

SOONERCHOICES

Employees
Benefits
Council

employees
Benefits council
2004
Enrollment
Guide

Active & New State Employees

SOONERCHOICES ONLINE ENROLLMENT!



The mission of the **EMPLOYEES BENEFITS COUNCIL** is "to provide expert benefits management that includes designing for choice and cost effectiveness, superior administration, and promoting healthy lifestyles."



EBC COUNCIL MEMBERS

Kim Holland, Chairman, *Tulsa*
Bryce Fair, Vice Chairman, *Oklahoma City*
Bill Goodwin, Secretary, *Stillwater*
Oscar Jackson, Member, *Oklahoma City*
Susan Reed, Member, *Perry*



Dear State Employee,

As you read this Enrollment Guide, you will find a lot of valuable information. Considerable effort has been spent to construct the booklet in a way that provides meaningful information in a precise and understandable manner. Please read the Table of Contents on the next page for a snapshot of what the booklet contains. I hope you agree it is a valuable resource in making your benefit decisions for the upcoming Plan Year 2004.

In today's economic environment, the public sector faces many challenges - employee benefits are no exception. Healthcare costs continue to increase while choices diminish. Every effort is being made to increase the number of benefit plan choices offered for all state employees, particularly medical and dental plans. The reasons this is very difficult to accomplish are numerous, but you can trust EBC is doing everything within its ability to overcome the obstacles.

Finally, EBC is most proud to introduce to you a new benefits online enrollment system. The new Benefits Administration System (BAS) is now available to you to enroll for Plan Year 2004 benefits. During a Quality Oklahoma Team Day awards ceremony held at the State Capitol Building on May 8, 2003, the Employees Benefits Council earned the Governor's Quality Oklahoma Red Tape Reduction Award for this new benefits system. Hopefully you will find this new system user friendly and worthy of this award. EBC is extremely happy to make this system available to all 37,000 state employees for this option period. More information about how to access and use this wonderful new system is available from both your agency's Benefits Coordinator and EBC.

The Employees Benefits Council and staff always keep your best interest in mind as indicated by the agency mission statement shown above. Please read it and be assured it is our 'mission'.

Sincerely,

Mitch Parsons
Executive Director

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FOR 2004, YOU MAY ENROLL VIA THE INTERNET ON THE NEW BAS SYSTEM OR USE THE PAPER ENROLLMENT FORM. CONTACT YOUR BENEFITS COORDINATOR FOR A TIP SHEET.

EXECUTIVE/ADMINISTRATION

Phone Extensions

Mitch Parsons 101
Executive Director

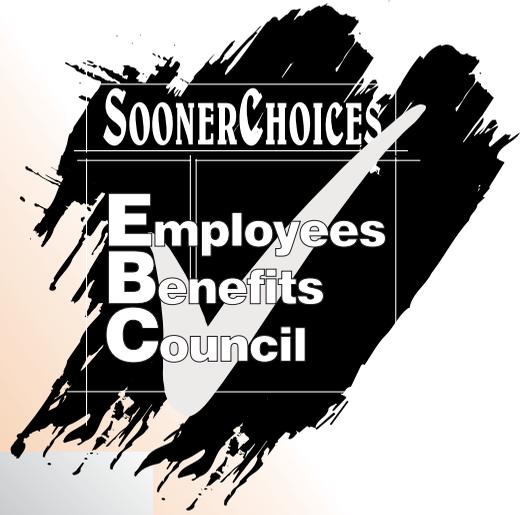
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Comptroller

Accountant 124

Mitzi Bennett 111
Human Resources Management Specialist

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Procurement Officer

Frank Wade 148
Information Systems Administrator

Steve Coffey 107
Network Administrator

Mike DeRose 149
Database Administrator

Phillip Moore 150
Web Applications Administrator

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Benefits Accounts Specialist

Tasha Franklin-Blevins 151
Benefits Accounts Specialist

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Flexible Benefits Analyst

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Administrative Assistant, Benefits

Barbara Wagoner 115
Flexible Benefits Representative

Beth Moore 113
Flexible Benefits Representative

Ray Kongsala 106
Flexible Benefits Representative

Sheila Petross 130
File Clerk

Nancy Haller 120
Manager, State Wellness Program

Christina Dyer 131
Health Educator

ONLINE at www.ebc.state.ok.us & On The Goooooo!

Start with your
**AGENCY
BENEFITS
COORDINATORS.**

They are available to answer questions and assist you with your enrollment. Locate at EBC's Website under Benefits.

EBC FLEXIBLE BENEFITS REPRESENTATIVES are also standing by from **7:45 am through 4:45 pm, Monday through Friday to answer your questions at (405) 232.1190 x300.**

THE INTERACTIVE ENROLLMENT WORKSHEET helps you analyze your out-of-pocket health care costs and identify which benefits may be most cost effective for you.

It's very important for you to evaluate all of your options and make informed choices. To help you make an informed choice, EBC continues to look for innovative planning tools and resources for you to use.

Access ONLINE :

**Provider Directories, Formularies,
Rx Tier Levels & Vision Info**

EBC

..... www.ebc.state.ok.us

HEALTHCHOICE

..... www.healthchoiceok.com

PACIFICARE HMO

..... www.pacificare.com

COMMUNITYCARE HMO

..... www.ccok.com

FORTIS DENTAL

..... www.fortisbenefitsdental.com

AMERITAS VISION

..... www.ameritasgroup.com

COMPBENEFITS VISION

..... www.visioncare.com



PVCS VISION

..... www.pvcs-usa.com

SPECTERA VISION

..... www.spectera.com

SUPERIOR VISION

..... www.superiorvision.com

VSP VISION

..... www.vsp.com

**EBC ONLINE at
WWW.EBC.STATE.OK.US
provides all Benefits,
Educational & Enrollment
Information**

Gold Foldout (Benefits Summaries)
Education Series
Benefits Broadcaster
Enrollment Guide
Zip Code/Provider Guide
Enrollment Worksheets
Benefits Coordinators Newsletter
Wellness Newsletter (Quarterly) & more!

**& DOWNLOADABLE FORMS
ARE AVAILABLE UNDER
"BENEFITS INFORMATION
/FORMS"**

Dependent Life
Supplemental Life
Life Insurance Beneficiary Form
COBRA Info/Rates/Forms
Spousal Exclusion
Evidence of Insurability (EOI)
Flexible Spending Accounts
(Health & Dependent
DayCare Claim Vouchers)

2004 CHANGES



EBC encourages (1) ONLINE

Enrollment via the Internet from a computer anywhere. First you must submit a Signature Authorization form to your agency Benefits Coordinator in order to receive a User ID and Temporary Password! (Paper enrollment still available) (Tip Sheet has authorization form)

(2) HealthChoice Low has been replaced

by HealthChoice BASIC with a new plan design.

(3) PacifiCare offers an alternative HMO option in a Nonstandardized plan design

[CommunityCare and PacifiCare still offer standardized HMO High and Low Options with some copay modifications].

(4) There are six Vision plans

from which to choose [two plans are new offerings and four plans are the same. EyeMed is not available for 2004].

(5) Under SB194 Retired Military Active state employees may Opt Out

of all benefits but elect Vision and

HealthCare Spending and DependentCare Spending accounts. This requires paper enrollment with a special Opt Out attachment plus proof of retired military status (DD2 Form, Retired). Ask your agency Benefits Coordinator for a copy of the EBC Emergency Rules providing details of Opt Out and Re-entry Regulations.

(6) There is a new form to apply for or to increase employee Supplemental Life Insurance.

You must use the form dated September 1, 2003 with the Evidence of Insurability

form on the back. Please send the form directly to the Group Insurance Board's address shown on the back of the form. There are new and stricter rules for processing this information.

(7) Most rates will show some increase this year.

[Only the Fortis Dental Plan rate remains the same as in 2003.]

(8) There is a new White & Blue health plan folder

for benefit summaries of the two new health plans: HealthChoice

BASIC and PacifiCare Alternative HMO [the Gold Foldout still compares standardized HMOs with high and low options and HealthChoice High both In Network and Out of Network.]

DISCLAIMER DISCLAIMER This guide highlights various employee benefit plans for eligible, active employees of the State of Oklahoma. The actual benefits available and the full descriptions of these benefits are governed in all cases by the relevant plan document, insurance contracts and/or Rules and Regulations of the Oklahoma State and Education Employees Group Insurance Board and/or those of the Employees Benefits Council, the IRC and other applicable state and federal regulations. If there are discrepancies between this guide and the actual plan documents, insurance contracts, and/or Rules and Regulations, the documents, contracts and Rules and Regulations will govern. **DISCLAIMER DISCLAIMER**

Do you know the *answers* to these basic health questions?

Can you name the (5) five food groups?

What is your LDL cholesterol number?

Can you name 3 sources of saturated fat?

What should your heart rate be while exercising?

Do you know how to find reliable health information on the web?



Let the **State Wellness Program** untangle the web and lead you to reliable health information for these basic questions in the **WELLNESS** section of the newly designed **Employees Benefits Council** website for state employees found at

<http://www.ebc.state.ok.us>

This WEBSITE not only provides easy to find information about **Wellness** programs, benefits information, and upcoming statewide events, but it also has a **Virtual Education Center** where you can find the

- * **Resource Library,**
- * **Health Calculators,**
- * **Health and Wellness Handouts/Packets, and**
- * **Helpful Links.**

You can also view past and present quarterly **Wellness Connection** newsletters and monthly **Wellness Grams**. Please bookmark <http://www.ebc.state.ok.us> as one of your favorites and visit often for your one-stop health gateway. If you have any comments about the new website or would like our office to add a health and wellness event, please contact the **State Wellness Program** at wellness@ebc.state.ok.us or 405-232-1190 x120 or 131 (800-219-8115).

State Wellness Program Mission:

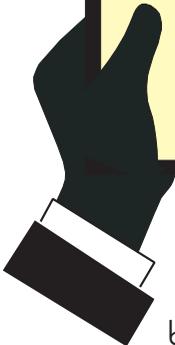
Provide support, resources, coordination, and development of wellness programs in state government. The State Wellness Council shall encourage the participation in wellness programs by state employees. Such health education and promotion programs will be designed to foster knowledge, attitudes, and behavioral skills necessary to improve the overall health status of all state employees, dependents, and their communities.

STATE CONTINUES TO FUND BIGGEST SHARE OF EMPLOYEE & FAMILY HEALTH COVERAGES UNDER THE

FLEXIBLE BENEFITS PROGRAM

State offers a helping hand with benefit allowances.

EMPLOYER MONEY FOR YOUR BENEFIT		TOTAL	Monthly	Yearly
Employee-Only receives			\$371.46	\$4457.52
Employee with Family receives amounts below				
\$371.46	Plus	=	Monthly =	Yearly
a Child	\$146.02	=	\$517.48	= \$6,209.76
Children	\$204.66	=	\$576.12	= \$6,913.44
a Spouse	\$282.62	=	\$654.08	= \$7,848.96
a Spouse & Child	\$428.64	=	\$800.10	= \$9,601.20
a Spouse & Children	\$487.28	=	\$858.74	= \$10,304.88



The State of Oklahoma continues to provide a benefit allowance to full-time employees based on a variable formula. For

2004, the Employee who only insures him/herself will receive \$371.46, a monthly amount which is NOT included in his/her taxable earnings, but is provided by the employer to purchase core benefits [health, dental, basic life, disability]. Any unused amounts go into gross earnings and are taxed or can offset purchases of other options. For choices that total more than the allowance, the employee will pay the excess.

The State's Dependent Benefit Allowance covers 75% of an average of all **HIGH Option HEALTH** premiums for each category of spouse or dependent health.

This additional amount is added to a base of \$371.46 to help the employee cover spouse and dependents with health insurance.

**EMPLOYEE PAYS
25% OF THE
AVERAGE COST OF
SPOUSE AND/OR
DEPENDENTS'
HEALTH
PREMIUMS, PLUS
SMALL
DIFFERENCE
ABOVE THE
AVERAGE.**



It is the personal responsibility of each employee to get Option Period Enrollment Information by going to the Option Period Meetings, by watching the Option Period video, by completing the enrollment form provided and returning it to his/her agency benefits coordinator by the deadline.

Option Period starts September 29, 2003 and ends October 29, 2003. Some agencies could have earlier but not later deadlines.

Each Plan Year every state employee **MUST HAVE CORE BENEFITS:**

- 1) HEALTH (pages 12-27)**
 - 2) DENTAL (pages 28-30)**
 - 3) BASIC LIFE (page 44)**
 - 4) DISABILITY (page 45)**
- Each Option Period, Employee must

elect 1 and 2. As long as you are an active state employee, 3 and 4 are in place.

