OSEEGIB

Oklahoma State and Education
Employees Group Insurance Board

Employee Benefit Options Guide

For Plan Year

January 1, 2009 through December 31, 2009

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

#2077

Update to Printed Version of this Handbook

Effective January 1, 2009, the TDD phone number for the HealthChoice USA Plan is 1-800-941-2160.

The following information was not available from GlobalHealth Alternative HMO when this guide went to print. These are changes to the benefits listed in the Comparison of Benefits for Health Plans on pages 10 through 21.

- The inpatient hospital copay is $250 per day with a $750 maximum per admission.
- Diagnostic x-ray and lab has a $250 copay per scan (MRI, MRA, CAT, or PET).
- After hours urgent care has a $25 copay/PCP and $50 copay/all others.
- Occupational, speech, or physical therapy has a limit of 60 consecutive days per illness or injury.

This guide has been updated to reflect these changes.

Oklahoma State and Education Employees Group Insurance Board

Monthly Premiums for Plan Year January 1, 2009 - December 31, 2009

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High	$409.12	$587.92	$199.98	$343.10
HealthChoice Basic	$347.96	$503.74	$171.56	$293.44
HealthChoice S-Account	$322.68	$468.90	$162.24	$276.72
Aetna Standard HMO	$668.30	$888.76	$654.90	$654.90
Aetna Alternative HMO	$431.16	$573.40	$422.52	$422.52
CommunityCare Standard HMO	$715.76	$1,023.52	$357.88	$572.60
CommunityCare Alternative HMO	$484.72	$693.14	$242.36	$387.78
GlobalHealth Standard HMO	$333.78	$495.26	$178.98	$285.40
GlobalHealth Alternative HMO	$303.44	$450.28	$162.74	$259.46
PacifiCare Standard HMO	$600.46	$858.64	$300.22	$480.36
PacifiCare Alternative HMO	$388.70	$555.68	$194.20	$310.81
DISABILITY (Employee only)	$7.62 (Limited county participation only)			
DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice Dental	$28.58	$28.58	$23.82	$61.84
Assurant Freedom Preferred	$24.84	$24.70	$18.52	$49.80
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 (POS)	$29.88	$29.90	$26.28	$66.88
Delta's Choice (PPO)	$12.88	$29.48	$29.26	$71.56
VISION PLANS - Voluntary	MEMBER	SPOUSE	CHILD	CHILDREN
Humana/CompBenefits VisionCare Plan	$6.76	$5.06	$3.57	$ 4.46
Primary Vision Care Services	$9.25	$8.00	$8.50	$10.75
Superior Vision Plan	$6.98	$6.90	$6.60	$ 6.60
UnitedHealthcare Vision	$8.18	$5.79	$4.59	$ 6.98
Vision Service Plan (VSP)	$8.96	$6.00	$5.74	$12.92
LIFE				
HealthChoice Basic Life ($20,000) $3.50		First $20,000 of Supplemental Life $3.50		
Age-Rated Supplemental Life – Cost Per $20,000				
< 30 ---------- $1.00	45 - 49 ------- $ 3.80		65 - 69 ------- $19.80	
30 - 34 ------- $1.00	50 - 54 ------- $ 6.40		70 - 74 ------- $33.40	
35 - 39 ------- $1.60	55 - 59 ------- $10.40		75+ ---------- $52.00	
40 - 44 ------- $2.40	60 - 64 ------- $12.00			

DEPENDENT LIFE	Low Option $2.16	Standard Option $3.60	Premier Option $7.20
Dependent Life Coverage Amounts	Spouse $6,000	Spouse $10,000	Spouse $20,000
	Children over 6 mos. $3,000	Children over 6 mos. $5,000	Children over 6 mos. $10,000
	Birth to 6 mos. $1,000	Birth to 6 mos. $1,000	Birth to 6 mos. $1,000

TABLE OF CONTENTS

Audio CDs and CD versions for PC of the Benefit Guides have been prepared and are available at the Oklahoma Library for the Blind and Physically Handicapped (OLBPH). Contact the OLBPH at 1-405-521-3514, toll-free 1-800-523-0288, and TDD 1-405-521-4672.

The participating carriers reviewed and approved the information in this material. There is no guarantee that all providers will remain with the plans or have open patient slots all year long. Please verify your provider is still participating in your plan's network.

This publication was printed by the Oklahoma State and Education Employees Group Insurance Board as authorized by 74 O.S. Section 1301, et seq. 109,000 copies have been printed at a cost of $0.382 each. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

2009 PLAN YEAR CHANGES

Health Plan Changes

HealthChoice Plans

- The number of visits allowed without prior authorization for occupational and speech therapy is being increased from 15 visits to 20 visits. There is a limit of 60 visits per year for each type of therapy. The maximum of three services per visit is being removed.
- The number of visits allowed without prior authorization for physical therapy/physical medicine is being increased from 15 visits to 20 visits. There is a limit of 60 visits per year. The maximum of three services per visit is being removed.
- The number of visits allowed without prior authorization for chiropractic therapy is being increased from 15 visits to 20 visits. There is a limit of 60 visits per year. The maximum of three services per visit is being removed.
- The health, dental, and life claims administrator for HealthChoice is changing to EDS Administrative Services, LLC. A new health/dental identification card is being sent to all HealthChoice members.
- The precertification administrator is changing to APS.

HealthChoice Pharmacy Benefit

- Most prescription **antihistamines, decongestants,** and **cough suppressants** are no longer covered medications. This includes all **non-sedating antihistamines** such as Allegra and Clarinex. Contact HealthChoice for more information, see Help Lines on the inside back cover.
- Members obtaining **specialty pharmacy medications** through Accredo Health Group will now pay the applicable copay for every 30-day fill.

HMOs

- Some of the HMO service areas are changing. See the HMO ZIP Code listing on pages 12-13.
- Several of the copays are changing. Please see the Comparison of Benefits for Health Plans on pages 10-17. The changes are in **bold text**.

Dental Plan Changes

HealthChoice Dental Plan

- The coinsurance for Network orthodontia services is being changed to 50%.
- The $50 orthodontia deductible for Network services and the $150 orthodontia deductible for non-Network services is being removed.
- The $1,800 lifetime maximum for orthodontia benefits is being removed.

Vision Plan Changes

- CompBenefits VisionCare Plan's name has changed to Humana/CompBenefits VisionCare Plan. The new web address is **www.compbenefits.com/custom/stateofoklahoma**.
- Spectera Vision's name has changed to UnitedHealthcare Vision. The new web address is **www.myuhcvision.com**.

If you have questions about any of the plans, use the contact information on the Help Lines page on the inside back cover of this Benefit Options Guide.

