OSEEGIB
Oklahoma State and Education Employees Group Insurance Board
A Division of the Office of State Finance

Employee Benefit Options Guide

State Bird, Scissortailed Flycatcher

Plan Year 2012
January 1 through December 31, 2012

Health

Dental

Life

Vision

State Animal, Buffalo

State Wild Flower, Indian Blanket

State Reptile, Mountain Boomer

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

Update to Printed Version of This Guide

Update to the HMO ZIP Code List on pages 13 and 15:

CommunityCare HMO is available in ZIP Code areas 73141 and 74464.

Oklahoma State and Education Employees Group Insurance Board

A Division of the Office of State Finance

Monthly Premiums for Current Employees

Plan Year January 1, 2012 - December 31, 2012

– IMPORTANT – IMPORTANT – IMPORTANT – IMPORTANT –

Before choosing a plan, it is very important that you review the list of network providers available in your area for that plan. Although a plan may be available in your area, the number of network providers may be limited. See the network provider listing on each plan's website or contact their customer service. See *Help Lines* on page 28 for contact information.

– IMPORTANT – IMPORTANT – IMPORTANT – IMPORTANT –

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High	$449.48	$ 668.10	$228.20	$352.08
HealthChoice High Alternative	$449.48	$ 668.10	$228.20	$352.08
HealthChoice Basic	$391.64	$ 571.84	$201.82	$310.80
HealthChoice Basic Alternative	$391.64	$ 571.84	$201.82	$310.80
HealthChoice S-Account	$382.56	$ 542.52	$190.18	$291.90
HealthChoice USA	$688.82	$ 688.82	$226.22	$348.86
CommunityCare Standard HMO	$803.22	$1,148.58	$401.60	$642.56
CommunityCare Alternative HMO	$553.96	$ 792.14	$276.98	$443.16
CommunityCare Wellness Alternative Plus HMO	$528.96	$ 792.14	$276.98	$443.16
GlobalHealth Standard HMO	$402.84	$ 660.72	$212.27	$338.44
GlobalHealth Alternative HMO	$366.24	$ 600.68	$193.00	$307.70
GlobalHealth Wellness Alternative Plus HMO	$341.24	$ 600.68	$193.00	$307.70
UnitedHealthcare Standard HMO (formerly PacifiCare)	$768.80	$1,105.36	$384.12	$614.72
UnitedHealthcare Alternative HMO	$530.20	$ 762.32	$264.90	$423.94
UnitedHealthcare Wellness Alternative Plus HMO	$505.20	$ 762.32	$264.90	$423.94
DISABILITY (Employee only)	$9.10 (Limited county participation only)			

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice Dental	$30.20	$30.20	$25.18	$65.32
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	$33.64	$33.62	$29.26	$74.04
Delta Dental Premier	$38.36	$38.36	$33.38	$84.46
Delta Dental PPO - Choice	$15.06	$34.18	$34.44	$83.60

Oklahoma State and Education Employees Group Insurance Board

A Division of the Office of State Finance

Monthly Premiums for Current Employees

Plan Year January 1, 2012 - December 31, 2012

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Humana/CompBenefits VisionCare Plan	$6.76	$5.06	$3.57	$ 4.46
Primary Vision Care Services	$9.25	$8.00	$8.50	$10.75
Superior Vision Plan	$7.14	$7.10	$6.72	$13.80
UnitedHealthcare Vision	$8.18	$5.79	$4.59	$ 6.98
Vision Service Plan (VSP)	$8.76	$5.87	$5.62	$12.64

LIFE	
HealthChoice Basic Life ($20,000) $4.00	First $20,000 of Supplemental Life $4.00

Age-Rated Supplemental Life – Cost Per $20,000		
< 30 ---------- $0.60	45 - 49 ------- $2.00	65 - 69 ------- $10.20
30 - 34 ------- $0.60	50 - 54 ------- $3.40	70 - 74 ------- $17.40
35 - 39 ------- $0.80	55 - 59 ------- $5.40	75+ ---------- $27.00
40 - 44 ------- $1.20	60 - 64 ------- $6.20	

Dependent Life	Low Option $2.60	Standard Option $4.32	Premier Option $8.64
Spouse	$6,000 of coverage	$10,000 of coverage	$20,000 of coverage
Child (age 6 months to 26)	$3,000 of coverage	$ 5,000 of coverage	$10,000 of coverage
Child (live birth to 6 months)	$1,000 of coverage	$ 1,000 of coverage	$ 1,000 of 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.

A text version of the *Employee Benefit Options Guide* is available on the OSEEGIB website at www.sib.ok.gov or www.healthchoiceok.com. This Guide is also available in CD format at the Oklahoma Library for the Blind and Physically Handicapped (OLBPH). Contact the OLBPH at 1-405-521-3514, toll-free 1-800-523-0288, or TDD 1-405-521-4672.