To enjoy a Monthly Tax Break, enroll in **PREMIUM CONVERSION** and receive a tax break on the following eligible premiums: Say "Yes" and save taxes.

- 1) Employee Life Insurance Premiums up to \$50,000 which includes the Basic \$20,000 & first \$30,000 of Supplemental Life.
- 2) An Employee's personal Vision Plan.
- 3) All Dependent Premiums *except* Dependent Life Insurance.

"TAX FREE" Options available.

- Premium ConversionPage 8
- Health & Dependent Care Reimbursement AccountsPages 46-48
- MyFlex ONLINEpage 49

BREAKFAST TIPS
NO TIME? Build a breakfast around foods that are ready to eat or take little preparation time. TAKE IT TO GO . . .Try celery stuffed with peanut butter or a meat or cheese spread, dried fruits, or vegetable juices.

ALL HEALTH PLANS AVAILABLE TO STATE EMPLOYEES WILL ALLOW DENTAL PRESCRIPTIONS TO BE FILLED UNDER THEIR PHARMACY BENEFITS.

PREMIUM CONVERSION

Flexible Benefits in a 125 Plan offer tax savings . . .

if you say **"NO"** on the enrollment form, pay your Premiums PLUS Taxes . . .

Gross Monthly Earnings (Taxable Income)	\$3,000.00
Tax estimate of 30%(Fed, State, & FICA)	-900.00
After-Tax Earnings	\$2,100.00
<u>Insurance amounts for illustration purposes only</u>	
Employee Supplemental Life (1st unit)	3.00
Spouse/Dependent's Health Insurance	175.00
Spouse/Dependent's Dental Insurance	68.00
Family Vision	26.50
Subtotal of Insurance Deductions	-272.50

Take-Home Pay **\$1827.50**

LOSE TAX SAVINGS

Employee pays for approximately 25% of Spouse and Dependent Health because the state's Benefit Allowance covers 75% of their average health premium costs. See Benefit Allowance information on page 6.

if you say **"YES,"** pay NO TAXES on eligible Premiums. . .

Gross Monthly Earnings	\$3,000.00
<u>Insurance amounts for illustration purposes only</u>	
Employee Supplemental Life (1st unit)	3.00
Spouse & Dependent's Health Insurance	175.00
Spouse & Dependent's Dental Insurance	68.00
Family Vision Insurance	26.50
Subtotal of Insurance Deduction	-272.50

Taxable Income **\$2727.50**
 Tax estimate of 30%(Fed, State & FICA) **-818.25**

Take-Home Pay **\$1909.25**

GAIN TAX SAVINGS

TAKE HOME AN EXTRA \$981.00 PER YEAR.

WHY SAY NO?

91% of state Employees use Premium Conversion which results in Tax Savings! Just remember that written requests to add or drop dependents must be made within 30 days of a qualified midyear change. See page 11 for a list of these qualified midyear changes.

ELIGIBILITY

Any ACTIVE STATE OF OKLAHOMA EMPLOYEE scheduled to work at least 1,000 hours per year is eligible if he/she is not a temporary or seasonal employee.

NEW HIRES' coverage is effective on the first day of the month following the entry-on-duty date. Coverage ends the last day of the termination month. **ELIGIBLE FAMILY MEMBERS** are: **LEGAL SPOUSE** and/or all **UNMARRIED CHILDREN**

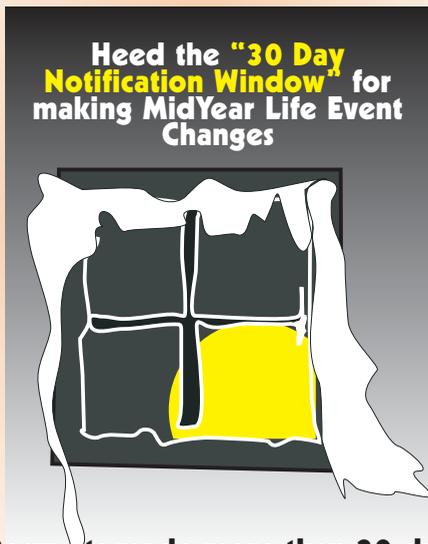
up to the age of 19; unmarried children who are **FULL TIME STUDENTS** up to age 25; or any incapacitated & **TOTALLY DISABLED CHILDREN** of any age if their incapacity occurred and was verified prior to age 19.

COVER ONE, COVER ALL signifies that all eligible family members must be covered when requesting health, dental, dependent life, or vision insurance unless proof of other group coverage is provided. This information must be declared by New Hires under HIPAA rules. **THE ONE EXCEPTION** is spousal exclusion from health and/or dental provided both spouses sign the "Exclusion for Spouse Coverage" form.

If both parents are state employees, each receives personal benefits and they must decide which parent opts to cover the children for health, dental, and vision. Both parents may request to add children to Dependent Life Insurance.

STUDENT STATUS means a 19 year old child, still in school, can still be covered until age 25 if enrolled as a full-time student at an accredited university or institution of higher learning, secondary school, or college. A signed "Certification of Student Status" form must be on file with the

agency Benefits Coordinator and EBC. **FORFEITURE** of premiums can be avoided by signing and submitting a **yellow change form** with support documentation to drop coverage through the agency Benefits Coordinator within 30 days of the "event" according to the IRS code, OSEEGIB and EBC rules.



Requests made more than 30 days after an event will not be processed.

EBC/OSEEGIB RULES

ENROLLMENT AND CHANGE NOTIFICATION

If you decide to drop any eligible dependents, they cannot be re-enrolled until after a 12 month waiting period. Since July 1st, 2001 per 360:10-3-25(a) the end of the 12 month wait qualifies as an allowable midyear change. (Written notice within 30 days of the 12 month anniversary date is required.)

Note: Reinstated **health** coverage may be subject to penalty for preexisting conditions and **dental** limitations of \$250 for HealthChoice members.

Midyear election changes for both EBC & OSEEGIB require compliance with section 125 of the IRS code. **The effective date for a Midyear Change is**

the 1st of the month following notification of the qualified midyear event.

EFFECTIVE DATE ALERT:

HealthChoice's **6-month PREEXISTING CONDITION CLAUSE** could come into play if you notify at the end of the 30-day window and end up with a month's break in coverage for dependent.

To avoid this:

- 1) turn in your change form the same month dependents lose coverage or
- 2) ask your BC about paying for the previous month on an after-tax basis for those dependents.

EXAMPLE 1: Evelyn Employee notifies her Benefits Coordinator on 8-30-2003 that she got married on 8-14-2003. BECAUSE SHE NOTIFIED WITHIN 30 DAYS OF THE QUALIFIED EXCEPTION TO THE IRREVOCABILITY RULE (EVENT) THEN ACCORDING TO THE EBC RULES HER COVERAGE WILL BECOME EFFECTIVE THE FIRST OF THE MONTH FOLLOWING NOTIFICATION

Event: 8/14/2003 (marriage)
Notification: 8/30/2003 (employee signed change form)
Effective date of change to add new spouse and/or spouse's children: 9/1/2003 (first of the month following notification)
A signed, completed CHANGE form with proper attached documentation is notification.

EXAMPLE 2: Evelyn Employee notifies her Benefits Coordinator on 9/13/2003 that she got married on 8/14/2003. BECAUSE SHE NOTIFIED WITHIN 30 DAYS SHE CAN MAKE THE CHANGE. SINCE SHE DIDN'T NOTIFY UNTIL 9/13/2003 THE COVERAGE WILL BECOME EFFECTIVE THE FIRST OF THE MONTH FOLLOWING NOTIFICATION (10/1/2003)

Event: 8/14/2003 (marriage)
Notification: 9/13/2003 (employee signed change form)
Effective date of change to add new spouse and/or spouse's children: 10/1/2003 (first of the month following notification)
Submit notification to Benefits Coordinator.

EBC Rules available ON WEBSITE at WWW.EBC.STATE.OK.US

QUALIFIED MIDYEAR BENEFIT ELECTION CHANGES (PERMITTED EXCEPTIONS TO THE IRREVOCABILITY RULE) AS ALLOWED WITHIN PLAN GUIDELINES:



A (1) **HIPAA special enrollment right** of marriage, birth, adoption or placement

or a **CHANGE** (6) in place of **residence** of employee, spouse or dependent. (7) The commencement or termination of **adoption proceedings**.

Any (8) **judgments, decrees or orders** (changes allowed only to Health, Health Care Reimbursement Account and Dental). (9) [a] **MEDICARE** or [b] **MEDICAID** (limit of one "ADD" & one "DROP" per year) **CHANGES** (limited to Health and Health Care Reimbursement Account).

(10) For **significant cost increases** (limited to Dependent Care Reimbursement Account using unrelated care provider) and (11) **CHANGES in coverage of** spouse or dependent under other employer's plan (except HCRA). For (12) **FMLA** Leave.

ment for adoption, loss of other coverage including exhaustion of COBRA coverage (all covered by other changes below).

Any CHANGE (2) in **employee's legal marital status** (3) in the **number of employee's dependents** or (4) in **employment status** of employee, spouse or dependent that affects eligibility. An **EVENT** (5) causing employee's **dependent** to satisfy or cease to satisfy **eligibility requirements,**

(13) **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 thereunder, and in accordance with **EBC and OSEEGIB Rules and Regulations.**

UNDERSTANDING BENEFITS TERMS

DEDUCTIBLE

A dollar amount you pay directly to your health care service providers (doctors, hospitals, etc.) each year before your plan begins paying for certain allowable expenses. There are different levels for individuals and families. Once you've paid your deductible for the year, your plan starts to pay for covered expenses, based on the coinsurance.

COINSURANCE

The percentage of cost for medical services that you are responsible for paying. Some plans require you to pay 100% until you've met your annual deductible, and then you pay the coinsurance percentage for the rest of the year (up to your annual out-of-pocket maximums).

COPAYMENT OR COPAY

A flat dollar amount that you pay at the time you receive services. Your plan will specify what that amount is.

GENERIC DRUG

No medical difference between brand-name drugs and generic drugs.

The generic drug contains the same active ingredients as its name-brand counterpart, but the generic is less expensive.

PREFERRED BRAND-NAME

A "preferred" brand-name drug is a medication that is identified as clinically superior or more cost effective when compared to other medication alternatives in a drug class.

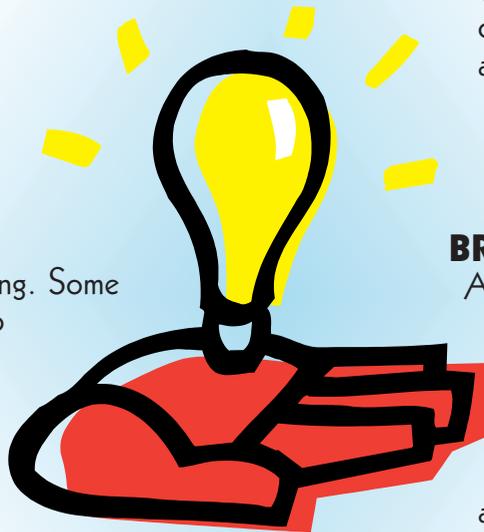
NON-PREFERRED BRAND-NAME

A brand-name drug which is not on the plan's list of preferred drug brands. The drug may still be available; however, your copay and or coinsurance will be higher.

Often, pharmaceutical companies have invested millions into the development and marketing of non-preferred brands, so they typically cost much more than generic or preferred drugs. However, generic or preferred drugs can be just as effective as non-preferred brands.

FORMULARY

A formulary is a list of preferred medications (including generic and



more Benefits **TERMS**

preferred brands) that can meet a patient's clinical needs at a lower cost than other brand-name drugs. Formulary medications are selected according to their safety (lower likelihood of adverse reactions or drug-to-drug interactions), efficacy (whether or not the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice and cost.

IN-NETWORK PROVIDER

Physicians, hospitals, and other health care providers who are part of a health plan's contracted network of service providers. Providers have agreed with the health plan on negotiated fees, quality standards, and other aspects of health care delivery

for in-network services.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you'll pay for allowable expenses under your health plan in a calendar year. After you reach your maximum, the plan pays 100% of eligible charges for the remainder of that year. Some expenses do not count toward the maximum.

OUT-OF-NETWORK

Health care services delivered by physicians or hospitals that are not part of your plan's contracted network.