INTRODUCTION

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

- Health
- Dental
- Life
- Disability
- Vision

Helpful Hints For Option Period

- Check Section B of your *Option Period Enrollment/Change Form* for the coverage you will have effective January 1, 2009, if you do not make any changes during Option Period.
- Contact your Insurance Coordinator if you have questions about your current coverage.
- Check plan changes for 2009. Plan changes are listed on page ii of this guide.
- **Check with your Insurance Coordinator about the need to return your form even if you are not making any changes.**
- Use the following resources to help you decide what coverage you (and your dependents) wish to carry:
  - This Guide
  - Plan websites
  - Customer Services telephone numbers
  - Provider Directories
  - OSEEGIB Member Services
  - Your Insurance Coordinator
- Decide on the coverage you want for you (and your dependents) for 2009.
- Complete your *Option Period Enrollment/Change Form* and return it to your Insurance Coordinator by his/her designated deadline.
- Check your Confirmation Statement when you receive it in the mail to verify your coverage is correct.
- Contact your Insurance Coordinator if your Confirmation Statement is not correct. **If you do not make any changes to your coverage, 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 what coverage you (and your dependents) wish to carry:
  - This Guide
  - Plan websites
  - Customer Services telephone numbers
  - Provider Directories
  - OSEEGIB Member Services
  - Your Insurance Coordinator
- Decide on the coverage you want for you (and your dependents) for 2009.
- Complete your *Enrollment Form* and return it to your Insurance Coordinator by his/her designated deadline.
- Check your Confirmation Statement when you receive it in the mail to verify your coverage is correct.
- Contact your Insurance Coordinator if your Confirmation Statement is not correct.

HEALTH PLAN HIGHLIGHTS

There are 12 health plans available:

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

See Comparison of Benefits for Health Plans on pages 10-17

- All plans have toll-free numbers for customer service - see **Help Lines** on the inside back cover.
- To enroll in the HealthChoice S-Account Plan, you must provide OSEEGIB with proof you have set up a Health Savings Account at a bank or other financial institution. This proof must be submitted by December 15, 2008.
- You must live or work within the HMO's ZIP Code service area to be eligible for that HMO. P.O. Box addresses cannot be used to determine your eligibility for an HMO. See pages 8-9 for the HMO ZIP Code listing.
- Check with each health plan if you have benefit questions.

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

DENTAL PLAN HIGHLIGHTS

Verify your employer offers dental coverage through OSEEGIB.

There are seven dental plans available:

- HealthChoice Dental
- Assurant Freedom Preferred
- Assurant Heritage Plus with SBA (Prepaid)
- Assurant Heritage Secure (Prepaid)
- CIGNA Dental Care Plan (Prepaid)
- Delta Dental PPO (POS)
- Delta's Choice (PPO)

See Comparison of Benefits for Dental Plans on pages 18-19

- All plans have toll-free numbers for customer service - see **Help Lines** on the inside back cover.
- Check with each dental plan if you have benefit questions.

VISION PLAN HIGHLIGHTS

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 Services
- UnitedHealthcare Vision (formerly Spectera)
- Vision Service Plan (VSP)

See Comparison of Benefits for Vision Plans on pages 20-21

- All plans have toll-free numbers for customer service - see **Help Lines** on the inside back cover.
- All vision plans have limited coverage for services received from non-participating providers.
- Verify your vision provider is a member of the vision plan's network by calling the toll-free numbers provided, or check each plan's website for the most up-to-date list of providers.
- Check with each vision plan if you have benefit questions.

The loss of your provider on any of the health, dental, or vision plans does not allow a change in plans until the next annual Option Period. You may change providers within your selected plan as needed.

Thinking About Retirement?

If you are a current employee thinking about retiring **before** January 1, 2009, please contact Member Services so we can send you the appropriate materials. You will select your benefits from the Former Pre-Medicare or Medicare Option Period Guide, not this Guide. To contact Member Services, refer to Help Lines on the inside back cover of this Guide.

HEALTHCHOICE LIFE INSURANCE

Verify your employer offers HealthChoice Life Insurance.

1. As a **new employee**, you may elect life coverage within 30 days following your initial entry-on-duty date or the date you become eligible. A limited amount (Guaranteed Issue) can be obtained without an approved Life Insurance Application.
2. As a **current employee**, if you did not enroll when first eligible, you may enroll at the next annual Option Period or if you have proof of loss of other group life coverage within the previous 30 days. An approved Life Insurance Application will be required for Option Period enrollment. See your Insurance Coordinator for this form.

Basic Life . . . For You

- To enroll during Option Period, you must provide a Life Insurance Application for review and approval.
- Basic Life pays a benefit of $20,000 to your beneficiary(ies) in the event of your death.
- Included in the Basic Life Plan is Accidental Death and Dismemberment (AD&D) coverage. This coverage automatically pays an additional $20,000 in benefits to your beneficiary(ies) if your death is due to an accident, or it pays you a reduced amount for the loss of sight or limb.

Supplemental Life Insurance . . . For You

- You may purchase additional life coverage in units of $20,000 with an approved Life Insurance Application.
- The first $20,000 unit of Supplemental Life provides you with an additional $20,000 of AD&D insurance.
- At the time of your initial enrollment only, you can purchase supplemental life coverage of two times your annual salary (Guaranteed Issue), rounded up to the next $20,000 unit, without providing a Life Insurance Application.
- You may also purchase supplemental life coverage up to an amount equal to five times your annual salary, rounded up to the next $20,000 unit, or $300,000, whichever is less, with an approved Life Insurance Application.
- Life Insurance Applications are available from your Insurance Coordinator.

Dependent Coverage . . . For Your Family

DEPENDENT	LOW OPTION	STANDARD OPTION	PREMIER OPTION
Spouse	$6,000	$10,000	$20,000
Child (age 6 months to 25)	$3,000	$5,000	$10,000
Child (live birth to 6 months)	$1,000	$1,000	$1,000

- If you enroll in Basic Life, you may purchase Dependent Life insurance for your spouse and/or your children at initial enrollment, during Option Period, or within 30 days of loss of other group life insurance.
- Dependent Life does not include AD&D coverage.
- You may choose Low Option, Standard Option, or Premier Option coverage. Regardless of the number of dependents, the monthly premium is the same.
- A Life Insurance Application is not required for Dependent Life coverage.

Beneficiary Designation

Benefits are paid to your beneficiary(ies) in a lump sum. *You must name your beneficiary(ies) when you enroll. Your beneficiary designation may be changed at any time.* Death benefits for covered dependents are always paid to the member. For a beneficiary form or more information, contact your Insurance Coordinator. Beneficiary forms are also available on our website at **www.sib.ok.gov** or **www.healthchoiceok.com**.

