OSEEGIB
Oklahoma State and Education
Employees Group Insurance Board

FORMER EMPLOYEES SURVIVING DEPENDENTS AND COBRA PARTICIPANTS OPTION PERIOD GUIDE

Plan Year 2011

January 1 through December 31, 2011

Health

Dental

Life

Vision

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

#2389

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 7, 2010.

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.

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

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

A text version of this 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, or TDD 1-405-521-4672.

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Oklahoma State and Education Employees Group Insurance Board
Monthly Premiums for Former Employees and Surviving Dependents
Plan Year January 1, 2011 - December 31, 2011

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High Option	$449.48	$ 682.74	$228.20	$352.08
HealthChoice Basic	$391.64	$ 598.48	$201.82	$310.80
HealthChoice S-Account	$382.56	$ 562.74	$190.18	$291.90
HealthChoice USA	$688.82	$ 688.82	$226.22	$348.86
CommunityCare Standard HMO	$772.34	$1,104.42	$386.16	$617.86
CommunityCare Alternative HMO	$532.66	$ 761.68	$266.34	$426.12
GlobalHealth Standard HMO	$366.56	$ 601.22	$193.12	$307.96
GlobalHealth Alternative HMO	$333.26	$ 546.58	$175.62	$279.98
PacifiCare Standard HMO	$686.42	$ 986.94	$342.96	$548.86
PacifiCare Alternative HMO	$473.39	$ 680.63	$236.51	$378.51

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice Dental	$29.84	$29.84	$24.88	$64.56
Assurant Freedom Preferred	$28.83	$28.67	$21.50	$57.80
Assurant Heritage Plus with SBA (Prepaid)	$11.74	$ 8.86	$ 7.60	$15.20
Assurant Heritage Secure (Prepaid)	$ 7.20	$ 5.98	$ 5.20	$10.38
CIGNA Dental Care Plan (Prepaid)	$ 9.26	$ 6.06	$ 7.08	$15.32
Delta Dental PPO	$31.14	$31.14	$27.10	$68.56
Delta Dental Premier	$35.52	$35.52	$30.90	$78.20
Delta Dental PPO – Choice	$13.94	$31.64	$31.90	$77.42

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Humana/CompBenefits VisionCare Plan	$6.76	$5.06	$3.57	$ 4.46
Primary Vision Care Services (PVCS)	$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)	$8.76	$5.87	$5.62	$12.64

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	

These 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, 2011 - December 31, 2011
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 26)	$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 Participants and Dependents
Current Employee and Pre-Medicare Former Employee Rates

HEALTH PLANS	MEMBER	SPOUSE*	CHILD*	CHILDREN*
HealthChoice High Option	$458.47	$ 696.39	$232.76	$359.12
HealthChoice Basic	$399.47	$ 610.45	$205.86	$317.02
HealthChoice S-Account	$390.21	$ 573.99	$193.98	$297.74
HealthChoice USA	$702.60	$ 702.60	$230.74	$355.84
CommunityCare Standard HMO	$787.79	$1,126.51	$393.88	$630.22
CommunityCare Alternative HMO	$543.31	$ 776.91	$271.67	$434.64
GlobalHealth Standard HMO	$373.89	$ 613.24	$196.98	$314.12
GlobalHealth Alternative HMO	$339.93	$ 557.51	$179.13	$285.58
PacifiCare Standard HMO	$700.15	$1,006.68	$349.82	$559.84
PacifiCare Alternative HMO	$482.86	$ 694.24	$241.24	$386.08
DENTAL PLANS	**MEMBER**	**SPOUSE***	**CHILD***	**CHILDREN***
HealthChoice Dental	$30.44	$30.44	$25.38	$65.85
Assurant Freedom Preferred	$29.41	$29.24	$21.93	$58.96
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	$31.76	$31.76	$27.64	$69.93
Delta Dental Premier	$36.23	$36.23	$31.52	$79.76
Delta Dental PPO – Choice	$14.22	$32.27	$32.54	$78.97
VISION PLANS	**MEMBER**	**SPOUSE***	**CHILD***	**CHILDREN***
Humana/CompBenefits VisionCare Plan	$6.90	$5.16	$3.64	$ 4.55
Primary Vision Care Services (PVCS)	$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)	$8.94	$5.99	$5.73	$12.89

*** It is the policy of the Oklahoma State and Education Employees Group Insurance Board 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 keep coverage, one person will always be billed at the primary member rate.**

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

YOUR FORM MUST BE POSTMARKED BY DECEMBER 7, 2010

If you are not making any changes, you do not need to return your *Option Period Enrollment/ Change Form.* Keep your form as proof of your coverage.

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

2011 PLAN CHANGES

All plan changes are indicated by **bold text** in the *Comparison of Benefits* charts.

Notice of Eligibility to Age 26

- Dependents are now eligible up to age 26, whether married or unmarried. **OSEEGIB is allowing a one-time opportunity during this Option Period for you to enroll eligible dependent children.** See the new definition of eligible dependents on page 7. The election to add a dependent child must be made prior to December 7, 2010. Use the form located on page 29 to enroll your dependent child.

Health Plan Changes

HealthChoice Health Plans

- **Patient Protection and Affordable Care Act Disclosure of Grandfather Status** – HealthChoice believes it is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your HealthChoice health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

  Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to HealthChoice, 3545 N.W. 58th, Ste.110, OKC, OK 73112 or call 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. You may also contact the U.S. Department of Health and Human Services at **www.healthcare.gov**.

