



OSEEIGIB

Oklahoma State and Education
Employees Group Insurance Board

Employee Benefit Options Guide

Plan Year 2011

January 1 through December 31, 2011



Health

Dental



Life



Vision



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

Oklahoma State and Education Employees Group Insurance Board

Monthly Premiums for Current Employees Plan Year January 1, 2011 - December 31, 2011

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High	\$ 449.48	\$ 682.74	\$ 228.20	\$ 352.08
HealthChoice Basic	\$ 391.64	\$ 598.48	\$ 201.82	\$ 310.80
HealthChoice S-Account	\$ 382.56	\$ 562.74	\$ 190.18	\$ 291.90
HealthChoice USA	\$ 688.82	\$ 688.82	\$ 226.22	\$ 348.86
CommunityCare Standard HMO	\$ 772.34	\$ 1,104.42	\$ 386.16	\$ 617.86
CommunityCare Alternative HMO	\$ 532.66	\$ 761.68	\$ 266.34	\$ 426.12
GlobalHealth Standard HMO	\$ 366.56	\$ 601.22	\$ 193.12	\$ 307.96
GlobalHealth Alternative HMO	\$ 333.26	\$ 546.58	\$ 175.62	\$ 279.98
PacifiCare Standard HMO	\$ 686.42	\$ 986.94	\$ 342.96	\$ 548.86
PacifiCare Alternative HMO	\$ 473.39	\$ 680.63	\$ 236.51	\$ 378.51
DISABILITY (Employee only)		\$9.10 (Limited county participation only)		
DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice Dental	\$ 29.84	\$ 29.84	\$ 24.88	\$ 64.56
Assurant Freedom Preferred	\$ 28.83	\$ 28.67	\$ 21.50	\$ 57.80
Assurant Heritage Plus with SBA (Prepaid)	\$ 11.74	\$ 8.86	\$ 7.60	\$ 15.20
Assurant Heritage Secure (Prepaid)	\$ 7.20	\$ 5.98	\$ 5.20	\$ 10.38
CIGNA Dental Care Plan (Prepaid)	\$ 9.26	\$ 6.06	\$ 7.08	\$ 15.32
Delta Dental PPO	\$ 31.14	\$ 31.14	\$ 27.10	\$ 68.56
Delta Dental Premier	\$ 35.52	\$ 35.52	\$ 30.90	\$ 78.20
Delta Dental PPO - Choice	\$ 13.94	\$ 31.64	\$ 31.90	\$ 77.42
VISION PLANS - Employee Paid	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)	\$ 8.76	\$ 5.87	\$ 5.62	\$ 12.64
LIFE				
HealthChoice Basic Life (\$20,000) \$4.56		First \$20,000 of Supplemental Life \$4.56		
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	Low Option \$2.60	Standard Option \$4.32	Premier Option \$8.64	
Spouse	\$ 6,000	\$ 10,000	\$ 20,000	
Child (age 6 months to 26)	\$ 3,000	\$ 5,000	\$ 10,000	
Child (live birth to 6 months)	\$ 1,000	\$ 1,000	\$ 1,000	

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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.

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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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2011 PLAN CHANGES

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

Notice of Eligibility to Age 26

- ◆ Your children are now eligible up to age 26, whether married or unmarried. Your election to re-enroll a dependent terminated due to turning age 25 must be made on your *Option Period Enrollment/Change Form* and submitted to your Insurance Coordinator by the due date. See the new definition of eligible dependents on page 5.

Health Plan Changes

HealthChoice Health Plans

- ◆ **Patient Protection and Affordable Care Act Disclosure of Grandfather Status** – HealthChoice believes it is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your HealthChoice health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
- ◆ Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to HealthChoice, 3545 N.W. 58th, Ste.110, OKC, OK 73112 or call 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

HealthChoice High Option and USA Plans

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

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

- ◆ One preventive services visit per calendar year, including one metabolic panel and one lipid panel, will be covered at 100% with no copay through a Network Provider for members and dependents age 20 and older.

HealthChoice Basic and S-Account Plans

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

HealthChoice Pharmacy Benefit

- ◆ The \$2 million lifetime limit on pharmacy benefits is being eliminated.

- ◆ HealthChoice offers certain prescription tobacco cessation medications for a \$5 copay. Additionally, HealthChoice partners with the Tobacco Settlement Endowment Trust (TSET) and Free and Clear to provide members with over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone coaching at no charge to HealthChoice health plan members.