HealthChoice Out-of-Network: When you obtain services that are not part of the network you would be going "out-of-network", and benefits would be paid at the network level, which is less generous than in-network benefits.

HMO Out-of-Network: When you obtain services from providers to which you were not referred by your Primary Care Physician. For example, if you decide to see a specialist without a referral from your PCP, then you are responsible for payment (there is no out-of-network HMO benefit unless an emergency).

IN-NETWORK

Health care services delivered by providers within a contracted network.

HealthChoice In-Network: When you obtain services in-network, benefits are paid at the in-network level, which are more generous than out-of-network benefits.

PRIMARY CARE PHYSICIAN (PCP)

A PCP is the physician you select to manage your care. The PCP must participate in the HMO plan that you select. Each

time you need health care services, you must first contact your PCP who provides most care and will coordinate other specialized care and services as needed.

PHARMACY TERMS & TIPS

PREFERRED BRAND-NAME

A “preferred” brand-name drug is a medication that is identified as clinically superior or more cost effective when compared to other medication alternatives in a drug class.

NONPREFERRED BRAND-NAME

A brand-name drug which is not on the plan’s list of preferred drug brands. The drug may still be available; however, your copay and or coinsurance will be higher.

Often, pharmaceutical companies have invested millions into the development and marketing of nonpreferred brands; so they typically cost much more than generic or preferred drugs. However, generic or preferred drugs can be just as effective as nonpreferred brands. Discuss with your doctor.

FORMULARY

A formulary is a list of preferred

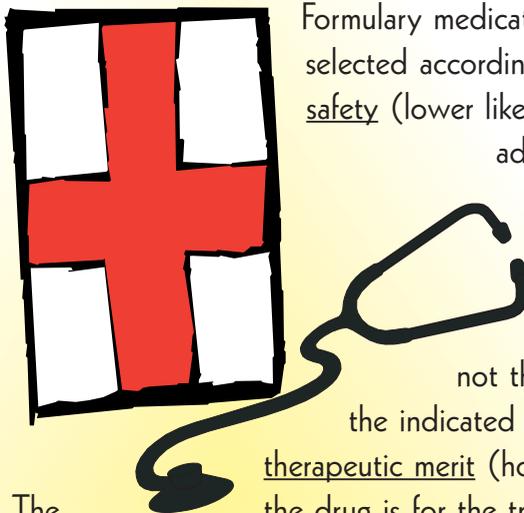
medications (including generic and preferred brands) that can meet a patient’s clinical needs at a lower cost than other brand-name drugs.

Formulary medications are selected according to their safety (lower likelihood of adverse reactions or drug-to-drug interactions), efficacy (whether or not the drug works for the indicated purpose),

therapeutic merit (how appropriate the drug is for the treatment of a particular condition), or current standard of practice and cost. Ask for generic or preferred brand drugs and save money.

ACCESS CHARGE

This term is used by the alternative HMO and works as a pharmacy deductible which must be met before you begin paying only a copay for prescriptions.



HMO PRESCRIPTION DRUG QUANTITIES
Select medications may require fewer than a 30 day supply or 100 units as determined by the prescribing physician.

HMO PHARMACY BENEFITS

HMOs offer Pharmacy Benefits in 3-Tier Structure Standardized CommunityCare HMO and Standardized PacifiCare HMO Copays:

New

PacifiCare's nonstandard Alternative HMO's \$200 Pharmacy Access Fee must be satisfied as a pharmacy deductible *prior to* using copays. (Copay per prescription unit or up to 30 days)

Tier 1 Generic Formulary \$10

Tier 2 Brand Name Formulary \$35

Tier 3 NonFormulary \$60

Mail Service Pharmacy Copays for 3 units or up to a 90 day supply

Tier 1 Generic Formulary \$30

Tier 2 Brand Name Formulary \$105

Tier 3 NonFormulary \$180

*Prior authorization is required to obtain Brand Name Formulary, Non-Formulary or any select medication in the nonstandard, alternative HMO.

STANDARDIZED HMO PHARMACY COPAYS DID NOT CHANGE FOR 2004

HIGH LOW

Tier 1 Formulary Generics

\$10 \$10

Tier 2 Brand Name

Formulary drugs which do not have a generic alternative and are listed on the plan's drug formulary

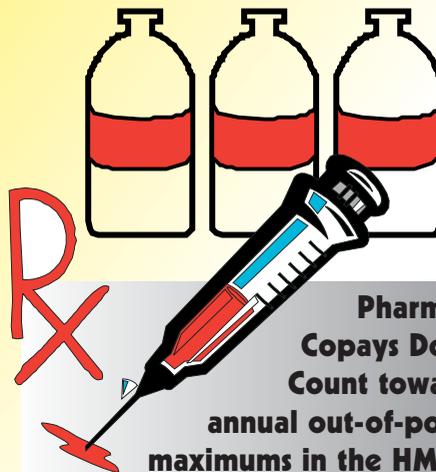
\$25 \$35

Tier 3 Formulary Brand

Name drugs (a) which have a generic alternative available under Tier 1 **or** (b) any drugs (provided they are covered benefits -- generic or Brand Name) not on the HMO's formulary **or** (c) all prescriptions requiring a special preauthorization.

\$45 \$60

Your physician and plan guidelines determine whether to prescribe the greater of a 30-day supply or 100 units.



Pharmacy Copays Do Not Count toward annual out-of-pocket maximums in the HMOs or HealthChoice, but if you use only Preferred medication under HealthChoice in network there is maximum out of pocket of \$2500.

HealthChoice

OKLAHOMA STATE & EDUCATION EMPLOYEES GROUP INSURANCE BOARD

New \$2 million lifetime pharmacy maximum

PHARMACY IN NETWORK

Preferred Medication	NonPreferred Medication	Brand Name when Generic is Available
\$100 or less You pay up to \$25, or actual cost if less	\$100 or less You pay up to \$50, or actual cost if less	The plan will cover only the cost of the generic
\$100 or more You pay 25% up to \$50 maximum	\$100 or more You pay 50% up to \$100 maximum	The plan will cover only the cost of the generic
Out of pocket maximum: \$2500, per person using Preferred Product in the Network pharmacy, then plan pays 100%	Out of pocket maximum— There is no limit	Out of pocket maximum— There is no limit

Note: If you choose a brand name and a generic medication is available, you are responsible for the difference in cost between the brand and the generic alternative.

PHARMACY OUT OF NETWORK

Preferred Medication	NonPreferred Medication	Brand Name when Generic is Available
No Deductible	No Deductible	No Deductible
Member pays cost of drug up to \$75 maximum plus dispensing fee	Members pays cost of medication up to \$125 maximum plus dispensing fee	The plan will cover only the cost of the generic

NEW BEGINNING JANUARY 1, 2004, STARTING WITH -0- BALANCE, MEMBER'S PHARMACY BENEFITS WILL ACCRUE TO A LIFETIME \$2 MILLION CAP.

EXAMPLES OF HOW PHARMACY BENEFIT PLAN WORKS Medication cost less than \$25

You take a generic medication and the cost is \$5.00 per 100 tablets.
You will pay the \$5.00.

Preferred costing over \$100 example - In Network

If you are taking a medication with an actual cost of \$132, your cost will be 25% of \$132 or \$33 with the plan paying the balance and the dispensing fee.

Nonpreferred costing over \$100 example - In Network

If your medication is nonpreferred and the actual cost is \$360, your cost will be \$100. Your cost is calculated at 50% of the medication cost, but is capped at \$100 with the plan paying \$260 and the dispensing fee.

**For more information HealthChoice is ONLINE at
www.healthchoiceok.com**

GENERAL EXCLUSIONS FROM HEALTH COVERAGE

Charges for supplies, services or procedures (cosmetic or elective) considered experimental, investigational, not medically necessary or any complications from noncovered services

Coverage for occupational illness or work injuries covered by Workers' Compensation

Charges for injuries resulting from war or from an act of war

Cost of routine corrective lenses and fittings except for the initial pair after cataract surgery

Expenses for sex transformation, or sexual dysfunction of any nature

Expenses for weight loss treatment, biofeedback, over-the-counter medications, mattresses or bedding, custodial care

Expenses for fitting exam and hearing aids [except for children up to age 18]

Cost of room humidifiers, jacuzzis, saunas, hot tubs, air purifiers, adaptive equipment, air conditioners, vacuum cleaners or other convenience items, even if recommended and/or prescribed by a doctor

Charges for medications or services prescribed before the start or after

the termination of coverage or made solely because one has insurance coverage or for services/supplies not listed as a Plan benefit or

for unkept appointments or forms completion

Charges for intentionally self-inflicted or attempted suicide injuries

Cost of marriage counseling

Services related to conception by artificial means; including but not limited to:

artificial insemination, in vitro fertilization, ovum transplant, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), embryo transport, surrogate parenting, donor semen, and reversal of voluntary sterilization



Note: This is a GENERALIZED EXCLUSION listing, and not plan specific. Each health plan has its own list of exclusions and its own prescription drug formulary. For a complete and accurate list of each plan's exclusions, please check your health plan's Evidence of Coverage Handbook or call their Customer Service. (Phone numbers are listed on the back cover.)

2004 HealthPlans

[For additional Out-of-Pocket Cost Comparison details see Gold Foldout and/or White&Blue Folder]

**Unlimited Lifetime Maximum on Eligible Medical benefits on any HealthPlan.
For greater benefit details refer to the Gold Foldout and the new White&Blue Folder.**

See New HealthChoice Basic page 19

	HealthChoice Network High Option	HMO Standard High Option (CommunityCare & PacifiCare)	HMO Standard Low Option (CommunityCare & PacifiCare)	PacifiCare Alternative NonStandard HMO *** 
Annual Deductible	High Option ** \$300 Individual \$900 Family	None	None	None on medical \$200 deductible on Pharmacy
Annual Out-of-Pocket Maximum	\$2500 + \$300 = \$2800	\$1000 individual \$2000 family	\$2000 individual \$4000 family	\$4500 individual \$9000 family
Doctor's Visit (Professional services)	\$25*	\$10 PCP \$25 Specialist	\$25 PCP \$40 Specialist	\$20 PCP \$40 Specialist
Hospital Inpatient Procedures require PreCertification	\$300 deductible then 20% of fee schedule per admission	\$100 per admission	\$250 per admission	20% per admission
Hospital Outpatient. Some procedures require precertification	\$300 deductible plus 20% of fee schedule	\$100 per visit for surgery or procedure	\$150 per visit for surgery or procedure	\$200 per visit for surgery or procedure
Pharmacy	Generic Mandate out of pocket expense depends on use of Preferred or non Preferred drugs and if purchased in or out of network	3 Tier: (1) \$10 (2) \$25 (3) \$45 Greater of 30 day supply or 100 units if available under terms of contract and with medical protocols	3 Tier: (1) \$10 (2) \$35 (3) \$60 Greater of 30 day supply or 100 units if available under terms of contract and with medical protocols	3 Tier, after deductible (1) \$10 (2) \$35 (3) \$60 Per unit or up to 30 day supply Mail order Rx available

* Current \$20.00 copays increase to \$25.00 for 2004.

** HealthChoice NonNetwork out-of-pocket expenses are higher than Network. See Gold Foldout for copays, coinsurance and deductibles for NonNetwork.

*** PacifiCare's provider network is the same for its standard HMO High-Low and Alternative Nonstandard plan.

There are no NonNetwork Benefits in the HMOs except for Emergency Care.

See the EBC Provider Guide for PCP listings for CommunityCare HMO and PacifiCare HMO. Failure to select a PCP could delay access and ID cards.

NEW

2004 HealthChoice BASIC How it works.

[Unlimited LifeTime Maximum on Eligible Health Benefits]
This new plan from HealthChoice replaces the former HealthChoice Low Option and offers a completely new plan design.

Eligible health Expenses paid at fee schedule	A CONSUMER-ORIENTED PROGRAM	Who Pays?
\$500	1) For the first \$500 of eligible health expenses, who pays?	The PLAN
+ \$500	2) For the next \$501 to \$1000 of eligible health expenses, who pays? (This amount is known as a corridor deductible.)	The MEMBER
+\$10,000	3) For the next \$10,000 of eligible health expenses, who pays? (This 50% paid by individual member is a coinsurance amount).	PLAN & MEMBER Split 50/50
=\$11,000	4) After the \$11,000 has been spent who pays for health costs?	The PLAN pays 100% of eligible

Annual out-of-pocket maximum—\$5500 per Individual/\$11,000 per family. The \$11,000 max can be reached as an aggregate with multiple family members.

