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OSEEGIB
Oklahoma State and Education
Employees Group Insurance Board

Plan Guide for Pre-Medicare Members

Plan Year 2011

January 1 through December 31, 2011

Health

Dental

Vision

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

#2454

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 23–24 of this Guide.

Provider Networks

HMO Plans

Be aware that even though some of the HMO plans have nationwide provider networks, the plans offered through OSEEGIB allow access only to the HMO plans' Oklahoma provider networks.

HealthChoice High Option, Basic, and S-Account Plans

These HealthChoice plans give you access to one of the largest Provider networks in Oklahoma.

HealthChoice USA Plan

The HealthChoice USA Plan is available to members who live outside of Oklahoma and Arkansas. The USA Plan provides access to a nationwide provider network.

For directions on how to access each health, dental, and vision plan's provider network, see pages 21–22. 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.

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

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TABLE OF CONTENTS

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.

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

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 *FAQ* section of the HealthChoice website and search for *blended rates*.

INTRODUCTION

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) produced this 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

Helpful Hints

- Review the premium rates listed on the previous page.
- 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

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 9–16 for specific benefit information.

*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 23–24 of this Guide.

- 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 5–7 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. 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 23–24 of this Guide.
- Check with each health plan if you have benefit questions.

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 17–18 for specific benefit information.

- All dental plans have toll-free numbers for customer service. See *Help Lines* on pages 23–24 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 19–20 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 23–24 of this Guide.
- Check with the individual vision plan if you have benefit questions.

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 becomes 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 sends you a letter that explains the Medicare plan options available to you. The letter also provides instructions on how to enroll with a Medicare supplement or MA-PD plan.

If you are enrolled in HealthChoice, you are automatically 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 one of the Medicare Supplement or MA-PD plans 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.

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 be available in more areas than indicated in the above list. Please contact GlobalHealth for complete service area information. See *Help Lines* on pages 23–24.

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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

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HMO ZIP Code List

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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 be available in more areas than indicated in the above list. Please contact GlobalHealth for complete service area information. See *Help Lines* on pages 23–24.

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

Health Plans	Calendar Year Health Plan Deductible (Network)	Calendar Year Out-of-Pocket Limits/Maximums
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 Limit
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 (medical and pharmacy combined)	$4,000/Individual
	$3,000/Family (medical and pharmacy combined)	$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 limit 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 Limit/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		$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.

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 23–24 for contact information.

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 preventive service office visit per calendar year for members and dependents age 20 and older covered at 100% 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	$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
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 23–24 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

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 23–24 for contact information.

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.

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 23–24 for contact information.

PHARMACY

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 23–24 for contact information.

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 23–24 for contact information.

DENTAL PLAN COMPARISON

COMPARISON OF BENEFITS FOR DENTAL PLANS

Your Costs for Network Services	HealthChoice Dental	Cigna Dental Care Plan (Prepaid)	Assurant Freedom Preferred
Annual Deductible	Network: $25 Basic and Major 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 limit 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
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 23–24. *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
Vision benefits apply from January 1 through December 31, 2011				*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 PLAN COMPARISON

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* under the *Provider Search* tab

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 *Welcome State of Oklahoma Employees*
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 *Search for Providers*

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 23–24.

HealthChoice (OSEEGIB) Help Lines

Health and Dental 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.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

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


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