HMOs

- ◆ **Attention current Aetna members** – Aetna is not a participating HMO for Plan Year 2011. If you are currently enrolled in Aetna Standard or Alternative Plan, you **must** choose another health plan.
- ◆ HMO service areas may have changed. See the *HMO ZIP Code List* on pages 8-10 to check your eligibility.
- ◆ All HMO Standard and Alternative plans will cover a preventive office visit with a primary care physician at 100% with no copay.
- ◆ All HMO Standard and Alternative plans will cover specific preventive services at no cost to you as required by the Patient Protection and Affordable Care Act. Check with the individual health plan for more information.
- ◆ Several of the copays and the quantity per fill for prescriptions are changing.

Dental Plan Changes

DMOs/Prepaid Dental

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

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

If you have questions about any of the plans, contact each plan directly. Contact information is located on the *Help Lines* page on the inside back cover of this Employee 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 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, 2011, 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 2011 on page ii 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 2011:
 - 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 not correct. **If you do not make 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 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 not correct.

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, 2011, or for new employees, the effective date of your coverage, through December 31, 2011.

After enrollment, the plans you have selected will provide more information about your benefits.

Once enrolled in any of the plans, it is your responsibility to review your benefits carefully so you know what is covered, as well as the plan's policies and procedures, before you use your benefits.

HEALTH PLANS

There are 10 health plans available:

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

See *Comparison of Benefits for Health Plans* on pages 11-18 for specific benefit information.

- ◆ There are no preexisting condition exclusions or limitations applied to any of the health plans.
- ◆ 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 8-10 for the *HMO ZIP Code List*.
- ◆ To enroll in the HealthChoice S-Account Plan, you must provide OSEEGIB with proof you have a Health Savings Account at a bank or other financial institution. This proof must be submitted by December 15, 2010. Without proof, your health plan will default to the HealthChoice Basic Plan.
- ◆ All health plans coordinate benefits with other group insurance plans you have in force. For more information, check with each health plan.
- ◆ All plans have toll-free numbers for customer service. See *Help Lines* on the inside back cover.
- ◆ 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 19-20 for specific benefit information.

- ◆ All dental plans have toll-free numbers for customer service. See *Help Lines* on the inside back cover.
- ◆ 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 21-22 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 the inside back cover.
- ◆ Check with the individual vision plan if you have benefit questions.

For directions on how to access each health, dental, and vision plan's provider network, see pages 23-24. If your provider leaves your health, dental, or vision plan, you cannot change plans until the next annual Option Period; however, you may change providers within your plan as needed.

Thinking About Retirement?

If you are a current employee who will be retiring **before** January 1, 2011, 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 the inside back cover.

HEALTHCHOICE LIFE INSURANCE

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*.
- ◆ As a **current employee**, if you did not enroll when first eligible, you can enroll:
 - During the annual Option Period. If you are enrolled in one of the health plans offered through OSEEGIB, an approved *Life Insurance Application* is required only if you apply for more than \$20,000 in coverage.
 - Within 30 days of a midyear qualifying event; however, 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 . . . For You

- ◆ You can enroll in Basic Life during Option Period without a *Life Insurance Application* as long as you are enrolled in one of the health plans offered through OSEEGIB. Mark the appropriate box on your *Option Period Enrollment/Change Form*.
- ◆ 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 providing a *Life Insurance Application*.
- ◆ You may purchase Supplemental Life in units of \$20,000. One \$20,000 unit of life insurance may be purchased during Option Period without a *Life Insurance Application* as long as you are already enrolled in Basic Life and one of the health plans offered through OSEEGIB. You cannot apply for Supplemental Life coverage that exceeds the Plan maximum of five times your annual salary or \$300,000, whichever is less. You must complete a *Life Insurance Application* to apply for coverage above \$20,000.
- ◆ 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 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	\$10,000	\$20,000
Child (age 6 months to 26)	\$3,000	\$ 5,000	\$10,000
Child (live birth to 6 months)	\$1,000	\$ 1,000	\$ 1,000

Beneficiary Designation

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

HEALTHCHOICE DISABILITY INSURANCE

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.

ENROLLMENT PERIODS

Option Period Enrollment – Coverage effective January 1, 2011

This is the time when eligible employees can:

- Enroll in plans
 - Change plans or drop coverage
 - Increase or decrease life insurance coverage
 - Add eligible family members or drop them 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. This does not include dependents who were dropped due to turning age 25. If you have dropped coverage, 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 insurance 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.
- ◆ 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 if 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 in order to enroll in dental and/or life insurance.