HealthChoice High Option and USA Plans

- Copays are being decreased to $30 for primary care physician office visits and other copay-related services received from a primary care physician; however, the copays for specialist office visits and other copay-related services received from a specialist will remain $50. The following are considered primary care physicians: General Practitioners, Internal Medicine physicians, OB/GYNs, Pediatricians, Physician Assistants, and Nurse Practitioners. HealthChoice members do not need to designate a primary care physician and can change physicians at any time.
- Preventive service visits for members and dependents under age 20 will be available with no copay through a Network Provider according to the following schedule:

Well Child Care Visits	Plan Year 2011
Age 0 to 12 months	8
Age 1 through 2 years	4
Age 3 through 5 years	2
Age 6 through 19 years	1

One preventive services visit per calendar year, including one metabolic panel and one lipid panel,

will be covered at 100% with no copay through a Network Provider for members and dependents age 20 and older.

HealthChoice Basic and S-Account Plans

- All plan provisions including deductibles, copays, and out-of-pocket maximums remain the same as Plan Year 2010; however, the schedule of well child care visits on the previous page applies.

HealthChoice Pharmacy Benefit

- The $2 million lifetime limit on pharmacy benefits is being eliminated.
- HealthChoice offers certain prescription tobacco cessation medications for a $5 copay. Additionally, HealthChoice partners with the Tobacco Settlement Endowment Trust (TSET) and Free and Clear to provide members with over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone coaching at no charge to HealthChoice health plan members.

HMOs

- **Attention current Aetna members** – Aetna is not a participating HMO for Plan Year 2011. If you are currently enrolled in Aetna Standard or Alternative Plan, **you must choose another health plan**.
- **Attention current CommunityCare members** – CommunityCare has restructured its provider network in the Oklahoma City area. Please verify your provider still participates in CommunityCare's provider network. See *Help Lines* on page 28 & 31.
- HMO service areas are changing. See the HMO ZIP Code List on pages 10-12 to check your eligibility.
- All HMO Standard and Alternative plans will cover a preventive office visit with a primary care physician at 100% with no copay.
- All HMO Standard and Alternative plans will cover specific preventive services at no cost to you as required by the Patient Protection and Affordable Care Act. Check with the individual health plan for more information.
- Several of the copays and the quantity per fill for prescriptions are changing.

Dental Plan Changes

DMOs/Prepaid Dental

- Delta Dental is not offering the Delta Dental PPO - Point of Service plan for 2011. If you are currently enrolled in this plan, **you must choose another dental plan for 2011**.
- Delta Dental is offering 3 plans: Delta Dental PPO, Delta Dental Premier, and Delta Dental PPO – Choice.
- Several of the out-of-pocket maximums and copays are changing.

All plan changes are indicated by **bold text** in the *Comparison of Benefits* charts.

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

See the *Monthly Premium Chart* and *Comparison of Benefits* charts to determine your costs under each plan.

Helpful Hints For Option Period

- Review the upper right-hand section of your pre-printed *Option Period Enrollment/Change Form*. This is the coverage you will have effective January 1, 2011, if you do not make changes during Option Period. Aetna HMO members and Delta Dental PPO – Point of Service plan members must choose a different plan. See plan changes on page 3.
- 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 the premium rates and plan changes for 2011. Premium rates are listed at the front of this Guide and plan changes are listed on pages 2-3 of this Guide.
- Use the following resources to help you decide on coverage for yourself and your dependents:
  - This Guide
  - Plan Websites
  - Customer Service Telephone Numbers
  - Provider Directories
  - OSEEGIB Member Services

- Check the appropriate box(es) 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 7, 2010.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact OSEEGIB Member Services right away if your *Confirmation Statement* is not correct.

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 PLANS

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 14-21 for specific benefit information.

- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- You must live within the HMO's ZIP Code service area to be eligible. Post Office Box addresses cannot be used to determine your HMO eligibility. See pages 10-12 for the *HMO ZIP Code List*.
- To enroll in the HealthChoice S-Account Plan, you must provide OSEEGIB with proof you have a Health Savings Account at a bank or other financial institution. This proof must be submitted by December 15, 2010. Without proof, your health plan will default to the HealthChoice Basic Plan.
- All health plans coordinate benefits with other group insurance plans you have in force. For more information, check with each health plan.
- All plans have toll-free numbers for customer service. See *Help Lines* on pages 28 & 31 of this Guide.
- Check with each health plan if you have benefit questions.

*Pre-Medicare retirees who live outside of Oklahoma and Arkansas are eligible to enroll in HealthChoice USA which includes a national provider network. Call HealthChoice for details. See *Help Lines* on pages 28 & 31 of this Guide.

DENTAL PLANS

There are eight 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
- Delta Dental Premier
- Delta Dental PPO – Choice

See *Comparison of Benefits for Dental Plans* on pages 22-23 for specific benefit information.

- All dental plans have toll-free numbers for customer service. See *Help Lines* on pages 28 & 31 of this Guide.
- Check with the individual dental plan if you have benefit questions.

VISION PLANS

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 24-25 for specific benefit information.

- Verify your vision provider participates in a vision plan's network by contacting the plan, visiting the plan's website, or by calling your provider.
- 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 28 & 31 of this Guide.
- Check with the individual vision plan if you have benefit questions.

For directions on how to access each health, dental, and vision plan's provider network, see pages 26-27. If your provider leaves your health, dental, or vision plan, you cannot change plans until the next annual Option Period; however, 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:

- Keep 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. Keep in mind that as a former employee or surviving dependent, you cannot reinstate any life insurance that you decrease or terminate.

