



**2012 BENEFITS ENROLLMENT GUIDE**

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**Smarter, Healthier Benefits Choices**



**OKHealth – New and Improved!**

In 2012, more than ever before, Wellness and Prevention will be gateways to your benefits. All three of the available HMO carriers will offer a new “Wellness Alternative Plus” plan. To take advantage of the 25 dollar per month savings off the Alternative rates, you must complete a brief Health Risk Assessment (HRA). That HRA will open the door to the new-and-improved OKHealth Wellness Program and to your better health.

OKHealth has been reinvented to be much more flexible, interactive and user-friendly. Free, one-on-one health coaching is available for state employees who need it, while many others will be able to “self coach” their way to better health by using the many resources available on the new OKHealth web site.



It’s customized! In fact, as an active state employee, you already have your own wellness page that can be tailored to fit your individual needs! For a free, no-obligation preview of what’s available, go to [www.ebc.ok.gov](http://www.ebc.ok.gov) and go to the OKHealth section.

The new web site includes social network functions where you can interact with other state employees who share your wellness goals. It has channels dedicated to weight management, fitness, nutrition, stress management, financial health and even a place to find a good laugh. YOU are the one who will decide what topics fit your lifestyle and goals. If you want, you can chart your progress with a food-intake tracker and exercise tracker. You’ll also find articles and blogs related to your wellness interests and calendars of wellness events.

All of our wellness services will continue to be FREE to active state employees. All active state employees are encouraged to participate; however, only the employees who choose a Wellness Alternative Plus health plan will receive the financial incentive of a discounted premium.

The new-and-improved OKHealth will be available to you starting October 3rd – the first day of the Option Period for benefits enrollment.

For more information about the exciting, new OKHealth program, visit the OKHealth section of [www.ebc.ok.gov](http://www.ebc.ok.gov).





## VISION PLANS

It's important for you to have a good "vision" of what combination of benefits choices will fit you and your family best. So this year, your benefits office is placing an increased emphasis on the eye-opening benefits of a good vision plan.

Routine eye exams help keep your vision sharp, allow eye professionals to treat eye infections and injuries more effectively, and help them spot early signs of eye conditions, like astigmatism or glaucoma. But the preventive advantages don't stop at the eyes. The exams also help eye doctors spot symptoms of diseases and conditions like diabetes, high blood pressure, osteoporosis and brain tumors.

For Vision plan rates, see pages 5 and 6.

COVERED SERVICES	<b>PVCS</b> <a href="http://www.pvcs-usa.com">www.pvcs-usa.com</a> 		<b>Humana</b> <a href="http://www.visioncare.com">www.visioncare.com</a>	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Eye Exams</b>	No Copay No limit to frequency	Plan pays up to \$40 Limit 1 exam	\$10 copay One exam for eyeglasses or contacts every calendar year	Plan pays up to \$35; One exam every calendar year
<b>Lenses Per Pair</b>	Member pays wholesale cost No limit to number of pairs	Member pays normal doctor Fees, reimbursed up to \$60 for one set of lenses & frame annually	\$25 Copay for single/multi-focal lenses	Plan pays up to: Single up to \$25 Bifocals up to \$40 Trifocals up to \$60 Lenticular up to \$100
<b>Frames</b>	Member pays wholesale cost No limit to number of frames	Member pays normal doctor fee reimbursed up to \$60 for one set of lenses and frames annually	\$25 Copay, up to plan limits. One frame every calendar year	Plan pays up to \$45
<b>Contact Lenses</b>	Member pays wholesale cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses. Member pays normal doctor fees reimbursed up to \$60	**\$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits every calendar year Medically necessary, plan pays 100%	**\$130 allowance for contacts, and fitting fee in lieu of all other benefits. Medically necessary, plan pays up to \$210
<b>Laser Vision Correction</b>	Discount nationwide at The Laser Center (TLC)	No Benefit	Discount thru TLC, member will pay no more than \$895 per eye for conventional Lasik. See notes below on Intralase (bladeless) options.	No Benefit
<b>Lens Options</b>	\$11 Copay: no limit	Member pays normal doctor Fees	Substantial discount \$15 member cost	No Benefit
<b>UV Coating</b>				
<b>Tint</b>	\$11 Copay and up: no limit	Member pays normal doctor Fees	Substantial discount \$13 member cost	No Benefit
<b>Standard scratch resist</b>	\$13 Copay: no limit	Member pays normal doctor Fees	Substantial discount \$16 member cost	No Benefit
<b>Standard Polycarbonate</b>	\$50 Copay and up for SV; no limit	Member pays normal doctor Fees	Substantial discount \$30 member cost	No Benefit
<b>Standard Progressive</b>	Wholesale cost, no limit	Member pays normal doctor Fees	Substantial discount \$82 member cost	No Benefit
<b>Anti-Reflective</b>	\$40 and up copay No Limit	Member pays normal doctor Fees	Substantial discount \$46 member cost	No Benefit

### NOTES:

**Humana:** If a member prefers contact lenses the plan provides an allowance for the exam and contacts, in lieu of all other benefits. \*\*Contact lens benefit provides a \$130 yearly allowance towards the exam and purchase of either conventional or disposable contacts. If lenses and frames are purchased at the same time only one \$25 copay applies. Over 23,000 frames are covered in full with in-network providers. Exams, lenses, frame benefits provided once every 12 months. Oklahoma City LasikPlus Traditional Intralase (bladeless) with a one year plan with insurance discount is \$695 per eye equals \$1,390. Traditional Intralase (bladeless) with a lifetime plan with insurance discount is \$1,395 per eye which equals \$2,790. CustomVue Intralase (bladeless) with

a lifetime plan with insurance discount is \$1,784.15 which equals \$3,568.30

**PVCS:** Member must select either in-network or out-of-network for entire plan year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A \$50.00 service fee applies to all soft contact lens fittings; a \$75.00 service fee applies to rigid or gas permeable contact lens fittings; and a \$150.00 service fee applies to hybrid contact lens fittings. Simple replacements are not assessed with these fees. Limitations/Exclusions include the following: 1) Medical eye care, 2) Vision Therapy, 3) Nonroutine vision services and tests, 4) Luxury frames (wholesale cost of frame is \$100

or more), 5) Premium prescription lenses, and 6) non-prescription eyewear. For more information call (888) 357-6912.

**United Healthcare:** For either glasses or contact lenses there is one \$25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fees, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to six boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC's covered contact lenses may vary by provider. Should you choose contact lenses outside of the covered selection, a \$150 allowance will be

<b>Superior</b> <i>www.superiorvision.com</i>		<b>UnitedHealthcare Vision</b> <i>Formerly Spectera</i> <i>www.myuhcvision.com</i>		<b>VSP</b> <i>www.vsp.com</i>	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$10 Copay	\$10 Copay then plan pays up to \$34 - Ophthalmologist \$26 - Optometrist	\$10 Copay	Reimbursement up to \$40	\$10 Copay	\$10 Copay then plan pays up to \$35
\$25 Copay  Lenses are covered in full after copay	\$25 Copay then plan pays up to Single up to \$26 Bifocals up to \$39 Trifocals up to \$49 Lenticular up to \$78	\$25 Copay	Single up to \$40 Bifocals up to \$60 Trifocals up to \$80 Lenticular up to \$80	\$25 Copay applies to lenses or frames. Single vision, lined bifocal and trifocal lenses covered in full. Average 35% discount on lens options.	\$25 Copay, then plan pays: Single up to \$25 Bifocals up to \$40 Trifocals up to \$55 Lenticular up to \$80
\$25 Copay*, then plan pays up to \$125 retail	Plan pays up to \$68	\$25 Copay	Reimbursement up to \$45	\$25 Copay, then plan pays up to \$120	\$25 Copay, then plan pays up to \$45
No Copay Plan pays up to \$120. Medically necessary contacts covered in full. (Contact lens fit copay: Standard \$25, after copay, covered in full. Specialty \$25, after copay, plan pays up to \$50.)	No Copay Plan pays up to \$100 All Contacts \$210 Medically necessary (Contact lens fit copay: Standard not covered. Specialty not covered.)	\$25 Copay On covered-in-full qualifying lenses (covers fitting and evaluation fees, contact lenses and up to 2 follow-up visits) (See Notes)	Reimbursement up to \$150 elective contact lenses, \$210 Medically necessary contact lenses	No Copay Plan pays up to \$120 Conventional or Disposable. Medically necessary contacts covered in full with prior authorization.	No Copay Plan pays up to \$105 Conventional or Disposable, \$210 Medically necessary
20%-50% Discount off surgical fees	No Benefit	Discount 15 percent off the usual & customary price, 5% off promotional price	No Benefit	15% average off usual and customary price or 5 percent off the laser center's promotional price	No Benefit
20% discount	No Benefit	Covered-in-full	No Benefit	\$14 copay	No Benefit
20% discount	No Benefit	Covered-in-full	No Benefit	\$13 - \$15 copay	No Benefit
20% discount	No Benefit	Covered-in-full	No Benefit	\$15 copay	No Benefit
20% discount	No Benefit	Available 20-40% discount	No Benefit	Covered in full for dependent children \$25 - \$30 copay for all others	No Benefit
\$25 Copay, *See notes below	Up to \$49 *See notes below	Available 20-40% discount	No Benefit	\$50 copay	No Benefit
20% discount	No Benefit	Available 20-40% discount	No Benefit	\$39 copay	No Benefit

applied toward the fitting/evaluation fees and purchase of contact lenses (materials copay does not apply). Toric, gas permeable, and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full after applicable copay. Exams, lenses, frame benefits provided once every calendar year.

**Superior:** \*Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, in-network contact lens materials available at [www.svcontacts.com](http://www.svcontacts.com). Exams, lenses, and frames benefits provided once per calendar year.

\*Progressive Lenses (no-line bifocals) – you will pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount.

Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The Specialty contact lens fitting applies to a new contact lens wearers and/or a member who wears toric, gas permeable or multifocal lenses.

**VSP:** Exam, lenses and frame benefit provided annually. The \$25 materials copay applies to lenses or frames, but not to both. Copays/price on premium lens options will vary. If you choose a frame valued at more than your allowance,

you'll save 20% on your out-of-pocket costs when you use a VSP doctor. Contact lenses are in lieu of spectacle lenses and frames. The \$120 in-network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to \$60. The \$105 out-of-network applies to the contacts and the contact lens exam. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses - 30% off additional complete pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months from your last WellVision Exam.

## New Login box

Your entry point for Online Enrollment in the Benefits Administration System (BAS) now looks a little different (see image at right). It is in the upper right corner of the EBC home page, [www.ebc.ok.gov](http://www.ebc.ok.gov).

Notice the “Go To” line, followed by a drop-down menu.

That is where you will choose either the new **OKHealth Portal** or the **Benefits Administration System**, which is where you’ll find Online Enrollment. Your User ID is your six-digit Employee ID. If you don’t know your password, either select “Forgot Your Password” or simply select LOGIN and you will be directed to a screen where you can update your password.



New login box

out can still take advantage of vision insurance offered by the State, as well as Flexible Spending Accounts (FSAs).

If you are considering opting out, please understand you are forfeiting the normal benefit allowance provided by your agency. In lieu of that benefit allowance, you will get \$150 per month from your agency. That \$150 can be used to pay for vision coverage, FSA contributions, and/or added to your net pay as taxable income.

## Retired Military

State employees who have retired from military service and have federal TRICARE insurance benefits can also opt out of the state’s basic plan. Those individuals will get no coverage for health, dental, life, disability, supplemental life or dependent life insurance. In lieu of the normal benefit allowance, TRICARE opt-outs will receive \$150 per month from their agencies. They can still elect vision coverage as well as flexible spending account participation. A copy of the participant’s military service card will be requested as proof of TRICARE coverage. Employees who go this route must opt out each year because the election does not roll over.

In response to Senate Bill 623, which also became law in 2011, your Benefits Office is making a TRICARE supplement available to military retirees in 2012. See page 5 for monthly rates and page 6 for biweekly rates.

## New Opt-out details

With the approval of House Bill 1062 in May 2011, state employees were given the right to opt out of state benefits. Specifically,

*“Any active employee eligible to participate or who is a participant may opt out of the state’s basic plan as outlined in Sections 1370 and 1371 of Title 74 of the Oklahoma Statutes, provided that the participant is currently covered by a separate group health insurance plan. Any active employee eligible to participate or who is a participant opting out of coverage pursuant to this section shall provide proof of the separate health insurance plan participation and sign an affidavit attesting that the participant is currently covered and does not require state-provided health insurance each plan year. Any active employee opting out of coverage pursuant to this section shall receive One Hundred Fifty Dollars (\$150.00) in lieu of the flexible benefit amount the employee would be otherwise eligible to receive.”*

As the new law spells out, you may opt out ONLY if you are currently covered by a separate group health insurance plan. In addition, you must provide proof of the separate health insurance plan participation and sign an affidavit before the opt-out will be approved. You will need to fill out a new form which is available through your Benefits Coordinator.

The “basic plan” described in the new law consists of the following: health, dental, basic life and disability insurance. If you opt out, you are no longer eligible for any of those coverages through the State. Because Basic Life insurance is a prerequisite for the optional Supplemental Life and Dependent Life, those are eliminated, as well. However, state employees who opt

## Benefit Allowance

### Your Benefit Allowance Helps

**Cover Your Costs** The State provides a Benefit Allowance to help you pay for insurance premiums that would otherwise come out of your own pocket. An estimated 90 percent of state employees and their families will continue having 100 percent of benefits paid with these dollars. Per state law, it is calculated using the average of the highest-cost health plans, the average of the dental plan premiums, plus the premiums for basic life and disability. As rates increase, so does your Benefit Allowance. For employees electing to cover dependents on health, an allowance is provided to cover 75 percent of the average of all high option premium dependent costs.