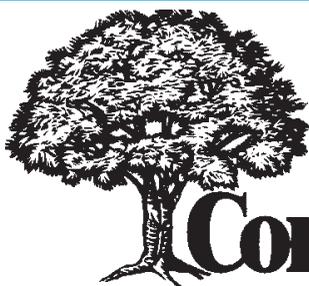
When “the Plan” pays providers, it will pay at the FEE SCHEDULE RATES whether for Network or NonNetwork providers. Using only NETWORK Providers will allow members to maximize their benefits. Amounts above fee schedule for NonNetwork providers and/or noncovered services do not apply to the out-of-pocket maximum. Network providers will not balance bill members for eligible costs.

HealthChoice BASIC is not available to members who are eligible for Medicare.

Refer to the White/Blue Benefits folder for more details

Rx What about Pharmacy Benefits under the HealthChoice Basic? Rx

The HealthChoice Pharmacy Benefits Program expenses are not included in the medical expense payments outlined above. The Pharmacy copays and coinsurance amounts are in addition to the medical expense benefits covered under the HealthChoice Basic or the HealthChoice High option. [See page 16 for details on the Pharmacy Program] Individual lifetime pharmacy maximum is \$2 million. Pharmacy benefits remain the same for HealthChoice High Option as for the new HealthChoice BASIC option.



CommunityCare

Managed Healthcare Plans Of Oklahoma



Joint Commission
on Accreditation of Healthcare Organizations

PRIMARY CARE PHYSICIANS (PCPS)

When you enroll in CommunityCare HMO, you select a Primary Care Physician and hospital network from our list of participating providers. The physician you select will manage and coordinate all of your health care needs. Generally, your health care will be arranged within your PCP's provider network. You may select a different PCP for each covered member of your family.

SPECIALIST REFERRALS

If your PCP determines that you need additional tests or a referral to a CommunityCare specialist, your provider will submit a referral request to the network's medical management department or CommunityCare. A large percentage of referrals are automatically approved by our medical management department. In most cases, the specialist will be in the same provider network as your Primary Care Physician.

HOSPITALS

CommunityCare is locally owned and operated by two of Oklahoma's premier hospitals: Saint Francis Hospital and St. John Medical Center in Tulsa. Your providers are Oklahomans, friends and neighbors you know and trust.

HOW TO USE OUR NETWORK

When you need medical care, first contact your Primary Care Physician. CommunityCare provides benefits only for care received directly from or directed by your PCP.

PHARMACY NETWORK

As a member of CommunityCare HMO, you may receive covered prescription medications prescribed by your participating physician and obtained from one of our contracted pharmacies. You simply present your prescription along with your ID card and pay the required copayment. Your pharmacy benefit has three copayment tiers and a prescription drug formulary.

ID CARDS

When you enroll in CommunityCare HMO, you and each enrolled family member will

receive a member identification card. Your ID card provides your PCP's telephone number, specifies copayment information and includes your personal identification number. Carry your ID card with you at all times so you can show it when you need to use your coverage.

URGENT CARE

Urgent care is defined as covered services that are medically necessary to treat unexpected illnesses and injuries that are severe or painful enough to require treatment within 24 hours, but are NOT emergency services. You must contact your PCP before receiving treatment for an urgently needed health service.

EMERGENCY CARE

If you have an emergency that is considered life or limb threatening, go to the nearest hospital or emergency room. After you have sought emergency care, you must notify your Primary Care Physician within 48 hours after the incident to arrange for authorization and any follow-up care that may be necessary.

GRIEVANCE / APPEAL PROCESS

Upon receipt of a written grievance from a member or employer, the CommunityCare Grievance and Appeals Department will take all steps necessary and reasonable to

investigate and solve the grievance. The complete process is explained in the CommunityCare Handbook.

ENHANCEMENTS

Well Woman Exam

An annual Well Woman examination including a pelvic exam, Pap smear and breast exam is important for your good health. To encourage members to have this exam,

CommunityCare allows you the option of choosing an OB/GYN rather than your Primary Care Physician to perform this exam. The OB/GYN you select must be on the CommunityCare panel and in the same provider network as your PCP.

VISION SCREENING

The vision screening includes a brief history, vision and glaucoma screenings and a refraction for glasses. Most optometrists in the vision network offer a 10 percent to 15 percent discount for eyeglasses and contact lenses purchased at the

optometrist's office.

24-HOUR NURSE LINE

The nurse line features an audio health library with more than 400 topics. Members may also speak to a registered nurse, 24 hours a day, seven days a week.

**NOTICE:
Some contracted providers are added or dropped at various times during the Plan Year. Complete provider directories are available. Contact our Member Services department at (800) 777.4890 for current physician availability.**

HealthChoice

HEALTHCHOICE offers a High Option Plan and a Basic Plan. Both plans offer 11,000 providers who accept Eligible Charges for covered services. HealthChoice High Option has a \$300 Deductible. Please see pages 19 and 24 for more information on the Basic Plan.

The HealthChoice High Option Plan member is responsible for the deductible copayments, coinsurance, and noncovered services for charges when using a HealthChoice Network Provider. For the HealthChoice High Option see the Gold Foldout for plan benefit summary.

For **PHARMACY**, HealthChoice is a mandatory generic plan. Network pharmacy benefits provide coverage at the preferred medication copay. NonNetwork pharmacy benefits are subject to a member's paying: cost of medications up to a maximum plus dispensing fee for preferred and Non-Preferred medications. Certain medications (tablets/capsules) may be written for a 34 day supply or 100 units, whichever is greater.

The **HEALTHCHOICE SELECT MEDICATION LIST** classifies medications as Preferred or NonPreferred. There are three (3) options when NonPreferred medications are pre-

scribed:

- 1) Purchase preferred medication or generic alternative;
- 2) Physician can apply for a medical necessity exception that, if approved, will allow the purchase of the medication for the copayment; or
- 3) Pay the cost difference between Preferred & NonPreferred medications plus pharmacy copayment.

DENTAL PRESCRIPTIONS are eligible under the member's health plan pharmacy benefits.

EMERGENCY CARE

Each hospital emergency room visit under HealthChoice High Option has an additional deductible of \$100 for Network and NonNetwork providers. This is waived if the member is admitted or death occurs.

Members may have certain benefits available for medical emergencies when NonNetwork inpatient services occur. An Emergency means a sudden and unexpected symptom that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual or others in serious jeopardy. If an inpatient admission occurs at a NonNetwork facility as a result of an

emergency, you must notify the HealthChoice by calling (800) 848-8121 within one working day of admission.

Emergency medical benefits are available only upon request. You must notify a case manager at HealthChoice by calling (800) 543-6044 to access these benefits.

Please see the HealthChoice Health Insurance Handbook for more information.

GRIEVANCE/APEAL PROCESS

If your claim is denied in whole or in part for any reason, you have the right to have that claim reviewed.

Requests for review must be submitted to our Claims Review Department. If after the claim review, the claim remains denied, you may appeal to the Grievance Panel. The Grievance Panel is an independent Review Panel. You must contact the Grievance Department for HealthChoice to request a hearing. All claim reviews and final decisions are made expeditiously. After exhausting the claim review and grievance procedures, appeal may be pursued in an Oklahoma District Court.

HEALTH EDUCATION LIFESTYLE PLANNING (HELP) PHONE (800) 318-2365

The mission of the HELP program is to promote responsible behaviors and the adoption of a lifestyle that is conducive to good health for HealthChoice members.

HELP was developed to provide plan participants with ways to adopt and maintain healthy lifestyles and encourage everyone to make lifestyle improvements.

Help Unit programs include:

Worksite Wellness Programs
Brown Bag Seminars
Challenges and Games
Incentive Programs
Walking Club
Health and Wellness Articles in HealthVoice Newsletter
HealthChoice Website

HEALTH CARE MANAGEMENT DIVISION (HCMD)

The HealthChoice staff of dedicated medical professionals will assist members in navigating the complex world of health care. HCMD is staffed by licensed, certified Registered Nurses seeking to promote the best possible outcomes in the most cost-effective manner.

SERVICES HCMD PROVIDES INCLUDE:

**Case management
Medical claims review
Prior authorization
Utilization Review/Quality
Assurance
Dental case reviews
Member questions relating to
healthcare benefits
Call (800) 543-6044 or (405)
717-8879 to speak to a nurse
for more information about the
above services.**

HealthChoice

BASIC

HealthChoice (THE OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD, OSEEGIB) has approved a new alternative plan for the 2004 calendar year. Members currently enrolled in the HealthChoice Low Option plan will have to make a health plan selection during Option Period. Members covered under the HealthChoice Low Option plan will not automatically be enrolled into the HealthChoice Basic plan. Failure to select a new health plan will result in a default to HealthChoice High Option.

HEALTHCHOICE Basic will replace the HealthChoice Low Option plan, and will not affect the HealthChoice High Option plan (or the HealthChoice Medicare Supplement plans).

The Basic Plan will provide first dollar coverage, have competitive premiums, and provide a safety-net of protection in the event of a catastrophic accident or illness. Our mission at HealthChoice is to provide our members with quality insurance benefits that meet the needs of our members.

HEALTHCHOICE BASIC PLAN KEY FEATURES:

1. Each covered member's first \$500 of eligible and allowable medical expenses will be covered completely;
2. An annual individual deductible of \$500 and a family deductible of \$1,000. The deductible begins after the first \$500 of individual coverage;
3. After meeting the deductible, the plan will pay 50% of all the eligible and allowable charges up to an individual maximum out-of-pocket expense (including the deductible) of \$5,500 per member or a family maximum of \$11,000 out-of-pocket;
4. After the maximum out-of-pocket has been reached, the plan will pay 100% of all eligible and allowable charges;
5. The plan will pay based on an allowable agreed to by the HealthChoice Network of health care providers. The member may use a non-network provider, but it will be more costly;
6. All pharmacy benefits will be paid the same as the HealthChoice High Option Plan. Premium rates for the HealthChoice Basic plan represent an overall savings of 12% when compared to the HealthChoice High Option plan;
7. The pharmacy benefit will be subject to a \$2 million lifetime maximum.

PacifiCare®



**PacifiCare of Oklahoma, Inc.
has earned National
Committee for Quality
Assurance (NCQA) EXCELLENT**

PRIMARY CARE PHYSICIANS (PCPS)

One of the most important things that Members of PacifiCare's HMO must do is select a Primary Care Physician (PCP) from the provider directory. Each enrollee may choose the same PCP, or may choose individually. When selecting a PCP you are limited to the specialists affiliated with your Medical Group/PCP's network.

On a monthly basis, you may transfer to another Medical Group and/or contracting PCP who is accepting new patients. You cannot return to your previous medical group for one year.

SPECIALIST REFERRALS

Your PCP is responsible for determining when it's Medically Necessary for you to see a Specialist. If your PCP determines you need a referral, he/she will refer you to a specialist within the network in which the PCP is contracted.

HOSPITALS

When you go to the hospital, your Primary Care Physician will arrange for your stay at a hospital where your doctor is on staff.

HOW TO USE THE CONTRACTING NETWORK

When you select a PCP, you are also selecting a Contracting Medical Group. This is the group that is affiliated with both your doctor and PacifiCare. If you need a referral to a specialist, you will generally be referred to a doctor or service within this group.

PHARMACY CONTRACTING NETWORK

Members can conveniently fill prescription drugs at contracting pharmacies.

ID CARDS

Each enrolled PacifiCare Member will receive an ID card. Your PacifiCare ID card is important in identifying you as a Member of

PacifiCare®

PacifiCare. Please contact customer service immediately upon receipt if your ID card is incorrect. A member should show this card each time he or she visits a PCP or, upon referral, any other Contracting Provider.

URGENT CARE

Urgent care is for unforeseen illnesses or injuries that are considered serious but not life threatening. Please call your PCP for authorization before seeking services.

EMERGENCY CARE

Emergency care is based on your presenting symptoms arising from injury, illness or a condition manifesting itself by acute symptoms of sufficient severity. Proceed to the nearest hospital or emergency room. You must notify your PCP within 48 hours or as soon as reasonably possible.

GRIEVANCE/APPEAL PROCESS

All initial complaints should be directed to PacifiCare Customer Service by telephone at 1-800-825-9355 or in writing to PacifiCare, PO Box 400046 San Antonio, TX 78229.

ENHANCEMENTS

*** WOMEN'S HEALTH SOLUTIONS:** a collection of 30+ programs and services designed with the needs of women and their families in mind.

*** PACIFICARE PERKS:** a members-only program which includes discounts of 5% to 25% through vendor arrangements for family safety products, health clubs, alternative care, vitamins, over-the-counter products and much more!