Dependents

- ◆ If one eligible dependent is covered, all eligible dependents must be covered. You can elect not to cover dependents who do not reside with you, are married, are not financially dependent on you for support, 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 may be covered under only one parent's health, dental, and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life insurance.
- ◆ Dependents 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. It also does not apply for dependents who were dropped due to turning age 25.
- ◆ Dependents can only be enrolled in the same types of coverage and in the same plans you have.
- ◆ To enroll your newborn, a 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 will not be able to do so until the next annual Option Period. Direct notification to an HMO will not enroll your newborn or any other dependents. The newborn's Social Security Number is not required at the time of initial enrollment, but must be provided once it is received from the Social Security Administration. Insurance premiums for the month the child was born must be paid. Under the HealthChoice plans, a separate deductible and coinsurance may apply.
- ◆ Without enrollment, newborns will be covered only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Deductible and coinsurance may apply.

Excluding Dependents From Coverage

- ◆ You can exclude your spouse from health and/or dental coverage. Your spouse must sign the Spouse Exclusion Certification section of the enrollment or change form.
- ◆ You can exclude your spouse or other dependents if they are covered under another group health or dental plan, 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 will be 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, 2011, if you do not make changes to your coverage during Option Period. If you don't make changes, 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 moving 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 coverage on dependents during Option Period is not a COBRA qualifying event.**

HMO ZIP Code List

C = CommunityCare G = GlobalHealth* P = PacifiCare

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

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HMO ZIP Code List

C = CommunityCare G = GlobalHealth* P = PacifiCare

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

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HMO ZIP CODE LIST

HMO ZIP Code List

C = CommunityCare G = GlobalHealth* P = PacifiCare

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

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COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan
Calendar Year Deductibles	\$500 individual \$1,500 family	\$500 individual \$1,000 family Deductible applies after Plan pays first \$500 of Allowed Charges	\$1,500 individual \$3,000 family The combined medical and pharmacy deductible must be met before benefits are paid
Calendar Year Out-of-Pocket Maximum	\$2,800 Network individual \$3,300 non-Network individual, plus amounts over Allowed Charges	\$5,500 individual \$11,000 family	\$4,000 individual \$8,000 family Non-Network charges do not apply
Office Visit (Professional Services)	\$30 copay/primary care physician office visit* \$50 copay/specialist office visit	•Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Option Plan	Member pays 100% of Allowed Charges until deductible is met \$50 office visit copay applies after deductible
Diagnostic X-ray and Lab	20% of Allowed Charges after deductible	For Network services: •\$0 the first \$500 of Allowed Charges •100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible	20% of Allowed Charges after deductible
Hospital Inpatient Admission	20% of Allowed Charges after deductible Additional \$300 deductible per non-Network admission	•50% of the next \$10,000 of Allowed Charges	20% of Allowed Charges after deductible Additional \$300 deductible per non-Network admission
Hospital Outpatient Visit	20% of Allowed Charges after deductible	•\$0 of Allowed Charges over \$5,500/individual or \$11,000/family •You may use non-Network providers, but it will be more costly*	20% of Allowed Charges after deductible
Well Child Care Visit	\$0 copay ; no deductible applies For the schedule of covered visits, refer to page ii		\$50 copay; no deductible applies
Immunizations	No charge for well child and adult immunizations \$30/\$50 office visit copay and/or administration fee may apply		No charge for well child and adult immunizations \$50 office visit copay and/or administration fee may apply

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

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
No deductible	No deductible	No deductible	No deductible	Calendar Year Deductibles
\$2,500 individual \$5,000 family	\$3,000 individual \$6,000 family	\$3,000 individual \$5,000 family	\$2,500 individual \$5,000 family	Calendar Year Out-of-Pocket Maximum
\$30 copay/PCP \$40 copay/specialist	\$35 copay/PCP \$50 copay/specialist	\$25 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist	Office Visit (Professional Services)
No copay for laboratory services or outpatient radiology \$150 copay per MRI, CAT, MRA, or PET scan	No additional copay for laboratory services or outpatient radiology \$200 copay per MRI, CAT, MRA, or PET scan	\$0 copay \$250 copay per MRI, MRA, PET, CAT, or nuclear scan	\$0 copay for standard lab and radiology \$200 copay per MRI, MRA, PET, or CAT scan	Diagnostic X-ray and Lab
\$350 copay Preauthorization required	\$500 copay Preauthorization required	\$250 copay per day \$750 maximum per admission Preauthorization required	\$1,000 copay/admission	Hospital Inpatient Admission
\$250 copay Preauthorization required	\$300 copay	\$250 copay Preauthorization required	\$500 copay	Hospital Outpatient Visit
\$0 copay	\$0 copay	\$0 copay ages 0 – 21	\$0 copay	Well Child Care Visit
\$0 copay ages birth through age 18 \$0 copay ages 19 and over	\$0 copay ages birth through age 18 years \$0 copay ages 19 and over When medically necessary	\$0 copay Office visit copay may apply	\$0 copay ages birth through age 18 (if no other service is rendered) \$0 copay ages 19 and over	Immunizations