Health	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare: Standard Plan	803.22	1,951.80	2,353.40	2,594.36	1,204.82	1,445.78
CommunityCare: Alternative Plan	553.96	1,346.10	1,623.08	1,789.26	830.94	997.12
CommunityCare: Wellness Alternative Plus	528.96	1,321.10	1,598.08	1,764.26	805.94	972.12
GlobalHealth: Standard Plan	402.84	1,063.56	1,275.83	1,402.00	615.11	741.28
GlobalHealth: Alternative Plan	366.24	966.92	1,159.92	1,274.62	559.24	673.94
GlobalHealth: Wellness Alternative Plus	341.24	941.92	1,134.92	1,249.62	534.24	648.94
United Healthcare Standard Plan	768.80	1,874.16	2,258.28	2,488.88	1,152.92	1,383.52
United Healthcare Alternative Plan	530.20	1,292.52	1,557.42	1,716.46	795.10	954.14
United Healthcare: Wellness Alternative Plus	505.20	1,267.52	1,532.42	1,691.46	770.10	929.14
HealthChoice High	449.48	1,117.58	1,345.78	1,469.66	677.68	801.56
HealthChoice High Alternative	449.48	1,117.58	1,345.78	1,469.66	677.68	801.56
HealthChoice Basic	391.64	963.48	1,165.30	1,274.28	593.46	702.44
HealthChoice Basic Alternative	391.64	963.48	1,165.30	1,274.28	593.46	702.44
HealthChoice USA	688.82	1,377.64	1,603.86	1,726.50	915.04	1,037.68
HealthChoice S-Account	382.56	925.08	1,115.26	1,216.98	572.74	674.46
TRICARE Supplement	59.00	118.00	177.00	218.00	118.00	159.00

Dental	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Heritage Plus Dental Plan	11.74	20.60	28.20	35.80	19.34	26.94
Assurant Freedom Preferred Dental Plan	28.83	57.50	79.00	115.30	50.33	86.63
Assurant Heritage Secure Dental Plan	7.20	13.18	18.38	23.56	12.40	17.58
CIGNA Dental	9.26	15.32	22.40	30.64	16.34	24.58
Delta Dental PPO	33.64	67.26	96.52	141.30	62.90	107.68
Delta's Choice PPO Choice	15.06	49.24	83.68	132.84	49.50	98.66
Delta Dental Premier	38.36	76.72	110.10	161.18	71.74	122.82
HealthChoice Dental	30.20	60.40	85.58	125.72	55.38	95.52

Vision	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana	6.76	11.82	15.39	16.28	10.33	11.22
Primary Vision Care Services	9.25	17.25	25.75	28.00	17.75	20.00
United HealthCare Vision	8.18	13.97	18.56	20.95	12.77	15.16
Superior Vision Services	7.14	14.24	20.96	28.04	13.86	20.94
Vision Service Plan	8.76	14.63	20.25	27.27	14.38	21.40

**Life Insurance Options**

Life	4.00	Supplemental Life First Unit		4.00		
Disability	9.10					
Dependent Life		Supplemental Life Age Rated (Per \$20,000)				
Low Option	2.60				Age	
Standard Option	4.32				<30	0.60
Premier Option	8.64				30-34	0.60
					35-39	0.80
					40-44	1.20
					45-49	2.00
					50-54	3.40
					55-59	5.40
					60-64	6.20
					65-69	10.20
					70-74	17.40
					75+	27.00

Monthly Benefit Allowance	
Employee	640.98
Plus Child	870.89
Plus Children	1,006.19
Plus Spouse	1,312.75
Plus Spouse & 1 Child	1,542.66
Plus Spouse & Children	1,677.96

Health	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare: Standard Plan	370.72	900.83	1,086.18	1,197.40	556.07	667.29
CommunityCare: Alternative Plan	255.67	621.27	749.11	825.81	383.51	460.21
CommunityCare: Wellness Alternative Plus	244.14	609.74	737.58	814.28	371.98	448.68
GlobalHealth: Standard Plan	185.93	490.88	588.85	647.08	283.90	342.13
GlobalHealth: Alternative Plan	169.03	446.27	535.35	588.29	258.11	311.05
GlobalHealth: Wellness Alternative Plus	157.50	434.74	523.82	576.76	246.58	299.52
United Healthcare Standard Plan	354.83	865.00	1,042.29	1,148.72	532.12	638.55
United Healthcare Alternative Plan	244.71	596.55	718.81	792.21	366.97	440.37
United Healthcare: Wellness Alternative Plus	233.17	585.01	707.27	780.67	355.43	428.83
HealthChoice High	207.45	515.80	621.12	678.30	312.77	369.95
HealthChoice High Alternative	207.45	515.80	621.12	678.30	312.77	369.95
HealthChoice Basic	180.76	444.69	537.84	588.14	273.91	324.21
HealthChoice Basic Alternative	180.76	444.69	537.84	588.14	273.91	324.21
HealthChoice USA	317.92	635.84	740.25	796.85	422.33	478.93
HealthChoice S-Account	176.57	426.96	514.74	561.68	264.35	311.29
TRICARE Supplement	27.23	54.46	81.69	100.61	54.46	73.38

Dental	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Heritage Plus Dental Plan	5.42	9.51	13.02	16.53	8.93	12.44
Assurant Freedom Preferred Dental Plan	13.31	26.54	36.46	53.22	23.23	39.99
Assurant Heritage Secure Dental Plan	3.32	6.08	8.48	10.87	5.72	8.11
CIGNA Dental	4.27	7.07	10.34	14.14	7.54	11.34
Delta Dental PPO	15.53	31.05	44.55	65.22	29.03	49.70
Delta's Choice PPO Choice	6.95	22.73	38.63	61.31	22.85	45.53
Delta Dental Premier	17.70	35.40	50.81	74.38	33.11	56.68
HealthChoice Dental	13.94	27.88	39.50	58.03	25.56	44.09

Vision	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana	3.12	5.46	7.11	7.52	4.77	5.18
Primary Vision Care Services	4.27	7.96	11.88	12.92	8.19	9.23
United HealthCare Vision	3.78	6.45	8.57	9.67	5.90	7.00
Superior Vision Services	3.30	6.58	9.68	12.95	6.40	9.67
Vision Service Plan	4.04	6.75	9.34	12.58	6.63	9.87

Life Insurance Options							
Life	1.85	Supplemental Life First Unit			1.85		
Disability	4.20						
Dependent Life		Supplemental Life Age Rated (Per \$20,000)					
Low Option	1.20					Age	
Standard Option	1.99					<30	0.28
Premier Option	3.99					30-34	0.28
						35-39	0.37
						40-44	0.55
						45-49	0.92
						50-54	1.57
						55-59	2.49
						60-64	2.86
						65-69	4.71
						70-74	8.03
						75+	12.46

Biweekly Benefit Allowance	
Employee	295.84
Plus Child	401.95
Plus Children	464.40
Plus Spouse	605.89
Plus Spouse & 1 Child	712.00
Plus Spouse & Children	774.45

## Premium Conversion

### Do You Want to Save on Your Taxes?

Premium Conversion is an optional, IRS-approved election chosen by more than 97 percent of state employees, allowing you to save by paying NO TAX on your eligible insurance premiums. By paying insurance premiums for health, dental, vision, flexible spending accounts and a portion of supplemental life pre-tax, you have more take-home pay than you would if you paid the same premiums with after-tax dollars.



The premium conversion option is automatic. You will be enrolled in premium conversion unless you elect to opt out. You can opt out of premium conversion in two ways.

- Select “No” to premium conversion during online enrollment
- Check the “No” box under the Premium Conversion section of the paper enrollment form

If you have questions about your premium conversion options, be sure to ask your Benefits Coordinator.

✓ **Yes = tax savings!**

## New Health plans with discounts!

**For the first time, you can get a discounted premium or lower deductible on state health insurance!**



Now that we have your attention...

Your Benefits Office proudly introduces the “Wellness Alternative Plus” plans. They are HMO Alternative plans that cost \$25 less per month. As long as you live or work in a zip code that is serviced by one of the state’s three HMOs, the only thing you have to do to get the discounted premium is complete a Health Risk Assessment (HRA). You’ll find it in the OKHealth section of [www.ebc.ok.gov](http://www.ebc.ok.gov). It only takes a few minutes to fill out, and in return, you’ll save \$300 during 2012. The discount is available to all state employees, including current and former OKHealth participants; however, a new HRA is required.

**You have until November 10th to complete the HRA. If you choose a Wellness Alternative Plus plan, but don’t complete the HRA by November 10th, you will be defaulted into that company’s Alternative plan, which has a higher rate.**

Wellness Alternative Plus plans are offered by each of the available HMOs: CommunityCare, GlobalHealth and UnitedHealthcare. **It is important to note:** the discounted rates for the new plans were not attained by increasing premiums on other plans. Best-and-final-offer rates for the HMO Standard and Alternative plans did not change after the new plans were requested. Your Benefits Office negotiated the \$25/month discounts by emphasizing that wellness program participants typically

have lower utilization of health care and are, therefore, less expensive to insure. The private-sector health plans agreed and support the initiative to improve the overall health of state employees. Check your zip code by going to the EBC web site, [www.ebc.ok.gov](http://www.ebc.ok.gov), go to the Benefits section and select “Provider Directory.” Select your zip code from the drop-down list. If it’s not on the list, please check with your Benefits Coordinators to check HMO availability in your area.

Most HealthChoice members have opportunities to save, as well. State employees who don’t smoke or use other tobacco products will continue to have a HealthChoice High annual deductible of \$500 (individual) or \$1,500 (family). Otherwise, the calendar year deductibles will be \$750 or \$2,250. In addition, HealthChoice members can complete the H.E.L.P. Health Risk Assessment as well as the biometric requirements and receive \$100. Look for the HRA link on the home page of [www.sib.ok.gov](http://www.sib.ok.gov) or [www.healthchoiceok.com](http://www.healthchoiceok.com).

## HealthChoice Health Plans

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

To enroll or remain enrolled in the HealthChoice High or Basic Plan for Plan Year 2012, you must attest that you and your covered dependents are tobacco-free by completing the *HealthChoice High and Basic Plans Tobacco-Free Attestation for Plan Year 2012* by October 28, 2011. The attestation is available to you:

- Online at [www.sib.ok.gov](http://www.sib.ok.gov) or [www.healthchoiceok.com](http://www.healthchoiceok.com)
- From your Benefits Coordinator
- By calling HealthChoice Member Services at 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

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

(continued on page 8)

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

The letter from TSET or your doctor must be provided to HealthChoice at 3545 N.W. 58 Street, Suite 110, Oklahoma City, OK 73112 by October 28, 2011. If you do not or cannot complete the tobacco-free attestation or provide one of the letters described previously, you and your covered dependents will be enrolled in the new HealthChoice High Alternative Plan or HealthChoice Basic Alternative Plan.

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

- No limit on visits and treatment days for mental health and substance abuse, certification required.
- Non-Network emergency room visits will be covered at the Network benefit level; however, you can still be billed for non-covered services and amounts over Allowed Charges.
- **Preventive Procedures Covered at 100% of Allowed Charges.** As an enhanced benefit for HealthChoice members, preventive procedures and many other services will be covered at 100% of Allowed Charges with no out-of-pocket costs when using a Network Provider. This means no-cost access to such services as:
  - Blood pressure, diabetes, and cholesterol tests
  - Breast, cervical, prostate, and colorectal cancer screenings
  - Osteoporosis screening
  - Counseling from your health care provider on topics including quitting tobacco, losing weight, eating healthy, treating depression, and reducing alcohol use
  - Prescription tobacco cessation products
  - Vaccines for children and adults
  - Flu and pneumonia shots
  - Screening for obesity and counseling from your doctor and other health professionals to promote sustained weight loss, including dietary counseling from your doctor

- Screening for conditions that can harm pregnant women or their babies, including iron deficiency, hepatitis B, a pregnancy related immune condition called Rh incompatibility, and a bacterial infection called bacteriuria
- Special pregnancy-tailored counseling from a doctor to help pregnant women quit smoking and avoid alcohol use
- Counseling to support breast-feeding and help nursing mothers

See the HealthChoice website at [www.sib.ok.gov](http://www.sib.ok.gov) or [www.healthchoicework.com](http://www.healthchoicework.com) for more details.

