amount of life insurance
- Reduce your amount of dependent life insurance, if enrolled
- 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 2010 plan year. Keep in mind that as a former employee or surviving dependent, you cannot reinstate any life insurance that you terminate or decrease.

Beneficiary Designation

Benefits are paid to your beneficiary(ies) in a lump sum. Your beneficiary designation may be changed at any time. For a *Beneficiary Designation Form* or more information, contact HealthChoice Member Services. See *Help Lines* on pages 25-26 of this Guide. *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.

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 and/or dental plans that are currently in place
- Drop benefits and/or dependents
- Decrease life insurance coverage
- Enroll in or change vision plans

COBRA participants can:

- Add dependents
- Add or change coverage (health, dental, or vision) as long as your former employer participates in that benefit
- Drop benefits and/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 2010 plan year.

The benefits you select will be in effect from January 1, 2010, through December 31, 2010. Please contact the insurance plans for more information. See *Help Lines* on pages 25-26 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, 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**.

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 because of 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 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 letter must be sent to OSEEGIB within 30 days of the birth. If you are a former employee or surviving spouse and do not enroll your newborn during this 30-day

period, you will not be able to do so at a later date. If you are a COBRA participant and 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 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. Contact OSEEGIB Member Services for more information. See *Help Lines* on pages 25-26 of this Guide.

COBRA Coverage

COBRA coverage may be available for dependents who become ineligible. Examples of COBRA qualifying events for dependents include:

- Reaching age 25 (See second bullet under Dependents on previous page)
- Divorce of a spouse
- Marriage of a child
- Death of the covered employee

Important Information When Becoming Eligible for Medicare

Eligible for Medicare Prior to Turning 65

If you are under age 65 and eligible for Medicare, you must notify OSEEGIB to begin the enrollment process into a Medicare supplement/Medicare Advantage Prescription Drug (MA-PD) plan. You will be asked to provide your Medicare ID number as it appears on your Medicare card. Depending on the plan you're enrolled in, you may have different options for your Medicare coverage. Your Medicare coverage will become effective as of the date you become eligible for Medicare or the first of the month after you complete the enrollment process, whichever is later.

Aging into Medicare

You will receive a letter approximately two months prior to your 65th birthday detailing your options for Medicare coverage. If you are enrolled in HealthChoice, you will automatically be enrolled in the HealthChoice Employer PDP High Option Medicare Supplement With Part D Plan. If you are enrolled in an HMO, you may enroll in either their Medicare supplement (if available) or MA-PD Plan (if available).

All Medicare Eligible Members

To maximize your benefits, you are encouraged to enroll in Medicare Part B. The HealthChoice Medicare Supplement plans do not require you to be enrolled in Part B, but pay as though you are enrolled in Part B. All other Medicare supplement plans and MA-PD plans offered through OSEEGIB **require** you to have both Medicare Part A and Part B.

HMO ZIP Code List

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

HMO ZIP CODE LIST

73002 G P	73039 G	73077 C	73115 A C G P	73152 A C G P	73425 G
73001 G	73040 G	73078 A C G P	73116 A C G P	73153 A C G P	73430 G
73003 A C G P	73041 G	73079 G P	73117 A C G P	73154 A C G P	73432 G
73004 A G P	73042 G	73080 A G P	73118 A C G P	73155 A C G P	73433 G
73005 G	73043 G	73082 G	73119 A C G P	73156 A C G P	73434 G
73006 G	73044 A C G P	73083 A C G P	73120 A C G P	73157 A C G P	73435 G
73007 A C G P	73045 A C G P	73084 A C G P	73121 A C G P	73159 A C G P	73436 G
73008 A C G P	73047 G	73085 A C G P	73122 A C G P	73160 A C G P	73437 G
73009 G	73048 G	73086 G	73123 A C G P	73162 A C G P	73438 G
73010 A G P	73049 A C G P	73089 A G P	73124 A C G P	73163 A C G P	73441 G
73011 G P	73050 A C G P	73090 A C G P	73125 A C G P	73164 C G P	73442 G
73012 A C G P	73051 A C G P	73091 G	73126 A C G P	73165 A C G P	73443 G
73013 A C G P	73052 G	73092 G P	73127 A C G P	73167 A C G P	73444 G
73014 C P G	73053 G	73093 A G P	73128 A C G P	73169 A C G P	73446 G
73015 G	73054 A C G P	73094 G	73129 A C G P	73170 A C G P	73447 G
73016 G P	73055 G	73095 G P	73130 A C G P	73172 A C G P	73448 G
73017 G	73056 A C G P	73096 G	73131 A C G P	73173 A C G P	73450 G
73018 G P	73057 G P	73097 A C G P	73132 A C G P	73177 C P	73453 G
73019 A C G P	73058 A C G P	73098 G	73134 A C G P	73178 A C G P	73455 G
73020 A C G P	73059 A G P	73099 A C G P	73135 A C G P	73179 A C G P	73458 G
73022 A C G P	73061 C	73100 C	73136 A C G P	73180 C P	73459 G
73023 G	73062 G	73101 A C G P	73137 A C G P	73184 A C G P	73460 G
73025 A C G P	73063 A C G P	73102 A C G P	73139 A C G P	73185 A C G P	73461 G
73026 A C G P	73064 A C G P	73103 A C G P	73140 A C G P	73189 A C G P	73463 G
73027 A C G P	73065 A G P	73104 A C G P	73141 A C G P	73190 A C G P	73481 G
73028 A C G P	73066 A C G P	73105 A C G P	73142 A C G P	73193 C P	73487 G
73029 G	73067 G P	73106 A C G P	73143 A C G P	73194 A C G P	73488 G
73030 G	73068 A C G P	73107 A C G P	73144 A C G P	73195 A C G P	73491 G
73031 A G P	73069 A C G P	73108 A C G P	73145 A C G P	73196 A C G P	73521 G
73032 G	73070 A C G P	73109 A C G P	73146 A C G P	73197 A C P	73522 G
73033 G	73071 A C G P	73110 A C G P	73147 A C G P	73198 A C G P	73523 G
73034 A C G P	73072 A C G P	73111 A C G P	73148 A C G P	73199 A C P	73526 G
73036 A C G P	73073 A C G P	73112 A C G P	73149 A C G P	73401 G	73529 G
73037 C P	73074 G	73113 A C G P	73150 A C G P	73402 G	73532 G
73038 G	73075 G	73114 A C G P	73151 A C G P	73403 G	73533 G