HEALTHCHOICE DISABILITY INSURANCE

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

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

Participation

You are enrolled in the Plan on the first day of the month following your entry-on-duty date or the date you become eligible. You become eligible for benefits after 31 consecutive days of employment. During that time, you must have continuously performed all of the material duties of your regular occupation. Any claim for disability benefits must be filed within one year of the beginning of the disability.

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 under your employer's Employee Benefit Plan.

The benefits you elect will be in effect from January 1, 2009, or the effective date of your coverage, through December 31, 2009. Please contact the insurance plan(s) at the phone number(s) or website(s) listed in the Help Lines on the inside back cover for more information on any of the plans.

After enrollment, the plan(s) you have selected will provide a member handbook or additional material with detailed information on your benefits.

Once enrolled in any of the plan choices, it is your responsibility to review your benefits carefully so you know what is covered or what the plan policies are before you have to use your benefits.

Option Period Enrollment

This is the time when eligible employees may:

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

- You may add health, dental, life, and/or vision coverage for yourself and/or your dependent(s) during Option Period, as long as you have not dropped that coverage within the past 12 months (limitations and/or exceptions may apply).
- If you want to enroll in or increase your life insurance coverage, you must complete and submit a Life Insurance Application for approval. See your Insurance Coordinator for this form.

Initial Enrollment

This is the time when new employees become eligible to:

- Enroll in insurance benefits
- Enroll eligible dependents in benefits
- 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 make your benefit selections. If you do not enroll within 30 days, you will not be able to elect benefits until the next annual Option Period unless a qualifying event occurs during the plan year. Your employer's Section 125 Plan (if applicable) determines any exception to this rule. Check with your Insurance Coordinator for more information.
- If you request life coverage of more than two times your annual salary (Guaranteed Issue), you must complete a Life Insurance Application. See your Insurance Coordinator for this form.
- Keep a copy of your enrollment form for your records.

ELIGIBILITY

Members

- You must be a current Education employee eligible to participate in the Oklahoma Teachers' Retirement System and 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 in order to enroll in dental or life insurance.

Dependents

- You may exclude your spouse from health and/or dental coverage. Contact your Insurance Coordinator for details. You and your spouse must both sign the spouse exclusion section of the *Enrollment Form* or the *Option Period Enrollment/Change Form*.

- If one eligible dependent is covered, all eligible dependents must be covered. Dependents can be excluded from coverage if they have other group coverage of the same type, or are eligible for Indian or military health benefits. Eligible dependents are:
  - Your legal spouse (including common-law)
  - Your unmarried children up to age 25; or regardless of age, a dependent who is incapable of self-support and who has a disability diagnosed prior to age 25, subject to medical review and approval
  - Children, including your natural child or stepchild, provided you are primarily responsible for their support, and your natural child or stepchild, regardless of residence, if ordered by the court; court documentation is required
  - Other dependent children with an approved Declaration of Dependency form (required if the child is not claimed on your income tax return)
  - If your spouse is enrolled separately in one of the OSEEGIB plans, children may be covered under either parent's health, dental, or vision plan (but not both); however, the spouse and children may be covered for dependent life by each employee
- 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 those dependents for a minimum of 12 months. The 12-month requirement does not apply when the dependents have lost other group health, dental, vision, and/or life insurance coverage and are seeking reinstatement.
- Family members may only be enrolled in the same coverages you have as the primary member.
- Newborns – A change form must be provided to your Insurance Coordinator within 30 days of the birth to enroll your newborn. If you do not enroll your newborn during this 30-day period, you will not be able to do so until the next annual Option Period. Direct notification to an HMO will not enroll your newborn, or any other dependents. The newborn's Social Security number is not required at the time of initial enrollment, but must be provided once it is received from the Social Security Administration. Insurance premiums for the month the child was born must be paid.
- Newborns will be covered only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth without enrollment.
- A dependent who loses eligibility may apply for continuation of health, dental, or vision coverage under COBRA for a maximum of 36 months. See your Insurance Coordinator for more information.

EFFECTIVE DATE OF COVERAGE

- **Option Period** elections become effective on January 1, 2009, the beginning of the new plan year.
- **New employee** coverage is effective the first day of the month following your employment date or the date you become eligible through your employer.
- **Midyear changes** become effective the first of the month following a qualifying event or the date the change is made.

CHANGES TO COVERAGE

Initial Enrollment

- As a new employee, you have a 30-day window following the date you became eligible to make changes to your original benefit selections. These changes are effective the first day of the month following the date the change in coverage is made.

Midyear Changes

- Midyear plan changes are allowed only if a qualifying event occurs. See your Insurance Coordinator for more information.

CONFIRMATION STATEMENT

- You will be provided a Confirmation Statement (CS) when you enroll or make changes to your coverage. The CS lists the coverage you are enrolled in, the effective date of the coverage, and the premium amounts for the coverage.
- Section B of your *Option Period Enrollment/Change Form* lists the coverage you will have effective January 1, 2009, if you do not make changes to your coverage during Option Period. In this event, you will not receive a CS from OSEEGIB. Keep a copy of your *Option Period Enrollment/Change Form* as proof of your coverage.
- Review your CS to ensure the coverage shown is correct. Any corrections must be submitted to your Insurance Coordinator within 60 days of the election. Corrections reported after 60 days will be effective the first of the month following notification.

TRANSFER EMPLOYEE

- When moving from one participating employer to another, you are eligible for continuous coverage provided there is no more than a 30-day break in coverage and premiums are paid upon reporting to work.
- Benefit options may vary from employer to employer. Changes may be made within the first 30 days of your transfer. See your Insurance Coordinator for more information.

TERMINATION OF COVERAGE

- Coverage will end on the last day of the month in which a termination event occurs. Examples of termination events are:
  - Loss of employment
  - A dependent becomes ineligible for coverage
  - Non-payment of premiums
  - Death

COBRA

Temporary Continuation of Coverage

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you or your dependents to continue health, dental, or vision insurance coverage after your employment terminates or after a dependent loses eligibility. Certain time limits apply to enrollment. An additional two percent administration fee is added for COBRA insurance premiums. 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. Your Insurance Coordinator will provide the necessary paperwork and information on COBRA enrollment and premiums. COBRA is limited to 18 months for eligible employee events; up to 29 months for certain eligible disabilities; and up to 36 months for dependents who lose coverage except for specific, qualifying events.