#### **HealthChoice High, High Alternative, and USA Plans**

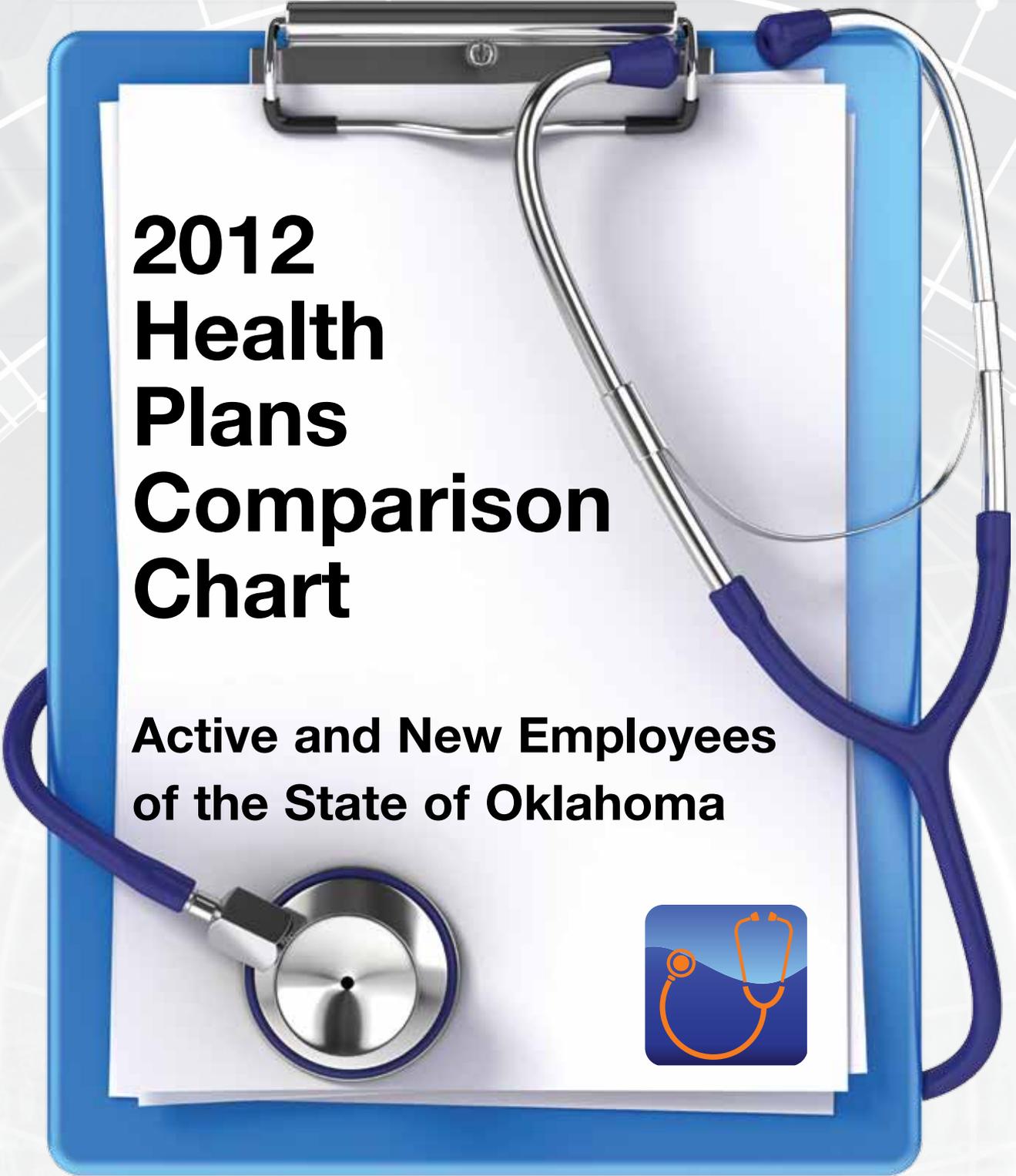
- HealthChoice is implementing a family out-of-pocket limit for the HealthChoice High, High Alternative and USA Plans. The family out-of-pocket limit for the High and USA Plans will be \$8,400 when using a Network Provider and \$9,900 when using a non-Network Provider. The family out-of-pocket limit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

#### **HealthChoice S-Account Plan**

- The out-of-pocket limits are being lowered to \$3,000/individual and \$6,000/family.
- Proof of a Health Savings Account (HSA) is not required to enroll.
- HealthChoice has contracted with American Fidelity Health Services Administration to make establishing and keeping a Health Savings Account easier and more convenient for S-Account members. See the Health Savings Accounts information page in the back pocket of this guide.

#### **HealthChoice Pharmacy Benefit**

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



# **2012 Health Plans Comparison Chart**

**Active and New Employees  
of the State of Oklahoma**



<b>Health Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard Plan</b> CommunityCare GlobalHealth UnitedHealthcare	<b>CommunityCare</b> HMO  Alternative and Wellness Alternative Plus	<b>GlobalHealth</b> HMO  Alternative and Wellness Alternative Plus	<b>UnitedHealthcare</b> HMO Alternative and Wellness Alternative Plus
<b>Choice of Provider</b>	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for some care received outside PCP office.	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) Members may self-refer to most specialists for initial visit.	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for all care received outside PCP office. You may self-refer to an in-network OB/GYN. For children, you may designate a pediatrician as the primary care provider.	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) However, no referral for your contracted specialist when the specialist is in UnitedHealthcare's SignatureValue HMO network (referral required for behavioral health and chiropractic providers)
<b>Calendar Year Deductible</b>	None	None	None	None
<b>Annual Out-of-Pocket Maximum</b>	Individual: \$2,500 Family: \$5,000	Individual: \$3,000 Family: \$6,000	Individual: \$3,000 Family: \$5,000	Individual: \$2,500 Family: \$5,000

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p> <p align="center">A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider</p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p> <p align="center">A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider</p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p> <p align="center">Additional out-of-pocket costs apply when using a non-Network provider</p>	<p align="center"><b>HealthChoice S-Account Network*</b></p> <p align="center">A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider</p>
<p>Choice of Network Provider for medically necessary services</p> <p>\$30 Physician \$50 Specialist</p> <p>Physicians include; General Practitioners Internal Medicine Physicians OB/GYNs Pediatricians Physician Assistants Nurse Practitioners</p>	<p>Choice of any Provider, Allowed Charges for medically necessary services. Member responsible for amount that exceeds the Allowed Charges when using a non-Network provider and all ineligible expenses.</p>	<p>Choice of any Provider, Allowed Charges for medically necessary services. Member responsible for amount that exceeds the Allowed Charges when using a non-Network provider and all ineligible expenses.</p>	<p>Choice of Provider for medically necessary services</p>
<p>High Individual: \$500 Family: \$1,500 High Alternative Individual: \$750 Family: \$2,250</p> <p>See Emergency Health Care for additional per service deductible.</p>	<p>High Individual: \$500 Family: \$1,500 plus \$300 per confinement hospital deductible. High Alternative Individual: \$750 Family: \$2,250 plus \$300 per confinement hospital deductible.</p> <p>See Emergency Health Care and Hospital Inpatient for additional per service deductible.</p>	<p>Basic Individual: \$500 Family: \$1,500 Deductible applies after Plan pays first \$500 of Allowed Charges. Basic Alternative Individual: \$750 Family: \$1,500 Deductible applies after Plan pays first \$250 of Allowed Charges. Plan offers same benefits and unlimited lifetime maximum on eligible health and pharmacy benefits as the HealthChoice High Plan.</p>	<p>Individual: \$1,500 Family: \$3,000 The combined medical and pharmacy deductible must be met before benefits are paid.</p>
<p>High Individual: \$2,800 Family: \$8,400 (includes deductible) High Alternative Individual: \$3,050 Family: \$9,150 (includes deductible) Non-covered services, copays &amp; ER deductible do not apply</p>	<p>High Individual: \$3,300 Family: \$9,900 (includes deductible) High Alternative Individual: \$3,550 Family: \$10,650 (includes deductible) plus Member is responsible for amount that exceeds the Allowed Charges, inpatient deductible, ER deductible &amp; charges over maximum benefit limitations</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Individual: \$3,000 Family: \$6,000</p> <p>Non-Network charges do not apply.</p>

**Health Plans Comparison Chart Active and New Employees of the State of Oklahoma**

**HMO Standard Plan**  
**CommunityCare**  
**GlobalHealth**  
**UnitedHealthcare**

**CommunityCare**  
**HMO Alternative and Wellness Alternative Plus**  


**GlobalHealth**  
**HMO Alternative and Wellness Alternative Plus**  


**UnitedHealthcare**  
**HMO Alternative and Wellness Alternative Plus**

**Office Visits (Professional Services)**

Copayments  
 \$30 PCP  
 \$40 Specialist per visit

Copays  
 \$35 PCP copay per visit  
 \$50 Specialist copay per visit

Copayments  
 \$25 PCP  
 \$50 Specialist

Copays  
 \$35 PCP  
 \$50 Specialist

**Prescription Drugs**



\$5/\$30/\$60  
 30 day supply  
 Selected medications may have restricted quantities.

Up to \$0 select generic formulary  
 Up to \$10 generic formulary  
 Up to \$40 brand formulary (when no generic is available)  
 Up to \$65 brand formulary (when generic is available)  
 Up to \$65 non formulary

30-day supply  
 Selected medications may have restricted quantities.  
 Convenience Mail Order Pharmacy  
 Up to 90 day supply for 3 copays

\$10/\$50/\$75  
 Includes a 1 month supply

\$5 copay for formulary generic drug  
 \$30 copay for formulary brand name drug  
 \$60 non-formulary generic and brand drug

The lesser of 30-day supply or 100 units; certain medications have restricted quantities

\*\*\*\*\*

Contraceptive Drugs:  
 \$5 copay for formulary generic drug  
 \$30 copay for formulary brand name drug  
 \$60 non-formulary generic and brand drug

The lesser of 30-day supply or 100 units; certain medications have restricted quantities

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>\$30 Physician copay; \$50 Specialist copay per office visit; for other professional services, the calendar year deductible applies first; member pays 20% of Allowed Charges</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>Once a Member spends \$5,500/\$5,750 out-of-pocket, the Basic Plan will pay 100% of all other Allowed Charges for that Plan Year. Family deductible is \$1,000/\$1,500 w/a maximum annual family out-of-pocket of \$11,000/\$11,500</p>	<p>After the calendar year deductible, \$50 copay</p>
<p><b>Retail-30 day supply</b> (Including first 3 fills of maintenance medications) <b>Preferred Generic</b> - Cost of medication up to a maximum of \$10; <b>Preferred Brand</b> – Cost of medication up to \$15 or maximum copay of \$30. <b>Non-Preferred Brands</b> - Cost of medication is up to \$60, or a maximum of \$120</p> <p><b>Mail Delivery and Retail Maintenance Pharmacies – 90 day supply:</b> <b>Preferred Generic</b> – Cost of medication up to maximum copay of \$25. <b>Preferred Brand</b> – Cost of medication up to \$30 or maximum copy of \$60. <b>Non-Preferred Brand</b> - Cost of medication up to \$60 or a maximum copay of \$120. <b>Specialty Medication Copay:</b> <b>Preferred</b> - \$60 per 30-day supply <b>Non-Preferred</b> - \$120 per 30-day supply <b>Brand/Generic difference:</b> Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a></p>	<p><b>Retail-30 day supply</b> (Including first 3 fills of maintenance medications) <b>Preferred Generic</b> - Cost of medication up to a maximum of \$10; <b>Preferred Brand</b> – Cost of medication up to \$15 or maximum copay of \$30. <b>Non-Preferred Brands</b> - Cost of medication is up to \$60, or a maximum of \$120 <b>Mail Delivery and Retail Maintenance Pharmacies – 90 day supply:</b> <b>Preferred Generic</b> –Cost of medication up to maximum copay of \$25. <b>Preferred Brand</b> – Cost of medication up to \$30 or maximum copy of \$60. <b>Non-Preferred Brand</b> - Cost of medication up to \$60 or a maximum copay of \$120. <b>Specialty Medication Copay:</b> <b>Preferred</b> - \$60 per 30-day supply <b>Non-Preferred</b> - \$120 per 30-day supply <b>Brand/Generic difference:</b> Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a></p>	<p><b>Retail-30 day supply</b> (Including first 3 fills of maintenance medications) <b>Preferred Generic</b> - Cost of medication up to a maximum of \$10; <b>Preferred Brand</b> – Cost of medication up to \$15 or maximum copay of \$30. <b>Non-Preferred Brands</b> - Cost of medication is up to \$60, or a maximum of \$120</p> <p><b>Mail Delivery and Retail Maintenance Pharmacies – 90 day supply:</b> <b>Preferred Generic</b> –Cost of medication up to maximum copay of \$25. <b>Preferred Brand</b> – Cost of medication up to \$30 or maximum copy of \$60. <b>Non-Preferred Brand</b> - Cost of medication up to \$60 or a maximum copay of \$120. <b>Specialty Medication Copay:</b> <b>Preferred</b> - \$60 per 30-day supply <b>Non-Preferred</b> - \$120 per 30-day supply <b>Brand/Generic difference:</b> Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a></p>	<p>After the \$1,500 individual or \$3,000 family deductible has been met, the pharmacy benefits are: <b>Retail-30 day supply</b> (Including first 3 fills of maintenance medications) <b>Preferred Generic</b> - Cost of medication up to a maximum of \$10; <b>Preferred Brand</b> – Cost of medication up to \$15 or maximum copay of \$30. <b>Non-Preferred Brands</b> - Cost of medication is up to \$60, or a maximum of \$120 <b>Mail Delivery and Retail Maintenance Pharmacies – 90 day supply:</b> <b>Preferred Generic</b> –Cost of medication up to maximum copay of \$25. <b>Preferred Brand</b> – Cost of medication up to \$30 or maximum copy of \$60. <b>Non-Preferred Brand</b> - Cost of medication up to \$60 or a maximum copay of \$120. <b>Specialty Medication Copay:</b> <b>Preferred</b> - \$60 per 30-day supply <b>Non-Preferred</b> - \$120 per 30-day supply <b>Brand/Generic difference:</b> Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a></p>