Beneficiary Designation

Benefits are paid to your beneficiary in a lump sum. Your beneficiary designation can be changed at any time. For a *Beneficiary Designation Form* or more information, contact HealthChoice Member Services. See *Help Lines* on pages 28 & 31 of this Guide. These 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

Former employees (retired, vested, and non-vested), COBRA participants, and surviving dependents can make certain changes during Option Period:

Former employees and surviving dependents can:

- Add eligible dependents up to age 26 (only during this Option Period)
- Change health and/or dental plans that are currently in place
- Drop coverage and/or dependents
- Decrease life insurance coverage
- Enroll in or change vision plans

COBRA participants can:

- Add eligible dependents up to age 26
- Add or change coverage (health, dental, and/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 2011 plan year.

Aetna HMO members and Delta Dental PPO – Point of Service plan members must choose a different plan. See plan changes on page 3.

The benefits you select will be in effect from January 1, 2011, through December 31, 2011. After enrollment, the plans you have selected will provide 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. You can elect not to cover dependents who do not reside with you, are married, are not financially dependent on you for support, have other group coverage, or are eligible for Indian or military health benefits. Eligible dependents include:

- Your legal spouse (including common-law).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child, or child legally placed with you for adoption up to age 26, whether married or unmarried.
- A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Subject to medical review and approval.
- Other unmarried dependent children up to age 26, upon completion of an *Application for Coverage for Other Dependent Children*. Guardianship papers or a tax return showing dependency may be provided in lieu of the application.

- If your spouse is enrolled separately in one of the OSEEGIB plans, your dependents may be covered under only one parent's health, dental, and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life insurance.

- Dependents can only be enrolled in the same types of coverage and in the same plans you have.
- To enroll your newborn, a letter requesting coverage of the newborn 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. Under the HealthChoice plans, a separate deductible and coinsurance may apply.
- Without enrollment, newborns will be covered only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Deductible and coinsurance may apply.

Excluding Dependents From Coverage

- You can exclude your spouse from health and/or dental coverage. Your spouse must sign the *Spouse Exclusion Certification* section of the enrollment or change form.
- You can exclude your spouse or other dependents who do not reside with you, are married, are not financially dependent on you for support, have other group coverage, or are eligible for Indian or military health benefits.

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

COBRA Coverage

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

- Reaching age 26 (applies only to dependent children)
- Divorce of a spouse
- Death of the covered employee

Important Information About Becoming Eligible for Medicare

Eligible for Medicare Prior to Turning 65

If you are under age 65 and become eligible for Medicare, you must notify OSEEGIB to begin the enrollment process into a Medicare supplement or 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 supplement or MA-PD coverage. Your Medicare supplement or MA-PD coverage will become effective 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

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 also provide instructions

on how to enroll with a Medicare supplement or MA-PD plan.

If you are enrolled in HealthChoice, you will automatically be enrolled in the HealthChoice Employer PDP High Option Medicare Supplement Plan With Part D. If you are enrolled in an HMO, you can enroll in either its Medicare supplement (if available) or MA-PD Plan (if available in your service area). If you or one of your dependents will soon become Medicare eligible, watch your mail for this important enrollment information.

All Medicare Eligible Members

OSEEGIB Rules state that all covered individuals who are eligible for Medicare, except current employees, must be enrolled in a Medicare supplement plan offered through OSEEGIB, regardless of age. To maximize your benefits, you need 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.

Notice of 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 as it applies to Medicare Part D 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 for Part D 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 for Part D, contact HealthChoice Member Services. See *Help Lines* on pages 28 & 31 of this Guide.

HMO ZIP Code List

C = CommunityCare G = GlobalHealth* P = PacifiCare

73001	G	73042	G	73086	G	73129	C G P	73179	C G P	73463	G
73002	G P	73043	G	73089	G P	73130	C G P	73180	C P	73481	G
73003	C G P	73044	C G P	73090	C G P	73131	C G P	73184	C G P	73487	G
73004	G P	73045	C G P	73092	G P	73132	C G P	73185	C G P	73488	G
73005	G	73047	G	73093	G P	73134	C G P	73189	C G P	73491	G
73006	G	73048	G	73094	G	73135	C G P	73190	C G P	73501	G
73007	C G P	73049	C G P	73095	G P	73136	C G P	73193	C P	73502	G
73008	C G P	73050	C G P	73096	G	73137	C G P	73194	C G P	73503	G
73009	G	73051	C G P	73097	C G P	73139	C G P	73195	C G P	73505	G
73010	G P	73052	G	73098	G	73140	C G P	73196	C G P	73506	G
73011	G P	73053	G	73099	C G P	73141	C G P	73197	C P	73507	G
73012	C G P	73054	C G P	73100	C	73142	C G P	73198	C G P	73520	G
73013	C G P	73055	G	73101	C G P	73143	C G P	73199	C P	73521	G
73014	C G P	73056	C G P	73102	C G P	73144	C G P	73401	G	73522	G
73015	G	73057	G P	73103	C G P	73145	C G P	73402	G	73523	G
73016	G P	73058	C G P	73104	C G P	73146	C G P	73403	G	73526	G
73017	G	73059	G P	73105	C G P	73147	C G P	73425	G	73527	G
73018	G P	73061	C G	73106	C G P	73148	C G P	73430	G	73528	G
73019	C G P	73062	G	73107	C G P	73149	C G P	73432	G	73529	G
73020	C G P	73063	C G P	73108	C G P	73150	C G P	73433	G	73530	G
73021	G	73064	C G P	73109	C G P	73151	C G P	73434	G	73532	G
73022	C G P	73065	G P	73110	C G P	73152	C G P	73435	G	73533	G
73023	G	73066	C G P	73111	C G P	73153	C G P	73436	G	73534	G
73024	G	73067	G P	73112	C G P	73154	C G P	73437	G	73536	G
73025	C G P	73068	C G P	73113	C G P	73155	C G P	73438	G	73537	G
73026	C G P	73069	C G P	73114	C G P	73156	C G P	73441	G	73538	G
73027	C G P	73070	C G P	73115	C G P	73157	C G P	73442	G	73539	G
73028	C G P	73071	C G P	73116	C G P	73159	C G P	73443	G	73540	G
73029	G	73072	C G P	73117	C G P	73160	C G P	73444	G	73541	G
73030	G	73073	C G P	73118	C G P	73162	C G P	73447	G	73542	G
73031	G P	73074	G	73119	C G P	73163	C G P	73448	G	73543	G
73032	G	73075	G	73120	C G P	73164	C G P	73449	G	73544	G
73033	G	73077	C G	73121	C G P	73165	C G P	73450	G	73546	G
73034	C G P	73078	C G P	73122	C G P	73167	C G P	73453	G	73548	G
73036	C G P	73079	G P	73123	C G P	73169	C G P	73455	G	73549	G
73037	C P	73080	G P	73124	C G P	73170	C G P	73456	G	73550	G
73038	G	73082	G	73125	C G P	73172	C G P	73458	G	73551	G
73039	G	73083	C G P	73126	C G P	73173	C G P	73459	G	73552	G
73040	G	73084	C G P	73127	C G P	73177	C P	73460	G	73553	G
73041	G	73085	C G P	73128	C G P	73178	C G P	73461	G	73555	G