HMO ZIP Code List

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

HMO ZIP CODE LIST

73002	G P	73069	A C G P	73121	A C G P	73173	A C G P	73768	G	74046	C G P
73003	A C G P	73070	A C G P	73122	A C G P	73177	C P	73770	G	74047	A C G P
73004	A G P	73071	A C G P	73123	A C G P	73178	A C G P	73772	G	74048	C
73007	A C G P	73072	A C G P	73124	A C G P	73179	A C G P	73838	G	74050	A C G P
73008	A C G P	73073	A C G P	73125	A C G P	73180	C P	74001	CG	74051	C
73010	A G P	73074	G	73126	A C G P	73184	A C G P	74002	C G P	74052	C G P
73011	G P	73075	G	73127	A C G P	73185	A C G P	74003	C	74053	A C G P
73012	A C P	73077	C	73128	A C G P	73189	A C G P	74004	C	74054	A C G P
73013	A C G P	73078	A C G P	73129	A C G P	73190	A C G P	74005	C	74055	A C G P
73014	C G P	73079	G P	73130	A C G P	73193	C G P	74006	C	74056	CG
73016	P	73080	A G P	73131	A C G P	73194	A C G P	74008	A C G P	74058	C
73018	G P	73082	G	73132	A C G P	73195	A C G P	74009	C	74059	C P
73019	A C G P	73083	A C G P	73134	A C G P	73196	A C G P	74010	C G P	74060	A C G P
73020	A C G P	73084	A C G P	73135	A C G P	73197	A C G P	74011	A C G P	74061	C P
73022	A C G P	73085	A C G P	73136	A C G P	73198	A C G P	74012	A C G P	74062	C P
73023	G	73089	A G P	73137	A C G P	73199	A C G P	74013	A C G P	74063	A C G P
73025	A C P	73090	A C G P	73139	A C G P	73432	G	74014	A C G P	74066	A C G P
73026	A C G P	73092	G P	73140	A C G P	73433	G	74015	A C G P	74067	A C G P
73027	A C G P	73093	A G P	73141	A C G P	73446	G	74016	A C G P	74068	C G P
73028	A C G P	73095	G P	73142	A C G P	73447	G	74017	A C G P	74070	A C G P
73031	A G P	73096	G	73143	A C G P	73450	G	74018	A C G P	74071	C G P
73034	A C G P	73097	A C G P	73144	A C G P	73455	G	74019	A C G P	74072	C
73036	A C G P	73098	G	73145	A C G P	73460	G	74020	C P	74073	A C G P
73037	C P	73099	A C G P	73146	A C G P	73461	G	74021	A C G P	74074	C P
73040	G	73100	C	73147	A C G P	73532	G	74022	C	74075	C P
73043	G	73101	A C G P	73148	A C G P	73537	G	74023	C P	74076	C P
73044	A C G P	73102	A C G P	73149	A C G P	73544	G	74026	G P	74077	C
73045	A C G P	73103	A C G P	73150	A C G P	73550	G	74027	C	74078	C
73048	G	73104	A C G P	73151	A C G P	73554	G	74028	C G P	74079	G P
73049	A C G P	73105	A C G P	73152	A C G P	73571	G	74029	C	74080	A C G P
73050	A C G P	73106	A C G P	73153	A C G P	73646	G	74030	C G P	74081	C P
73051	A C G P	73107	A C G P	73154	A C G P	73658	G	74031	A C G P	74082	C P
73052	G	73108	A C G P	73155	A C G P	73669	G	74032	C P	74083	C
73054	A C G P	73109	A C G P	73156	A C G P	73718	G	74033	A C G P	74084	CG
73056	A C G P	73110	A C G P	73157	A C G P	73724	G	74034	C	74085	C P
73057	G P	73111	A C G P	73159	A C G P	73729	G	74035	C G P	74100	C
73058	A C G P	73112	A C G P	73160	A C G P	73737	G	74036	A C G P	74101	A C G P
73059	A G P	73113	A C G P	73162	A C G P	73744	G	74037	A C G P	74102	A C G P
73061	C	73114	A C G P	73163	A C G P	73747	G	74038	C P	74103	A C G P
73063	A C G P	73115	A C G P	73164	C G P	73755	G	74039	A C G P	74104	A C G P
73064	A C G P	73116	A C G P	73165	A C G P	73757	C	74041	C G P	74105	A C G P
73065	A G P	73117	A C G P	73167	A C G P	73760	G	74042	C	74106	A C G P
73066	A C G P	73118	A C G P	73169	A C G P	73762	P	74043	A C G P	74107	A C G P
73067	G P	73119	A C G P	73170	A C G P	73763	G	74044	C G P	74108	A C G P
73068	A C G P	73120	A C G P	73172	A C G P	73764	G	74045	C	74110	A C G P

continued on next page

continued from previous page

HMO ZIP Code List

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

74112	A C G P	74193	A C G P	74427	C	74522	C	74759	C	74868	C G P
74114	A C G P	74194	A C G P	74428	C	74523	C	74760	C	74869	A G P
74115	A C G P	74301	C P	74429	A C G P	74526	C	74761	C	74871	G
74116	A C G P	74330	A C G P	74430	C	74528	C	74801	A C G P	74872	G
74117	A C G P	74331	C	74431	C G P	74529	C	74802	A C G P	74873	A C G P
74119	A C G P	74332	C	74432	C	74530	G	74804	A C G P	74875	G P
74120	A C G P	74333	C	74434	C	74531	G	74818	C G P	74878	A C G P
74121	A C G P	74335	C	74435	C	74536	C	74820	G	74880	G P
74126	A C G P	74337	A C G P	74436	C G P	74543	C	74821	G	74881	A G P
74127	A C G P	74338	C	74437	C G P	74545	C	74824	G P	74882	P
74128	A C G P	74339	C	74438	C	74546	C	74825	G	74883	G
74129	A C G P	74340	A C G P	74439	C	74547	C	74826	A C G P	74884	C G P
74130	A C G P	74342	C	74440	C	74548	C	74827	G	74901	C
74131	A C G P	74343	C	74441	C	74549	C	74829	P	74902	C
74132	A C G P	74344	C	74442	C	74552	C	74830	C G P	74930	C
74133	A C G P	74345	C	74444	C	74553	C	74831	AP	74931	C
74134	A C G P	74346	C	74445	C G P	74554	C	74832	G P	74932	C
74135	A C G P	74347	C	74446	C G P	74557	C	74833	P	74935	C
74136	A C G P	74349	A C G P	74447	C G P	74558	C	74834	G P	74936	C
74137	A C G P	74350	A C G P	74450	C	74559	C	74835	P	74937	C
74141	A C G P	74352	A C G P	74451	C	74560	C	74836	G	74939	C
74145	A C G P	74353	C P	74452	C	74561	C	74837	C G P	74940	C
74146	A C G P	74354	C	74454	C G P	74562	C	74838	P	74941	C
74147	A C G P	74355	C	74455	C	74563	C	74839	G	74942	C
74148	A C G P	74358	C	74456	C G P	74565	C	74840	A C G P	74943	C
74149	A C G P	74359	C	74457	C	74567	C	74842	G	74944	C
74150	A C G P	74360	C	74458	C G P	74570	G	74843	G	74945	C
74152	A C G P	74361	A C G P	74459	C	74571	C	74844	G	74946	C
74153	A C G P	74362	A C G P	74460	C G P	74574	C	74845	C	74947	C
74155	A C G P	74363	C	74461	C	74577	C	74848	G	74948	C
74156	A C G P	74364	A C G P	74462	C	74578	C	74849	C G P	74949	C
74157	A C G P	74365	A C G P	74463	C	74604	C	74850	G	74951	C
74158	A C G P	74366	A C G P	74464	C	74630	C	74851	A C G P	74953	C
74159	A C G P	74367	A C G P	74465	C	74633	CG	74852	A C G P	74954	C
74169	A C G P	74368	C	74466	C P	74637	CG	74854	A C G P	74955	C
74170	A C G P	74369	C	74467	C G P	74644	C	74855	A G P	74956	C
74171	A C G P	74370	C	74468	C	74650	C	74856	G	74959	C
74172	A C G P	74401	C	74469	C	74651	C	74857	A C G P	74960	C
74182	A C G P	74402	C	74470	C	74652	CG	74859	G P	74962	C
74183	A C G P	74403	C	74471	C	74727	C	74860	P	74964	C
74184	A C G	74421	C G P	74472	C	74735	C	74862	P	74965	C
74186	A C G P	74422	C G P	74477	C G P	74738	C	74864	G P	74966	C
74187	A C G P	74423	C	74501	C	74743	C	74865	G		
74189	A C G P	74425	C	74502	C	74748	G	74866	A C G P		
74192	A C G P	74426	C	74521	C	74756	C	74867	C G P		