*** 24-HOUR HEALTH INFORMATION PROGRAM:**

This program offers Internet-based resources at www.pacificare.com. Search through a variety of health information or register for interactive information such as health diaries and a "live chat" feature. Registered users may also call our toll-free 24-hour Nurse Line and Audio Library.

*** WEB SITE:** Just type in www.pacificare.com to get important information such as provider directories, pharmacy listings and customer service information. We also offer a password protected member area that allows you to view your benefit plan summary, update your address, request both a change in your PCP or a replacement ID card while you're online.

*** DIRECT ACCESS TO AN OB/GYN:**

Women may self-refer to a contracting OB/GYN physician with their Contracting Medical Group, if applicable, for a routine Pap smear and pelvic and breast exam once a year.

PacifiCare®

* HEALTH AND WELLNESS

PROGRAMS: including Free & Clear(r) StopSmokingSM program, Taking Charge of Diabetes, Taking Charge of Your Heart Health Program, Taking Charge of Depression Program, Taking Charge of Asthma Program, Migraine Program, HealthBeat Magazine and many more.

* ROUTINE VISION REFRACTION EXAMINATION:

One annual refraction and screening is covered with a contracting provider.

ALTERNATIVE HMO PLAN OPTION

PacifiCare's alternative plan is a lower cost plan that offers all of the same exciting benefits that are listed above. It also offers one exciting new Value-Added Benefit: A Solution for Caregivers.

Today, up to 25% of State of Oklahoma employees could be struggling to balance the demands of work with the pressure of providing care for an elderly parent or other relative.

PacifiCare's Solution for Caregivers provides comprehensive assistance through all stages of caregiving. Service are organized into two main areas that work together to create a powerful, personalized and comprehensive support system.

PACIFICARE VISION AND VALUES

We are a health and consumer services company where caring is good, doing something is better. We want members to feel healthier and more secure.

* CARE RESOURCE CENTER (CRC)

The CRC is a centralized information and research service managed by experienced geriatric specialists who quickly deliver the right information. This eliminates time-consuming legwork so you can focus on your job.

* GERIATRIC CARE MANAGER (GCM)

When caregiving needs become more complicated, CRC connects caregivers with Geriatric Care Managers under contract with the program who work one-on-one with the caregivers and their families.

- * Saves you time
- * Reduces your stress level
- * Improves your decision making abilities at home and work
- * Increases your overall well-being

HealthChoice

Oklahoma State & Education Employees Group Insurance Board

Selecting a participating dentist from the HealthChoice Network will allow the best benefit level. NonNetwork benefits are available; there is a difference in the member's responsibility. A \$1500 yearly maximum benefit applies for Class A, B and C combined. We are ONLINE at

www.healthchoiceok.com

EXAMPLES OF COMMON DENTAL SERVICES

SEE MEMBER HANDBOOK FOR MORE DETAILS	Network Benefits		NonNetwork	
	Member Pays	Plan Pays	Member Pays	Plan Pays
PREVENTIVE CARE - Class A Adult cleaning/Child cleaning/Bitewings Panoramic Film (once every 3 years) Sealants (single application per tooth, through age 16)	\$0.00	100%*	\$100** Deductible	100%** After Deductible
MINOR RESTORATIONS - Class B Amalgam (fillings)	15%+*	85%*	30%+**	70%**
ENDODONTICS/PERIODONTICS - Class B Root Canal Therapy Gingivectomy per quadrant	15%+*	85%*	30%+**	70%**
ORAL SURGERY - Class B Tooth Extraction	15%+*	85%*	30%+**	70%**
MAJOR RESTORATIONS - Class C Crowns	40%+*	60%*	50%+**	50%**
ORTHODONTIA -Class D Insureds under age 19 & Over age 19 with TMD (Lifetime Maximum \$1800 network, \$1500 non-network for Services initiated 1/1/2004)	40%+ \$50 Deductible	60%*	50%+ \$150 Deductible	50%**

* **Network Benefits:** Based on the HealthChoice allowable fee schedule. Calendar year deductible is \$25 per person for Class B and Class C combined. The member is responsible for the deductible, coinsurance and all noncovered services.

** **NonNetwork Benefits:** Based on the HealthChoice allowable fee schedule. Calendar year deductible is \$100 per person for Class A, B and/or C combined. The use of a NonNetwork provider means the member is responsible for a larger deductible, co-insurance and noncovered charges plus the difference between the billed charges and the HealthChoice allowable fee schedule.

Deductible: Network and NonNetwork deductibles accumulate separately. The Class D deductible does not count toward meeting the Class A, B or C deductibles.

If employees or dependents are enrolled in HealthChoice Dental after the 30 day initial entry-on-duty date, benefits will be limited to reimbursement of \$250 during the first 12 months of coverage, unless proof of continuous group dental coverage is certified.

Participants subject to the late dental penalty will have a 12 month waiting period for ORTHODONTIA BENEFITS.



FORTIS

Solid partners, flexible solutionsSM

Benefits provided by or underwritten by UDC Life and Health Insurance Company (dba UDC in Oklahoma)

No deductibles, no waiting periods for covered Members, coverage for Preexisting Conditions and no referrals required should you need the services of a dental care Specialist. Also includes a Specialty Benefit Amendment (SBA) for procedures performed by Specialists in and out of Network. No benefits are available outside the Fortis Benefits Network of General Dentists. ONLINE at

www.fortisbenefitsdental.com

EXAMPLES OF COMMON DENTAL SERVICES for FORTIS Pinnacle

SEE PLAN BOOKLET FOR COMPLETE LIST OF SERVICES	Network Benefits Member Pays	NonNetwork Benefits Member Pays
<u>PREVENTIVE CARE</u> Application of Sealant, Per Tooth Routine Cleaning (once every 6 months) Topical Flouride Application (up to age 18) Periodic Oral Evaluations	\$8.00 No Charge No Charge No Charge	100% 100% 100% 100%
<u>MINOR RESTORATIONS</u> Amalgam 1 surface, permanent teeth	\$15.00	100%
<u>ENDODONTICS/PERIODONTICS</u> Root Canal, Anterior Perio/Scaling/Root Planing (per quadrant)	\$145.00 \$ 60.00	100% 100%
<u>ORAL SURGERY</u> Extraction, Single tooth	\$11.00	100%
<u>ANESTHESIA/LOCAL ANESTHESIA</u> Nitrous Oxide (per 30 minutes)	\$8.00	100%
<u>ORTHODONTICS</u> 25% Discount	75%	100%

GOOD NEWS about the Specialty Benefit Amendment (SBA). Should you need the services of a dental care specialist you may do so **without a referral** from your Plan dentist. If you use a Specialist who is a part of our provider network for a procedure listed on the SBA, you will simply pay the copayment amount at the time of service. However, if the procedure is not listed on the SBA, you will receive a 25% discount (15% from Endodontists, includes root canal therapy) off of the Specialist's normal retail charges. You also have out-of-network Specialty Care Benefits available. See plan materials for details. **For procedures performed by a Specialist, there is a \$2,000 annual maximum benefit.** See the plan materials for details of the Specialty Benefit Amendment.

This is a brief description only and does not list all member benefits and copayments. This is not an Evidence of Coverage. Please see the Group Dental Service Agreement, Evidence of Coverage and Copayment Schedule, which determine all rights, benefits, and applicable Limitations and Exclusions.

DENTAL PLAN COMPARISONS

No dental plan provider may charge state employee members an OSHA infection control fee!

	HealthChoice State Plan	FORTIS Pinnacle Plan
Annual Deductible	Network —\$25 combined for Class B and/or C. \$50 for Class D. NonNetwork —\$100 for Class A, B, and/or C. \$150 for Class D.	None.
Preventive Care^A	Network —100% (fee schedule). NonNetwork —\$100 deductible applies before plan pays.	100% with no copayment.
Basic Care^B	Network —85% (fee schedule). NonNetwork —70% Member pays deductible (Network or NonNetwork) if not already applied under another class.	Plan saves member 50% to 60% of usual and customary charge after \$5 office visit copayment.
Major Care^C	Network —60% (fee schedule). NonNetwork —50% Member pays deductible (Network or NonNetwork) if not already applied under another class.	Plan saves member 50% to 60% of usual and customary charge after \$5 office visit copayment.
Orthodontic Care^D	Network —60% after \$50 deductible up to \$1800 lifetime maximum for members under age 19 or over age 19 with TMD. NonNetwork —50% after a \$150 deductible up to \$1500 lifetime maximum for members under age 19 or over age 19 with TMD.	25% discount with a participating specialist.
Annual Max. Benefit	Network and NonNetwork —\$1,500 per member (calendar year).	None.
Filing Claims	Network —No claims to file NonNetwork —Member files whatever claims occur.	No claims to file.

- a) Preventive care includes check-ups, cleanings, and x-rays for adults and children, and fluoride treatments for children only. HealthChoice includes sealants through age 16.
- b) Basic care includes fillings, extractions, root canals, periodontal care, and some oral surgery.
- c) Major care includes crowns, bridges, and dentures
- d) Orthodontic care benefits are based upon continued eligibility.

HealthChoice Dental Plan:

Dentists who participate in the HealthChoice Network will not bill the difference between the billed and the (fee schedule) allowed charge unless your calendar year maximum has been met. NonNetwork providers can charge members the difference between the billed and allowed amounts. **Enrolling 30 days past NEW HIRE STATUS will limit reimbursement to \$250 during the first 12 months of coverage.**

This is a brief summary. More detailed information about benefits, limitations and exclusions can be found by reading the preceding pages, by checking the plan's member handbook or by calling their customer service department.



VISION

is taxed. (pretax basis)

**The following SIX
VISION PLANS are
available for 2004:
AMERITAS
COMPBENEFITS
PRIMARY VISION CARE
SERVICES (PVCS)
SPECTERA
SUPERIOR
VISION SERVICE PLAN**

- Senate Bill 354 passed by the 49th Legislature in 2003 requires anyone electing a vision plan to submit an annual election form thereby prohibiting a default enrollment. [for Vision]
- Under the Premium Conversion provision of the State's Flexible Benefits Program, vision premiums will be paid before your paycheck

- Employee and all eligible family members may enroll, but if one dependent is covered, then all eligible dependents must also be covered.
- Family members must enroll in the same vision plan as does the employee
- In adding spouse and eligible dependents, the "Cover One, Cover All" rule applies. List names of all eligible dependents on the back of the Enrollment Form or on the appropriate screen in the BAS system.

**See Vision
Providers in
PROVIDER
GUIDE.**

Vision Plan enrollment must be selected and made each year.



The Dental and Eye Care ExpertsSM

A Division of Ameritas Life Insurance Corp.
AN AMERITAS ACACIA COMPANY

How our plan works

Ameritas' Focus[®] eye care plan provides insured employees and dependents with an annual eye exam, and discounts on materials and services when visiting a participating network doctor. Insureds have the option of visiting a network or out-of-network provider, although benefits vary. ID cards are not issued. Insured employees simply let the doctor know they are insured with Ameritas' Focus[®] plan and the rest is taken care of.

What you get with our plan

The Ameritas Focus[®] plan provides insured members with an annual eye exam, covered at 100% when visiting a network provider. The plan pays up to \$47.00 for an annual exam when visiting an out-of-network provider. The member is responsible for a \$10.00 copay at the time of the exam. Insured members who visit a network provider are also eligible to receive an annual 20 percent discount on prescription glasses and an annual 15 percent discount on the professional services associated with contact lenses (ordering, fitting and adjusting).

Our network and how to use it

The Ameritas Focus[®] plan utilizes the VSP network, which is the largest network of eye care doctors nationwide. Insured members have the option of visiting a VSP doctor or

an out-of-network provider. For out-of-network providers, services are reimbursed according to the plan schedule. To locate a VSP doctor log on to Ameritas' web site (www.ameritasgroup.com) or call (800) 877-7195. The insured pays a \$10.00 copay when receiving an annual eye exam.

Enhanced benefits

Insured members receive on-average savings of 15 percent off LASIK or PRK laser vision correction surgery when coordinated by a VSP network doctor and performed at a contracted laser surgery center.

What is unique about our plan

Seventy percent of the workforce needs corrective lenses. A comprehensive eye exam can detect numerous medical conditions, including diabetes, glaucoma and high blood pressure. The Ameritas Focus[®] plan is an inexpensive way to help safeguard your eyesight. Insured members have access to the largest available network of eye care doctors nationwide. In addition to an annual eye exam, members who visit a VSP network doctor can receive discounts on materials and services, and discounts on corrective laser surgery.