*GlobalHealth may not be available in all the ZIP Codes indicated. Please contact GlobalHealth for correct service area information. See *Help Lines* on pages 28 & 31.

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HMO ZIP Code List

C = CommunityCare G = GlobalHealth* P = PacifiCare

73556	G	73718	G	73901	G	74038	C G P	74084	C G	74153	C G P
73557	G	73720	G	73939	G	74039	C G P	74085	C G P	74155	C G P
73558	G	73724	G	73942	G	74041	C G P	74100	C	74156	C G P
73559	G	73727	G	73944	G	74042	C G	74101	C G P	74157	C G P
73560	G	73729	G	73945	G	74043	C G P	74102	C G P	74158	C G P
73561	G	73730	G	73951	G	74044	C G P	74103	C G P	74159	C G P
73564	G	73733	G	74001	C G	74045	C G	74104	C G P	74169	C G P
73565	G	73734	G	74002	C G P	74046	C G P	74105	C G P	74170	C G P
73566	G	73735	G	74003	C G	74047	C G P	74106	C G P	74171	C G P
73567	G	73736	G	74004	C G	74048	C G	74107	C G P	74172	C G P
73569	G	73737	G	74005	C G	74050	C G P	74108	C G P	74182	C G P
73570	G	73738	G	74006	C G	74051	C G	74110	C G P	74183	C P
73571	G	73742	G	74008	C G P	74052	C G P	74112	C G P	74184	C
73573	G	73743	G	74009	C	74053	C G P	74114	C G P	74186	C G P
73601	G	73744	G	74010	C G P	74054	C G P	74115	C G P	74187	C G P
73620	G	73747	G	74011	C G P	74055	C G P	74116	C G P	74189	C P
73622	G	73750	G	74012	C G P	74056	C G	74117	C G P	74192	C G P
73624	G	73753	G	74013	C G P	74058	C G	74119	C G P	74193	C G P
73625	G	73754	G	74014	C G P	74059	C G P	74120	C G P	74194	C P
73626	G	73755	G	74015	C G P	74060	C G P	74121	C G P	74301	C G P
73627	G	73756	G	74016	C G P	74061	C G P	74126	C G P	74330	C G P
73632	G	73757	C G	74017	C G P	74062	C G P	74127	C G P	74331	C G
73639	G	73758	G	74018	C G P	74063	C G P	74128	C G P	74332	C G
73641	G	73759	G	74019	C G P	74066	C G P	74129	C G P	74333	C G
73644	G	73760	G	74020	C G P	74067	C G P	74130	C G P	74335	C G
73645	G	73761	G	74021	C G P	74068	C G P	74131	C G P	74337	C G P
73647	G	73762	G P	74022	C G	74070	C G P	74132	C G P	74338	C G
73648	G	73763	G	74023	C G P	74071	C G P	74133	C G P	74339	C G
73651	G	73764	G	74026	G P	74072	C G	74134	C G P	74340	C G P
73655	G	73766	G	74027	C G	74073	C G P	74135	C G P	74342	C G
73661	G	73768	G	74028	C G P	74074	C G P	74136	C G P	74343	C G
73662	G	73770	G	74029	C G	74075	C G P	74137	C G P	74344	C G
73664	G	73771	G	74030	C G P	74076	C G P	74141	C G P	74345	C G
73668	G	73772	G	74031	C G P	74077	C G	74145	C G P	74346	C G
73669	G	73773	G	74032	C G P	74078	C G	74146	C G P	74347	C G
73701	G	73834	G	74033	C G P	74079	G P	74147	C G P	74349	C G P
73702	G	73838	G	74034	C G	74080	C G P	74148	C G P	74350	C G P
73703	G	73848	G	74035	C G P	74081	C G P	74149	C G P	74352	C G P
73705	G	73851	G	74036	C G P	74082	C G P	74150	C G P	74353	C P
73706	G	73855	G	74037	C G P	74083	C G	74152	C G P	74354	C G

*GlobalHealth may not be available in all the ZIP Codes indicated. Please contact GlobalHealth for correct service area information. See *Help Lines* on pages 28 & 31.