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

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan
Periodic Health Exams	\$0 copay for one preventive service office visit per calendar year for members and dependents age 20 and older One mammogram per year at no charge for women age 40 and older	One mammogram per year at no charge for women age 40 and over	\$50 copay per exam One mammogram per year at no charge for women age 40 and older
Allergy Treatment and Testing	20% of Allowed Charges after deductible Limit: 60 tests every 24 months	<ul style="list-style-type: none"> •Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Option Plan 	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	For Network services: •\$0 the first \$500 of Allowed Charges	20% of Allowed Charges after deductible Additional \$100 ER deductible – waived if admitted
After Hours Urgent Care	20% of Allowed Charges after deductible	<ul style="list-style-type: none"> •100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible •50% of the next \$10,000 of Allowed Charges 	20% of Allowed Charges after deductible
Mental Health or Substance Abuse Inpatient Admission	20% of Allowed Charges after deductible Limit: 30 days per year*	<ul style="list-style-type: none"> •\$0 of Allowed Charges over \$5,500/individual or \$11,000/family 	20% of Allowed Charges after deductible Limit: 30 days per year*
Mental Health or Substance Abuse Outpatient Visit	20% of Allowed Charges after deductible Limit: 26 visits per year*	<ul style="list-style-type: none"> •You may use non-Network providers, but it will be more costly 	20% of Allowed Charges after deductible Limit: 26 visits per year*
Durable Medical Equipment (DME)	20% of Allowed Charges after deductible for purchase, rental, repair, or replacement		20% of Allowed Charges after deductible for purchase, rental, repair, or replacement

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

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

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

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

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option	HealthChoice Basic Plan	HealthChoice S-Account Plan
Occupational and Speech Therapy Visits	20% of Allowed Charges after deductible <u>For each service</u> Limit: 20 visits per year without certification Maximum of 60 visits per year	<ul style="list-style-type: none"> •Copays do not apply •All services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Option Plan For Network services: <ul style="list-style-type: none"> •\$0 the first \$500 of Allowed Charges 	20% of Allowed Charges after deductible <u>For each service</u> Limit: 20 visits per year without certification Maximum of 60 visits per year
Physical Therapy/Physical Medicine Visit	20% of Allowed Charges after deductible Limit: 20 visits per year without certification Maximum of 60 visits per year	<ul style="list-style-type: none"> •100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges apply to the deductible •50% of the next \$10,000 of Allowed Charges 	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	<ul style="list-style-type: none"> •\$0 of Allowed Charges over \$5,500/individual or \$11,000/family •You may use non-Network providers, but it will be more costly 	Chiropractic services: 20% of Allowed Charges after deductible Limit: 20 visits per year without certification Maximum of 60 visits per year Manipulative therapy: see Physical Therapy/Physical Medicine
Maternity Pre and Post Natal Care	20% of Allowed Charges after deductible Includes one postpartum home visit - criteria must be met		20% of Allowed Charges after deductible Includes one postpartum home visit - criteria must be met
Hearing Screening and Hearing Aids	\$50 copay/specialist \$30 copay/primary care physician* Basic hearing screening Limit: one per year Hearing aids are covered as durable medical equipment for children up to age 18		\$50 copay after deductible Basic hearing screening Limit: one per year Hearing aids are covered as durable medical equipment for children up to age 18

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

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
No copay inpatient \$30 copay/PCP \$40 copay/specialist Limit: 60 treatment days per illness	No copay inpatient \$50 copay outpatient therapy Limit: 60 days per illness	No copay inpatient \$50 copay per outpatient therapy Limit: 60 consecutive days per illness	\$0 copay inpatient \$35 copay/PCP \$50 copay/specialist Limit: 60 days per illness	Occupational or Speech Therapy Visit
No copay inpatient \$30 copay/PCP \$40 copay/specialist Limit: 60 treatment days per illness	No copay inpatient \$50 copay outpatient therapy Limit: 60 days per illness	No copay inpatient \$50 copay per outpatient visit Limit: 60 consecutive days per illness	\$0 copay inpatient \$35 copay/PCP \$50 copay/specialist Limit: 60 days per illness	Physical Therapy/ Physical Medicine Visit
\$40 copay Limit: 15 visits per year PCP referral required	\$50 copay Limit: 15 visits per year PCP referral required	\$50 copay Must be preauthorized	\$50 copay Limit: 15 visits per year - referral required Limited to treatment of neurological and orthopedic conditions	Chiropractic and Manipulative Therapy Visit
\$30 copay for initial visit \$350 copay per hospital admission	\$35 copay for initial visit \$500 copay per hospital admission	\$25 copay for initial visit only \$250 copay per hospital admission per day \$750 maximum per admission	\$35 copay/PCP \$50 copay/specialist for initial visit once diagnosis of pregnancy is confirmed \$1,000 copay per hospital admission	Maternity Pre and Post Natal Care
\$0 copay children birth – age 21 \$30 copay age 22 and over Limit: One per year Hearing aids – 20% coinsurance for children up to age 18	\$0 copay Limit: One per year Hearing aids – 20% coinsurance for children up to age 18	\$0 copay children birth – age 21 \$25 copay age 22 and over Limit: One per year Hearing aids – 20% coinsurance Covered for children up to age 18	\$0 copay/PCP Hearing aids – covered for children up to age 18	Hearing Screening and Hearing Aids