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Calendar Year Deductibles	$500 individual $1,500 family	$500 individual $1,000 family Deductible applied after Plan pays first $500 of Allowed Charges	The combined medical and pharmacy deductible must be met before benefits are paid. $1,500 individual $3,000 family	No deductible
Calendar Year Out-of-Pocket Maximum	$2,800 Network, individual $3,300 + amounts over Allowed Charges non-Network, individual	$5,500 individual $11,000 family	$4,000 individual $8,000 family Non-Network charges do not apply	**$2,000 individual** **$4,000 family**
Office Visit (Professional Services)	$25 copay	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan **For Network services:** •$0 of Allowed Charges through first $500 •100% through next $500 of deductible (only Allowed Charges apply to the deductible) •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $11,000 •You may use non-Network providers, but it will be more costly	Member pays 100% of Allowed Charges until deductible is met $25 copay applies after deductible	**$25 copay/PCP** $35 copay/specialist
Diagnostic X-ray and Lab	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	No copay/laboratory services or outpatient radiology $100 copay per MRI, CAT, MRA, or PET scan
Hospital Inpatient Admission	20% of Allowed Charges after deductible Additional $300 non-Network deductible per admission		20% of Allowed Charges after deductible Additional $300 non-Network deductible per admission	**$250 copay** Preauthorization required
Hospital Outpatient Visit	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	**$175 copay** Preauthorization required
Well Baby Care Visit	$25 copay; no deductible applies		$25 copay; no deductible applies	$0 copay up to age 2
Immunizations	No charge for well-baby and adult immunizations $25 office visit copay and/or administration fee may apply		No charge for well-baby and adult immunizations $25 office visit copay and/or administration fee may apply	$0 copay/birth through age 18 $10 copay/ages 19 and over

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
No deductible	No deductible	No deductible	No deductible	**Calendar Year Deductibles**
$3,000 individual **$6,000 family**	**$2,500 individual** **$5,000 family**	**$3,000 individual** **$5,000 family**	$2,000 individual $4,000 family	**Calendar Year Out-of-Pocket Maximum**
$30 copay/PCP **$45 copay**/specialist	**$30 copay**/PCP **$45 copay**/specialist	$25 copay/PCP **$50 copay**/specialist	**$30 copay**/PCP $50 copay/specialist	**Office Visit (Professional Services)**
$45 copay	No additional copay/ laboratory services or outpatient radiology $100 copay per MRI, CAT, MRA, or PET scan	$0 copay	$0 copay/standard lab and radiology **$300 copay** per MRI, MRA, PET, or CAT	**Diagnostic X-ray and Lab**
$500 copay Preauthorization required	**$350 copay**	$250 copay **$750 maximum per admission**	**$1,000 copay**/ admission	**Hospital Inpatient Admission**
$300 copay	**$200 copay**	**$250 copay**	$500 copay	**Hospital Outpatient Visit**
$0 copay	$0 copay up to age 2	$0 copay up to age 2	$0 copay	**Well Baby Care Visit**
$0 copay/birth through age 18 $10 copay/ages 19 and over	$0 copay/ages birth through 18 years $25 copay/ages 19 and over	$0 copay/birth to age 18 $25 copay/PCP office visit for adults Standard copays may apply in conjunction with office visit	$0 copay/birth through age 18 (if no other service is rendered) **$30 copay**/PCP **$50 copay**/specialist 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 the plan. See the Help Lines page on the inside back cover of this guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Periodic Health Exams	$25 copay per exam 1 mammogram at no charge for women age 40 and over	1 mammogram at no charge for women age 40 and over Women under 40 pay $25 copay •Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan **For Network services:** •$0 of Allowed Charges through first $500 •100% through next $500 of deductible (only Allowed Charges apply to the deductible) •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $11,000 •You may use non-Network providers, but it will be more costly	20% of Allowed Charges after deductible 1 mammogram at no charge for women age 40 and over	$10 copay per visit for routine physicals
Allergy Treatment and Testing	20% of Allowed Charges after deductible Limit: 60 tests every 24 months		20% of Allowed Charges after deductible Limit: 60 tests every 24 months	**$25 copay/PCP** $35 copay/specialist **$25 for 6 week supply of antigen (including shots)**
Emergency Health Care Facility Visit	20% of Allowed Charges after deductible Additional $100 ER deductible – waived if admitted		20% of Allowed Charges after deductible Additional $100 ER deductible – waived if admitted	**$125 copay**; waived if admitted
After Hours Urgent Care	20% of Allowed Charges after deductible		20% of Allowed Charges after deductible	**$35 copay**
Mental Health or Substance Abuse Inpatient Admission*	20% of Allowed Charges after deductible Limit: 30 days per year		20% of Allowed Charges after deductible Limit: 30 days per year	**$250 copay** 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	**$25 copay**/PCP $35 copay/specialist 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	20% coinsurance initial device 20% coinsurance repair and replacement