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HMO ZIP Code List

C = CommunityCare G = GlobalHealth* P = PacifiCare

74355	C G	74447	C G P	74549	C G	74720	G	74824	G P	74873	G P
74358	C G	74450	C G	74552	C G	74721	G	74825	G	74875	G P
74359	C G	74451	C G	74553	C G	74722	G	74826	G P	74878	G P
74360	C G	74452	C G	74554	C G	74723	G	74827	G	74880	C G P
74361	C G P	74454	C G P	74557	C G	74724	G	74829	G P	74881	G P
74362	C G P	74455	C G	74558	C G	74726	G	74830	C G P	74882	P
74363	C G	74456	C G P	74559	C	74727	C G	74831	G P	74883	G
74364	C G P	74457	C G	74560	C G	74728	G	74832	G P	74884	C G P
74365	C G P	74458	C G P	74561	C G	74729	G	74833	G P	74901	C G
74366	C G P	74459	C G	74562	C G	74730	G	74834	G P P	74902	C G
74367	C G P	74460	C G P	74563	C	74731	G	74835	P	74930	C G
74368	C G	74461	C G	74565	C G	74733	G	74836	G	74931	C G
74369	C G	74462	C G	74567	C G	74734	G	74837	C G P	74932	C G
74370	C G	74463	C G	74570	C G	74735	C G	74838	P	74935	C G
74401	C G	74464	C G	74571	C	74736	G	74839	G	74936	C G
74402	C G	74465	C G	74574	C G	74737	G	74840	G P	74937	C G
74403	C G	74466	C P	74576	C G	74738	C G	74842	G	74939	C G
74421	C G P	74467	C G P	74577	C G	74740	G	74843	G	74940	C G
74422	C G P	74468	C G	74578	C	74741	G	74844	G	74941	C G
74423	C G	74469	C G	74601	G	74743	C G	74845	C G	74942	C G
74425	C G	74470	C G	74602	G	74745	G	74848	G	74943	C G
74426	C G	74471	C G	74604	C G	74747	G	74849	C G P	74944	C G
74427	C G	74472	C G	74630	C G	74748	G	74850	G	74945	C G
74428	C G	74477	C G P	74631	G	74750	G	74851	G P	74946	C G
74429	C G P	74501	C G	74632	G	74752	G	74852	G P	74947	C G
74430	C G	74502	C G	74633	C G	74753	G	74854	G P	74948	C G
74431	C G P	74521	C G	74636	G	74754	G	74855	G P	74949	C G
74432	C G	74522	C G	74637	C G	74755	G	74856	G	74951	C G
74434	C G	74523	C G	74640	G	74756	C G	74857	G P	74953	C G
74435	C G	74526	C	74641	G	74759	C G	74859	G P	74954	C G
74436	C G P	74528	C G	74643	G	74760	C G	74860	G P	74955	C G
74437	C G P	74529	C G	74644	C G	74761	C G	74862	P	74956	C G
74438	C G	74530	G	74646	G	74764	G	74864	G P	74957	G
74439	C G	74531	G	74647	G	74766	G	74865	G	74959	C G
74440	C G	74536	C G	74650	C G	74801	G P	74866	G P	74960	C G
74441	C G	74543	C G	74651	C G	74802	G P	74867	C G P	74962	C G
74442	C G	74545	C	74652	C G	74804	G P	74868	G P	74963	G
74444	C G	74546	C G	74653	G	74818	C G P	74869	G P	74964	C G
74445	C G P	74547	C G	74701	G	74820	G	74871	G	74965	C G
74446	C G P	74548	C	74702	G	74821	G	74872	G	74966	C G

*GlobalHealth may not be available in all the ZIP Codes indicated. Please contact GlobalHealth for correct service area information. See *Help Lines* on pages 28 & 31.

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 (3 or more members)	No Family Out-of-Pocket Maximum
HealthChoice Basic	$500/Individual	$5,500/Individual
	$1,000/Family (2 or more members)	$11,000/Family (2 or more members)
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.**

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan
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
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
Office Visit (Professional Services)	**$30 copay/primary care physician office visit*** **$50 copay/specialist office visit**	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Option Plan For Network services: •$0 the first $500 ofAllowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $5,500/individual or $11,000/family •You may use non-Network providers, but it will be more costly*	Member pays 100% of Allowed Charges until deductible is met $50 office visit copay applies after deductible
Diagnostic X-ray and Lab	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible
Hospital Inpatient Admission	20% of Allowed Charges after deductible Additional $300 deductible per non-Network admission		20% of Allowed Charges after deductible Additional $300 deductible per non-Network admission
Hospital Outpatient Visit	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible
Well Child Care Visit	**$0 copay**; no deductible applies For the schedule of covered visits, refer to page 2		$50 copay; no deductible applies
Immunizations	No charge for well child and adult immunizations **$30/$50 office visit copay** and/or administration fee may apply		No charge for well child and adult immunizations $50 office visit copay and/or administration fee may apply

*HealthChoice members do not need to designate a primary care physician and can change physicians at any time.