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TABLE OF CONTENTS

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 documents, insurance contracts, handbooks, and Rules of the Oklahoma State and Education Employees Group Insurance Board, a division of the Office of State Finance. 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

2012 PLAN CHANGES

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

Health Plan Changes

HealthChoice Health Plans

Each year, tobacco use costs the HealthChoice health plans and their members approximately $52 million. Because these costs affect the premiums of all health plan members, HealthChoice is encouraging our members to stay or become tobacco-free by freezing the deductibles and out-of-pocket limits of the HealthChoice High and Basic Plans at 2011 amounts for non-tobacco users. The HealthChoice High Alternative and HealthChoice Basic Alternative Plans are being introduced for tobacco users. The individual deductibles and out-of-pocket limits for these two plans are $250 higher than the High and Basic Plans.

To enroll or remain enrolled in the HealthChoice High or Basic Plan for Plan Year 2012, you must attest that you and your covered dependents are tobacco-free by completing the *HealthChoice High and Basic Plans Tobacco-Free Attestation for Plan Year 2012* by November 15, 2011. The Attestation is available to you:

- Online at **www.sib.ok.gov** or **www.healthchoiceok.com**
- From your Insurance Coordinator
- By calling HealthChoice Member Services at 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.

If you cannot complete the tobacco-free Attestation because you and/or your covered dependents are not tobacco-free, you can still qualify for the HealthChoice High or HealthChoice Basic plan if you can show proof of an attempt to quit using tobacco or provide a letter from your doctor. To qualify for the tobacco-free plans, you must provide one of the following:

- A letter from Alere Wellbeing indicating you and/or your covered dependents have enrolled in the quit tobacco program available through the Oklahoma Tobacco Settlement Endowment Trust (TSET) and Alere Wellbeing within the previous 90 days.
- A letter from Alere Wellbeing indicating you and/or your covered dependents have completed the quit tobacco program available through the Oklahoma Tobacco Settlement Endowment Trust (TSET) and Alere Wellbeing within the previous 90 days.
- A letter from your doctor indicating it is not medically advisable for you or your covered dependents to quit tobacco.

The letter from Alere Wellbeing or your doctor must be provided to HealthChoice, 3545 N.W. 58 Street, Suite 110, Oklahoma City, OK 73112 by November 15, 2011. Be sure to write your name and member ID number located in *Section A* of your pre-printed *Option Period Enrollment/Change Form* on your letter. If you do not or cannot complete the tobacco-free Attestation or provide one of the letters described previously, you and your covered dependents will be enrolled in the new HealthChoice High Alternative Plan or Basic Alternative Plan.

HealthChoice High, High Alternative, Basic, Basic Alternative, S-Account, and USA Plans

- No limit on visits and treatment days for mental health and substance abuse.
- Non-Network emergency room visits will be covered at the Network benefit level; however, you are still responsible for non-covered services and amounts over Allowed Charges.
- As an enhanced benefit for HealthChoice members, preventive procedures and many other services will be covered at 100% of Allowed Charges with no out-of-pocket costs when using a Network Provider. This means no-cost access to:
  - Blood pressure, diabetes, and cholesterol tests
  - Breast, cervical, prostate, and colorectal cancer screenings
  - Osteoporosis screening
  - Counseling from your health care provider on topics including quitting tobacco, losing weight, eating healthy, treating depression, and reducing alcohol use
  - Prescription tobacco cessation products

- Vaccines for children and adults
- Flu and pneumonia shots
- Screening for obesity and counseling from your doctor and other health professionals to promote sustained weight loss, including dietary counseling from your doctor
- Screening for conditions that can harm pregnant women or their babies, including iron deficiency, hepatitis B, a pregnancy related immune condition called Rh incompatibility, and a bacterial infection called bacteriuria
- Special, pregnancy-tailored counseling from a doctor to help pregnant women quit smoking and avoid alcohol use
- Counseling to support breast-feeding and help nursing mothers

See the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com** for more details.

HealthChoice High, High Alternative, and USA Plans

- HealthChoice is implementing a family out-of-pocket limit for the HealthChoice High, High Alternative, and USA Plans. The family out-of-pocket limit for the High and USA Plans will be $8,400 when using a Network Provider and $9,900 when using a non-Network Provider. The family out-of-pocket limit for the High Alternative Plan will be $9,150 when using a Network Provider and $10,650 when using a non-Network provider.

HealthChoice S-Account Plan

- The out-of-pocket limits are being lowered to $3,000/individual and $6,000/family.
- Proof of a Health Savings Account (HSA) is not required to enroll.
- HealthChoice has contracted with American Fidelity Health Services Administration to make establishing and keeping a Health Savings Account easier and more convenient for S-Account members. HSA deposits are invested in a money market account and all interest is applied to your account. The monthly maintenance fee is waived as long as you continue to be an employee of the state of Oklahoma. See pages 8-9 for more information.