If there is a problem

If you have questions or concerns about the Ameritas Focus[®] eye care plan please contact a VSP representative at (800) 877-7195.

Ameritas Group Dental and Eye Care
5900 O Street
Lincoln, NE 68510
(800) 776-9446

www.ameritasgroup.com

Ameritas benefits at a glance

This form is a benefits highlight, not a certificate of insurance. The coverage outlined here highlights the eye care benefits available through Ameritas Life Insurance Corp. For details on exclusions and limitations, or a complete list of covered procedures, contact Ameritas at the website below.

www.ameritasgroup.com

EXAMPLES OF COMMON EYECARE SERVICES for Ameritas

Visit www.ameritasgroup.com FOR COMPLETE LIST OF SERVICES	Network Benefits Member Pays	NonNetwork Benefits Member Pays
Vision Exam	\$10 copay	\$10 copay
Lenses per pair Single Bifocal Trifocal Lenticular	Member Receives 20% discount on pre- scription glasses	Plan pays up to \$47 per visit
Lens Options UV Coating Tints Scratch Resistant Polycarbonate Anti-Reflective	Member Receives 20% discount all	No Benefit All
Frames	Member Receives 20% discount all	No Benefit
Contact Lenses Conventional/Exam Plus Lenses Disposables Medically Necessary	Member Receives 15 % discount all	No Benefit
Special Services LASIK & PRK	Member Receives 15 % discount	No Benefit

EVERY 12 MONTHS FOR ALL SERVICES

Monthly Ameritas Rates for each category

Employee	Spouse	\$Child	Children
\$4.28	\$3.68	\$3.68	\$6.80

Monthly Cumulative Ameritas Rates for each category

Employee	+ Spouse	+ Spouse + Child	+ Child	+ Children	+ Spouse + Children
\$4.28	\$7.96	\$11.64	\$7.96	\$11.08	\$14.76

Vision Plan enrollment must be selected and made each year.

CompBenefits

VISIONCARESM

Our focus is your care. **P L A N**

How our plan works

Choose a doctor from the Provider list, call CompBenefits/VisionCare Customer Care (800) 865-3676 and request a benefit form. Make your appointment, and give the doctor the benefit form at your first visit. If you use a non-network doctor you will be reimbursed for covered expenses according to a specific schedule of allowances. Send your itemized receipts to CompBenefits for processing.

What you get with our plan

Each year you get a complete eye exam, eyeglass lenses and frames. A small copayment of \$10 for the exam and \$25 for the glasses allows you to choose any frame you like, with a small cost upgrade for designer frames. All upgrades, designer frames, or non-medical contacts will be billed at wholesale cost.

Our Network and How to use it

Staying within the CompBenefits network gives you the convenience of "one-stop shopping" with everything on a paid-in-full basis. The doctor is paid directly for the full cost of your covered services. After copayment you have no out-of-pocket expenses unless you also choose cosmetic options.

There are other extras, such as a 20%

discount on a second pair of eyeglasses and/or a 15% discount on professional service fees for elective contact lenses (exam and fittings). All extras are available for 12 months after the covered eye exam from the network doctor who performs that initial exam.

Enhanced Benefits

The LASIK procedure is available for near-sighted or astigmatic plan members already wearing glasses or contacts if qualified as a LASIK candidate by the network provider. CompBenefits has contracted with many of the finest LASIK facilities and eye doctors to offer this procedure at substantially reduced fees. At the TLC facilities a member will be charged no more than \$1800 per eye and receive a 10% discount at other participating locations. Family members are also covered at no additional cost.

If there is a problem?

Call (800) 865-3676 and a Member Service Representative will assist you.

Address, Phone & Website

**CompBenefits/VisionCare Plan
1511 N Westshore Blvd. Ste 1000
Tampa, FL 33607-4591
(800) 865-3676
www.visioncare.com**

CompBenefits at a glance

Open your eyes to high-quality vision care! VisionCare Plan offers you and your family a benefit option that covers all routine eye care, including eye exams and eyeglasses (lenses and frame) or contacts. As one of the nation's largest and most experienced prepaid vision programs, VisionCare covers more than half a million employees and their families through a national network of thousands of eye doctors. Visit us on the web at

W W W . V I S I O N C A R E . C O M

COMMON VISION SERVICES for CompBenefits/VisionCare

Visit www.visioncare.com FOR COMPLETE LIST OF SERVICES	Network Benefits	NonNetwork Benefits Plan Pays
Vision Exam Lenses per pair Single Bifocal Trifocal Lenticular	Member Pays \$10 Copay Member Pays \$25 Copay for all lenses & frames	\$35 all less \$10/\$25 copays \$25 \$40 \$60 \$100
Lens Options UV Coating Tints Scratch Resistant Polycarbonate Anti-Reflective	Member Purchases at substantial discounts	Member pays for Optional Upgrades
Frames	Paid in full up to \$40 Wholesale	\$40
Contact Lenses Conventional/Exam Plus Lenses Disposables Medically Necessary	\$105 \$105 Paid in full	\$105 \$105 \$210
Special Services LASIK (no more than, per eye)	\$1800	No Benefit

EVERY 12 MONTHS FOR ALL SERVICES

Monthly CompBenefits/VisionCare Rates for each category

Employee	Spouse	Child	Children
\$6.98	\$5.06	\$3.57	\$4.46

Monthly Cumulative CompBenefits/VisionCare Rates for each category

Employee	+ Spouse	+ Spouse + Child	+ Child	+ Children	+ Spouse + Children
\$6.98	\$12.04	\$15.61	\$10.55	\$11.44	\$16.50

Vision Plan enrollment must be selected and made each year.

Primary Vision Care Services, Inc.



How our plan works

No ID cards or pre-authorization. Simply call a PVCS doctor for an appointment, identify yourself as a PVCS Plan member and the doctor will verify your eligibility. At your appointment, there is no copayment for your eye exam. All eyeglasses and/or contact lenses, and lens options available through your doctor are provided at wholesale cost. The wholesale cost is about 50% to 70% off what you would normally pay and is your responsibility at the time of service.

What you get with our plan

In-Network, Plan members get unlimited exams, unlimited pairs of eyeglasses and contact lenses, all at wholesale cost. Out-of-Network is limited to one eye exam and one set of eyeglasses or contact lenses annually, at the doctor's normal fees.

Our Network and How to use it

Locate a PVCS doctor using the Provider Guide, calling PVCS, or going to our website. Contact the doctor, provide your name and identification number, and the doctor will handle the rest. Exams are covered by the premium with no co-payment. Eyeglasses, contacts, and lens options are purchased at wholesale cost.

Enhanced Benefits

Discounted laser refractive surgery through TLC (Oklahoma City, Tulsa, Ardmore), Southern Oklahoma Laser Eye Center (Ardmore), Dr. Thomas Wolf (Edmond), and Oklahoma Eye Care (Midwest City).

What is Unique about our plan

PVCS is a non-traditional Vision Plan. All materials in the PVCS plan are priced at wholesale cost regardless of categories. A member may get as many eye exams, pairs of glasses and/or contact lenses as needed or wanted during the Plan year, all covered by the Plan's wholesale purchase benefit.

PVCS is the only Oklahoma owned and operated Vision Care Plan. PVCS is certified by the Oklahoma State Department of Health.

If there is a problem?

Call PVCS Customer Service (888) 357-6912.

Address, Phone & Website

**Primary Care Vision Services, Inc.
2518 W. Gore Blvd., Suite C,
Lawton, Oklahoma 73505-6315
(888) 357-6912**

www.pvcs-usa.com

PVCS at a glance

▼Best Value Vision Plan ▼Unlimited eye exams in-network with no co-payment ▼No limits on frames, lenses, and contact lenses, all at wholesale cost ▼All lens options provided at wholesale cost ▼Large network of independent Optometrists and Ophthalmologists Doctor may use own lens fabrication laboratory resulting in faster service time than other plans ▼Discounted laser refractive surgery at multiple locations Visit us on the web at

W W W . P V C S - U S A . C O M

EXAMPLES OF COMMON VISION SERVICES for PVCS

Visit www.pvcs-usa.com FOR COMPLETE LIST OF SERVICES	Network Benefits Member Pays	NonNetwork Benefits
Vision Exam Lenses per pair Single Bifocal Trifocal Lenticular	\$0 Wholesale cost	Normal Dr. fees Reimbursed up to \$40 \$30 \$50 \$50 \$50
Lens Options UV Coating Tints Scratch Resistant Polycarbonate (Single/Multi Vision) Anti-Reflective	\$8 \$8 \$12 \$20/\$30 \$40	Member pays All Normal Dr. fees
Frames	Wholesale Cost	Reimburse up to \$60 to member
Contact Lenses Conventional/Exam Plus Lenses Disposables Medically Necessary	Wholesale cost after one-time \$50 copay	Reimburse up to \$60 to member
Special Services LASIK	Discounted, see page 36	

MEMBER MUST SELECT EITHER NETWORK OR NON-NETWORK FOR ENTIRE PLAN YEAR. ALL NETWORK SERVICES ARE UNLIMITED. NON-NETWORK SERVICES (1 EYE EXAM, 1 SET OF EYEGLASSES OR CONTACTS) ARE LIMITED TO ONCE ANNUALLY.

Limitations/Exclusions: (1) medical eye care; (2) vision therapy; (3) non-routine vision services (for explanation of services contact customer service at (888) 357-6912); (4) non-prescription eyewear; and (5) luxury frames (wholesale cost frames of \$100 or more).

Monthly VISION Rates for each category

Employee \$9 Spouse \$7.50 Child \$8 Children \$10

Monthly Cumulative VISION Rates for each category

Employee	+Spouse	+Spouse +Child	+Child	+Children	+Spouse +Children
\$9	\$16.50	\$24.50	\$17	\$19	\$26.50

Vision Plan enrollment must be selected and made each year.

SPECTERA®



A United Health Group Company

How our plan works

With Spectera, you have a choice of network private practice providers and retail chain providers. To find a Network provider, check the attached Provider listings, visit Spectera's Web site - or call Spectera's Provider Locator Service at (800) 839-3242 and follow the voice prompts. Before using your benefits at a network provider, call the provider, make an appointment and inform the provider that you are a Spectera member.

What you get with our plan

A Spectera member is eligible for a yearly exam by a participating network optometrist or ophthalmologist with a \$10 copay. An additional \$25 copay covers frames and lenses at 100% within the designated frame selection. Out-of-network provider coverage is reimbursed according to a predetermined schedule.

Our Network and How to use it

Spectera has an easy to access network of optometrists and ophthalmologists using the Provider Guide, our website or by phone.

Enhanced Benefits

Standard scratch-resistant coating is covered-in-full. You may be able to discount purchase additional options not covered by the program such as progressive lenses,

polycarbonate lenses, tints, UV, and anti-reflective coating. Laser Eye Surgery is available for members at numerous provider locations throughout the United States. Locate a participating laser eye surgeon in your area on our Web site.

What is unique about our plan

Spectera's network gives you access to either private practice providers (including Optometrists and Ophthalmologists) and retail chains including EyeMasters, EyeMart Express and Texas State Optical. Spectera also provides an additional frame allowance of \$50 (private) or \$100 (retail) and \$105 Contact Lens allowance.

If there is a problem?

If you have questions or concerns contact Spectera's Customer Service Center: Eastern Standard Time

Monday - Friday 8:30am - 8pm

Saturday 9am - 5pm

Address, Phone & Website

SPECTERA
2811 Lord Baltimore Drive
Baltimore, MD 21244
(800) 638-3120

www.spectera.com

Spectera at a glance

Spectera's Vision care Program provides affordable, quality vision care. Through Spectera's provider network, you will receive a complete eye examination, as well as materials (if needed). Visit us on the Web at

W W W . S P E C T E R A . C O M

EXAMPLES OF COMMON VISION SERVICES for Spectera

Visit www.spectera.com FOR COMPLETE LIST OF SERVICES	Network Benefits Member Pays	*NonNetwork Benefits Plan Pays
Vision Exam	\$10 Copay	Up to \$40
Lenses per pair		
Single	\$25 Copay	Up to \$40
Bifocal	\$25 Copay	Up to \$60
Trifocal	\$25 Copay	Up to \$80
Lenticular	\$25 Copay	Up to \$80
Lens Options		
UV Coating	Discount \$16-23	No Benefit
Tints	Discount \$13-15	
Scratch Resistant	Covered Full	
Polycarbonate	Discount \$25-30	
Anti-Reflective	\$40	
Frames	\$25 Copay	Up to \$45
Contact Lenses		
Conventional/Exam Plus Lenses	\$25 Copay	\$105
Disposables	\$25 Copay	\$105
Medically Necessary	\$25 Copay	\$210
Special Services		
LASIK	Discounted w/ participating Providers	No Benefit

SERVICES ARE LIMITED TO ONCE A YEAR

*NonNetwork claims must be submitted to:
Spectera Claims Dept., PO Box 26618, Baltimore, MD, 21207-6618

Monthly Spectera Rates for each category

Employee	Spouse	Child	Children
\$8.20	\$5.80	\$4.60	\$7.00

Monthly Cumulative SPECTERA Rates for each category

Employee	+Spouse	+Spouse & Child	+Child	+Children	+Spouse & Children
\$8.20	\$14.00	\$18.60	\$12.80	\$15.20	\$21.00

Vision Plan enrollment must be selected and made each year.