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

***Mental Health Parity provides that certain biological conditions for severe mental illness are not limited as other mental health conditions. This does not apply to substance abuse.**

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
$10 copay for adults	$25 copay	$25 copay/PCP Limit: 1 per year	**$30 copay/PCP** $50 copay/specialist	Periodic Health Exams
$20 copay per visit $20 copay for 6 week supply of antigen (including shots)	**$30 copay**/PCP visit **$45 copay**/specialist visit **$30 copay** for 6 week supply of serum (including shots)	$25 copay/PCP visit **$50 copay**/specialist **$30 copay** for 6 week supply of antigen (including shots)	**$30 copay/PCP** $50 copay/specialist	Allergy Treatment and Testing
$150 copay	**$150 copay; waived if admitted**	**$150 copay; waived if admitted**	**$200 copay; waived if admitted**	Emergency Health Care Facility Visit
$75 copay	**$35 copay** per visit	$25 copay/PCP **$50 copay**/specialist	**$30 copay**/PCP $50 copay/specialist	After Hours Urgent Care
$500 copay Limit: 30 days per calendar year	$400 copay Limit: 30 days per year	$250 per day **$750 maximum per admission** Limit: 30 days per year	**$1,000 copay**/admission Limit: 30 consecutive days per year	Mental Health or Substance Abuse Inpatient Admission*
$45 copay Limit: 26 visits per calendar year	**$30 copay**/PCP **$45 copay**/specialist Limit: 26 visits per year	**$50 copay** Limit: 26 visits per year	**$30 copay/PCP** $50 copay/specialist Limit: 26 days per year	Mental Health or Substance Abuse Outpatient Visit*
20% of contracted rate	20% coinsurance	20% coinsurance $5,000 annual maximum	20% coinsurance Limit: $10,000 per 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 the inside back cover of this guide for contact information.

*Mental Health Parity provides that certain biological conditions for severe mental illness are not limited as other mental health conditions. This does not apply to substance abuse.

COMPARISON OF BENEFITS FOR HEALTH PLANS

This chart reflects your cost for the listed Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Occupational or Speech Therapy Visit	20% of Allowed Charges after deductible Each service limited to 20 visits per year without prior authorization Each service limited to 60 visits per year	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan **For Network services:** •$0 of Allowed Charges through first $500 •100% through next $500 of deductible (only Allowed Charges apply to the deductible) •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over $11,000 •You may use non-Network providers, but it will be more costly	20% of Allowed Charges after deductible Each service limited to 20 visits per year without prior authorization Each service limited to 60 visits per year	No copay inpatient **$25 copay**/PCP $35 copay/specialist Limit: 60 treatment days per course of therapy
Physical Therapy/ Physical Medicine Visit	20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Limited to 60 visits per year		20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization Limited to 60 visits per year	No copay inpatient **$25 copay**/PCP $35 copay/specialist Limit: 60 treatment days per course of therapy
Chiropractic and Manipulative Therapy Visit	**Chiropractic services only**: 20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization; **for manipulative therapy, see Physical Therapy/ Physical Medicine** Limited to 60 visits per year		**Chiropractic services only**: 20% of Allowed Charges after deductible Limit: 20 visits per year without prior authorization; **for manipulative therapy, see Physical Therapy/ Physical Medicine** Limited to 60 visits per year	$35 copay Limit: 15 visits per year PCP referral required
Maternity Pre and Post Natal Care	20% of Allowed Charges after deductible Includes 1 postpartum home visit - criteria must be met		20% of Allowed Charges after deductible Includes 1 postpartum home visit - criteria must be met	**$25 copay** for initial visit **$250 copay** per hospital admission
Hearing Screening and Hearing Aids	$25 copay/basic hearing screening Limit: 1 per year Hearing aids covered for children up to age 18 as durable medical equipment		$25 copay after deductible/basic hearing screening Limit: 1 per year Hearing aids covered for children up to age 18 as durable medical equipment	**$25 copay** Limit: 1 per year Hearing aids – 20% coinsurance for children up to age 18

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
No copay/inpatient **$45 copay**/outpatient therapy Limit: 60 consecutive days per course of therapy	No copay/inpatient **$45 copay** outpatient therapy Limit: 60 days per disability	No copay/inpatient **$50 copay** per outpatient visit Limit: 60 consecutive days combined inpatient and outpatient	**$1,000 copay inpatient** Outpatient - **$30 copay/PCP** $50 copay/specialist Limit: 60 days per episode	**Occupational or Speech Therapy Visit**
$45 copay/outpatient therapy Limit: 60 consecutive days per course of therapy	No copay/inpatient **$45 copay** outpatient therapy Limit: 60 days per disability	No copay/inpatient **$50 copay** per outpatient visit Limit: 60 consecutive days combined inpatient and outpatient	**$1,000 copay inpatient** Outpatient - **$30 copay/PCP** $50 copay/specialist Limit: 60 days per episode	**Physical Therapy/ Physical Medicine Visit**
$45 per visit Limit: 15 visits per calendar year	**$45 copay** Limit: 15 visits per year	**$50 copay** Limit: 15 visits per year – referral required	$20 copay Limit: 15 visits per year - referral required Limited to treatment of neurological and orthopedic conditions	**Chiropractic and Manipulative Therapy Visit**
$45 copay for initial visit; thereafter covered at 100% $500 per hospital admission	**$30 copay** for initial visit **$350 copay** per hospital admission	$25 copay initial visit only $250 copay/hospital admission per day **$750 maximum per admission**	**$30 copay/PCP** **$50 copay/specialist** for initial visit once diagnosis of pregnancy is confirmed **$1,000 copay hospital admission**	**Maternity Pre and Post Natal Care**
$10 copay Hearing aids covered for children up to age 18; limit 1 per ear every 48 months	**$30 copay** Limit: 1 per year Hearing aids – 20% coinsurance for children up to age 18	$25 copay per visit Limit: 1 visit per year Hearing aids – 20% coinsurance Limit: $5,000 combined DME, orthotics, and prosthetics Covered for children up to age 18	**$30 copay/PCP** $50 copay/specialist 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 the inside back cover of this guide for contact information.