HealthChoice Pharmacy Benefit

- Two 90-day courses of certain prescription tobacco cessation products will be covered at 100% with no cost to members.
- HealthChoice is introducing a mail order pharmacy benefit and changing the quantity of medication you can get per copay. A 30-day supply of medication will be covered, when purchased at a retail pharmacy, for one copay. A 90-day supply of a maintenance medication will be covered for one copay when purchased through Medco's mail order service or one of the Network Retail Maintenance Pharmacies. See the *Comparison of Benefits for Health Plans* for copay amounts.

HMOs

CommunityCare Wellness Alternative Plus, GlobalHealth Wellness Alternative Plus, and UnitedHealthcare Wellness Alternative Plus HMO Plans

- To be eligible for one of the Wellness Alternative Plus plans, you must complete the Health Risk Assessment (HRA) available at **www.sib.ok.gov** or **www.healthchoiceok.com**. After completing the HRA, print the last screen, which states you have completed it, and give it to your Insurance Coordinator with your *Option Period Enrollment/Change Form*. If you completed the HRA as a HealthChoice member after July 1, 2011, you do not have to complete it again, but you will have to give your enrollment/change form to your Insurance Coordinator indicating which Wellness Alternative Plus plan you choose.
- If you are a new employee and wish to enroll in one of the HMO Wellness Alternative Plus plans, you must first enroll in the HMO's Alternative plan. You then have until the end of your 30-day enrollment period to complete the HRA, print the last screen, and return it to your Insurance Coordinator. Your enrollment in the Wellness Alternative Plus plan will be effective the first of the month following the date you complete this process. If you

do not complete the process during this 30-day period, you will remain enrolled in the HMO Alternative plan for the remainder of the plan year.

- HMO service areas have changed. See the *HMO ZIP Code List* on pages 13-15 to check your eligibility.

Life Plan Changes

HealthChoice Life Insurance

- You must submit a *Life Insurance Application* to enroll in or increase the amount of your life insurance.
- The maximum amount of Supplemental Life insurance you can carry is being increased to $500,000 regardless of your salary.

Vision Plan Changes

Superior Vision Plan

- For in-Network services, there is a $25 fitting fee copay for standard and specialty fitting of contact lenses. The Plan then pays 100% for standard fitting and up to $50 for specialty fitting. The fitting fee is not a covered benefit when out-of-network.

UnitedHealthcare Vision

- UV coating and tinting will be covered in full when using in-Network providers.

Vision Service Plan (VSP)

- After a copay of up to $60, a contact lens exam is covered in full when using in-Network providers.

There are no dental plan changes for 2012.

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

If you have questions about any of the plans, contact each plan directly. See *Help Lines* on page 28 of this *Employee Benefit Options Guide* for contact information.

INTRODUCTION

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

- Health
- Dental
- Vision
- Life
- Disability

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

Helpful Hints For Option Period

- Review Section B of your pre-printed *Option Period Enrollment/Change Form.* This is the coverage you will have effective January 1, 2012, if you do not make changes during Option Period.
- Contact your Insurance Coordinator if you have questions about your current coverage.
- Review the plan changes for 2012 starting on page 1 of this Guide.
- **Ask your Insurance Coordinator about returning your form even if you are not making changes.**
- Use the following resources to help you decide on coverage for you and your dependents for 2012:

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

- Complete your *Option Period Enrollment/Change Form* and return it to your Insurance Coordinator by the deadline set by your coordinator.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact your Insurance Coordinator right away if your *Confirmation Statement* is incorrect. **If you do not make changes to your coverage and you are not automatically enrolled in one of the HealthChoice alternative plans (see page 1), you will not receive a *Confirmation Statement* from OSEEGIB.** Keep a copy of your *Option Period Enrollment/Change Form* as verification of your insurance coverage.

Helpful Hints For New Employees

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

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

- Complete your *Insurance Enrollment Form* and return it to your Insurance Coordinator by the deadline set by your coordinator.
- Review your *Confirmation Statement* when you receive it in the mail to verify your coverage is correct.
- Contact your Insurance Coordinator right away if your *Confirmation Statement* is incorrect.

GENERAL ENROLLMENT INFORMATION

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

The benefits you select will be in effect from January 1, 2012, or for new employees, the effective date of your coverage, through December 31, 2012.

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.

HEALTH PLANS

There are 15 health plans available:

- HealthChoice High and High Alternative Plans
- HealthChoice Basic and Basic Alternative Plans
- HealthChoice S-Account Plan
- HealthChoice USA Plan*
- CommunityCare Standard, Alternative, and Wellness Alternative Plus HMO
- GlobalHealth Standard, Alternative, and Wellness Alternative Plus HMO
- UnitedHealthcare Standard, Alternative, and Wellness Alternative Plus HMO

See *Comparison of Benefits for Health Plans* on pages 16-23 for specific benefit information.

- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- To be eligible for the HealthChoice High or Basic Plan, you must complete the tobacco-free Attestation located on the OSEEGIB website.
- You must **live or work** within an HMO's ZIP Code service area to be eligible. Post Office Box addresses cannot be used to determine your HMO eligibility. See pages 13-15 for the *HMO ZIP Code List*.
- If you select an HMO, you must use the provider network designated by your plan for Oklahoma.
- You must complete the HRA through the OSEEGIB website to enroll in an HMO Wellness Alternative Plus 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 page 28.
- Check with the individual health plan if you have benefit questions.

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

DENTAL PLANS

Verify your employer offers dental coverage through OSEEGIB.

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 24-25 for specific benefit information.

- All dental plans have toll-free numbers for customer service. See *Help Lines* on page 28.
- Check with the individual dental plan if you have benefit questions.

VISION PLANS

Verify your employer offers vision coverage through OSEEGIB.

There are five vision plans available:

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

See *Comparison of Benefits for Vision Plans* on pages 26-27 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 calling your provider.
- All vision plans have limited coverage for services provided by out-of-network providers.
- All plans have toll-free numbers for customer service. See *Help Lines* on page 28.
- Check with the individual vision plan if you have benefit questions.

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

Thinking About Retirement?

If you are a current employee who is retiring **before** January 1, 2012, please contact OSEEGIB Member Services and request the appropriate materials. You will select your benefits from either the former pre-Medicare Option Period guide or the Medicare Option Period guide. To contact Member Services, refer to *Help Lines* on page 28.

HEALTHCHOICE LIFE INSURANCE PLAN

Verify your employer offers HealthChoice Life Insurance through OSEEGIB.

- As a **new employee**, you can elect life insurance coverage within 30 days of your employment date or the date you become eligible. You can enroll in a limited amount of coverage, known as **Guaranteed Issue**, without an approved *Life Insurance Application*. All requests for coverage above *Guaranteed Issue* require an approved *Life Insurance Application*.
- As a **current employee**, if you did not enroll when first eligible, you can enroll:
  - During the annual Option Period. An approved *Life Insurance Application* is required to enroll in or increase life insurance coverage.
  - Within 30 days of a midyear qualifying event. An approved *Life Insurance Application* is required.
  - Within 30 days of the loss of other group life coverage. You can enroll in the amount of coverage you lost, rounded up to the next $20,000 unit, without a *Life Insurance Application*. Proof of loss is required.

Basic Life Insurance. . . For You

- Basic Life pays a benefit of $20,000 to your beneficiary in the event of your death.
- Basic Life includes Accidental Death and Dismemberment (AD&D) coverage. This coverage pays an additional $20,000 to your beneficiary if your death is due to an accident. It also pays benefits if you lose your sight or a limb due to an accident.

Supplemental Life Insurance . . . For You

- At the time of initial enrollment, you can purchase Supplemental Life coverage in an amount equal to two times your annual salary, rounded up to the next $20,000. This amount, known as **Guaranteed Issue**, is available without an approved *Life Insurance Application*.

- You may purchase Supplemental Life in units of $20,000. The maximum amount of Supplemental Life coverage available is $500,000, regardless of your salary. You must complete a *Life Insurance Application* to apply for coverage.
- The first $20,000 unit of Supplemental Life provides an additional $20,000 of AD&D coverage.
- A *Life Insurance Application* is available from your Insurance Coordinator.

Dependent Life Insurance . . . For Your Family

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

DEPENDENT	LOW OPTION	STANDARD OPTION	PREMIER OPTION
Spouse	$6,000 of coverage	$10,000 of coverage	$20,000 of coverage
Child (age 6 months to 26)	$3,000 of coverage	$ 5,000 of coverage	$10,000 of coverage
Child (live birth to 6 months)	$1,000 of coverage	$ 1,000 of coverage	$ 1,000 of coverage

Beneficiary Designation

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

HEALTHCHOICE DISABILITY INSURANCE PLAN

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

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

Eligibility

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

HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is an individually owned savings account that allows you to set aside money for health care tax-free whenever you select an HSA qualified High Deductible Health Plan (HDHP). Money left in the account can accumulate interest tax-free and money used to pay for qualified medical expenses can be paid tax-free. Through your employer's Section 125 plan, you can make HSA contributions on a pre-tax basis up to the yearly maximum allowed.