Superior Vision Services, Inc.

Superior Vision Plan

How our plan works

With Superior Vision you can enjoy one of the largest and most diverse provider networks in the nation and be able to choose from ophthalmologists, optometrists, opticians and optical chains such as Lenscrafters, EyeMasters and Pearle Vision.

What you get with our plan

You will receive a personalized I.D. card and a provider directory at your home address. The I.D. card will list your benefits and contact information for Superior Vision. The I.D. card is not required but may simplify the identification process

Our Network and How to use it

Select a provider from the Superior Vision provider network listings. Make an appointment and identify yourself as a member with your personalized I.D. card. The provider will handle all claims for in-network services. Pay the provider directly for any applicable co-pay amounts and for any charges over and above your covered benefits. For Non-Network, pay the provider in-full for all services and materials. Submit an itemized invoice or receipt to Superior Vision Claims Services for reimbursement. You will be reimbursed in accordance with the non-network schedule of reimbursements printed in

your enrollment materials, less any applicable co-pay amount(s).

Enhanced Benefits

You may also receive special discounts on the LASIK refractive surgery procedure from our contracted Refractive Surgery Network. Please see your benefit information for complete details.

What is Unique about our plan

Receive a 20% discount on any add-on to the insured pair plus special discounts on additional glasses or contacts. Superior Vision has one of the largest and most diverse provider networks in the nation.

If there is a problem?

Help is close at hand. Member Services is open from Monday through Friday, 7am to 8pm, CST and Saturdays from 10am to 3pm. Simply call 1-800-507-3800 and we'll be there for you.

Address, Phone & Website

SUPERIOR VISION SERVICES, INC.
11101 White Rock Road, Suite 150
Rancho Cordova, CA 95670
(800) 507-3800

www.superiorvision.com

Superior at a glance

Choose your provider from the largest nationwide network of 25,000 ophthalmologists, optometrists, opticians and optical chains, such as Lenscrafters, EyeMasters, and Pearle vision. Provider listings are available on our website, from printed directories, or by calling our toll-free Customer Service line at (800) 507-3800. Covered out of state dependents can easily access this network for their vision benefits. Visit us on the web at

www.superiorvision.com

EXAMPLES OF COMMON VISION SERVICES for SUPERIOR

Visit www.superiorvision.com FOR COMPLETE LIST OF SERVICES	Network Benefits	NonNetwork Benefits Member Receives
Vision Exam Ophthalmologist Optometrist Lenses per pair Single Bifocal Trifocal Lenticular	\$10 copay \$10 copay all \$25 copay	Up to \$34 Up to \$26 Up to \$26 Up to \$39 Up to \$49 Up to \$78
Lens Options UV Coating Tints Scratch Resistant Polycarbonate Anti-Reflective	All 20% off retail	All No Coverage
Frames (only one \$25 Copay for frames & lenses)	All Covered Up to \$125	Up to \$68
Contact Lenses Lenses Disposables Medically Necessary	All Covered Up to \$120 Up to \$120 Full	Up to \$100 Up to \$100 Up to \$210
Special Services LASIK & Cosmetic eyelid Surgery(blepharoplasty)	Both 20% off UCR	No coverage

EVERY 12 MONTHS FOR ALL SERVICES

In-network copayments are paid directly to the provider. Non-network copayments will be deducted from the non-network reimbursement. Superior Vision provides the most options for "one-hour" and "same-day" services.

Monthly SUPERIOR Rates for each category

Employee	Spouse	Child	Children
\$6.98	\$6.90	\$6.58	\$6.58

Monthly Cumulative SUPERIOR Rates for each category

Employee	+ Spouse	+ Spouse + Child	+ Child	+ Children	+ Spouse + Children
\$6.98	\$13.88	\$20.46	\$13.56	\$13.56	\$20.46

Vision Plan enrollment must be selected and made each year.

Vision Service Plan



How our plan works

No ID cards. No claim forms. Easy as 1-2-3.

1. Find a VSP network doctor at vsp.com or call 800-877-7195.
2. Make an appointment and tell the doctor you are a VSP member.
3. Your doctor and VSP will handle the rest. It's that simple.

What you get with our plan

When visiting a VSP network doctor, you'll receive an exam and prescription glasses or contacts every 12 months after your copays. Your prescription glasses include single vision, lined trifocal or lined bifocal lenses and a frame of your choice covered up to an allowance. Plus, 20% off any out of pocket costs. For contacts the allowance applies to the cost of your lenses and the additional fitting and evaluation exam required for the proper contact fit.

Copays still apply for Non-Network, non-VSP Doctor and services. Full payment is required at the time of your appointment and a claim form must be submitted for partial reimbursement. Call (800) 877-7195 before seeing a Non-network provider.

Our network and how to use it

VSP network doctors are located right where you need them — close to work, home and shopping malls. They provide top quality care and offer a wide selection of frames to choose from — all at one convenient location.

Enhanced Benefits

Below are additional discounts and savings at

your VSP Doctor

Prescription Glasses

* Up to 20% savings on lens extras (scratch resistance, anti-reflective coatings and progressives)

* 20% off additional prescription glasses and sunglasses

* If you select a frame above your \$105 allowance, you receive a 20% discount on any amount above the allowance.

Contacts

* Exclusive pricing on annual supplies of popular brands

* 15% off contact lens exam (fitting & evaluation)

Laser Vision Correction Discounts

What is Unique about our plan

An eyecare plan with you in mind. With your VSP eye exam, we'll help you see clearly, and possibly early detect serious health conditions.

If there is a problem?

At VSP, your satisfaction is guaranteed. For resolution contact us Monday through Friday, 6:00 AM to 7:00 PM (PST) by phone or on the web.

Address, Phone, Website

**Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195**

www.vsp.com

VSP benefits at a glance

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. Always accepting new patients, VSP network doctors are located right where you need them — close to work, home and shopping malls. Call (800) 877-7195 or go on the web www.vsp.com to find a VSP network doctor — Answers Anytime, Anywhere. Do you need an evening appointment? Interested in a doctor who focuses on sports or children's eye wear? Looking for a credible resource for an eye condition? Visit us on the web today — you'll like what you see. Visit us on the Web at

W W W . V S P . C O M

EXAMPLES OF COMMON VISION SERVICES for VSP

Visit www.vsp.com FOR COMPLETE LIST OF SERVICES	Network Benefits Member Pays	NonNetwork Benefits Plan Pays
Vision Exam	\$10 copay	Reimbursement up to \$35
Lenses per pair Single Bifocal (Lined) Trifocal (Lined) Lenticular	\$25 Copay All other charges covered in full	Up to \$25 Up to \$40 Up to \$55 Up to \$80
Lens Options (additional lens options available) UV Coating Tints Scratch Resistant Polycarbonate Anti-Reflective	Member receives 20% Discount on all Add-ons	No Benefit
Frames	Plan covers Up to \$105	Plan covers Up to \$45
Contact Lenses Conventional/Exam Plus Lenses Disposables Medically Necessary (Prior Authorization, Covered in Full)	Covered Up to \$105 Up to \$105 Up to \$210	Covered Up to \$105 Up to \$105 Up to \$210
Special Services Laser Vision Correction	Discounts at Contracted Centers	No Benefit

EVERY 12 MONTHS FOR ALL SERVICES

Monthly VISION SERVICE PLAN Rates for each category

Employee	Spouse	Child	Children
\$8.88	\$5.33	\$5.62	\$10.95

Monthly Cumulative VISION SERVICE PLAN Rates for each category

Employee	+ Spouse	+ Spouse + Child	+ Child	+ Children	+ Spouse + Children
\$8.88	\$14.21	\$19.83	\$14.50	\$19.83	\$25.16

LIFE INSURANCE

Required BASIC LIFE

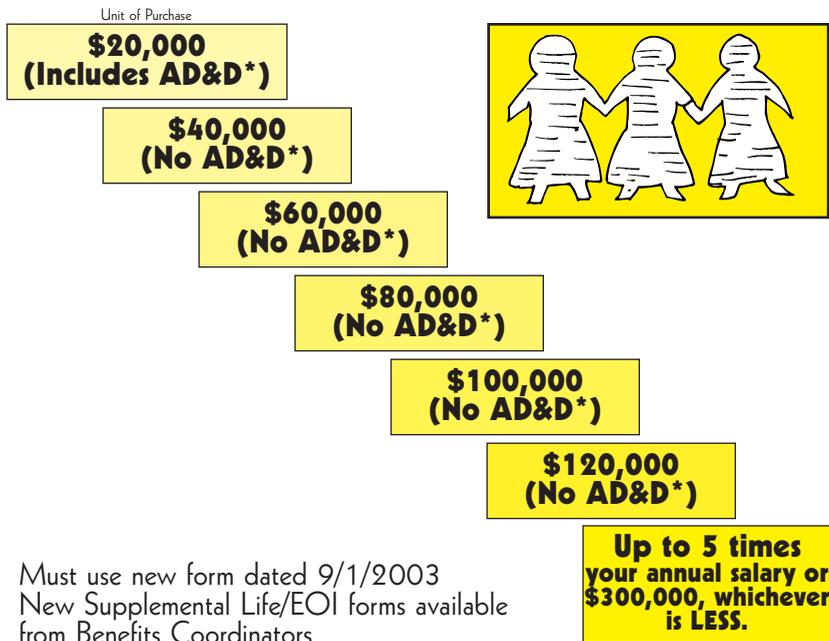
(\$3.90 a month paid out of the State Benefit Allowance)

\$20,000 Includes AD&D*

Each eligible state employee is automatically enrolled in Basic Life coverage which remains in force until the employee leaves state service. You do **NOT** enroll at each Option Period.

Optional SUPPLEMENTAL LIFE

(employee only)
Requires Supplemental Life Application Form and EOI (Medical History). Must be Purchased in Units of **\$20,000 ONLY**



Must use new form dated 9/1/2003
New Supplemental Life/EOI forms available from Benefits Coordinators

NOTE! The Guaranteed Issue (2 times salary) will only be offered to NEW HIRES during their 30 day enrollment period. All new hire purchases above that amount and all Option Period life insurance applications require an EOI. Use only the new form dated 9/1/2003.

*AD&D—Accidental Death & Dismemberment provides additional benefits due to loss of life or dismemberment under certain circumstances. See member handbook for details.

SINCE JANUARY 1, 2002

1) **Nonvested employees may continue their life insurance benefits following termination of employment if the employee has completed at least eight (8) years of service with an employer participating in the Oklahoma Public Employees Retirement System, or at least ten(10) years of service with an employer participating in the Teachers' Retirement System of Oklahoma. This election must be made within thirty (30) days after the date of termination. Nonvested members will have the same life insurance rights as normally provided by law.**

2) **Former employees reemployed by the same employer within twenty-four (24) months of a termination date may elect only the previous life coverage amount in force before termination without Evidence of Insurability (EOI). The reemployed employee can only increase coverage after submission and approval of an EOI form.**

It is not something you expect, but you can plan for the financial burden it can bring...just in case. To help you plan, the State covers all eligible State employees under the State Disability Plan.

Disability paid for a maximum of 150 days after a 30 day elimination period. (E.P. + Maximum benefits = 180 days). Long Term Disability begins after 180 days of Short Term Disability.

The Disability Plan provides you with a partial income if you are unable to work due to illness or injury.