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

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

COMPARISON OF BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High Option and HealthChoice Basic Plan	HealthChoice S-Account Plan
Pharmacy Benefits	<p>NETWORK: Generic Mandate Preferred Medication: •If the cost of medication is \$100 or less - You pay up to \$30 or actual cost if less •If the cost of medication is more than \$100 - You pay 25% up to a \$60 maximum •Out-of-pocket maximum - \$2,500 per person using Preferred products at Network pharmacies, then you pay \$0</p> <p>Non-Preferred Medication: •If the cost of medication is \$100 or less - You pay up to \$60 or actual cost if less •If the cost of medication is more than \$100 - You pay 50% up to a \$120 maximum •Out-of-pocket maximum does not apply to non-Preferred medications</p> <p>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</p> <p>If you choose a brand-name medication when a generic is available, you will be responsible for the difference in cost, plus the copay</p> <p>NON-NETWORK: Preferred Medication: •You pay the cost of medication up to a \$75 maximum plus a dispensing fee Non-Preferred Medication: •You pay the cost of medication up to a \$125 maximum plus a dispensing fee</p>	<p>After the combined medical and pharmacy deductible (\$1,500 individual/\$3,000 family) has been met, the pharmacy benefits are: NETWORK: Generic Mandate Preferred Medication: •If the cost of medication is \$100 or less - You pay up to \$30 or actual cost if less •If the cost of medication is more than \$100 - You pay 25% up to a \$60 maximum</p> <p>Non-Preferred Medication: •If the cost of medication is \$100 or less - You pay up to \$60 or actual cost if less •If the cost of medication is more than \$100 - You pay 50% up to a \$120 maximum</p> <p>NOTE: ♦ Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater ♦ Some medications have a limit on quantity and/or duration of therapy ♦ Some medications require prior authorization ♦ Specialty medications are covered when ordered through Accredo Health Group</p> <p>If you choose a brand-name medication when a generic is available, you will be responsible for the difference in cost, plus the copay</p> <p>NON-NETWORK: Preferred Medication: •You pay the cost of medication up to a \$75 maximum plus a dispensing fee Non-Preferred Medication: •You pay the cost of medication up to a \$125 maximum plus a dispensing fee</p>

\$5 copay per fill for certain prescription tobacco cessation products

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

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COMPARISON OF BENEFITS FOR HEALTH PLANS

HMO Standard Option	CommunityCare Alternative HMO	GlobalHealth Alternative HMO	PacifiCare Alternative HMO	Your Costs for Network Services
<p>Up to \$5 generic formulary Up to \$30 brand formulary (when no generic is available) Up to \$60 brand formulary (when generic is available)</p> <p>30-day supply</p> <p>Certain medications have restricted quantities</p> <p>Mail order may be available, contact Plans for details</p> <p>Please note: Tier categories will be determined by each HMO based on its formulary design</p>	<p>Tier 1: \$10 Tier 2: \$40 Tier 3: \$65</p> <p>\$0 copay for selected generics</p> <p>Up to \$65 non-formulary</p> <p>30-day supply</p> <p>Certain medications have restricted quantities.</p>	<p>Tier 1: \$10 Tier 2: \$50 Tier 3: \$75</p> <p>30-day supply</p> <p>Certain medications may have restricted quantities</p> <p>These copays do not apply to the maximum out-of-pocket</p>	<p>\$5 copay for formulary generic drugs</p> <p>\$30 copay for formulary brand-name drugs</p> <p>\$60 copay non-formulary generic and non-formulary brand drugs</p> <p>Lesser of a 30-day supply or 100 units</p> <p>Certain medications have restricted quantities</p>	<p>Pharmacy Benefits</p>