<b>Health Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard Plan CommunityCare GlobalHealth UnitedHealthcare</b>	<b>CommunityCare HMO Alternative and Wellness Alternative Plus</b> 	<b>GlobalHealth HMO Alternative and Wellness Alternative Plus</b> 	<b>UnitedHealthcare HMO Alternative and Wellness Alternative Plus</b>
<b>OKHealth Program</b>  <b>(Only for State employees participating in OKHealth Program, dependents do not qualify.)</b>	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program. <b>If any other services are provided during this PCP office visit, member will be charged office visit copay and other appropriate charges.</b>	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program. If any other services are provided during PCP office visit, member will be charged an office copay and other appropriate charges	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program	No charge one time per plan year for PCP visits biometric measurements and lab work related to the OK Health Program. If any other services are provided during this PCP office visit, member will be charged an Office Visit copay.
<b>Hospital Inpatient</b>	\$350 per admission	\$500 copay per admission (prior authorization from PCP required)	\$250 copayment per inpatient day \$750 max. per admission  Precertification from PCP required	\$1,000 Copay per admit
<b>Hospital Outpatient</b>	\$250 per visit	\$300 copay per visit outpatient surgical facility	\$250 copayment per visit  As authorized by PCP	\$500 copay per Outpatient Surgery visit
<b>Emergency Health Care</b>	\$150 per visit (waived if admitted)	\$200 per visit copay (waived if admitted)	\$150 per visit copayment (waived if admitted)	\$200 copay per visit (waived if admitted as an inpatient from emergency room)
<b>After Hours Urgent Care</b>	\$40 per visit	\$50 copay per visit (prior authorization required)	\$25 PCP/\$50 all other providers NOTE: Must use in-network facilities.	\$50 copay per visit

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>One free initial doctor's office visit related to OK Health Program requirements.</p> <p>One free fasting lipid (Cholesterol/triglycerides) profile</p> <p>One fasting glucose (sugar) test</p>	<p>Not covered for non-Network</p>	<p>One free initial Network provider's office visit related to OK Health Program requirements.</p> <p>One free fasting lipid (Cholesterol/triglycerides) profile, one fasting glucose (sugar) test</p>	<p>One free initial doctor's office visit related to OK Health Program requirements.</p> <p>One free fasting lipid (Cholesterol/triglycerides) profile</p> <p>One fasting glucose (sugar) test</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required</p>	<p>HealthChoice Basic plan offers the same benefits as the HealthChoice High (Network) Plan Using Network providers will maximize your benefits. Certification required</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital deductible when using a non-Network provider plus amount that exceeds the Allowed Charges and all ineligible expenses Certification required</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required for certain outpatient surgeries</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required for certain outpatient surgeries</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required for certain outpatient surgeries</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible.</p> <p>\$100 ER deductible; waived if hospitalized</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible, plus amount that exceeds the allowed charges.</p> <p>\$100 ER deductible; waived if hospitalized</p>	<p>The \$100 ER deductible does not apply to the Basic and Basic Alternative Plans</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible.\$100 ER deductible; waived if hospitalized</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>

Health Plans Comparison Chart Active and New Employees of the State of Oklahoma	HMO Standard Plan CommunityCare GlobalHealth UnitedHealthcare	CommunityCare HMO  Alternative and Wellness Alternative Plus	GlobalHealth HMO  Alternative and Wellness Alternative Plus	UnitedHealthcare HMO Alternative and Wellness Alternative Plus
<b>Diagnostic X-ray and Lab</b>	No additional copayment for Laboratory services or Outpatient Radiology \$150 copayment per scan for MRI, CT, MRA and PET Scan	No additional copay for Laboratory services or Outpatient Radiology. \$200 copay per scan for MRI, CT, MRA and PET Scan	No additional copayment for Laboratory services or Outpatient Radiology \$250 copayment per scan for MRI, CT, MRA and PET Scan	Standard Laboratory and Radiology: \$0 copay Specialized scanning and imaging (MRI, MRA, PET, CAT, Nuclear Scans): \$200 copay per scan
<b>Allergy Treatment And Testing</b>	\$30 per visit to PCP \$40 per visit to Specialist \$30 for Allergy Serum and shots, including (6) six week supply Antigen and administration	\$35 copay per visit to PCP \$50 copay per visit to Specialist \$30 copay for Allergy Serum (six week supply - including shots)	\$25 PCP /\$50 Specialist \$30 copayment per 6 weeks antigen and shots	\$35 PCP \$50 Specialist \$35 Serum and shots including a six (6) week supply of antigen and administration
<b>Well-child Care</b>	No Charge	No copay	No Copayment up to age 21	No copay
<b>Immunizations</b>	No Charge (Ages birth – 18) No Charge (Ages 19 and over)	No copay for childhood immunizations up to 18 No copay for medically necessary immunizations 19 and over	No copayment Office copayments may apply	No copay (if no other service is rendered) In accordance with the US Preventive Services Task Force and other health organizations required guidelines.
<b>Maternity</b>	\$30 for initial visit \$350 per admission	\$35 copay for initial visit only (includes prenatal and postnatal care) No copay for Prenatal Classes Amniocentesis (medically necessary; outpatient surgical facility copay may apply) \$500 per admission	\$25 physician services copayment for initial visit only \$250 copayment per day hospital admission <b>\$750 max. per admission</b>	\$35 PCP \$50 Specialist. copay for initial visit once diagnosis of pregnancy is confirmed; \$1,000 copay per admit for Hospitalization

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Limit: Battery of 60 tests every 24 months</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses Limit: Battery of 60 tests every 24 months</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500 Limit: Battery of 60 tests every 24 months</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible Limit: Battery of 60 tests every 24 months</p>
<p>\$0 copay for preventive well baby exam</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>\$0 Copay for preventative well-baby exam</p>	<p>\$0 copay for preventive well baby exam</p>
<p>Well-baby and adult immunizations covered at 100%, \$50 copay per specialist office visit. Administration charge may apply \$30 Physician \$50 Specialist Physicians include; General Practitioners, Internal Medicine Physicians, OB/GYN, Pediatricians, Physicians Assistants, Nurse Practitioners</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>Well-baby &amp; Adult immunizations covered at 100%</p>	<p>Well-baby and adult immunizations covered at 100%. Office visit is subject to \$50 copay. Administration charge is subject to deductible and coinsurance</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible Includes one postpartum home visit (must meet criteria) Also see Hospital Inpatient Benefits</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Includes one postpartum home visit (must meet criteria) Also see Hospital Inpatient Benefits</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Includes one postpartum home visit (must meet criteria) Also see Hospital Inpatient Benefits</p>

<b>Health Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard Plan CommunityCare GlobalHealth UnitedHealthcare</b>	<b>CommunityCare HMO Alternative and Wellness Alternative Plus</b> 	<b>GlobalHealth HMO Alternative and Wellness Alternative Plus</b> 	<b>UnitedHealthcare HMO Alternative and Wellness Alternative Plus</b>
<b>Contraceptive Services</b>	\$30 PCP \$40 Specialist per visit for consultation \$30 PCP/\$40 Specialist for surgical procedure	\$35 PCP/\$50 Specialist copay per visit for consultation \$35 PCP/\$50 Specialist copay for surgical procedure (in office)	\$50 copayment for services performed in office setting	Consultation, \$35 PCP copay \$50 Specialist copay \$35PCP/\$50 Specialist Surgical Procedure If Outpatient surgery \$500 copay
<b>Contraceptive Drugs</b>	Tier 1: \$ 5 Tier 2: \$30 Tier 3: \$60 30 day supply Selected medications may have restricted quantities. One copay per injectable contraceptive	See Prescription Drug Benefits Up to \$0 select generic formulary Up to \$10 generic formulary Up to \$40 brand formulary (when no generic is available) Up to \$65 brand formulary (when generic is available) Up to \$65 non formulary  30-day supply Selected medications may have restricted quantities. One copay per injectable contraceptive.	Covered under prescription drug benefit  Tier 1: \$4/\$10 Tier 2: \$50 Tier 3: \$75	Please refer to prescription drug benefit; \$50 copay for Depo-Provera Injection
<b>Infertility Services</b>	25% of cost + office visit copayment – includes diagnosis and some treatment including drug treatment \$30 PCP/\$40 Specialist	\$35 PCP copay per visit \$50 Specialist copay per visit. Office visit copays apply. Infertility Services 50% Copay. Infertility Medications (require prior authorization) are subject to a 50% copay	50% coinsurance, office visit copayments apply	25% of Total Charges (Basic Services)  25% cost plus copay  \$35 PCP \$50 Specialist
<b>Mental Health Inpatient</b>	\$350 Inpatient  No limit on treatment days	\$500 copay per admission (requires preauthorization and approval through CCOK Behavioral Health Services)	\$250 per inpatient day copayment <b>(\$750 max. per admission)</b> Must be preauthorized	\$1,000 copay per admission
<b>Mental Health Outpatient Including Gambling Addiction</b>	\$30 PCP  No limits on visits	\$35 PCP copay per visit \$50 Specialist copay per visit (requires preauthorization and approval through CCOK Behavioral Health Services)	\$25 copayment per visit  Must be preauthorized	\$35 PCP

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>See Prescription Drugs.</p>	<p>See Prescription Drugs.</p>	<p>See Prescription Drugs</p>	<p>After the \$1,500 individual or \$3,000 family deductible has been met, all Pharmacy copays apply. See Prescription Drugs.</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible Benefits available for diagnosis and some treatment. See exclusions in member materials</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds Allowed Charges and all ineligible expenses. Benefits available for diagnosis and some treatment. See exclusions in member materials.</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible Benefits available for diagnosis and some treatment. See exclusions in member materials</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible plus \$300 per confinement deductible, plus amount that exceeds Allowed Charges and all ineligible expenses. Certification required</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>
<p>Member pays 20% of Allowed Charges after calendar year deductible. Requires certification after 15 visits or penalty will apply.</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Requires certification after 15 visits or penalty will apply.</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty will apply.</p>

<b>Health Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard Plan CommunityCare GlobalHealth UnitedHealthcare</b>	<b>CommunityCare HMO Alternative and Wellness Alternative Plus</b> 	<b>GlobalHealth HMO Alternative and Wellness Alternative Plus</b> 	<b>UnitedHealthcare HMO Alternative and Wellness Alternative Plus</b>
<b>Substance Abuse Inpatient</b>	\$350 Inpatient  No limit on treatment days	\$500 copay per admission (requires preauthorization and approval through CCOK Behavioral Health Services)	\$250 per inpatient day copayment <b>\$750 max. per admission</b> Must be preauthorized	\$1,000 copay per admission
<b>Substance Abuse Outpatient</b>	\$30 PCP \$40 Specialist  No limit on visits	\$35 copay per visit PCP \$50 copay per visit specialist (requires preauthorization and approval through CCOK Behavioral Health Services)	\$25 copayment per visit  Must be preauthorized	\$35 PCP
<b>Hearing Screening</b>	No charge ages 0 to 21 Hearing Screening Adult One (1) visit per year \$30	\$0 copay per visit (covered under preventive care services and limited to one per year)	No copayment per visit up to age 21 \$25 copayment per visit age 22 and over limited to 1 per year	\$0 PCP copay per visit
<b>Hearing Aids</b>	Not covered except for children up to 18 years of age: audiological services and hearing aids are covered (as durable medical equipment) Limited 1 hearing aid per ear every 48 months.	20% copay for children up to age 18. Coverage shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, such coverage may provide for up to four (4) additional ear molds per year for children up to two (2) years of age.	Covered for children up to age 18 only 20% coinsurance	No Charge (Ages 0-17) 20% coinsurance for adults age 18 and over. Limited to a single hearing aid every 3 years. Maximum benefit of \$5,000 per calendar year.
<b>Physical, Occupational, or Speech Therapy</b>	No Charge for Inpatient care (limited to sixty (60) treatment days per course of therapy).  Outpatient is \$30 PCP/\$40 Specialist	No copay for Inpatient Rehabilitation \$50 copay for Outpatient Physical, Occupational or Speech Therapy (up to 60 treatment days per disability)	No copayment for inpatient rehabilitation \$50 Specialist copayment per visit for outpatient  Limited to 60 days per illness or injury	Inpatient: No Charge Outpatient: \$35 PCP \$50 Specialist copay per visit Combined limit of 60 treatment days per medical episode

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital deductible, plus amount above the Allowed Charges and all ineligible expenses. Certification required</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible Certification required</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty will apply</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges &amp; all ineligible expenses. Requires certification after 15 visits or penalty will apply</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty will apply</p>
<p>\$30 Physician copay,\$50 Specialist copay per office visit for a basic hearing screening only (does not include a comprehensive hearing exam) One per calendar year *See Choice of Provider</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Basic hearing screening only</p>		<p>\$50 copay per visit after the calendar year deductible for a basic hearing screening (does not include a comprehensive hearing exam) One per calendar year</p>
<p>Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required</p>	<p>Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required</p>
<p>Member pays 20% of Allowed Charges after calendar year deductible. Certification required after 20 visits. Each service limited to 60 visits per year</p>	<p>Member pays 50% of Allowed Charges after calendar year deductible plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required after 20 visits. Each service limited to 60 visits per year</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required after 20 visits. Each service limited to 60 visits per year</p>

**Health Plans Comparison Chart  
Active and New  
Employees of the  
State of Oklahoma**

**HMO Standard Plan**  
**CommunityCare**  
**GlobalHealth**  
**UnitedHealthcare**

**CommunityCare**  
**HMO**   
**Alternative  
and Wellness**  
**Alternative Plus**

**GlobalHealth**   
**HMO**  
**Alternative  
and Wellness**  
**Alternative Plus**

**UnitedHealthcare**  
**HMO**  
**Alternative  
and Wellness**  
**Alternative Plus**

**Chiropractic &  
Manipulative Therapy**

\$40 Specialist per visit  
limited to 15 visits per  
calendar year

\$50 copay per visit  
(15 visits per year)  
(PCP prior  
authorization  
required)

\$50 copayment per  
visit  
Must be preauthorized

\$50 Specialist copay  
per visit;  
15 visits per calendar  
year,  
limited to treatments of  
neurological and  
orthopedic conditions  
(Referral required)

**Durable Medical  
Equipment (DME)**

20% for initial  
device/20% for repair and  
replacement

20% copay  
(prior authorization  
required)