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	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**
$2,500 individual $5,000 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**
$30 copay/PCP $40 copay/specialist	$35 copay/PCP $50 copay/specialist	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist	**Office Visit (Professional Services)**
No copay for laboratory services or outpatient radiology $150 copay per MRI, CAT, MRA, or PET scan	No additional copay for laboratory services or outpatient radiology $200 copay per MRI, CAT, MRA, or PET scan	$0 copay $250 copay per MRI, MRA, PET, CAT, or nuclear scan	$0 copay for standard lab and radiology $200 copay per MRI, MRA, PET, or CAT scan	**Diagnostic X-ray and Lab**
$350 copay Preauthorization required	$500 copay Preauthorization required	$250 copay per day $750 maximum per admission Preauthorization required	$1,000 copay/admission	**Hospital Inpatient Admission**
$250 copay Preauthorization required	$300 copay	$250 copay Preauthorization required	$500 copay	**Hospital Outpatient Visit**
$0 copay	$0 copay	$0 copay **ages 0 – 21**	$0 copay	**Well Child Care Visit**
$0 copay ages birth through age 18 **$0 copay**/ages 19 and over	$0 copay ages birth through age 18 years **$0 copay** ages 19 and over **When medically necessary**	**$0 copay** **Office visit copay may apply**	$0 copay ages birth through age 18 (if no other service is rendered) **$0 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 28 & 31 for contact information.

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan
Periodic Health Exams	**$0 copay for one preventive service office visit per calendar year for members and dependents age 20 and older** One mammogram per year at no charge for women age 40 and older	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 to the HealthChoice High Option Plan For Network services: •$0 the first $500 ofAllowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $5,500/individual or $11,000/family •You may use non-Network providers, but it will be more costly*	$50 copay per exam One mammogram per year at no charge for women age 40 and older
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
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
After Hours Urgent Care	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible
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*
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*
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

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See *Help Lines* on pages 28 & 31 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.**

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
$0 copay per visit for routine physicals	**$0 copay**	**$0 copay/PCP** Limit: One per year	**$0 copay**/PCP $50 copay/specialist	**Periodic Health Exams**
$30 copay/PCP $40 copay/specialist $30 serum and shots including a 6-week supply of antigen	$35 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen	$25 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen	$35 copay/PCP $50 copay/specialist $35 serum and shots including a 6-week supply of antigen	**Allergy Treatment and Testing**
$150 copay; waived if admitted	$200 copay; waived if admitted	$150 copay; waived if admitted	$200 copay; waived if admitted	**Emergency Health Care Facility Visit**
$40 copay per visit	$50 copay per visit Preauthorization required	$25 copay/PCP $50 copay/all others Must use Network facilities	$50 copay per visit	**After Hours Urgent Care**
$350 copay	$500 copay Must be preauthorized and approved through CCOK Behavioral Health Services	$250 per day $750 maximum per admission Must be preauthorized	$1,000 copay per admission	**Mental Health or Substance Abuse Inpatient Admission**
$30 copay/PCP $40 copay/specialist	$35 copay/PCP $50 copay/specialist Must be preauthorized and approved through CCOK Behavioral Health Services	**$25 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 initial device 20% coinsurance repair and replacement	20% coinsurance	20% coinsurance	**Durable Medical Equipment (DME)**

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact the plan. See *Help Lines* on pages 28 & 31 for contact information.

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan
Occupational and Speech Therapy Visits	20% of Allowed Charges after deductible For each service Limit: 20 visits per year without certification Maximum of 60 visits per year	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Option Plan For Network services: •$0 the first $500 ofAllowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $5,500/individual or $11,000/family •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 certification Maximum of 60 visits per year
Physical Therapy/ Physical Medicine Visit	20% of Allowed Charges after deductible Limit: 20 visits per year without certification Maximum of 60 visits per year		20% of Allowed Charges after deductible Limit: 20 visits per year without certification Maximum of 60 visits per year
Chiropractic and Manipulative Therapy Visit	Chiropractic services: 20% of Allowed Charges after deductible Limit: 20 visits per year without certification Maximum of 60 visits per year Manipulative therapy: see Physical Therapy/Physical Medicine		Chiropractic services: 20% of Allowed Charges after deductible Limit: 20 visits per year without certification Maximum of 60 visits per year Manipulative therapy: see Physical Therapy/Physical Medicine
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
Hearing Screening and Hearing Aids	**$50 copay/specialist** **$30 copay/primary care physician*** 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

*HealthChoice members do not need to designate a primary care physician and can change physicians at any time.

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
No copay inpatient $30 copay/PCP $40 copay/specialist Limit: 60 treatment days per illness	No copay inpatient $50 copay outpatient therapy Limit: 60 days per illness	No copay inpatient $50 copay per outpatient therapy Limit: 60 consecutive days per illness	**$0 copay** inpatient $35 copay/PCP $50 copay/specialist Limit: 60 days per illness	**Occupational or Speech Therapy Visit**
No copay inpatient $30 copay/PCP $40 copay/specialist Limit: 60 treatment 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	**$0 copay** inpatient $35 copay/PCP $50 copay/specialist Limit: 60 days per illness	**Physical Therapy/ Physical Medicine Visit**
$40 copay Limit: 15 visits per year PCP referral required	$50 copay Limit: 15 visits per year **PCP referral required**	$50 copay Must be preauthorized	$50 copay Limit: 15 visits per year - referral required Limited to treatment of neurological and orthopedic conditions	**Chiropractic and Manipulative Therapy Visit**
$30 copay for initial visit $350 copay per hospital admission	$35 copay for initial visit $500 copay per hospital admission	$25 copay for 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**
$0 copay children birth – age 21 **$30 copay age 22 and over** Limit: One per year Hearing aids – 20% coinsurance for children up to age 18	**$0 copay** Limit: One per year Hearing aids – 20% coinsurance for children up to age 18	**$0 copay children birth – age 21** $25 copay age 22 and over Limit: One per year Hearing aids – 20% coinsurance Covered for children up to age 18	**$0 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 28 & 31 for contact information.