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HMO ZIP Code List

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

73534 G	73733 G	74011 A C G P	74050 A C G P	74103 A C G P	74153 A C G P
73536 G	73734 G	74012 A C G P	74051 C G	74104 A C G P	74155 A C G P
73537 G	73735 G	74013 A C G P	74052 C P G	74105 A C G P	74156 A C G P
73539 G	73736 G	74014 A C G P	74053 A C G P	74106 A C G P	74157 A C G P
73544 G	73737 G	74015 A C G P	74054 A C G P	74107 A C G P	74158 A C G P
73549 G	73738 G	74016 A C G P	74055 A C G P	74108 A C G P	74159 A C G P
73550 G	73742 G	74017 A C G P	74056 C G	74110 A C G P	74169 A C G P
73554 G	73743 G	74018 A C G P	74058 C	74112 A C G P	74170 A C G P
73556 G	73744 G	74019 A C G P	74059 C G P	74114 A C G P	74171 A C G P
73559 G	73747 G	74020 C P	74060 A C G P	74115 A C G P	74172 A C G P
73560 G	73750 G	74021 A C G P	74061 C G P	74116 A C G P	74182 A C G P
73564 G	73753 G	74022 C G	74062 C P	74117 A C G P	74183 A C P
73566 G	73754 G	74023 C G P	74063 A C G P	74119 A C G P	74184 A C
73571 G	73755 G	74026 G P	74066 A C G P	74120 A C G P	74186 A C G P
73601 G	73756 G	74027 C	74067 A C G P	74121 A C G P	74187 A C G P
73620 G	73757 C	74028 C P G	74068 C P G	74126 A C G P	74189 A C P
73625 G	73760 G	74029 C	74070 A C G P	74127 A C G P	74192 A C G P
73639 G	73762 G P	74030 C P G	74071 C P G	74128 A C G P	74193 A C G P
73646 G	73763 G	74031 A C G P	74072 C	74129 A C G P	74194 A C P
73651 G	73764 G	74032 C P	74073 A C G P	74130 A C G P	74301 C P
73655 G	73768 G	74033 A C G P	74074 C P	74131 A C G P	74330 A C G P
73658 G	73770 G	74034 C	74075 C P	74132 A C G P	74331 C
73669 G	73772 G	74035 C G P	74076 C P	74133 A C G P	74332 C G
73701 G	73773 G	74036 A C G P	74077 C	74134 A C G P	74333 C
73702 G	73838 G	74037 A C G P	74078 C	74135 A C G P	74335 C
73703 G	73860 G	74038 C P G	74079 G P	74136 A C G P	74337 A C G P
73705 G	74001 C G	74039 A C G P	74080 A C G P	74137 A C G P	74338 C
73706 G	74002 C G P	74041 C P G	74081 C G P	74141 A C G P	74339 C
73716 G	74003 C G	74042 C	74082 C P	74145 A C G P	74340 A C G P
73718 G	74004 C	74043 A C G P	74083 C	74146 A C G P	74342 C
73720 G	74005 C	74044 C P G	74084 C G	74147 A C G P	74343 C
73724 G	74006 C	74045 C	74085 C G P	74148 A C G P	74344 C
73727 G	74008 A C G P	74046 C P G	74100 C	74149 A C G P	74345 C
73729 G	74009 C	74047 A C G P	74101 A C G P	74150 A C G P	74346 C
73730 G	74010 C P G	74048 C G	74102 A C G P	74152 A C G P	74347 C