SOME HIGHLIGHTS OF HSAs

- HSA contributions are tax-free.
- Interest accrues tax-free.
- Interest earned is applied to your account starting with the first dollar contribution.
- Withdrawals are not taxed when funds are used for qualified medical expenses.
- You decide when and how to use your money.
- No "use it or lose it" requirement meaning whatever deposits you make each year can be left in the HSA to earn interest and to be available to pay for future medical expenses.
- You can pay for qualified medical expenses on yourself, your spouse, or your tax dependents regardless of whether or not they are covered by your health plan.
- No matter where you go, your account follows you. Even if you change jobs, change medical coverage, become unemployed, move to another state, or change your marital status, your HSA goes with you. You own it!
- If you do not remain a qualified individual, you can continue to earn interest and pay for qualified medical expenses as long as there are funds in your account.

CONTRIBUTIONS

You can contribute up to the annual maximum amount allowed by law in any given tax-year. The IRS establishes the maximum amounts on an annual basis. The 2011 maximum allowable is $3,050 for an individual or $6,150 for a family. Effective January 1st 2012 the maximum allowable will increase to $3,100 for an individual or $6,250 for a family. If your HDHP is effective on a date other than January 1 and you wish to make the maximum contribution, you must meet certain requirements. Visit **www.afhsa.com** for more information.

If you are age 55 and older, you are eligible to make an additional catch-up contribution of $1,000 per year. An HSA is owned by one individual, so if you and your spouse are covered under the family HDHP and both of you are age 55 or older, only you as the owner of the account can make the catch up contribution. Your spouse would be required to establish his or her own HSA to make catch-up contributions.

QUALIFIED MEDICAL EXPENSES

There are many expenses that qualify for tax-free distributions. For a listing, you can refer to the HSA Eligible Expenses listed on **www.afhsa.com**. If you use funds for any expenses that are not eligible, then the funds withdrawn are subject to income taxes and a 20% additional tax penalty. The non-qualified distributions must be reported on your annual income tax return.

Additional information on eligible expenses can be found in IRS Publication 502 at **www.irs.gov**. Even though Publication 502 is a valuable resource on what qualifies as a medical expense, it addresses only what expenses are deductible.

MAKING WITHDRAWALS FROM YOUR HSA

You can withdraw funds from your account in three ways:

1. HSA Debit Card
2. On-Line Distribution Request
3. Distribution Form

SB-22136(State of Oklahoma)-0811

You can use the money from your HSA as follows:

1. You can only use the funds that have been deposited.
2. You can withdraw funds for qualified medical expenses incurred after the date your account is established.
3. You may elect to make withdrawals from your HSA when expenses are incurred, or you may make withdrawals for these expenses anytime in the future. There is no time limit.

In order to receive the tax benefit, the IRS requires that you keep records to prove that your HSA funds were used to pay for qualified medical expenses and that the qualified expense was not reimbursed from another source. Although you are not required to send your receipts with your tax returns, keeping your receipts with your tax information is an excellent way to ensure proper documentation. You will receive two forms each year as a result of having an HSA: 1) a 1099-SA which shows the total distributions from your account will be mailed by January 31, and 2) a 5498-SA which shows total contributions to your account will be mailed by May 31. Each of these forms will also be sent to the IRS.

ELIGIBILITY REQUIREMENTS

To be eligible to establish and contribute to an HSA, you must meet the following requirements:

1. You must be covered by an HSA-qualified HDHP.
2. You cannot be claimed as a dependent on anyone else's tax return.
3. You cannot be covered under a non-HDHP coverage other than "permitted coverage" or "permitted insurance" and/or preventative care. Products such as Cancer, Accident, Long Term Care, and Disability Income are usually considered permitted coverage/insurance. Check with your employer or visit **www.irs.gov** to be sure.
4. You cannot have a general purpose Health FSA-Medical Reimbursement Account. However, you can have a Limited Purpose Health FSA which allows for dental and vision reimbursement only should your employer offer this benefit. Note: If you are covered under your spouse's general purpose Health FSA, then you are not eligible to establish and contribute to an HSA.
5. You cannot be enrolled in Medicare.

INTEREST & ACCOUNT FEES

HSA deposits are invested in a money market account and all interest is applied to your account. The monthly maintenance fee is waived as long as you continue to be employed by the State of Oklahoma. This fee covers unlimited account withdrawals, the debit card, and other investment funds for balances above the minimum $2,500 required in the money market account. A $15 fee will also apply for an additional or replacement debit card.

SUMMARY

HSAs give you the savings potential, flexibility, portability, and tax savings unlike any other savings account. By enrolling in a qualified HDHP, you save on premiums. By investing those savings into an HSA, you can save for medical expenses in the future.

Individuals who elect an HSA with us will receive a welcome packet outlining all the information associated with the account. This flyer is meant to provide you high level information on HSAs. For more information on HSAs visit our website at **www.afhsa.com**. There you will find an overview specific to employees/individuals along with other helpful information. You can also find additional information about HSAs in the IRS Publication 969 at **www.irs.gov**.