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option and HealthChoice Basic Plan	HealthChoice S-Account Plan
Pharmacy Benefits	**NETWORK**: **Generic Mandate** **Preferred Medication**: •If the cost of medication is $100 or less - You pay up to $30 or actual cost if less •If 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:** •If the cost of medication is $100 or less - You pay up to $60 or actual cost if less •If the cost of medication is more than $100 - You pay 50% up to a $120 maximum **•Out-of-pocket maximum does 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 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 deductible ($1,500 individual/$3,000 family) has been met, the pharmacy benefits are: **NETWORK:** **Generic Mandate** **Preferred Medication:** •If the cost of medication is $100 or less - You pay up to $30 or actual cost if less •If the cost of medication is more than $100 - You pay 25% up to a $60 maximum **Non-Preferred Medication:** •If the cost of medication is $100 or less - You pay up to $60 or actual cost if less •If 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 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 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

$5 copay per fill for certain prescription tobacco cessation products

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 28 & 31 for contact information.

All plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
Up to $5 generic formulary Up to $30 brand formulary (when no generic is available) Up to $60 brand formulary (when generic is available) **30-day supply** 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	Tier 1: $10 Tier 2: $40 Tier 3: $65 **$0 copay for selected generics** Up to $65 non-formulary **30-day supply** Certain medications have restricted quantities.	Tier 1: $10 Tier 2: $50 Tier 3: $75 **30-day supply** 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**

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 28 & 31 for contact information.

All plan changes are indicated by **bold text**.

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 services combined Non-Network: $25 Preventive, Basic, and Major services combined	No deductible or plan maximum $5 office copay applies	$25 per person, per year, waived for preventive services in-network
Preventive Care ex: cleaning, routine oral exam **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 ex: extractions, oral surgery **Allowed Charges apply**	Network: 15% Non-Network: 30% Deductible applies	Amalgam: One surface, permanent teeth **$21**	Network: 15% Non-Network: 30% Plan pays 85% of usual and customary when in-network Deductible applies
Major Care ex: dentures, bridge work **Allowed Charges apply**	Network: 40% Non-Network: 50% Deductible applies	Root canal, anterior: **$355** 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 maximum for Network or non-Network Covered for members under age 19 and members age 19 and older with TMD	**$2,280** out-of-pocket for children through age 18 **$3,120** out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding	Network: 40% Non-Network: 50% Up to **$2,000** lifetime maximum for members under age 19* **12-month** waiting period may apply ***Increase in orthodontic lifetime maximum will apply to treatment beginning on or after January 1, 2011**
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 In-Network and Out-of-Network	Delta Dental Premier In-Network and Out-of-Network	Delta Dental PPO – Choice PPO Network
No deductibles	$25 per person, per year, applies to Basic and Major Care only	**$50** per person, per year, applies to Diagnostic, Preventive, Basic, and Major Care	$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 Includes diagnostic	$0 of allowable amounts after deductible **Includes diagnostic**	Schedule of covered services and copays Copay examples: Routine cleaning $5 Periodic oral evaluation $5 Topical fluoride application (up to age 19) $5 Includes diagnostic
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 **$2,000** No deductible No waiting period **Orthodontic benefits are available to the employee and his/her lawful spouse and eligible dependent children.**	40% of allowable amounts, up to lifetime maximum of **$2,000** No deductible No waiting period **Orthodontic benefits are available to the employee and his/her lawful spouse and eligible dependent children.**	You pay amounts in excess of $50 per month Lifetime maximum up to $1,800 No deductible No waiting period **Orthodontic benefits are available to the employee and his/her lawful spouse and eligible dependent children.**
No annual maximum for general dentist	**$2,500** per person, per year	$3,000 per person, per year	$2,000 per person, per year
No claims to file	Claims are filed by participating dentists	Claims are filed by participating dentists	Claims are filed by participating dentists

COMPARISON OF BENEFITS FOR VISION PLANS

	Humana/CompBenefits VisionCare Plan		Primary Vision Care Services, Inc.	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network***
Eye Exams	$10 copay One exam for eyeglasses or contacts per year	Copays do not apply Plan pays up to $35 One exam per year	$0 copay No limit on exams per year	Plan pays 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	You pay normal doctor's fee, reimbursed up to $60 for one set of lenses and frames per year
Frames	$25 material copay applies to lenses and/or frames $45 wholesale frame allowance One pair of frames per year	$25 copay Plan pays up to $45 One pair of frames per year	You pay wholesale cost. No limit on number of frames	You pay normal doctor fee, reimbursed up to $60 for one set of lenses and frames per year
Contact Lenses	$130 allowance for conventional or disposable contact 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 $50 service fee applies to all soft contact lens fittings; $75 to rigid or gas permeable lens fittings; $150 to hybrid contact lens fittings Replacement lenses do not have these fees	Limit of one set annually in lieu of eyeglasses You pay normal doctor fees, reimbursed up to $60
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	Discount nationwide at The Laser Center (TLC)	No benefit
Vision benefits apply from January 1 through December 31, 2011			For information on limitations/exclusions, please contact PVCS. See *Help Lines* on pages 28 & 31. *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 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 pair of frames per year	Plan pays up to $68	$25 copay $130 allowance One pair of frames per year	Plan pays up to $45	$25 copay* $120 allowance 20% off any out-of-pocket costs above the allowance One pair of frames per year	$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 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, 2011