COMPARISON OF BENEFITS FOR HEALTH PLANS

PHARMACY

This chart reflects your cost for the listed Network Services	HealthChoice High Option and HealthChoice Basic Plan	HealthChoice S-Account Plan	HMO Standard Option
Pharmacy Benefits	**NETWORK:** **Generic Mandate** **Preferred Medication:** •The cost of medication is $100 or less - You pay up to $25 or actual cost if less •The cost of medication is more than $100 - You pay 25% up to a $50 maximum •Out-of-pocket maximum - $2,500 per person using Preferred products at Network pharmacies, then you pay $0 **Non-Preferred Medication:** •The cost of medication is $100 or less - You pay up to $50 or actual cost if less •The cost of medication is more than $100 - You pay 50% up to a $100 maximum •Out-of-pocket maximums do not apply to non-Preferred medications **NOTE**: ♦ Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater. ♦ Some medications may have a limit on quantity and/or duration of therapy. ♦ Some medications require prior authorization. Specialty medications are covered when ordered through Accredo Health Group. ♦ HealthChoice Health Plans offer each covered individual a lifetime pharmacy benefit of $2,000,000 If you choose a brand-name medication when a generic is available, you will be responsible for the difference in cost, **plus** the copay **NON-NETWORK:** **Preferred Medication:** •You pay the cost of medication up to $75 maximum plus a dispensing fee **Non-Preferred Medication:** •You pay the cost of medication up to $125 maximum plus a dispensing fee	After the combined medical and pharmacy $1,500 individual and/or $3,000 family deductible has been met, the pharmacy benefits are: **NETWORK:** **Generic Mandate** **Preferred Medication:** •The cost of medication is $100 or less - You pay up to $25 or actual cost if less •The cost of medication is more than $100 - You pay 25% up to a $50 maximum **Non-Preferred Medication:** •The cost of medication is $100 or less - You pay up to $50 or actual cost if less •The cost of medication is more than $100 - You pay 50% up to a $100 maximum **NOTE**: ♦ Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater. ♦ Some medications may have a limit on quantity and/or duration of therapy. ♦ Some medications require prior authorization. Specialty medications are covered when ordered through Accredo Health Group. ♦ HealthChoice Health Plans offer each covered individual a lifetime pharmacy benefit of $2,000,000 If you choose a brand-name medication when a generic is available, you will be responsible for the difference in cost, **plus** the copay **NON-NETWORK:** **Preferred Medication:** •You pay the cost of medication up to $75 maximum plus a dispensing fee **Non-Preferred Medication:** •You pay the cost of medication up to $125 maximum plus a dispensing fee	Up to $10 generic formulary **Up to $30 brand formulary (when no generic is available)** **Up to $50 brand formulary (when generic is available)** Greater of 30-day supply or 100 units Certain medications have restricted quantities Mail order may be available, see Plans for details **Please note:** Tier categories will be determined by each HMO based on their own formulary design

COMPARISON OF BENEFITS FOR HEALTH PLANS

Aetna Alternative HMO	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	This chart reflects your cost for the listed Network Services
Tier 1: $20 **Tier 2: $40** **Tier 3: $70** Mail order 90-day supply: **$40 copay** for formulary generic drugs **$80 copay** for formulary drugs **$140 copay** for non-formulary brand name and non-formulary generic drugs Greater of 30-day supply or 100 units Certain medications have restricted quantities	Tier 1: $10 **Tier 2: $40** **Tier 3: $65**	Tier 1: $10 **Tier 2: $50** **Tier 3: $75** Greater of 30-day supply or 100 units Certain medications may have restricted quantities These copays do not apply to the maximum out-of-pocket	**$10 copay** for formulary generic drugs **$30 copay** for formulary brand-name drugs **$50 copay** non-formulary generic and non-formulary brand drugs 30-day supply or 100 units Certain medications have restricted quantities	**Pharmacy Benefits**

PHARMACY

COMPARISON OF BENEFITS FOR DENTAL PLANS

	HEALTHCHOICE DENTAL	CIGNA DENTAL CARE PLAN (PREPAID)	ASSURANT FREEDOM PREFERRED
ANNUAL DEDUCTIBLE	♦ Network: $25 Basic and Major ♦ Non-Network: $25 Preventive, Basic, and Major	♦ No deductibles or plan maximums ♦ $5 office copay applies	♦ $25 per person, per calendar year, waived for preventive services in-network
PREVENTIVE CARE Allowed Charges apply	♦ Network: 100% ♦ Non-Network: 100% of Allowed Charges after deductible ♦ No charge for topical fluoride application (up to age 16)	♦ 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	100% of usual and customary with no deductible when in-network
BASIC CARE Allowed Charges apply	♦ Network: 85% ♦ Non-Network: 70% Deductible applies	♦ Amalgam: 1 surface, permanent teeth $20	♦ Network: 85% ♦ Non-Network: 70% Plan pays 85% of usual and customary when in-network, deductible applies
MAJOR CARE Allowed Charges apply	♦ Network: 60% ♦ Non-Network: 50% Deductible applies	♦ Root canal, anterior: $325 ♦ Periodontal/scaling/root planing 1-3 teeth (per quadrant): $65	♦ Network: 60% ♦ 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 ♦ No lifetime maximum for Network or non-Network	♦ $2,100 out-of-pocket for child through age 18 ♦ $2,900 out-of-pocket for adult 24 month treatment excludes orthodontic treatment plan and banding	♦ Network: 60% ♦ Non-Network: 50% Up to $1,800 lifetime maximum for members under age 19
PLAN YEAR MAXIMUM	♦ Network and non-Network $2,000	♦ No calendar year maximum	♦ $2,000
FILING CLAIMS	♦ Network: No claims to file ♦ Non-Network: You file claims	♦ No claims to file	♦ Member/provider must file claims