CONTACT INFORMATION

American Fidelity Health Services Administration
2000 N. Classen Blvd, Suite G16
Oklahoma City, OK 73125
(405) 523-5699 – Local Number

Toll-Free - 1-866-326-3600
Fax - (405) 523-5072
Web site - **www.afhsa.com**
email - **HSA-Suppost@af-group.com**

ENROLLMENT PERIODS

Option Period Enrollment – Coverage effective January 1, 2012

This is the time when eligible employees can:

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

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

Initial Enrollment – Coverage effective the first of the month following your employment date or the date set by your employer

This is the time when new employees are eligible to:

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

♦ As a new employee, you have 30 days from your employment date, or the date you become eligible, to enroll in coverage. If you do not enroll within 30 days, you cannot enroll until the next annual Option Period unless you experience a qualifying event. Check with your Insurance Coordinator for more information.

♦ You have 30 days following your eligibility date to make changes to your original enrollment.

♦ You have 30 days following your eligibility date to complete the HRA if you want to enroll in one of the HMO Wellness Alternative Plus plans.

♦ If you request life insurance coverage in an amount greater than two times your annual salary, known as *Guaranteed Issue*, you must complete and submit a *Life Insurance Application* for approval. See your Insurance Coordinator for an application.

♦ Keep a copy of your *Insurance Enrollment Form* for your records.

Midyear Changes – Coverage generally effective the first of the month following a qualifying event

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

ELIGIBILITY

Members

♦ Your employer must participate in the plans offered through OSEEGIB.

♦ You must be a current Education employee eligible to participate in the Oklahoma Teachers' Retirement System working a minimum of four hours per day or 20 hours per week, or a current State of Oklahoma or Local Government employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.

♦ You must be enrolled in a group health plan to enroll in dental and/or life insurance.

Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. You can choose not to cover dependents who do not reside with you, are married, are not financially dependent on you for support, or have other group coverage. 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 can be covered under one parent's health, dental, and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life insurance.
- Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage, or loss of other group coverage occurs. If eligible dependents are dropped from coverage, you cannot re-enroll them for a minimum of 12 months. The 12-month requirement does not apply when dependents lose other group health, dental, vision, and/or life insurance coverage and are seeking reinstatement of coverage through OSEEGIB.
- Dependents can only be enrolled in the same types of coverage and in the same plans you enroll in.
- To enroll your newborn, an *Insurance Change Form* must be provided to your Insurance Coordinator within 30 days of the birth. If you do not enroll your newborn during this 30-day period, you cannot do so until the next annual Option Period. Direct notification to a plan 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 are 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 while covering other dependents on these benefits. 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.

Confirmation Statement

- You are mailed a *Confirmation Statement* (CS) when you enroll or make changes to your coverage. Your CS lists the coverage you are enrolled in, the effective date of your coverage, and the premium amounts.
- Always review your CS to verify your coverage is correct. Corrections to your coverage must be submitted to your Insurance Coordinator within 60 days of your election. Corrections reported after 60 days are effective the first of the month following notification.
- Section B of your *Option Period Enrollment/Change Form* lists the coverage you will have effective January 1, 2012, if you don't make changes during Option Period and you are not automatically enrolled in one of the HealthChoice alternative plans (see page 1). If you don't make changes and you are not automatically enrolled in one of the HealthChoice alternative plans, you will not receive a CS from OSEEGIB. Keep a copy of your *Option Period Enrollment/Change Form* as verification of your coverage.

Transfer Employee

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

Termination of Coverage

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

COBRA – Temporary Continuation of Coverage

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and/or your dependents to continue health, dental, and/or vision insurance coverage after your employment terminates or after your dependent loses eligibility. Certain time limits apply to enrollment. Contact your Insurance Coordinator immediately upon termination of your employment, or when changes to your family status occur, to find out more about your COBRA rights. **Be aware, dropping dependent coverage during Option Period is not a COBRA qualifying event.**

HMO ZIP Code List

C = CommunityCare G = GlobalHealth U = UnitedHealthCare

72761	C G	73039	G U	73079	G U	73118	C G U	73160	C G U	73437	G U	73528	G U
73001	G U	73040	G U	73080	G U	73119	C G U	73162	C G U	73438	G U	73529	G U
73002	G U	73041	G U	73081	G U	73120	C G U	73163	C G U	73439	G U	73530	G U
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HMO ZIP Code List

