OSEEGIB
Oklahoma State and Education
Employees Group Insurance Board

Guide to Pre-Medicare Health Plans

Plan Year 2010

January 1 through December 31, 2010

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

#2330

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 page 17 of this Guide.

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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.

Oklahoma State and Education Employees Group Insurance Board

Monthly Health Plan 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
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

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.

The information contained in this Guide is only a brief summary of the listed options. All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks, and Rules of the Oklahoma State and Education Employees Group Insurance Board. The Federal Regulation at 42 C.F.R. § 423 et seq. and the Rules of the Oklahoma Administrative Code, Title 360, are controlling in all aspects of Plan benefits. No oral statement of any person shall modify or otherwise affect the benefits, limitations, or exclusions of any plan.

This publication was printed by the Oklahoma State and Education Employees Group Insurance Board as authorized by 74 O.S. Section 1301, et seq; 200 copies have been printed at a cost of $0.06 each. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

INTRODUCTION

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) produced this Guide to help you select your health plan. It is a summary of the available health plans for the following members who are not yet eligible for Medicare:

- Former employees and their dependents
- Surviving dependents

Helpful Hints

- Review the premium rates listed at the front 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 the health coverage for yourself (and your dependents) for the remainder of 2010.
- Follow the instructions provided in the letter you received with this Guide to select your health plan.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact OSEEGIB Member Services immediately 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 10 health plans available:

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

See *Comparison of Benefits for Health Plans* on pages 9-16 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 page 17 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 within 30 days of your enrollment in the Plan. 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 5-7 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 page 17 of this Guide.

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

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

C = CommunityCare G = GlobalHealth P = PacifiCare

HMO ZIP CODE LIST

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

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HMO ZIP Code List

C = CommunityCare G = GlobalHealth P = PacifiCare

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

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HMO ZIP Code List

C = CommunityCare G = GlobalHealth P = PacifiCare

74349 C G P	74436 C P G	74502 C	74633 C G	74838 P	74901 C
74350 C G P	74437 C G P	74521 C	74637 C G	74839 G	74902 C
74352 C G P	74438 C	74522 C	74640 G	74840 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 C G P	74446 C P G	74536 C	74738 C	74850 G	74940 C
74362 C G P	74447 C G P	74543 C	74743 C	74851 C G P	74941 C
74363 C	74450 C	74545 C	74748 G	74852 C G P	74942 C
74364 C G P	74451 C	74546 C	74756 C	74854 C G P	74943 C
74365 C G P	74452 C G	74547 C	74759 C	74855 G P	74944 C
74366 C G P	74454 C P G	74548 C	74760 C	74856 G	74945 C
74367 C G P	74455 C	74549 C	74761 C	74857 C G P	74946 C
74368 C	74456 C G P	74552 C	74801 C G P	74859 G P	74947 C
74369 C	74457 C	74553 C	74802 C G P	74860 G P	74948 C
74370 C	74458 C P G	74554 C	74804 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 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 C G P	74869 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 C G P	74964 C
74428 C	74468 C	74570 G	74831 G P	74875 G P	74965 C
74429 C G P	74469 C	74571 C	74832 G P	74878 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 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 page 17 of this Guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
No deductible	No deductible	No deductible	Calendar Year Deductibles
$3,000 individual $6,000 family	$3,000 individual $5,000 family	$2,500 individual $5,000 family	Calendar Year Out-of-Pocket Maximum
$35 copay/PCP $50 copay/specialist	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist	Office Visit (Professional Services)
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
$500 copay	$250 copay per day $750 maximum per admission	$1,000 copay/admission	Hospital Inpatient Admission
$300 copay	$250 copay	$500 copay	Hospital Outpatient Visit
$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 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 page 17 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 page 17 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

CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
$25 copay	$25 copay/PCP Limit: One per year	$35 copay/PCP $50 copay/specialist	Periodic Health Exams
$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 copay; waived if admitted	$150 copay; waived if admitted	$200 copay; waived if admitted	Emergency Health Care Facility Visit
$50 copay per visit	$25 copay/PCP $50 copay/all others	$50 copay per visit	After Hours Urgent Care
$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
$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% 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 page 17 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 page 17 of this Guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
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
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
$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
$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
$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 page 17 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, <u>plus</u> 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, <u>plus</u> 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

CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
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 Lesser of a 30-day supply or 100 units Certain medications have restricted quantities	**Pharmacy Benefits**

PHARMACY

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

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

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