COMPARISON OF BENEFITS FOR DENTAL PLANS

Assurant Prepaid Plans Heritage Plus with SBA and Heritage Secure	Delta Dental PPO – *"Point of Service"*		Delta's Choice – PPO
	PPO Network	Premier Network and Non-Network	PPO Network
♦ No deductibles	♦ $25 per person, per calendar year applies to Basic and Major Care only	♦ $100 per person, per calendar year applies to all care except Orthodontic Care (Level 4)	♦ $100 per person, per calendar year applies to Major Care (Level 4) only
♦ 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	♦ Plan pays 100% of allowable amounts	♦ Plan pays 100% of allowable amounts after deductible	Schedule of covered services and enrollee copays. Copay examples: ♦ Routine cleaning: $5 ♦ Periodic oral evaluations: $5 ♦ Topical fluoride application (up to age 19): $5
♦ Fillings ♦ Minor oral surgery Refer to the copayment schedule for each plan	♦ Plan pays 85% of allowable amounts after deductible	♦ Plan pays 70% of allowable amounts after deductible	Schedule of covered services and enrollee copays. Copay examples: ♦ Amalgam: 1 surface, permanent teeth $12
♦ Root canal ♦ Periodontal ♦ Crowns Refer to the copayment schedule for each plan	♦ Plan pays 60% of allowable amounts after deductible	♦ Plan pays 50% of allowable amounts after deductible	Schedule of covered services and enrollee copays. Copay examples: ♦ Crown: porcelain/ ceramic substrate $241 ♦ Complete denture: maxillary $320
♦ 25% discount ♦ Adults and Children	♦ Plan pays 60% of allowable amounts, up to lifetime maximum of $1,800	♦ Plan pays 60% of allowable amounts, up to lifetime maximum of $1,800	♦ You pay amounts in excess of $50 per month ♦ Lifetime maximum of $1,800
♦ No annual maximum for general dentist	♦ $2,000 per person, per calendar year	♦ $2,000 per person, per calendar year	♦ $2,000 per person, per calendar 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 every calendar year	Copays do not apply Plan pays up to $35; One exam every calendar year	$0 copay No limit on exams per year	Exam fee reimbursed up to $40 One exam every calendar year
Lenses Each Pair	$25 material copay applies to lenses and/or frames (single, lined bifocal, trifocal, lenticular covered at 100%). Progressive at wholesale cost. One pair of lenses every calendar year	Plan pays up to: $25 single $40 bifocals $60 trifocals $100 lenticular One pair of lenses every calendar year	You pay wholesale cost with no limit on number of pairs	Fees reimbursed up to $40-$60 for one set of lenses and frames
Frames	$25 material copay applies to lenses and/or frames. $45 wholesale frame allowance. One set of frames every calendar year	Copay does not apply Plan pays up to $45 One set of frames every calendar year	You pay wholesale cost with no limit on number of pairs	Fees reimbursed up to $40-$60 for one set of lenses and frames
Contact Lenses	$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits Medically necessary, Plan pays 100% One set of contacts every calendar year	$130 allowance for exam, contacts, and fitting fee in lieu of all other benefits Medically necessary, Plan pays $210 One set of contacts every calendar year	You pay wholesale cost for an annual supply of contacts. For 1st time fittings, $50 copay on soft lens and $75 copay on all rigid gas permeable lenses	Fees reimbursed up to $60 One set annually (in lieu of glasses)
Laser Vision Correction	$895 copay conventional $1,295 copay custom $1,895 copay custom plus bladeless when services are rendered by a TLC Network Provider	No benefit	Discounted laser refractive surgery at multiple state locations	No benefit
All vision plan benefits are based on a calendar year instead of a 12-month basis			***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 Services		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 every calendar year	OD-$26 max MD-$34 max	$10 copay One exam every calendar year	Plan pays up to $40	$10 copay One exam every calendar year	$10 copay Plan pays up to $35
$25 copay One pair of lenses every calendar year	Plan pays up to: $26 single $39 bifocals $49 trifocals $78 lenticular	$25 copay One pair of lenses every calendar year	Plan pays up to: $40 single $60 bifocals $80 trifocals $80 lenticular	$25 copay* One set of lenses every calendar year Polycarbonate lenses covered in full for dependent children	$25 copay* Plan pays up to: $25 single $40 bifocals $55 trifocals $80 lenticular
$25 copay Plan pays up to $125 One set of frames every calendar year	Plan pays up to $68	$25 copay One set of frames every calendar year	Plan pays up to $45	$25 copay* One frame per calendar year, $120 allowance. 20% off any out-of-pocket costs above the allowance	$25 copay* Plan pays up to $45
$0 copay Plan pays up to $120 Medically necessary contacts are covered in full (in lieu of glasses)	$0 copay Plan pays up to $100 For medically necessary contacts, Plan pays up to $210 (in lieu of glasses)	$25 copay covers fitting/evaluation fees, contacts (including disposables) and up to 2 follow-up visits (in lieu of glasses)	Plan pays up to $150 For medically necessary contacts, Plan pays up to $210 (in lieu of glasses)	$0 copay $120 allowance applied to the cost of your contact lens exam and the contact lenses. 15% discount on contact lens exam (in lieu of glasses)	$0 copay Plan pays up to $105 for disposable or conventional contact lenses (in lieu of glasses)
20% off retail price	No benefit	Members have access to discounted refractive eye surgery from numerous provider locations throughout the U.S.	No benefit	Laser vision correction services (PRK, LASIK, and Custom LASIK) are provided at a reduced cost through VSP's contracted laser surgery centers	No benefit
All vision plan benefits are based on a calendar year instead of a 12-month basis				***Benefit includes an annual $25 materials copay on lenses or frames, but not both. Contact VSP, see Help Lines for details on the In-Network added value discounts.**	

Notes

HealthChoice Help Lines

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

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

Pharmacy Claims / Pharmacy ID Cards

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

Precertification

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	1-405-949-2281 or All Areas 1-866-447-0436

Disability Plan

Oklahoma City Area	1-405-841-9686
All Areas	1-800-722-2567
TDD All Areas	1-800-863-5488

HealthChoice USA

Customer Service & Claims	1-800-782-5218
Provider Information	1-877-877-0715 ext. 4059
TDD All Areas	1-800-941-2160
Website	www.choicecarenetwork.com

HMO Plans' Help Lines

Aetna

All Areas	1-800-949-3104
TDD All Areas	1-800-628-3323
Website	www.aetna.com/okstateemployees/

CommunityCare

All Areas	1-800-777-4890
TDD All Areas	1-800-722-0353
Website	www.ccok.com

GlobalHealth, Inc.

Oklahoma City Area	1-405-280-2990
All Other Areas	1-877-280-2990
TDD All Areas	1-800-522-8506
Website	www.globalhealth.cc

PacifiCare

All Areas	1-800-825-9355
TDD All Areas	1-800-557-7595
Website	www.pacificare.com

Dental Plans' Help Lines

Assurant, Inc. Dental

Prepaid Plan	1-800-443-2995
Indemnity Plan	1-800-442-7742
Website	www.assurantemployeebenefits.com

CIGNA Prepaid Dental

All Areas	1-800-367-1037
Hearing Impaired Relay Svc	1-405-948-3303
Website	www.cigna.com

Delta Dental

Oklahoma City Area	1-405-607-2100
All Other Areas	1-800-522-0188
Website	www.deltadentalok.org/state_employees/

Vision Plans' Help Lines

Humana/CompBenefits

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

Primary Vision Care Services (PVCS)

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

Superior Vision Plan

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

UnitedHealthcare Vision

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

Vision Service Plan (VSP)

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

HealthChoice

3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112
www.sib.ok.gov or www.healthchoiceok.com
Phone Number - 405-717-8780
Toll Free - 1-800-752-9475
Hearing Impaired - 405-949-2281
Toll Free Hearing Impaired - 1-866-447-0436

Presorted
Standard
U. S. Postage
PAID
Okla. City, OK
Permit #1067

OPTION PERIOD GUIDE
PLAN YEAR 2009