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HMO ZIP Code List

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

74349	A C G P	74436	C P G	74502	C	74633	C G	74838	P	74901	C
74350	A C G P	74437	C G P	74521	C	74637	C G	74839	G	74902	C
74352	A C G P	74438	C	74522	C	74640	G	74840	A C G P	74930	C
74353	C P	74439	C	74523	C	74644	C	74842	G	74931	C
74354	C	74440	C	74526	C	74650	C G	74843	G	74932	C
74355	C	74441	C	74528	C	74651	C	74844	G	74935	C
74358	C	74442	C	74529	C	74652	C G	74845	C	74936	C
74359	C	74444	C	74530	G	74727	C	74848	G	74937	C
74360	C	74445	C G P	74531	G	74735	C	74849	C G P	74939	C
74361	A C G P	74446	C P G	74536	C	74738	C	74850	G	74940	C
74362	A C G P	74447	C G P	74543	C	74743	C	74851	A C G P	74941	C
74363	C	74450	C	74545	C	74748	G	74852	A C G P	74942	C
74364	A C G P	74451	C	74546	C	74756	C	74854	A C G P	74943	C
74365	A C G P	74452	C G	74547	C	74759	C	74855	A G P	74944	C
74366	A C G P	74454	C P G	74548	C	74760	C	74856	G	74945	C
74367	A C G P	74455	C	74549	C	74761	C	74857	A C G P	74946	C
74368	C	74456	C G P	74552	C	74801	A C G P	74859	G P	74947	C
74369	C	74457	C	74553	C	74802	A C G P	74860	G P	74948	C
74370	C	74458	C P G	74554	C	74804	A C G P	74862	P	74949	C
74401	C	74459	C	74557	C	74818	C G P	74864	G P	74951	C
74402	C	74460	C G P	74558	C	74820	G	74865	G	74953	C
74403	C G	74461	C	74559	C	74821	G	74866	A C G P	74954	C
74421	C G P	74462	C	74560	C	74824	G P	74867	C G P	74955	C
74422	C G P	74463	C	74561	C	74825	G	74868	C G P	74956	C
74423	C	74464	C	74562	C	74826	A C G P	74869	A G P	74959	C
74425	C	74465	C	74563	C	74827	G	74871	G	74960	C
74426	C	74466	C P	74565	C	74829	P	74872	G	74962	C
74427	C	74467	C P G	74567	C	74830	C G P	74873	A C G P	74964	C
74428	C	74468	C	74570	G	74831	A G P	74875	G P	74965	C
74429	A C G P	74469	C	74571	C	74832	G P	74878	A C G P	74966	C
74430	C	74470	C	74574	C	74833	P	74880	G P		
74431	C G P	74471	C	74577	C	74834	G P	74881	A G P		
74432	C	74472	C	74578	C	74835	P	74882	P		
74434	C G	74477	C P G	74604	C G	74836	G	74883	G		
74435	C	74501	C	74630	C	74837	C G P	74884	C G P		

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

Health Plans	Calendar Year Health Plan Deductible (Network)	Calendar Year Out-of-Pocket Maximum
HealthChoice High	$500/Individual	$2,800/Individual – Network $3,300/Individual – Non-Network + amounts above Allowed Charges
	$1,500/Family	No Family Out-of-Pocket Maximum
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	$2,500/Individual
	$0/Family	$5,000/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 maximum must be met before the plan pays 100% of Allowed Charges for the rest of the calendar year.**

HEALTH PLAN COMPARISON

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 pages 25-26 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 copay per visit 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

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 pages 25-26 of this Guide for contact information.

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

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 pages 25-26 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	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)**

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 pages 25-26 of this Guide for contact information.

HEALTH PLAN COMPARISON

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 pages 25-26 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 pages 25-26 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

DENTAL PLAN COMPARISON

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 applies	$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

VISION PLAN COMPARISON

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
				*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.	

Vision benefits apply from January 1 through December 31, 2010

VISION PLAN COMPARISON

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).

All HealthChoice prescription drug benefits meet or exceed the standards set by CMS; therefore, the HealthChoice plans provide our members with Creditable Coverage. Additionally, all other health plans offered through the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) also provide Creditable Coverage.

Since you have Creditable Coverage through one of the plans offered through OSEEGIB, 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* on pages 25-26 of this Guide.

Nearing Medicare Eligibility

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

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

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 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

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 Oklahoma City Area	1-405-949-2281
TDD 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.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	1-405-280-5600
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

Notes

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