How to Access the Online Provider Networks

HealthChoice Health Plans

HealthChoice High Option, Basic, and S-Account
Visit **www.healthchoiceok.com**
Click on *Find a Provider* and follow the on-screen instructions

HealthChoice USA Plan
Visit **www.choicecarenetwork.com**
Click on *ChoiceCare Physician Finder Plus* under *Provider Search*
Select *ChoiceCare Network PPO* under *Coverage and Network*
Follow the on-screen instructions

HMO Plans

CommunityCare Standard and Alternative HMO
Visit **www.ccok.com**
Click on *Find a Provider*
Select *State, Education and Local Government Employees*

GlobalHealth Standard and Alternative HMO
Visit **www.globalhealth.com**
Click on *STATE* and choose *State Employees and Educators*
Click on *PROVIDER LOOKUP*

PacifiCare Standard and Alternative HMO
Visit **www.pacificare.com**
Click on *Find a Doctor*
Select *Plan or Service Type* choose *PacifiCare SignatureValue (HMO)*

Dental Plans

HealthChoice Dental
Visit **www.healthchoiceok.com**
Click on *Find a Provider* and follow the on-screen instructions

Assurant Freedom Preferred (Options for PPO)
Visit **www.assurantemployeebenefits.com**
Click on *Find a Dentist*
Select *DHA Network*

continued from previous page

Assurant Heritage Plus with SBA and Heritage Secure (Options for Prepaid)
Visit **www.assurantemployeebenefits.com**
Click on *Find a Dentist*
Select *The Heritage Series*

CIGNA Dental
Visit **www.cigna.com**
Click on *Provider Directory*
Click *Dentist* for the type of provider
Select *CIGNA Dental Care (HMO)*

Delta Dental
Visit **www.deltadentalok.org**
Click on *Click here* under *State of Oklahoma Dental Plans*
Click *here* on the *3 NEW Dental Plans for 2011* and select your dental plan
(*Delta Dental PPO, Delta Premier, and Delta Dental PPO – Choice*)

Vision Plans

Humana/CompBenefits Vision Care Plan
Visit **www.compbenefits.com/custom/stateofoklahoma**
Click on *Provider Directory*

Primary Vision Care Services (PVCS)
Visit **www.pvcs-usa.com**
Click on *Find a Doctor*

Superior Vision Plan
Visit **www.superiorvision.com**
Click on *Locate a Provider*

UnitedHealthcare Vision
Visit **www.myuhcvision.com**
Click on *Provider Locator*

Vision Services Plan (VSP)
Visit **www.vsp.com**
Either click on *Find the right doctor for you* under the *Members* tab or click on *Choose VSP through your employer* under *Prospective Members* tab
Click on *Find a VSP Doctor*
Select *VSP Signature Network*

For assistance in locating the correct provider network, contact each plan's customer service. See *Help Lines* on pages 28 & 31

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	1-405-316-7492
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

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.com

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

Continued after
Former Employee Dependent Enrollment Form

Oklahoma State & Education Employees Group Insurance Board
FORMER EMPLOYEE DEPENDENT ENROLLMENT FORM

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. This act requires plans that provide dependent coverage to continue to make coverage available until an adult child (married or unmarried) turns 26.

OSEEGIB is allowing a one-time opportunity for you to enroll eligible dependent children. This Option Period you may add a dependent child up to age 26 to your coverage. If you decide to add a dependent, that coverage will become effective January 1, 2011.

To add a dependent child (or children) to your coverage, complete and return this form with your 2011 Option Period Form by December 7, 2010. Your child can be added only to a benefit that you already carry.

MEMBER INFORMATION (Please Print)

Member Name _____ **Member ID/SSN** _____

Mailing Address _____ **Phone (____)** _____

☐ **New Address** _____ **Alt Phone (____)** _____
City **State** **ZIP Code**

DEPENDENT CHILD INFORMATION (Please Print)

Name _____ **SSN** _____ **Date of Birth** _____
☐ **Male** ☐ **Female**

Name _____ **SSN** _____ **Date of Birth** _____
☐ **Male** ☐ **Female**

Remember, you and your dependents must all be covered under the same plan. For example, if you are enrolled in a HealthChoice plan and you are adding a dependent, your dependent must also be enrolled in a HealthChoice plan. If you are enrolled in an HMO plan, your dependent must be enrolled in the same HMO.

☐ **ADD Health Plan – Add dependent(s) to your existing health plan**

Health Plan Name _____

Primary Physician (HMO only) _____ ☐ New Patient ☐ Current Patient

☐ **ADD Dental Plan – Add dependent(s) to your existing dental plan**

Primary Dentist (Prepaid only) _____ ☐ New Patient ☐ Current Patient

☐ **ADD Vision Plan – Add dependent(s) to your existing vision plan**

CERTIFICATION SIGNATURE

Member Signature _____ **Date** _____

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Vision Plans' Help Lines

Humana/CompBenefits

All Areas	1-800-865-3676
TDD All Areas	1-877-553-4327
Website	www.compbenefits.com/custom/stateofoklahoma

Primary Vision Care Services (PVCS)

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

Superior Vision Plan

All Areas	1-800-507-3800
TDD	1-916-852-2382
Website	www.superiorvision.com

UnitedHealthcare Vision

All Areas	1-800-638-3120
TDD All Areas	1-800-524-3157
Website	www.myuhcvision.com

Vision Service Plan (VSP)

All Areas	1-800-877-7195
TDD All Areas	1-800-428-4833
Website	www.vsp.com

HealthChoice

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

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OPTION PERIOD Guide
PLAN YEAR 2011