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

COMPARISON OF BENEFITS FOR DENTAL PLANS

Your Costs for Network Services	HealthChoice Dental	CIGNA Dental Care Plan (Prepaid)	Assurant Freedom Preferred
Annual Deductible	Network: \$25 Basic and Major services combined Non-Network: \$25 Preventive, Basic, and Major services combined	No deductible or plan maximum \$5 office copay applies	\$25 per person, per year, waived for preventive services in-network
Preventive Care ex: cleaning, routine oral exam Allowed Charges apply	Network: \$0 Non-Network: \$0 of Allowed Charges after deductible	Sealant: \$15 per tooth No charge for routine cleaning once every 6 months No charge for topical fluoride application (through age 18) No charge for periodic oral evaluations	\$0 with no deductible when in-network
Basic Care ex: extractions, oral surgery Allowed Charges apply	Network: 15% Non-Network: 30% Deductible applies	Amalgam: One surface, permanent teeth \$21	Network: 15% Non-Network: 30% Plan pays 85% of usual and customary when in-network Deductible applies
Major Care ex: dentures, bridge work Allowed Charges apply	Network: 40% Non-Network: 50% Deductible applies	Root canal, anterior: \$355 Periodontal/scaling/root planing 1-3 teeth (per quadrant): \$65	Network: 40% Non-Network: 50% Plan pays 60% of usual and customary when in-network Deductible applies
Orthodontic Care Allowed Charges apply	Network: 50% Non-Network: 50% 12-month waiting period may apply No lifetime maximum for Network or non-Network Covered for members under age 19 and members age 19 and older with TMD	\$2,280 out-of-pocket for children through age 18 \$3,120 out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding	Network: 40% Non-Network: 50% Up to \$2,000 lifetime maximum for members under age 19* 12-month waiting period may apply *Increase in orthodontic lifetime maximum will apply to treatment beginning on or after January 1, 2011
Plan Year Maximum	Network and non-Network: \$2,000 per person per year	No maximum	\$2,000
Filing Claims	Network: No claims to file Non-Network: You file claims	No claims to file	Member/provider must file claims

COMPARISON OF BENEFITS FOR DENTAL PLANS

Assurant Prepaid Plans Heritage Plus with SBA and Heritage Secure	Delta Dental PPO In-Network and Out-of-Network	Delta Dental Premier In-Network and Out-of-Network	Delta Dental PPO – Choice PPO Network
No deductibles	\$25 per person, per year, applies to Basic and Major Care only	\$50 per person, per year, applies to Diagnostic, Preventive, Basic, and Major Care	\$100 per person, per year, applies to Major Care only (Level 4)
No charge for routine cleaning (once every 6 months) No charge for topical fluoride application (up to age 18) No charge for periodic oral evaluations	\$0 of allowable amounts No deductible applies Includes diagnostic	\$0 of allowable amounts after deductible Includes diagnostic	Schedule of covered services and copays Copay examples: Routine cleaning \$5 Periodic oral evaluation \$5 Topical fluoride application (up to age 19) \$5 Includes diagnostic
Fillings Minor oral surgery Refer to the copayment schedule for each plan	15% of allowable amounts after deductible	30% of allowable amounts after deductible	Schedule of covered services and copays Copay example: Amalgam - One surface, primary or permanent tooth \$12
Root canal Periodontal Crowns Refer to the copayment schedule for each plan	40% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Crown - porcelain/ceramic substrate \$241 Complete denture - maxillary \$320
25% discount Adults and children	40% of allowable amounts, up to lifetime maximum of \$2,000 No deductible No waiting period Orthodontic benefits are available to the employee and his/her lawful spouse and eligible dependent children	40% of allowable amounts, up to lifetime maximum of \$2,000 No deductible No waiting period Orthodontic benefits are available to the employee and his/her lawful spouse and eligible dependent children	You pay amounts in excess of \$50 per month Lifetime maximum up to \$1,800 No deductible No waiting period Orthodontic benefits are available to the employee and his/her lawful spouse and eligible dependent children
No annual maximum for general dentist	\$2,500 per person, per year	\$3,000 per person, per year	\$2,000 per person, per year
No claims to file	Claims are filed by participating dentists	Claims are filed by participating dentists	Claims are filed by participating dentists