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HMO ZIP CODE LIST

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HMO ZIP Code List

C = CommunityCare G = GlobalHealth U = UnitedHealthCare

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COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative, and USA Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice S-Account Plan
Calendar Year Deductibles	**High and USA Plans** $500 individual $1,500 family	**Basic Plan** $500 individual $1,000 family 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
	High Alternative Plan **$750 individual** **$2,250 family**	**Basic Alternative Plan** **$750 individual** **$1,500 family** **Applies after Plan pays first $250 of Allowed Charges**	
Calendar Year Out-of-Pocket Limit	**High and USA Plans** $2,800 Network individual **$8,400 Network family** $3,300 non-Network individual **$9,900 non-Network family,** plus amounts over Allowed Charges	**Basic Plan** $5,500 individual $11,000 family	**$3,000 individual** **$6,000 family** Non-Network charges do not apply
	High Alternative Plan **$3,050 Network individual** **$9,150 Network family** **$3,550 non-Network individual** **$10,650 non-Network family, plus amounts over Allowed Charges**	**Basic Alternative Plan** **$5,750 individual** **$11,500 family**	
Office Visit (Professional Services)	$30 copay/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 Plan **Basic Plan** •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible **Basic Alternative Plan** **•$0 the first $250 of Allowed Charges** **•100% of the next $750 of Allowed Charges (deductible)** **Only Allowed Charges apply to the deductible** **Both Basic Plans** •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit **•No deductible for well child care visit.** •You may use non-Network providers, but it will be more costly	You pay 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		**$0 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

*The $30 copay applies to general practioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants, and nurse practitioners. Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative & Wellness Alternative Plus HMO	GlobalHealth Alternative and Wellness Alternative Plus HMO	UnitedHealthcare Alternative and Wellness Alternative Plus HMO	Your Costs for Network Services
No deductible	No deductible **Wellness Alternative Plus** **To be eligible for this Plan, you must complete a Health Risk Assessment. For instructions, see page 2**	No deductible **Wellness Alternative Plus** **To be eligible for this Plan, you must complete a Health Risk Assessment. For instructions, see page 2**	No deductible **Wellness Alternative Plus** **To be eligible for this Plan, you must complete a Health Risk Assessment. For instructions, see page 2**	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 Limit
$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, CAT, or nuclear 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 In accordance with the US Preventive Services Task Force and other health organizations required guidelines	Immunizations

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

Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative and USA Plans	HealthChoice Basic and Basic Alternative Plans	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	**$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 over •Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible **Basic Alternative Plan** •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible **Both Basic Plans** •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit •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 **No limit on the number of days per year**		20% of Allowed Charges after deductible **No limit on the number of days per year**
Mental Health or Substance Abuse Outpatient Visit	20% of Allowed Charges after deductible **No limit on the number of visits per year**		20% of Allowed Charges after deductible **No limit on the number of 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 page 28 of this guide for contact information.

Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative & Wellness Alternative Plus HMO	GlobalHealth Alternative and Wellness Alternative Plus HMO	UnitedHealthcare Alternative and Wellness Alternative Plus HMO	Your Costs for Network Services
$0 copay per visit for routine physicals	$0 copay	$0 copay/PCP Limit: One per year	$0 copay In accordance with the US Preventive Services Task Force and other health organizations required guidelines	**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 and 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 $10,000 maximum benefit per calendar year	**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 page 28 for contact information.

Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative, and USA Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice S-Account Plan
Occupational and Speech Therapy Visits	20% of Allowed Charges after deductible Occupational therapy* Limit: 20 visits per year without certification Speech therapy* **Certification not required for age 18 and older** *Maximum of 60 visits per year	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible **Basic Alternative Plan** •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible **Both Basic Plans** •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit •You may use non-Network providers, but it will be more costly	20% of Allowed Charges after deductible Occupational therapy* Limit: 20 visits per year without certification Speech therapy* **Certification not required for age 18 and older** *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

**The $30 copay applies to general practioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants, and nurse practitioners.

Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative & Wellness Alternative Plus HMO	GlobalHealth Alternative and Wellness Alternative Plus HMO	UnitedHealthcare Alternative and Wellness Alternative Plus 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 medical episode	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 medical episode	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 For children up to age 18	$0 copay/PCP ages 0-17 20% coinsurance ages 18 and over Limited to a single hearing aid every 3 years – maximum benefit of $5,000 per calendar year	Hearing Screening and Hearing Aids