20% coinsurance

20% coinsurance

**Blood and Blood  
products**

No Charge

No copay

No copayment

Applies Autologous,  
donor directed, and  
donor designated blood  
processing costs are  
limited to \$120 per  
unit and must be for a  
scheduled procedure

**Skilled Nursing Facility**

No Charge

No copay  
(Limit: Max 100 days  
per year)

Limit: 100 days per  
Plan Year  
\$250/day copayment  
\$750 max. per  
admission

\$1,000 copay per  
admission;  
Limited to 100  
consecutive days/  
calendar year

**Periodic Health Exams**

No Charge

\$0 copay  
Routine Physicals

No copayment per  
PCP limited to 1 per  
year

\$0 PCP copay per visit  
\$50 Specialist copay  
per Visit



<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>Member pays 20% of Allowed Charges after calendar year deductible Certification required after 20 visits. Each service limited to 60 visits per year</p>	<p>Member pays 50% of Allowed Charges after calendar year deductible plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required after 20 visits. Each service limited to 60 visits per year</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible Certification required after 20 visits. Each service limited to 60 visits per year</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible for covered items. Purchase, rental, repair, or replacement must be certified</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Purchase, rental, repair, or replacement must be certified</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible for covered items. Purchase, rental, repair, or replacement must be certified</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 days per year</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required Limit: 100 days per year</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 days per year</p>
<p>\$0 copay for one preventive services visit per calendar year for members and dependents age 20 and older. H.E.L.P. Check program pays primary member \$100 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, \$30 Physician copay or \$50 Specialist copay per office visit. Some guidelines apply *See Choice of Provider</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. No copay or deductible for one mammogram per calendar year for women age 40 and over, member pays charges over \$115. Some guidelines apply</p>	<p>One preventive services visit covered at 100% of Allowed Charges for members and dependents age 20 and older. H.E.L.P. Check program pays primary member \$100 for completing preventive services visit, metabolic and lipid panels, and health risk assessment.</p>	<p>\$0 copay for one preventive services visit per calendar year for members and dependents age 20 and older. H.E.L.P. Check program pays primary member \$100 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, \$30 Physician copay or \$50 Specialist copay per office visit. Some guidelines apply *See Choice of Provider</p>

<b>Health Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard Plan CommunityCare GlobalHealth UnitedHealthcare</b>	<b>CommunityCare HMO Alternative and Wellness Alternative Plus</b> 	<b>GlobalHealth HMO Alternative and Wellness Alternative Plus</b> 	<b>UnitedHealthcare HMO Alternative and Wellness Alternative Plus</b>
<b>Temporomandibular Joint (TMD) Dysfunction</b>	\$50 per treatment plan  Lifetime non-surgical maximum of \$1,500 Surgery is under medical	\$100 copay per treatment plan (lifetime non-surgical maximum of \$1,500)	\$100 copayment per treatment plan NOTE: Lifetime non-surgical maximum of \$1,500. Surgical is under medical.	\$50 copay, \$1,500 lifetime maximum for nonsurgical benefits
<b>Home Health Services</b>	No Charge	No copay (prior authorization required)	\$25 copayment per visit Must be prescribed by PCP	\$50 copay per visit
<b>Medical Transportation</b>	No Charge	Ambulance No copay (must have prior authorization except for emergencies)	\$100 copayment	No Charge Non-emergency transportation requires prior authorization.
<b>Transplants</b>	No Charge	No copay (all transplant services, including evaluations must be preauthorized)	Inpatient copayment applies Preapproval and precertification required	\$1,000 per admit
<b>Hospice</b>	No Charge	No copay	No copayment for terminal illness of six months or less Preapproval required	\$50 copay per visit
<b>Preventive Services</b>				
<b>Eye Care</b>		\$10 copay Vision Screening and Refraction (one every 365 days) Contact Members Services for a contracted provider		

<p align="center"><b>HealthChoice High &amp; High Alternative Network</b></p>	<p align="center"><b>HealthChoice High &amp; High Alternative Non-Network</b></p>	<p align="center"><b>HealthChoice Basic &amp; Basic Alternative</b></p>	<p align="center"><b>HealthChoice S-Account Network*</b></p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 visits per calendar year</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required Limit: 100 visits per calendar year</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 visits per calendar year</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. If not an emergency, medically necessary services require certification</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. If not an emergency, medically necessary services require certification</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. If not an emergency, medically necessary services require certification</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required</p>	<p>Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. For life expectancy of six months or less Certification is required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. For life expectancy of six months or less Certification is required</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible. For life expectancy of six months or less Certification is required</p>
<p>Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member \$100 for completing preventive services visit, metabolic and lipid panels, and health risk assessment.</p>	<p>Member pays 50% of Allowed Charges after the individual calendar year deductible, plus amount above Allowed Charges and all ineligible expenses</p>	<p>Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member \$100 for completing preventive services visit, metabolic and lipid panels, and health risk assessment.</p>	<p>Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member \$100 for completing preventive services visit, metabolic and lipid panels, and health risk assessment.</p>

## Health care reform update

In 2011, state employees and their families saw several changes in their health plans, thanks to the Patient Protection and Affordable Care Act passed by Congress and signed by the President. In contrast, 2012 will bring few, if any, noticeable changes.

Once again, HMO plans will cover most preventive services at 100 percent provided the services are done In-network. In 2012, HealthChoice will also cover most preventive services at 100 percent. For you, this means no-cost access to such services as:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings
- Counseling from your health care provider on topics including quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use
- Routine vaccines for diseases such as measles, meningitis or tetanus
- Flu and pneumonia shots
- Counseling, screening and vaccines for healthy pregnancies
- Regular well-baby and well-child visits, from birth to age 21

*(See the Health Plan Comparison section of this guide for details.)*

## CAUTION:

### Make Sure Your Dependents Are Eligible

Are you covering an ineligible dependent? Enrolled ineligible dependents can result in significant and unnecessary costs to the State and its employees. Even the very conservative estimates put the value in the millions of dollars.

## Now is the time to make sure the dependents you claim are eligible for state coverage.

Although no official action has been taken, an audit is being considered. Philip K. Kraft, Executive Director of the Employees Benefits Council of the Office of State Finance, has directed staff to prepare for a comprehensive dependent audit for Plan Year 2013. A dependent eligibility audit is a controlled process designed to preserve the integrity of an employer's benefit plan by identifying enrolled, but ineligible participants. Examples include:

- Ineligible spouses
  - Member forgets to inform employer of a divorce
  - Once a divorce decree is issued, the employee's spouse is no longer an eligible dependent and does not qualify for state benefits. If the court orders the employee to provide the spouse with health (or other) insurance, that coverage cannot be through the State and will need to be obtained from another source.
- Ineligible children
  - Grandchildren, nieces and nephews (unless employee has been granted legal custody)
  - Spouses of married dependents (daughter in-law or son in-law)

While there are financial benefits to a dependent audit, it is by no means a popular move. However, an audit may become necessary as a way to reduce costs in state government, to validate insurance claims and to make sure the State is in compliance with federal laws.

While the "honor system" is still in effect for Plan Year 2012, protect yourself by verifying the eligibility of all the people you are claiming as dependents. If you're unsure whether a dependent is eligible, contact your Benefits Coordinator or the Employees Benefits Council at (405) 232-1190 or 1-800-219-8115.



## Mental Health Parity and Addiction Equity

Federal law, the Mental Health Parity and Addiction Equity Act of 2008, requires health insurance providers to include mental health and substance abuse coverage equal to physical health coverage in terms of the financial and treatment requirements. The law removed differences in co-pays and removed limits on visits and treatment days. Provisions of the law will be in effect in all of the state's available health plans in 2012.

## Benefits Enrollment Calculator

Your benefits costs can be easily estimated using the online Benefits Enrollment Calculator located on the EBC web site at [www.ebc.ok.gov](http://www.ebc.ok.gov). Be sure to choose the monthly calculator if you are paid once a month and the bi-weekly calculator if you are paid every two weeks. The Benefits Enrollment Calculator can add your benefits costs, apply your benefits allowance and provide an estimated total, showing any out-of-pocket expense or additional take-home pay you may realize in your paycheck.

### Important Notes about the Enrollment Calculator:

- Print your benefits calculator results for easy reference during online enrollment.
- Use the calculator as many times as you want, but to actually enroll you must use the Benefits Administration System (BAS) link on the web site or complete your paper enrollment form.
- The online Benefits Calculator provides estimates only. Although every attempt has been made to provide accurate information, the calculator provides no guarantee of compensation, benefits or tax implications.

## Online Enrollment

Hit the "Easy Button" – Enroll Online!

Remember: Online Enrollment opens October 3 and closes October 28, 2011.



Customer assistance is available October 3rd through 27th from 8 a.m. – 4 p.m. and October 28th from 8 a.m. – 8 p.m. Assistance is also available by submitting a help ticket through the help desk of the EBC website at: [www.ebc.ok.gov](http://www.ebc.ok.gov)

Last year, 78 percent of state employees went to [ebc.ok.gov](http://ebc.ok.gov) and used online enrollment to make their benefit elections. Join your co-workers and discover how easy it is to enroll online. The average enrollment takes just a few minutes and you can log on anytime, 24 hours a day, seven days a week during Option Period.

Online Enrollment allows you to:

- Print your confirmation of elections instantly

Option	Carrier	Coverage	Rate
Health	CommunityCare Standard HMO	Employee only	\$772.34
Dental	Assurant Heritage Plus PPO	Employee only	\$13.74
Vision	Assurant	Employee only	\$9.00
Supplemental Life	Assurant	Employee only	\$9.00
Dependent Life	Assurant	Employee only	\$9.00
Invalidity Bracket	Assurant	Employee only	\$9.00
Basic Life	Assurant	Employee only	\$4.88
Disability	Assurant	Employee only	\$9.13
Health Care Account	Assurant	Employee only	\$ 0.00
Supplement Care Account	Assurant	Employee only	\$ 0.00
Mass Trans Account	Assurant	Employee only	\$ 0.00
<b>Total Benefits Cost</b>			<b>\$797.74</b>
<b>Benefits Allowance</b>			<b>\$937.03</b>
<b>Out of Pocket Cost *</b>			<b>\$-139.23</b>

- Update address and telephone information online
  - Change your elections and make corrections as many times as you like, until the close of Option Period (remember, your final election is the official enrollment!)
1. Look for the Welcome Letter distributed by your Benefits Coordinator. Find your User ID and password.
  2. Log on to EBC's secure web site, [www.ebc.ok.gov](http://www.ebc.ok.gov). Sign on to the Benefits Administration System using instructions found in your Welcome Letter.
  3. Change password: Follow instructions to set your personal password.
  4. Choose Online Enrollment and begin.

On the home page of [ebc.ok.gov](http://ebc.ok.gov), the Benefits Administration System (BAS) access window is in the top right corner of the screen. Inside BAS, updated videos featuring step-by-step online enrollment instructions are available. Online enrollment is not currently available for newly hired employees outside of Option Period.

## Eligibility Reminder:

If you experience a qualifying life event during the year; for example, marriage, divorce, birth or adoption, you may be allowed to make certain changes to your insurance elections without waiting for Option Period. You must complete a change form within 30 days of the life event (see page 39 for a full list), or wait until the next Option Period to make any changes.

Remember, it is a 30-day deadline!

Help is available by phone at the Employees Benefits Council: (405) 232-1190 or 1-800-219-8115.

## Invisible Bracelet



Like a virtual medical ID bracelet, the Invisible Bracelet may help save your life during emergencies. The early medical alert involves an eight-digit code that appears on a keychain fob and/or a sticker to be placed on the back of your driver's license. The fob can also be attached to a child's backpack.

If you are unconscious or otherwise unable to be understood, emergency medical service providers can enter your code on a secure, HIPAA-compliant web site and get valuable information in seconds, including your identity, medications, allergies, chronic conditions, insurance and emergency contacts.



First responders in many communities around Oklahoma, such as EMSA, are already trained to look for the fob or sticker. The information they'll find is entered by you, so it's important to keep the information current. Invisible Bracelet offers "Auto Reminders" to help you keep your health information and emergency contacts up to date.

Employees, spouses and other eligible dependents can take advantage of this benefit. The cost is only \$3 per person, per year. So, for example, if an employee, spouse and two children all get Invisible Bracelets, the cost will be \$12. The membership fee(s) will be deducted during the employee's first pay period of 2012. The Invisible Bracelet benefit is a pre-tax deduction for employees who choose premium conversion.

To learn more about this innovative "Made in Oklahoma" service or to see if the service is available in your area, visit [www.invisiblebracelet.org](http://www.invisiblebracelet.org).



## Flexible Spending Accounts (FSAs)

Want to Save More On Your Taxes?

FSAs are money-saving ways to pay for qualified health, day care and mass transit expenses because the accounts are funded with pre-tax dollars. Here's how the average person, contributing just \$100 per month, can increase their take-home pay by using an FSA:

	Without FSA	With FSA
Annual Salary	\$35,000	\$35,000
FSA Deposit (annual)	0	1,200
Taxable Income	35,000	33,800
Estimated Taxes (30%)	- 10,500	-10,140
Health Care Expenses	- 1,200	0
Take Home Pay	23,300	23,660
<b>Annual Increase in Take Home Pay</b>		<b>\$360</b>

FSAs can no longer be used to pay for some over-the-counter drugs and health products without a prescription. Check out the list of eligible items provided at [ebc.ok.gov](http://ebc.ok.gov) in the "Flexible Spending" section.

## Experience the Convenience of the Free FSA Debit Card!

It's fast, flexible and free! The optional Flexible Spending Account (FSA) debit card can be used at hundreds of merchants.

Simply present the FSA debit card to pay for medical and dependent care expenses. The money is taken directly from your FSA account, resulting in fewer paper claims to file.