COMPARISON OF BENEFITS FOR VISION PLANS

Covered Services	Humana/CompBenefits VisionCare Plan		Primary Vision Care Services, Inc.	
	In-Network	Out-of-Network	In-Network	Out-of-Network*
Eye Exams	\$10 copay One exam for eyeglasses or contacts per year	Copays do not apply Plan pays up to \$35 One exam per year	\$0 copay No limit on exams per year	Plan pays up to \$40 One exam per year
Lenses Each Pair	\$25 material copay applies to lenses and/or frames (single, lined bifocal, trifocal, lenticular are covered at 100%). A discount applies to progressive lenses One pair of lenses per year	Plan pays up to: \$25 single \$40 bifocals \$60 trifocals \$100 lenticular One pair of lenses per year	You pay wholesale cost with no limit on number of pairs	You pay normal doctor's fee, reimbursed up to \$60 for one set of lenses and frames per year
Frames	\$25 material copay applies to lenses and/or frames \$45 wholesale frame allowance One pair of frames per year	\$25 copay Plan pays up to \$45 One pair of frames per year	You pay wholesale cost. No limit on number of frames	You pay normal doctor fee, reimbursed up to \$60 for one set of lenses and frames per year
Contact Lenses	\$130 allowance for conventional or disposable contact lenses and fitting fee In lieu of all other benefits Medically necessary, Plan pays 100% One set of contacts per year	\$130 allowance for exam, contacts, and fitting fee In lieu of all other benefits Medically necessary, Plan pays \$210 One set of contacts per year	You pay wholesale cost for an annual supply of contacts \$50 service fee applies to all soft contact lens fittings; \$75 to rigid or gas permeable lens fittings; \$150 to hybrid contact lens fittings Replacement lenses do not have these fees	Limit of one set annually in lieu of eyeglasses You pay normal doctor fees, reimbursed up to \$60
Laser Vision Correction	\$895 copay conventional \$1,295 copay custom \$1,895 copay custom plus bladeless when services are rendered by a TLC Network Provider	No benefit	Discount nationwide at The Laser Center (TLC)	No benefit
<div style="background-color: #003366; color: white; padding: 5px; border: 1px solid black;"> Vision benefits apply from January 1 through December 31, 2011 </div>			For information on limitations/exclusions, please contact PVCS. See <i>Help Lines</i> on inside back cover *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 PLAN COMPARISON

COMPARISON OF BENEFITS FOR VISION PLANS

Superior Vision Plan		UnitedHealthcare Vision		Vision Service Plan (VSP)	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$10 copay One exam per year	OD-\$26 max MD-\$34 max	\$10 copay One exam per year	Plan pays up to \$40	\$10 copay One exam per year	\$10 copay Plan pays up to \$35
\$25 copay One pair of lenses per year	Plan pays up to: \$26 single \$39 bifocals \$49 trifocals \$78 lenticular	\$25 copay One pair of lenses per year	Plan pays up to: \$40 single \$60 bifocals \$80 trifocals \$80 lenticular	\$25 copay* One set of lenses per year Polycarbonate lenses covered in full for dependent children Average 35-40% savings on non-covered lens options	\$25 copay* Plan pays up to: \$25 single \$40 bifocals \$55 trifocals \$80 lenticular
\$25 copay Plan pays up to \$125 One pair of frames per year	Plan pays up to \$68	\$25 copay \$130 allowance One pair of frames per year	Plan pays up to \$45	\$25 copay* \$120 allowance 20% off any out-of-pocket costs above the allowance One pair of frames per year	\$25 copay* Plan pays up to \$45
\$0 copay Plan pays up to \$120 Medically necessary contacts are covered in full (in lieu of glasses)	\$0 copay Plan pays up to \$100 Medically necessary contacts, Plan pays up to \$210 (in lieu of glasses)	\$25 copay covers fitting/evaluation fees, contacts (including disposables), and up to 2 follow-up visits (in lieu of glasses)	Plan pays up to \$150 For medically necessary contacts, Plan pays up to \$210 (in lieu of glasses)	\$0 copay \$120 allowance applied to the cost of your contact lens exam and the contact lenses 15% discount on contact lens exam (in lieu of glasses)	\$0 copay Plan pays up to \$105 for disposable or conventional contact lenses (in lieu of glasses)
20% off retail price	No benefit	Members have access to discounted refractive eye surgery from numerous provider locations throughout the U.S.	No benefit	Laser vision correction services (PRK, LASIK, and Custom LASIK) are provided at a reduced cost through VSP's contracted laser surgery centers	No benefit
<div style="background-color: #003366; color: white; padding: 5px; display: inline-block;"> Vision benefits apply from January 1 through December 31, 2011 </div>				*Benefit includes an annual \$25 materials copay for lenses or frames, but not both. Contact VSP at 1-800-877-7195 for additional information regarding in-network added value discounts.	