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

Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative, Basic, Basic Alternative, and USA Plans	HealthChoice S-Account Plan
Pharmacy Benefits	**NETWORK** **Retail Pharmacy** **•Up to a 30-day supply** **•Generic medication – $10 copay or cost of medication if less** **•Preferred brand-name medication – cost of medication up to $15 or a maximum copay of $30** **•Non-Preferred brand-name medication – cost of medication up to $30 or a maximum copay of $60** **•Maintenance medication – 50% of ingredient cost plus dispensing fee for fourth and all subsequent fills; minimum copay of $10 for generics, $15 for Preferred brand-name, and $30 for non-Preferred brand-name medication** **Mail Order and Retail Maintenance Pharmacies** **•Up to a 90-day supply** **•Generic medication – $25 or cost of medication if less** **•Preferred brand-name medication – cost of medication up to $30 or a maximum copay of $60** **•Non-preferred brand-name medication – cost of medication up to $60 or a maximum copay of $120** **•Specialty medication covered only when ordered through Accredo Health Group** • **Preferred medication $60 per 30-day supply** • **Non-Preferred $120 per 30-day supply** Pharmacy out-of-pocket maximum - $2,500 per person using Preferred products at Network pharmacies, then you pay $0	After combined medical and pharmacy deductible ($1,500 individual/$3,000 family) has been met, the pharmacy benefits are: **NETWORK** **Retail Pharmacy** **•Up to a 30-day supply** **•Generic medication – $10 copay or cost of medication if less** **•Preferred brand-name medication – cost of medication up to $15 or a maximum copay of $30** **•Non-Preferred brand-name medication – cost of medication up to $30 or a maximum copay of $60** **•Maintenance medication – 50% of ingredient cost plus dispensing fee for fourth and all subsequent fills; minimum copay of $10 for generics, $15 for Preferred brand-name, and $30 for non-Preferred brand-name medication** **Mail Order and Retail Maintenance Pharmacies** **•Up to a 90-day supply** **•Generic medication – $25 or cost of medication if less** **•Preferred brand-name medication – cost of medication up to $30 or a maximum copay of $60** **•Non-preferred brand-name medication – cost of medication up to $60 or a maximum copay of $120** **•Specialty medication covered only when ordered through Accredo Health Group per 30-day supply** • **Preferred medication $60 per 30-day supply** • **Non-Preferred $120 per 30-day supply**

Plan changes are indicated by **bold text**.

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative & Wellness Alternative Plus HMO	GlobalHealth Alternative and Wellness Alternative Plus HMO	UnitedHealthcare Alternative and Wellness Alternative Plus 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 (non-Preferred) These copays do not apply to the maximum out-of-pocket 30-day supply Certain medications have restricted quantities Convenient mail-order is available. Contact Plan for details	Tier 1: $10 Tier 2: $50 Tier 3: $75 $4 copay for selected generics 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**

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 plus amounts above Allowed Charges	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% plus amounts above Allowed Charges 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% plus amounts above Allowed Charges Deductible applies	Root canal, anterior: $355 Periodontal/scaling/root planing 1-3 teeth (per quadrant): $71	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% plus amounts above Allowed Charges 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
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 their 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 their 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 their 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's 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's fee, 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
			For information on limitations/exclusions, please contact PVCS. See *Help Lines* on page 28 *Out-of-Network limited to one eye exam and one set of eyeglasses or contact lenses annually. Cannot be used with In-Network services.	

Vision benefits apply from January 1 through December 31, 2012

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 **Lens options covered in full:** **•UV coating** **•Tints**	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
$25 fitting copay for standard fitting **After copay, Plan pays 100%** **$25 fitting copay for specialty fitting** **After copay, Plan pays up to $50** Plan pays up to $120 for elective contacts Medically necessary contacts are covered in full (in lieu of glasses)	**Fitting fee is not a covered benefit** Plan pays up to $100 for elective contacts Plan pays up to $210 for medically necessary contacts (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 lenses (in lieu of glasses) **Contact lens exam is covered in full after a copay of up to $60**	$0 copay Plan pays up to $105 for disposable or conventional contact lenses (in lieu of glasses)
20% to 50% savings on LASIK surgery	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, 2012

HealthChoice (OSEEGIB) Help Lines

Health, Dental, and Life Claims, Benefits, Verification of Coverage, and ID Cards

Oklahoma City Area	1-405-416-1800
All Other Areas	1-800-782-5218
TDD Oklahoma City Areas	1-405-416-1525
TDD All Other Areas	1-800-941-2160
Website	www.sib.ok.gov or www.healthchoiceok.com

Pharmacy Claims/Pharmacy ID Cards

All Areas	1-800-903-8113
TDD All Areas	1-800-825-1230

Member Services/Provider Directory

Oklahoma City Area	1-405-717-8780
All Other Areas	1-800-752-9475
TDD	1-405-949-2281 or All Areas 1-866-447-0436

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

American Fidelity Health Services Administration

Health Savings Account (HSA)

Oklahoma City Area	1-405-523-5699
All Areas	1-866-326-3600
Website	www.afhsa.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

UnitedHealthcare

All Areas	1-800-825-9355
TDD All Areas	1-800-557-7595
Website	www.UHCwest.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
Toll-free Hearing Impaired Relay Svc	1-800-654-5988
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

HealthChoice

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

OPTION PERIOD GUIDE
PLAN YEAR 2012