When using the FSA debit card, some charges may require proof after purchase. Save your receipts!

Please Note the Following:

- FSAs have a "Use it or Lose it" rule. Simply stated, if you have money left in your account after March 15th of the following year, that money will be forfeited. But don't let that scare you. With a little planning, you can take advantage of this tax-reducing benefit without losing any money.
- Debit cards are not currently available for use in the Mass Transportation Accounts. FSA debit cards are available only in conjunction with the health and dependent care accounts.
- You cannot enroll in a Flexible Spending Health Care Account if you choose the HealthChoice S-Account Plan.

Type	Item	Yearly Cost
	Health Plan Annual Deductible	\$0.00
	Dr/Copay	
	Co-payments	\$75.00
	Hospital/ER	\$0.00
	Outpatient Surgeries	\$250.00
	Drugs	
	Prescription drugs	\$240.00
	Flu shots/immunizations	\$20.00

## Add Up Your Savings with our FSA Savings Calculator

- How much in taxes will I save?
- How much should I contribute annually?
- What expenses should I consider when calculating my contribution?

To see how you might benefit from enrolling in an FSA, log on to [www.ebc.ok.gov](http://www.ebc.ok.gov) and use the FSA savings calculator. It can help you estimate your qualifying annual expenses and calculate how much you can save in taxes by paying for your health care and dependent care expenses on a pre-tax basis.

## Health Care Account (HCA)



By signing up for a Health Care Account, you can set aside up to \$5,000 for you and your family's health care related expenses. Realize significant tax savings on qualified, un-reimbursed expenses by paying for the services and items pre-tax. Enroll for an HCA online or with your paper enrollment, indicating the pay period contribution you want deducted from your paycheck. Some qualifying expenses include:

- Doctors visits, deductibles and copays
- Prescription drugs
- Vision care, laser eye surgery, eyeglasses or lenses
- Dental care, orthodontic expenses
- Physical therapy

As many FSA users are already aware, restrictions on pre-tax purchases of some over-the-counter (OTC) medications like Tylenol and Claritin took effect in 2011 and will continue to be in place for 2012. In accordance with a provision of the health care reform law, OTC drugs, medicines and biologicals can be purchased with Health Care FSA funds, but only with a letter of medical necessity from a medical provider. Also, the items can no longer be purchased with the "Benny" debit card. However, products like bandages and contact lens solution will still be allowed as Benny card purchases.

Check out the list provided at [ebc.ok.gov](http://ebc.ok.gov) in the "Flexible Spending" section.

**HCA Monthly Minimum: \$10**

**HCA Monthly Maximum: \$416.66**

- You may be restricted from enrollment in the HealthChoice S-Account if you have funds remaining in your FSA Health Care Account on January 1, 2012.
- In limited circumstances, you may be eligible to roll over certain remaining amounts from your FSA Health Care Account to your newly established HSA account.
- You can continue to participate in the FSA Dependent Care Account or the New Mass Transportation Account if you elect the HealthChoice S-Account Plan.

## Grace Period Extension

The IRS allows a grace period for incurring approved expenses from your FSA. You have until March 15th of the following year to use funds from your current year's account.

So go to the doctor, buy a prescription or incur any approved expenses such as bandages, diabetes testing supplies, and contact lens solution until March 15th, 2013 and still file for reimbursement from your remaining 2012 FSA account fund. Check out the full list of eligible products in the Flexible Spending section of [www.ebc.ok.gov](http://www.ebc.ok.gov).

When calculating your FSA contribution for Plan Year 2012, it is important to plan conservatively. Calculate based on your Plan Year estimated expenses. Do not include the extended grace period in your calculations. This extension may help you reduce the risk of losing unused funds in your FSA accounts.



## Dependent Care Account (DCA)

Daycare expenses can add up quickly. By contributing to a Dependent Care Account, you can pay for child or adult daycare with pre-tax dollars resulting in substantial tax savings. Monthly contributions are deducted from your paycheck before your taxes are calculated. Enroll for the DCA online or by paper, but be sure to indicate your pay period contribution.

**DCA Monthly Minimum: \$50**

**DCA Monthly Maximum: \$416.66**

## Mass Transportation Accounts (MTA)

By enrolling in this option, employees can have pre-tax deductions directed to this account for employees to utilize mass transit and be able to be reimbursed for bus tokens with pre-tax funds for their commute to and from state employment. This account is designed for Employees' use only. You may be reimbursed only for the employee's use of Mass Transit. No reimbursement for dependents is permissible. To utilize the account, you simply enroll any time during the plan year (this account does not require a family status event). You will then purchase a monthly mass transit pass from your area provider and submit a copy of the pass along with a claim form to EBC. You will be reimbursed once funds are in your Mass Transit Account. The maximum amount you can contribute is \$115 a month (\$1,380 annually). You are allowed to change your monthly election during the plan year between a minimum of \$10 to the maximum of \$115. You may also discontinue the account during the year if your needs change. See your Benefits Coordinator for additional information or contact EBC.

**MTA Monthly Minimum: \$10**

**MTA Monthly Maximum: \$115**

- See additional important rules and regulations for Mass Transit accounts on page 38 of this Guide.

## Important Notes on FSA Accounts:

- You must re-enroll every year.
- Indicate your per-pay-period contribution on your enrollment (not your annual contribution).
- View account balances and claim information on line by logging onto the Benefits Administration System (BAS) via the EBC website at [www.ebc.ok.gov](http://www.ebc.ok.gov). After logging in using your employee ID and password, select Flexible Spending from the left menu.
- See additional important rules and regulations for FSAs on page 37 of this Guide.

## HealthChoice S-Account Plan

The S-Account Plan is a qualified high deductible health plan to be used exclusively with a Health Savings Account (HSA).<sup>1</sup>

- For information on participating in this account on a pre-tax basis, contact EBC at (405) 232-1190, ext. 110.
- **Please note the following:**
- **You cannot enroll in a Health Care flexible spending account (FSA) if you choose the HealthChoice S-Account Plan. You may, however, elect either the Dependent care account and/or the Mass Transportation account if you have a HSA.**
- **You may be restricted from enrollment in the HealthChoice S-Account if you have funds remaining in your Health Care flexible spending account on January 1, 2012.**
- **In limited circumstances, you may be eligible to roll over certain remaining amounts from your Health Care flexible spending account to your newly established HSA account.<sup>2</sup>**

The \$1,500 individual/\$3,000 family deductible for the HealthChoice S-Account Plan must be met before any health or pharmacy benefits are paid by the plan. There are certain exceptions for preventive care. Refer to the Health Plan Comparison Section for details.

<sup>1</sup> Although OSEEGIB and the Health Savings Account (HSA) trustee/custodian together provide health insurance benefits, each are independent entities with separate responsibilities. OSEEGIB expressly disclaims any fiduciary obligation to manage the member's HSA funds or accounts. HSA account information concerning contributions, IRS determinations, withdrawals, or any matters regarding the HSA is the sole responsibility of the HSA trustee/custodian chosen by the member.

<sup>2</sup> Confer with your tax professional for possible eligibility questions and tax consequences of enrollment in a high deductible health plan and health savings account.

**For further information, contact OSEEGIB at 405-717-8780 or toll-free 1-800-752-9475**



## Employee Life Insurance

All eligible current state employees are covered by the HealthChoice Life Insurance Plan which provides a \$20,000 basic term life insurance policy called Basic Life. An additional term life policy, called Supplemental Life, is available in \$20,000 units for employees who need more coverage.

### Basic Life Coverage

As a state employee, you are automatically enrolled in Basic Life. This also includes Accidental Death and Dismemberment (AD&D) coverage.

### Supplemental Life Coverage

You can elect to increase your life insurance coverage in \$20,000 units up to a maximum of \$500,000. To increase your coverage, a Life Insurance Application must be submitted and approved. Your application must be approved before coverage can take effect. The postmark deadline for submitting the Life Insurance Application is Tuesday, November 15, 2011.

### AD&D Coverage

Basic Life (\$20,000) and the first unit (\$20,000) of Supplemental Life include Accidental Death and Dismemberment coverage. AD&D coverage pays additional benefits for the loss of life, loss of limb or limbs, or the loss of sight. See the HealthChoice Life Insurance Handbook for more information. The handbook is available online at [www.healthchoiceok.com](http://www.healthchoiceok.com) or [www.sib.ok.gov](http://www.sib.ok.gov).

### Guaranteed Issue (New employees only)

You may enroll in life insurance coverage in an amount up to two times your base annual salary without completing a Life Insurance Application. See your Benefits Coordinator for details.

### How to Increase Your Life Insurance Coverage

To increase your life insurance coverage, please complete a Life Insurance Application and obtain your Coordinator's signature, if required. Mail directly to the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), a division of the Office of State Finance. The address is located on the back of the form.

For a complete description of life insurance coverage, eligibility and benefits, please refer to the HealthChoice Life Insurance Handbook. The handbook is available online at [www.healthchoiceok.com](http://www.healthchoiceok.com) or [www.sib.ok.gov](http://www.sib.ok.gov).

## Dependent Life Insurance

You have three options to choose from when purchasing dependent life insurance coverage:

### Dependent Life Premier Option

- \$20,000 term life policy for spouse
- \$10,000 term life policy for each child
- \$1,000 term life policy for newborns to 6 months

### Dependent Life Standard Option

- \$10,000 term life policy for spouse
- \$5,000 term life policy for each child
- \$1,000 term life policy for newborns to 6 months

### Dependent Life Low Option

- \$6,000 term life policy for spouse
- \$3,000 term life policy for each child
- \$1,000 term life policy for newborns to 6 months

To enroll, complete the back of your enrollment form or select this option during your online enrollment.

	Monthly Premium
<b>Basic Life (\$20,000)</b>	
Includes AD&D . . . . .	<b>\$4.00</b>
<b>First \$20,000 Supplemental Life</b>	
Includes AD&D . . . . .	<b>\$4.00</b>
<b>Additional Units of Supplemental Life</b>	
<b>Age-Rated (Per \$20,000)</b>	
<b>Under 30 years</b> . . . . .	<b>\$0.60</b>
<b>30-34 years</b> . . . . .	<b>\$0.60</b>
<b>35-39 years</b> . . . . .	<b>\$0.80</b>
<b>40-44 years</b> . . . . .	<b>\$1.20</b>
<b>45-49 years</b> . . . . .	<b>\$2.00</b>
<b>50-54 years</b> . . . . .	<b>\$3.40</b>
<b>55-59 years</b> . . . . .	<b>\$5.40</b>
<b>60-64 years</b> . . . . .	<b>\$6.20</b>
<b>65-69 years</b> . . . . .	<b>\$10.20</b>
<b>70-74 years</b> . . . . .	<b>\$17.40</b>
<b>75+ years</b> . . . . .	<b>\$27.00</b>
<b>Dependent Life</b>	
<b>Low Option</b> . . . . .	<b>\$2.60</b>
<b>Standard Option</b> . . . . .	<b>\$4.32</b>
<b>Premier Option</b> . . . . .	<b>\$8.64</b>
<b>Disability</b> . . . . .	<b>\$9.10</b>



**2012 Dental Plans**  
See the Dental Monthly Rates on page 5.

	Assurant Freedom Preferred <i>www.assurantemployeebenefits.com</i>		Assurant Heritage <i>www.assurantemployeebenefits.com</i>	
	In-Network	Out-of-Network	SECURE Prepaid Plan <i>(Requires choosing a primary care dentist)</i>	PLUS Prepaid Plan <i>(Requires choosing a primary care dentist)</i>
<b>Deductibles</b>	\$25 per person (Waived for Class A Services)	\$25 per person	None	None
<b>Preventive Care (Class A)</b> Includes routine cleanings, check-ups, X-rays and topical fluoride treatments	100% of allowable amounts <b>Includes routine cleanings, check-ups and some X-rays for adults and children, and fluoride treatments</b>	100% of allowable amounts <b>Includes routine cleanings, check-ups and some X-rays for adults and children, and fluoride treatments</b>	Example Services Copays Sealant per tooth: \$22 copay Routine Cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	Example Services/Copays Sealant per tooth: \$15 copay Routine Cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge
<b>Basic Care (Class B)</b> Includes fillings, extractions, periodontal care, root canal, and oral surgery	85% of allowable amounts after deductible. <b>Includes fillings, some X-rays, extractions, periodontal care, and some root canal oral surgery</b>	70% of allowable amounts after deductible. <b>Includes fillings, some X-rays, extractions, periodontal care, and some root canal oral surgery</b>	Example Services/Copays Amalgam - one surface, permanent teeth \$32	Example Services/Copays Amalgam - one surface, permanent teeth \$25
<b>Major Care (Class C)</b> Includes crowns, bridges and dentures	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Example Services/Copays Root Canal, Anterior \$175 Periodontal/Scaling/Root Planing 1-3 teeth (per quadrant) \$54 Endodontist: 15 percent discount	Example Services/Copays Root Canal, Anterior \$165 Periodontal/Scaling/Root Planing 1-3 teeth (per quadrant) \$36 Speciality rider pays specialist at set copays.
<b>Orthodontic Care (Class D)</b>	No deductible, plan pays 60% up to lifetime maximum of \$2,000	No deductible, plan pays 50% up to lifetime maximum of \$2,000	25% discount for Adults and Children	25% discount for Adults and Children
<b>Annual Maximum Benefit</b>	\$2,000 per person per calendar year	\$2,000 per person per calendar year	No plan year dollar maximum	No plan year dollar maximum