VISION PLAN COMPARISON

How to Access the Online Provider Networks

HealthChoice Health Plans

HealthChoice High Option, Basic, and S-Account Plans

Visit www.healthchoiceok.com

Click on *Find a Provider* and follow the on-screen instructions

HealthChoice USA Plan

Visit www.choicecarenetwork.com

Click on *ChoiceCare Physician Finder Plus* under *Provider Search*

Select *ChoiceCare Network PPO* under *Coverage and Network*

Follow the on-screen instructions

HMO Plans

CommunityCare Standard and Alternative HMO

Visit www.ccok.com

Click on *Find a Provider*

Select *State, Education and Local Government Employees*

GlobalHealth Standard and Alternative HMO

Visit www.globalhealth.com

Click on *STATE* and choose *State Employees and Educators*

Click on *PROVIDER LOOKUP*

PacifiCare Standard and Alternative HMO

Visit www.pacificare.com

Click on *Find a Doctor*

Select *Plan or Service Type* choose *Pacificare SignatureValue (HMO)*

Dental Plans

HealthChoice Dental Plan

Visit www.healthchoiceok.com

Click on *Find a Provider* and follow the on-screen instructions

Assurant Freedom Preferred (Options for PPO)

Visit www.assurantemployeebenefits.com

Click on *Find a Dentist*

Select *DHA Network*

Assurant Heritage Plus with SBA and Heritage Secure (Options for Prepaid)

Visit www.assurantemployeebenefits.com

Click on *Find a Dentist*

Select *The Heritage Series*

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CIGNA Dental Care Plans

Visit www.cigna.com

Click on *Provider Directory*

Click *Dentist* for the type of provider

Select *CIGNA Dental Care (HMO)*

Delta Dental Plans

Visit www.deltadentalok.org

Click on *Click here* under *State of Oklahoma Dental Plans*

Click *here* on the *3 NEW Dental Plans for 2011* and select your dental plan

(*Delta Dental PPO, Delta Premier, and Delta Dental PPO – Choice*)

Vision Plans

Humana/CompBenefits Vision Care Plan

Visit www.compbenefits.com/custom/stateofoklahoma

Click on *Provider Directory*

Primary Vision Care Services (PVCS)

Visit www.pvcs-usa.com

Click on *Find a Doctor*

Superior Vision Plan

Visit www.superiorvision.com

Click on *Locate a Provider*

UnitedHealthcare Vision

Visit www.myuhcvision.com

Click on *Provider Locator*

Vision Services Plan (VSP)

Visit www.vsp.com

Either click on *Find the right doctor for you* under the *Members* tab or click on *Choose VSP through your employer* under *Prospective Members* tab

Click on *Find a VSP Doctor*

Select *VSP Signature Network*

For assistance in locating the correct provider network, contact each plan's customer service. See *Help Lines* on the inside back cover.

HIPAA Waiver

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans beginning with plan year anniversary dates after June 30, 1997. Requirements regarding mental health benefits apply beginning with plan year anniversary dates occurring on or after January 1, 1998, and other requirements regarding benefits for substance abuse apply beginning with plan year January 1, 2010. HIPAA provides that the plan sponsor of a self-funded non-federal governmental plan may elect to exempt the plan from any or all of the following requirement:

Parity in mental health and substance use disorder benefits. Group health plans offering mental health benefits may not set annual or lifetime limits on mental health or substance abuse benefits that are lower than limits for medical and surgical benefits. A plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose a limit on mental health or substance abuse benefits.

The Oklahoma State and Education Employees Group Insurance Board has elected to exempt the Plan from the requirement listed above.

The exception from these Federal requirements will be in effect for the Plan Year January 1 through December 31, 2011, and may be renewed for subsequent plan years.

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

Certification

All Areas	1-800-848-8121
TDD All Areas	1-877-267-6367

Member Services / Provider Directory

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

Disability Plan

Oklahoma City Area	1-405-316-7492
All Areas	1-800-722-2567
TDD All Areas	1-800-863-5488

HealthChoice USA

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

HMO Plans' Help Lines

CommunityCare

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

GlobalHealth, Inc.

Oklahoma City Area	1-405-280-5600
All Other Areas	1-877-280-5600
TDD All Areas	1-800-522-8506
Website	www.globalhealth.com

PacifiCare

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

Dental Plans' Help Lines

Assurant, Inc. Dental

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

CIGNA Prepaid Dental

All Areas	1-800-244-6224
Vqm/htggHearing 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 58th Street, Suite 110
Oklahoma City, OK 73112

**OPTION PERIOD 2011
PLAN YEAR 2011
GUIDE**