<b>CIGNA Dental</b> <i>www.cigna.com</i>	<b>Delta Dental</b> <i>www.DeltaDentalOK.org</i>	<b>Delta Dental</b> <i>www.DeltaDentalOK.org</i>	<b>Delta Dental</b> <i>www.DeltaDentalOK.org</i>	<b>HealthChoice Dental</b> <i>www.healthchoiceok.com</i>	
<b>Prepaid Plan</b> <i>(Requires choosing a primary care dentist)</i>	<b>PPO In-Network and Out-of-Network</b>	<b>Premier In-Network and Out-of-Network</b>	<b>PPO - Choice Delta Dental PPO Network</b>	<b>Network Provider</b>	<b>Non Network Provider</b>
None \$5 office copay applies	\$25 per person per calendar year-Classes B & C only	\$50 per person per calendar year-Classes A, B and C only	\$100 deductible per person on Major Services only (level 4)	\$25 per person Basic Care and Major Care combined;	\$25 per person Preventive, Basic, and Major Care combined
Example Services Copays Sealant per tooth: \$15 copay Routine cleaning (once every 6 months): no charge Topical Fluoride Application (up to age 18): no charge Periodic Oral Evaluations: no charge	100% of allowable amounts No deductible applies	100% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/ Copays Routine Cleaning: \$5 copay Periodic oral evaluations:\$5 copay Topical fluoride application (up to age 19): \$5 copay	100% of allowed charges	100% of allowed charges after the deductible
Example Services/Copays Amalgam - one surface, permanent teeth \$21	85% allowable amounts after deductible	70% allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/ Copays Amalgam one surface, primary or permanent tooth \$12 copay	85% of allowed charges after deductible	70% of allowed charges after deductible
Example Services/Copays Root Canal, Anterior \$355 copay Periodontal Scaling/ Root planning 1-3 teeth (per quadrant) \$71 copay	60% allowable amounts after deductible	50% allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/ Copays Crown-porcelain/ceramic substrate: \$241 copay Complete denture-maxillary \$320 copay	60% of allowed charges after deductible	50% of allowed charges after deductible
\$2,280 out-of-pocket child; \$3,120 out-of-pocket adult (24 month treatment); excludes orthodontic treatment plan and banding.	60% of allowable amounts up to \$2,000 lifetime maximum	60% of allowable amounts up to \$2,000 lifetime maximum	You pay charges in excess of \$50 per month. Lifetime maximum up to \$1,800	50% of allowed charges 12-month waiting period may apply* No deductible or lifetime maximum for Network or Non-Network	50% of allowed charges 12-month waiting period may apply* No deductible or lifetime maximum for Network or Non-Network
No plan year dollar maximum	\$2,500 per person per calendar year	\$3,000 per person per calendar year	\$2,000 per person per calendar year	\$2,000 per person per calendar year Preventive, Basic, and Major Care combined	\$2,000 per person per calendar year Preventive, Basic, and Major Care combined

## IMPORTANT DETAILS

### ABOUT DENTAL COVERAGE:

- Pay special attention to the plan's participating dentists. Call to confirm your dentist accepts your selected plan. Be specific in your questions. For example, ask if the dentist participates as a Delta Dental PPO network provider, not just if they accept Delta Dental.
- If you choose a dentist out-of-network, you will receive lower benefits and may be subject to additional costs.
- Dental prescriptions are covered under health plan benefits.

## Disability Insurance

No one expects to become disabled, but the financial burden can be eased by your coverage under the HealthChoice Disability Plan. Disability coverage pays an amount equal to 60 percent of your base salary up to a maximum dollar limit based on your age, salary, and years of service from the onset of your disability.



### Eligibility

Disability benefits are available to all employees who have completed at least one month of continuous employment. No benefits are payable for any disability caused by a pre-existing condition.\* Claims must be filed within one year of the date you first became disabled.

### Definition of Disability

Disability is defined as the inability to perform the major duties of your job. After two years of disability, it is defined as the inability to perform the duties of any job for which you are or may become reasonably qualified by training, education or experience.\*

### What the Plan Pays

The disability plan will pay a monthly income equal to 60 percent of your base pay up to a maximum (minus offsets).

### Monthly Maximum Disability Income

- **Short-Term: \$2,500**
- **Long-Term: \$3,000**

Benefits paid will be offset by any other income you may receive such as Social Security Disability, Workers' Compensation, Leave, or Disability Retirement.

### When the Plan Pays

Payments begin after you have been disabled for 30 days. Short-term disability pays a benefit for the first 150 days. Generally, long-term disability pays a benefit after 180 days of disability and continues to age 65 or recovery, whichever is first, based on age, salary, and years of service at the onset of your disability. Other limitations may apply.

\*For a complete description of the disability plan's eligibility and benefits, please refer to the HealthChoice Disability Insurance Handbook. The handbook is available online at [www.healthchoiceok.com](http://www.healthchoiceok.com) or [www.sib.ok.gov](http://www.sib.ok.gov).

## Employee Assistance Program (EAP)

The EAP is a cooperative effort between employees and administration, offering employees and their families an opportunity to seek and receive free assistance in resolving personal issues. Some of these issues include family, financial, emotional, alcohol/drug abuse, addiction, trauma, and work relationships, which adversely affect safe and efficient performance on the

job. The EAP is available to help employees deal with personal issues before they result in deterioration of health, family life, or job performance. EAP specialists provide confidential assistance, information and referrals for employees/family members in using their behavioral health benefit and/or finding a community resource. EAP specialists also consult with supervisors/managers on how employees can be referred for assistance. For more information, contact your agency's Human Resource Office, review Merit Rule 530:10-21-1 through 9, or go to EBC's web site, [ebc.ok.gov](http://ebc.ok.gov), click on OKHealth, then Wellness, then Programs.

## SoonerSave

### SoonerSave – Prepare for Retirement Wisely



SoonerSave is a voluntary long-term retirement savings plan available to State employees only. It is a division of the Oklahoma Public Employees Retirement System (OPERS) and is designed to supplement the benefit you receive from your State retirement system. SoonerSave is comprised of two defined contribution plans: The Deferred Compensation 457 Plan and the Deferred Savings Incentive 401(a) Plan. When you contribute money to SoonerSave, your contribution is deposited in the Deferred Compensation 457 Plan. As an incentive to contribute to SoonerSave, the State will contribute \$25 per month to the Deferred Savings Incentive 401(a) Plan.

SoonerSave is an excellent way to defer federal and state taxes from your current income while saving for the future. In both plans, contributions and any earnings grow tax-deferred until money is withdrawn, usually during retirement when the participant is typically receiving less income and may be in a lower tax bracket than while working.

A few reasons to join SoonerSave today include:

- **Easy Enrollment and Savings**—You can now enroll in SoonerSave using the same Online Enrollment process that you use to make your other benefit elections. Just decide how much you want to contribute and how you want it invested—then you are on your way to investing for your retirement through convenient payroll deduction.

You may also enroll in SoonerSave by going directly to <http://www.dcpvider.com/oklahoma/> and entering your social security number and password (savenow).

- **Tax Savings**—Your contributions are deducted from your paycheck before federal and state income taxes are calculated—lowering your taxable income. Plus, your contributions and any earnings grow on a tax-deferred basis.

## SoonerSave *continued*

- **Money from the State of Oklahoma**—You will receive a \$25 state contribution each month just for participating in SoonerSave.
- **Tax Credit**—Some SoonerSave participants may be eligible for a tax credit to help save for tomorrow by reducing taxes today. The amount of credit depends on your adjusted gross income and filing status (e.g., single, married, head of household). To learn more about the tax credit, you should consult your tax advisor or visit [www.irs.gov](http://www.irs.gov) and search for “Saver’s Credit” or Form 8880.

Are you already participating in SoonerSave? Great! You’ve taken the first step to preparing yourself for retirement. Now, you may want to take the next step and increase your contribution amount using the Online Enrollment process. Increasing your contributions to SoonerSave by even a small amount could make a big difference in your long-term retirement savings plan. The table below illustrates the impact an increased contribution could have on your account balance and the benefit you receive from your account when you retire.



Employee Contribution Amount	Employer Contribution Amount	Total Contribution Amount	SoonerSave Balance After 20 Years*	Monthly Benefit for 20 Years (Before Tax Withholding)*
\$50/month	\$25/month	\$75/month	\$44,177	\$279.48
\$100/month	\$25/month	\$125/month	\$73,628	\$465.81
\$150/month	\$25/month	\$175/month	\$103,079	\$652.13
\$200/month	\$25/month	\$225/month	\$132,530	\$838.45

**\* FOR ILLUSTRATIVE PURPOSES ONLY.** This hypothetical illustration does not represent the performance of any investment options. The accumulation stage assumes an 8% rate of return, reinvestment of earnings and no withdrawals. The payout stage assumes 12 monthly payments per year with a 4.5% rate of return. Withdrawals of tax-deferred accumulations are subject to ordinary income tax. This illustration does not reflect any charges, expenses or fees that may be associated with your Plan. The tax-deferred accumulations shown above would be reduced if these fees had been deducted. In order to properly plan for your retirement years, OPERS strongly encourages you to consider participating in SoonerSave (if you are eligible) as a way to supplement the income you will receive from your defined benefit plan and Social Security. For more information about SoonerSave or to update your beneficiary information, call 1-800-733-9008 or (405) 858-6781. You can also obtain information, change your contribution amount or find enrollment forms by visiting [www.soonersave.com](http://www.soonersave.com). SoonerSave is a division of the Oklahoma Public Employees Retirement System.

## Benefits Details

### General

Enrollment in a medical or dental plan does not guarantee that a particular doctor, dentist, clinic, or hospital will remain in your plan's network for the entire year. **You enroll with the PLAN and not the provider. If your provider terminates his or her contract during the Plan Year, this does not allow you to change medical or dental plan carriers.** These benefits are effective January 1, 2012. Keep this book as a reference throughout the year. This booklet is only intended to be a brief summary of certain provisions of the State of Oklahoma Employee benefit plans. In the event of a conflict between the booklet and the laws of the State of Oklahoma or administrative rules of the Employees Benefits Council (Council) and the Oklahoma State & Education Employees Group Insurance Board (Insurance Board), the laws and administrative rules shall govern in all cases.

### Dental

Out-of-network benefits may allow dentist to balance bill.

Balance Billing – the practice of a provider charging full fees and billing the member for the portion of the bill insurance doesn't cover.

Orthodontic benefits on the PPO options are typically only available for dependents under the age of 19 or anyone with TMD. Contact the plan to determine limits on Orthodontic benefits prior to enrollment.

If new hires and/or new enrollees did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental; and Assurant Freedom PPO a 12-month waiting period is applied for orthodontic services.

\*No waiting period applies for orthodontic benefits under the Delta Dental plans.

See each dental plan's website for a list of the dentists participating in each plan's network.

Delta Dental and Assurant Freedom Preferred both have statewide and nationwide networks and will have the same benefits if treatment is provided out of state.

\*\*There is no applicable copayment schedule for Assurant Plan Specialist services. Assurant Plan Specialists reduce their charges as follows: a 15 percent discount off normal retail charges for Endodontist and a 25 percent discount for any other Plan Specialist including Orthodontist.

### HealthChoice Dental Notes:

You are responsible for non-Network amounts that exceed the Allowed Charges and for all non-covered services. Age limits and restrictions may apply, please consult each plan.

Orthodontic benefits are only available to dependents under the age of 19 with certification required for members greater than 19 years of age. Contact the plan to determine limits on orthodontic benefits prior to enrollment.

\*If you are a new hire and/or a new enrollee and you did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental; a 12-month waiting period will be applied to orthodontic services.

See each dental plan's website for a list of the dentists participating in each plan's network.

### Consumer Information & Annual Notices

The Council and the Insurance Board comply with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 known as HIPAA. The Council, the Insurance Board and each HMO, dental, and vision plan offered to State employees has a Privacy

Notice which describes the organization protections and acceptable uses of information. To obtain a Privacy Notice from a particular plan, contact the plan directly or contact the Council. HIPAA also provides you and your dependents certain rights to enroll if you lose your group health plan coverage. HIPAA also prohibits a group health plan from keeping you (or your dependents) out of the plan based on anything related to your health. Finally, HIPAA also gives you the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without pre-existing condition exclusions. The HealthChoice medical products offered by the Insurance Board are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on pre-existing conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity, and reconstructive mastectomies. See the section on General Eligibility Information for more details. The WOMEN'S HEALTH & CANCER RIGHTS ACT of 1998, a Federal Law, provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling 1-866-444-3272. The BREAST CANCER PATIENT PROTECTION ACT, an Oklahoma State Law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection. The NEWBORNS & MOTHERS ACT of 1996, a Federal Law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery. The PROSTATE CANCER PROTECTION ACT, an Oklahoma State Law, provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery Side Effects Law provides that all health benefit plans offered by OSEEGIB & EBC shall provide coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including, but not limited to impotence and incontinence, and for other prostate related conditions. THE MANDATED BENEFIT FOR OB/GYN COVERAGE LAW requires any health benefit plan offered in the state of Oklahoma which provides medical and surgical benefits to also provide coverage for routine annual obstetrical/gynecological examinations. The law does not diminish already allowed health benefit diagnostics. In addition the law also specifies that obstetrical/gynecological examinations do not have to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist. If you have a problem which cannot be resolved through your benefit plan's grievance process, you may have remedies with the Oklahoma State Department of Health, Oklahoma Department of Insurance, or a remedy of law. Once you become covered under a group health plan, you have certain rights under the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you can contact the Council or the Insurance Board. You may also have rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. The law also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. See your agency for more information.

## General Eligibility Information

The following are rules of eligibility that apply to commonly occurring situations. The rules are listed in no particular order. This is not an exhaustive list. Any active state of Oklahoma employee scheduled to work at least 1,000 hours per year is eligible for benefits coverage if he/she is not a temporary or seasonal employee. New Hire coverage is effective on the first day of the month following the entry-on-duty date. Coverage ends on the last day of the termination month. All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided. Eligible dependents can include a spouse, children up to the age of 26 and incapacitated or totally disabled children of any age if their incapacity occurred and was verified prior to age 26. Two State employees cannot claim coverage for the same dependents for health, dental, and vision benefits. The Working Families Tax Relief Act of 2004 changed the definition of dependent for federal income tax purposes, effective January 1, 2005. The IRS indicates that the change is not intended to affect the coverage of dependents under employer sponsored medical plans. However if you cover dependents, EBC suggests you obtain professional tax advice when completing your income tax return(s). Thirty-day written notice is required to reinstate coverage.

## Electing a TRICARE Supplement Plan

Electing to purchase a TRICARE supplement plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare.

## Changes to Benefit Plan Elections

Benefit elections made during the Option Period are generally irrevocable. Changes can be made to Option Period elections only if the change is authorized and consistent with Internal Revenue Service regulations. If you experience an event which you believe qualifies you to change your benefit elections, contact your Benefits Coordinator **within 30 days of the event**. Life events that qualify you to change your benefit elections include: marriage, birth, adoption or placement of an adopted child, loss of other coverage, change in marital status, change in the number of dependents, change in employment status of employee, spouse or dependent that affects eligibility, event causing employee's dependent to satisfy or cease to satisfy eligibility requirements, change in place of residence of employee, spouse or dependent (HMO coverage), commencement of or termination of adoption proceedings, judgments, decrees or orders, Medicare or Medicaid, significant cost increases (limited to Dependent Care Account using unrelated care provider), changes in coverage of spouse or dependent under other Employer's plan (except HCA), FMLA Leave, or other such events, which may permit such modification of election under the IRS consistency rule as found in Treasury Regulations 1.125-4 and in accordance with other applicable and prevailing Internal Revenue Code regulations promulgated under, and in accordance with EBC and OSEEGIB rules and regulations.

## Flexible Spending Accounts Information

These accounts let you set aside money from your paycheck, pre-tax, to pay for planned dependent care charges and expected out-of-pocket healthcare expenses. You must enroll each Option Period or you lose the account. Plan carefully when deciding your contributions. Direct deposit of your reimbursements into the same account as your payroll deposit is required by state law. If you terminate employment with the state, any daycare or medical services must be incurred prior to the last day of your termination month. If you are not on active payroll (on some type of leave) it is your responsibility to mail in your pledged contribution. Viewing your account information is easy using the EBC website. For further information on allowable expenses see EBC's website at [www.ebc.ok.gov](http://www.ebc.ok.gov). Reimbursement can also be made for expenses incurred

by any participant during the Grace Period. The "Grace Period" is the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period. The "Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year. You cannot pay for prior year expenses from current year account funds. All expenses use the date of service, not the date they are paid for eligibility purposes.

## Debit Cards

The Council will reimburse an FSA participant for eligible expenses incurred through use of the participant's debit card provided the participant properly activates the debit card, properly substantiates the claim for expenses, and abides by the terms of use of the debit card. The Council reserves the right to set the fee charged to participants for use of the card, waive the annual fee, discontinue use of the debit card, or require paper substantiation of expenses. The rules of eligibility for Dependent Care Accounts and Health Care Accounts apply to participants using the debit card. Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator. Amounts remaining in a participant's healthcare and/or dependent care accounts following final payment of all healthcare and/or dependent care expenses incurred during the periods described in OAC 87:10-25-9(b) shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

## FSA Health Care (Medical) Account Information

You spend your own money for after-insurance, qualified medical expenses, deductibles, copays and certain over-the-counter items. These expenses may be eligible for reimbursement according to the IRS Code, enabling you to submit a claim voucher with the appropriate documentation and receive reimbursement from your own tax-free account. Attach the itemized bill and/or the Insurance Explanation of Benefits (HealthChoice State Plan or Dental Indemnity Plan EOB) to your signed EBC Expense Reimbursement Voucher (claim form) and mail to the address on the form. Funds will be disbursed for the amount requested within ten days of receipt if you submit all required documentation. Check out the list of approved over-the-counter items on the EBC website. Documentation required for approved OTC items is the computerized receipt, name of item, date of purchase, and amount paid. Pharmacy labels need to include the printed name of the drug. The date of service is the date you incur the expense (i.e. date you drop off the prescription at the pharmacy, date you receive the medical care). This date must be during the plan year and while actively participating in the program (making monthly contributions). Claim deadlines are Fridays, at 1:00 p.m. (Subject to change during holidays).

## FSA Dependent Care Account Information

If you have an eligible dependent (children 12 or younger who have been included on your income tax return or any other eligible dependent person physically or mentally incapable of self-care) who spends at least eight hours a day in your home, you may want to participate in the Dependent Care Flexible Spending Account. This account pays daycare provider expenses while you and your spouse work up to a combined calendar year total of \$5,000. The daycare provider cannot also be your tax dependent.

The individual calendar year limit is \$2,500. Form 2441 must still be filed with your taxes. You can receive reimbursement for the amount you have currently deposited in your Dependent Care Account. With proof of payment and the dates of service your daycare provider is

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no longer required to sign the Dependent Care acknowledgement form.

### **Mass Transportation Accounts**

Since January 1, 2009 the EBC has been offering employees an option to elect to have funds taken from payroll on a pre-tax basis and placed into an account to reimburse employees for qualified Mass Transit expenses incurred on behalf of the employee. The employee makes an election to participate (on line or paper enrollment) and the employee selects a monthly amount to take pretax from payroll (or biweekly). The employee purchases a monthly Mass Transit pass that the employee will use to commute to and from State employment. The employee will fill out a mass transit reimbursement voucher and send the voucher along with a copy of their monthly transit pass to the plan administrator. The administrator will verify the voucher and supporting documents and process a reimbursement to the employee. An employee may begin the option anytime during a plan year, increase the option up to a maximum of \$115 a month or decrease the option amount to a minimum of \$10 per month. An employee may also drop the option during a plan year. Any amounts remaining after the option has been dropped will be forfeited. If the option is continued into future plan years without being dropped, any unused amounts will be rolled over pursuant to limits under *IRC §132(f)*. *An employee will be allowed to add the option only once during a plan year. Once the option is dropped, re-enrollment during the same plan year will not be allowed. Reimbursements will be allowed for monthly passes only; daily or weekly passes will not be reimbursed. Reimbursement will be made only on behalf of the employee, reimbursements for mass transit expenses of spousal or dependents are not allowed.*

### **Termination of Employment**

If your employment terminates, you have certain rights under federal law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to receive a Certificate of Creditable Prior Coverage from the State that you can present to a future employer. This certificate can verify up to 18 months of your prior insurance coverage in order to allow a reduction in your new employer's pre-existing condition limitation. If your employment terminates, contact your Benefits Coordinator or EBC immediately to determine your rights under HIPAA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you to continue insurance coverage after your employment terminates in most situations. Certain time limits apply to be eligible to continue coverage and an additional fee is added to your insurance premiums. Contact your Benefits Coordinator or OSEEGIB immediately upon termination of your employment to determine your COBRA rights. The Insurance Board administers the COBRA program for state employees.

### **Change of Address**

The Employees Benefits Council must be notified immediately of any change of address for the employee and/or dependents. In the event of the change of address, contact your agency's Benefits Coordinator or make your address change online in EBC's Benefits Administration System (BAS) under the Basic Information screen.

### **Prescription Drug Plan Creditable Coverage Statement**

The Employees Benefits Council has determined that the prescription drug coverage with the State of Oklahoma Employees Benefits Council Health Plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because your coverage through your health plan offered through the Council is on average at least as good as standard Medicare prescription drug coverage, you can keep your coverage and not pay extra if you later decide to enroll in Medicare coverage. If you decide to enroll in a Medicare prescription drug plan and drop your State of Oklahoma Employees Benefits Council prescription drug coverage, be aware that you may not be able to get this coverage back. A notice of creditable coverage is provided in the back pocket of this Guide and can also be obtained by contacting the Employees Benefits Council at (405) 232-1190 or downloading a copy from the EBC website at [www.ebc.state.ok.us](http://www.ebc.state.ok.us)

### **Automatic Premium Conversion Election:**

An "automatic" enrollment into Premium Conversion has been instituted by the Employees Benefits Council effective January 1, 2007. The employee is automatically enrolled in the cafeteria (pre-tax premium) program unless he or she explicitly elects not to enroll. The employee can decline coverage under premium conversion resulting in not having his or her salary reduced. During new hire enrollment, an employee can decline coverage by checking the "No" box in the Premium Conversion section of the paper enrollment form. During Option Period, the employee can decline coverage by electing "No" to premium conversion during online enrollment, or checking the "No" box in the Premium Conversion section of the paper enrollment form. An election made will be effective for the entire plan year and is subject to the Internal Revenue Service irrevocability rules for benefit elections. Changes can be made to Option Period elections only if the change is authorized and consistent with Internal Revenue Service regulations. If near or contemplating retirement, employees are advised to consult a tax professional to discuss participation in the cafeteria plan on a pre-tax basis and determine the impact, if any, on their future retirement benefits.

### **Invisible Bracelet**

This option is intended to be qualified under Section 125 of the Internal Revenue Code as an optional benefit within the State Employee Flexible Benefits Plan, and is therefore, included as part of the cafeteria plan described in OAC 87:10-1-1. The Plan Administrator shall at all times administer this option in a manner consistent with the terms and provisions hereof, in a uniform and nondiscriminatory manner, and in accordance with the Internal Revenue Code and applicable regulations promulgated thereunder. The period of coverage will be on a calendar basis beginning January 1 and ending December 31 of each calendar year. Midyear enrollees must continue to pay the annual cost regardless of entry date. There is no pro-rated premium available. Re-enrollment on a calendar year basis is required. Employees may elect to participate during the open enrollment period prior to the plan year. New Hires may elect to participate during the plan year.

## Glossary

**BAS** – Benefits Administration System – Benefits system for all active state employees. You can sign on from [www.ebc.ok.gov](http://www.ebc.ok.gov) (upper right corner).

**Co-insurance** – A percentage of each health insurance claim above the deductible paid by the member. For a 20-percent health coinsurance clause, the policyholder pays for the deductible and co-pay, plus 20 percent of covered charges, while the plan pays the other 80 percent.

**Co-pay** – A predetermined, flat fee an individual pays for health, dental or vision care services, in addition to what insurance covers.

**“Cover One, Cover All”** – All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided.

**Coverage** – The scope of protection provided under an insurance policy.

**Date of Service** – The date the medical care is provided to the participant (date of prescription, order date of glasses, dentures, hearing aids, etc.), not when formally billed, charged for, or paid. For terminated employees: date of medical care must be prior to the end of the month of the termination month.

**Deductible** – Amount of loss that the insured pays before the insurance kicks in.

**Dependent** – A family member or other person who is supported financially by another, especially one living in the same house. This typically includes the spouse and/or eligible children of the state employee.

**Employee ID** – 6-digit number assigned by the Office of State Finance for all employees. The Employee ID appears on your payroll stub. The Employee ID is used to access the Benefits Administration System (BAS).

**Explanation of Benefits (EOB)** – A report from your insurance carrier that shows what recent treatment was allowed as covered under your plan, what they have paid, what the provider must write off, and what the employee owes for particular dates of service.

**Flexible Spending Account (FSA)** – An account in which an employee can deposit payroll deductions for future medical or childcare expenses and in so doing, reduce taxable income.

**Grace Period** – January 1 to March 15. This is the period of time when you can use previous year funds from your spending account for current year services. This period of time allows employees with a previous years balance to continue to spend funds that would otherwise have been forfeited. Our system is programmed to use these funds first whenever claims are processed during the grace period.

**HMO** – Health Maintenance Organization. Available HMOs feature Standard (higher levels of coverage) and Alternative options. Out-of-pocket expenses for members are limited to set co-pays. All have defined coverage areas, based on zip codes.

**Health Savings Account (HSA)** – An account that allows you to contribute pre-tax money to be used for qualified medical expenses. HSAs, which are portable, must be linked to a high-deductible health insurance policy.

**Itemized Statement** – Itemized Invoice from the person providing services showing NATURE OF the expense, FOR WHOM it was incurred, AMOUNT CHARGED for the services, and DATES OF SERVICES including insurance payment and any write off (or denies to pay) . Cancelled checks and charge receipts do not include the necessary information.

**OTC Rule** – The health care reform legislation signed into law by the President impacts over-the-counter (OTC) purchases with Health Care Flexible Spending Accounts beginning in January of 2011. OTC drugs, medicines and biologicals remain eligible, but only with a letter of medical necessity from a medical provider. NOTE: Because these items now require a doctor’s directive, these items can no longer be purchased by the debit card program; however, they could be reimbursed by filing a paper claim with a doctor’s letter of medical necessity.

**Password letter** – Letter provided to each employee before option period to access the Benefits Administration System (BAS) for enrollment.

**PCP** – Primary Care Physician. This is the doctor you typically see first for medical problems and routine care. Naming a PCP is required for state employees and their families who choose an HMO.

**PPO** – Preferred Provider Organization. The only PPO-like options for state employees and their families come from HealthChoice’s plans, which operate as PPOs and self-insured indemnity plans. The plans are available statewide and out-of-pocket expenses include co-pays, deductibles and co-insurance.

**Premium Audit** – A review of an employee’s benefits account that seeks to reconcile premiums paid with premiums due, according to enrolled options. Accounts are periodically audited to assure accuracy. A notification may be sent to the employee and their agency if insurance premiums or flexible spending accounts are found to have been overpaid or underpaid.

**Premium Conversion** – A program based on federal tax rules that let employees deduct their share of insurance premiums from their taxable income, thereby reducing their taxes.

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