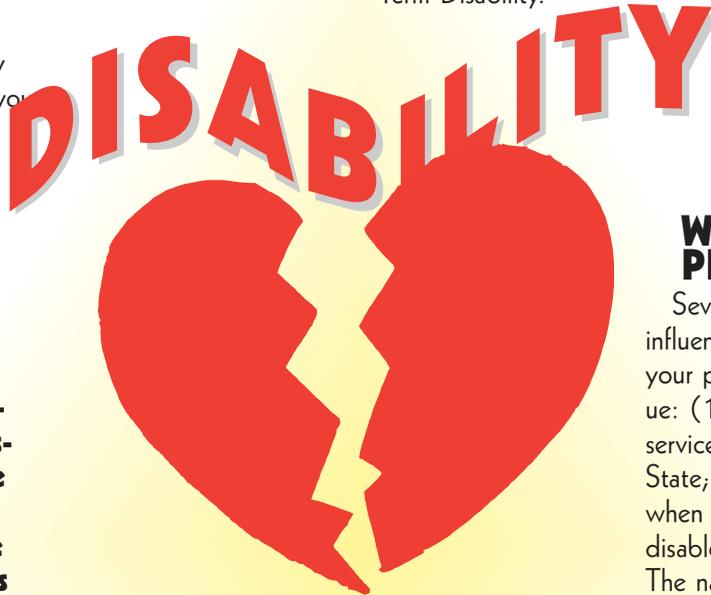
The definition of a disability is the inability to perform the major duties

of your job as the result of an injury or illness that is expected to last

for 31 consecutive calendar days or longer. Medical documentation is required. **After two years from the date of the disability, you must be unable to perform the duties of any job**, for which you are reasonably qualified, in order to be considered disabled. In 2001 state legislation restored a ninety (90) day preexisting condition limitation. **No benefits are payable for any disability caused by a preexisting condition.**

What the Plan Pays

For disabilities after July 1, 1998, the Plan will pay a **monthly benefit** (less offsets) of 60% of your base pay up to the following maximum dollar limits: Short Term



Monthly STD Max = \$1800
Monthly LTD Max = \$3000

When the Plan Pays

Several factors influence how long your payments continue: (1) Your years of service with the State; (2) Your age when you became disabled; and (3) The nature and extent of your disability.

Generally, payments continue until you recover or up to age 65, whichever occurs first. Other limitations apply if you have fewer than five years of service, or if you are age 65 or over and still employed when you become disabled. All benefits are subject to plan maximums.

SPECIAL NOTICE
Your disability benefit from the State will be reduced by other income (such as leave, disability retirement, Social Security Disability, Workers' Compensation, etc.) you receive for the same disability. Disability Benefits are taxable because the employer pays the monthly premiums (\$6.28).

FLEXIBLE Spending Accounts

Information

ENROLLMENT 1) You must enroll (Year ends).

each Option Period or you lose the account. Decide how much money you will need for the Plan Year. 2) With your signature authorization on the Option Period Enrollment Form, you designate a per-pay-period

amount as the contribution. This money is set aside before your earnings are taxed. This decision cannot be changed during the Plan Year unless you experience an allowable midyear change and complete the proper yellow change form within 30 days of that event.

Services must be incurred during the PLAN YEAR January 1, 2004 through December 31, 2004. You may file claims through March 31, 2005 for eligible services utilized during the Plan Year. **USE IT OR LOSE IT!**

According to IRS rules, any funds unused at the end of the Plan Year will be forfeited (90 days after Plan

For current week processing, the claim must be received at EBC's 12th floor reception area at 200 N Harvey located on the corner of Park & Harvey directly east of the Oklahoma County Courthouse no later than Tuesday by 1 pm. Around holidays this deadline is subject to change.

DIRECT DEPOSIT of your reimbursement will be provided to the same account as your payroll deposit. Contact OPM if you change your banking information.

If you **TERMINATE** your 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.

CLAIM INFORMATION: Please call (405) 232-1190 x 301 or (800) 219-8115 x 301 with any questions or visit our NEW website <http://www.ebc.state.ok.us> for claim forms and for frequently asked questions & IRS Regulations.

ONLINE INFORMATION

EBC brings you ONLINE Flexible Spending Account information.

Participants contact us by email to request a personal PIN. ONLINE service allows you to:

- 1) View your account balance & claim information.**
- 2) View a partial list of eligible & non-eligible expenses for reimbursement.**
- 3) Receive answers to FSA claim questions by emailing us at "myflex@ebc.state.ok.us".**
- 4) Print claim forms after you fill in your personal information; it does the math for you.**

Flexible Spending Accounts

HealthCare (Medical)

Must enroll each option period

Under the IRC's Uniform Reimbursement Rule, you have access to your full Health Care Account election **after your first payroll withholding activates your account.** For example, \$50 monthly contribution begins in January for the Plan Year.

At the end of January or early February you receive qualified services not

covered under your medical plan. You may file a reimbursement voucher for the full election amount and continue to make the \$50 monthly contribution as pledged.

If you spend your own money for after-insurance, qualified medical expenses, deductibles, copays and other items NOT PAID by any benefit plan 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.

A few **ELIGIBLE EXPENSES** with the proper documentation are copayments, acupuncture, chiropractic care, vision expenses (glasses, contacts, contact solution, Laser

corrective eye surgery), orthodontics, deductibles, gynecological exams, immunizations, insulin and diabetic supplies, lab exams, psychiatric care, oxygen, orthopedics, sterilization fees, wheelchair, dentures, hearing exam and devices, smoking program, and weight loss program weekly meeting fees (doctor letter of necessity and medical diagnosis

required [diagnosis can be obesity]), and mileage at \$0.12 per mile.

Attach the itemized bill and/or the Insurance Explanation of Benefits (HealthChoice State Plan EOB) to your signed EBC Expense Reimbursement Voucher (CLAIM FORM) and mail to the address on the form. Your reimbursement check will be mailed within ten days of receipt if you submit all required documentation.

MONTHLY MINIMUM = \$ 10.00
MONTHLY MAXIMUM = \$300.00

A few NON-ELIGIBLE EXPENSES are:

**Over-the-counter items,
Warranties,
Handling Charges,
Membership/Health Club Dues,
Food items of any kind,
Clip-on Sunglasses,
Teeth Whitening,
Vitamins or Dietary Supplements.**

Prescriptions, items or services for cosmetic purposes are not reimbursable.

Flexible Spending Accounts

Dependent Care (Daycare)

Pays qualified caregiver expenses for your children or an adult dependent while you and your spouse work.

Eligible Dependents are: 1) Children age 12 or younger who have been included on your income tax return; 2) a spouse physically or mentally incapable of self-care; or 3) any other

person physically or mentally incapable of self-care, regardless of age, who spends at least eight hours a day in your home (such as a disabled parent or older child) is considered a dependent for tax purposes.

If both you and your spouse have dependent care accounts, your COMBINED calendar year total is \$5,000. If you and your spouse file separate income tax returns, your individual calendar year dependent care account limit is \$2,500. (Caution: Only the custodial parent may use this account.) If you are single with an eligible dependent, you may elect up to

\$5,000 per calendar year. The tax credit utilizing Form 2441 does allow up to a \$6,000 credit; however, under IRS Code Section 129, reimbursement accounts did not change and remain at the \$5,000 maximum limit.

MONTHLY MINIMUM = \$ 50.00
MONTHLY MAXIMUM = \$416.66

Medical & Daycare Reimbursement accounts may be used for qualified out-of-pocket expenses of any tax-eligible dependent even if they aren't covered under any of your SoonerChoices.

The Uniform Reimbursement Rule does not apply to the Dependent Care Account. You can receive reimbursement for the amount you have currently deposited in your Dependent Care Reimbursement Account.

The signed Expense Reimbursement Voucher allows you to send proof of payment for reimbursement. With proof of payment and the dates of service, your daycare provider is no longer required to sign the Daycare Acknowledgment form.

MEDICAL & DAYCARE

For further information on allowable expenses, review Section 213 of the Internal Revenue Code and IRS Publication #502 (Medical) and #503 (Daycare). Keep in mind that the state's plan is a qualified Flexible Benefit Program. Some #502 and #503 information may not describe these plan restrictions. Ask your tax accountant or view information on the web at

www.irs.ustreas.gov/prod/forms_pub/index.html



CLICK & TRACK YOUR ACCOUNTS . .

FLEXIBLE SPENDING ACCOUNT PARTICIPANTS . . . Don't miss out on the easy-to-use tracking system for the status of your flexible Spending Accounts. If you have not yet received a PIN, just contact us at MYFLEX@EBC.STATE.OK.US to request one. We will send your PIN via first class mail to your home address.

You'll be able to track the following transactions in either the Health Care Reimbursement (Spending) Account and/or the Dependent Care (DayCare) Reimbursement (Spending) Account as illustrated in the table below.

[View Account](#) [File A Claim](#) [Enrollment](#) [Change User Info](#) [Contact Us](#) [Log Out](#)

[Redacted]

Current as of 2/01/2004 2:00:28 AM

2004 Plan Start Date : 01/01/04

[▶ View Claim Detail](#)

Claims for this plan year must be received by the Final claims Deadline.

Benefit	Annual Election	Deposits to Date	Claims to Date	Paid to Date	Balance	Last Paid Date	Last Paid Amount	Final Claims Deadline
Medical Reimbursement Account	\$XXX.XX	\$XXX.XX	\$XXX.XX	\$XXX.XX	\$XXX.XX	00/00/04	\$XXX.XX	03/31/05

Claims cannot be filed online, but status can be tracked. If you have questions, you may contact our Flexible Spending Account Specialists at (405) 232.1190 x301 or (800) 219.8115 x301.

Anytime between September 29, 2003 and October 29, 2003, you have the option of ONLINE enrollment for PLAN YEAR 2004, (see page 64 for step-by-step enrollment) information).

issues IRC Section 125 and related regulations governing Flexible Benefits Plans. These federal rules apply to the SOONERCHOICES program. The EBC rules in the OAC Title 87: Chapters 1,10 and 15 along with those applicable from the Treasury Regs provide the authority for the



AFTER ENROLLMENT — THEN WHAT??

After your enrollment elections are made...During December, you should receive a Confirmation of Benefits (COB) from your agency Benefits Coordinator. **READ IT CAREFULLY** to verify that your Enrollment is as you had intended.

HMO enrollees will receive new **ID** cards by the end of December and new plan materials by the first part of January. There are some changes to the benefits; so read your plan information thoroughly. Only first-time HealthChoice (Health &/or Dental) enrollees will receive an ID Card. All plans will issue replacement ID cards if requested.

KNOW THE RULES...

The U.S. Treasury formulates and

administration of the State's Flexible Benefits Program. Basic eligibility rules found in OAC Title 360: Chapters 1,10 and 15 of the State Group Insurance Board are also applied in the administration of the State program.

30 days=TIMELY NOTICE of Life Events Which Occur during the Plan Year

If you marry, remarry, adopt a child or have one of your own, spouse gains insurance, etc., you must notify your Benefits Coordinator within 30 days of that event if you wish to modify who is covered or not covered on your benefits plan.

If timely notice is not received by means of a yellow CHANGE FORM and related documentation, EBC is legally required to refuse to accept such request for processing and the change request will be denied.

THINK 30 DAYS!!

FOR YOUR INFORMATION

consumer info & annual
notices

The **WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998**

This 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: Notice Requirements under WHCRA (November 1998), can be obtained by calling (800) 998.7542, or by accessing the publication **ONLINE AT WWW.DOL.GOV/DOL/PWBA/WELCOME.HTML**. Questions and answers pertaining to WHCRA also are available on the HCFA's Website **ONLINE AT WWW.HCFA.GOV/HIPAA**.

BREAST CANCER PATIENT PROTECTION ACT OKLAHOMA STATE LAW provides for at least 48 hours of inpatient care follow-

ing a mastectomy and not fewer than 24 hours following a lymph node dissection.

NEWBORNS AND MOTHERS ACT OF 1996

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.

PROSTATE CANCER PROTECTION ACT OKLA-

HOMA 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.

PROSTATE SURGERY SIDE EFFECTS OKLAHOMA

STATE 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.



Changes in federal law in 1996 may affect your health coverage. The “portability” provision of this law requires that you receive a Certificate of Creditable Prior Coverage from your terminating employer. This certificate can verify up to 18 months of your prior coverage in order to allow a reduction in the new employer’s preexisting condition limitation.

If you enroll when new employee/dependent coverage is initially offered to you (or under a “special enrollment” event), then your new employer cannot require more than a 12-month preexisting condition limitation. If you fail to enroll at the initial offering, then the new employer may apply up to an 18-month preexisting condition limitation on all late enrollees. **[ONLY THE OKLAHOMA STATE HEALTHCHOICE PLAN APPLIES A PREEXISTING LIMITATION UP TO 180 DAYS. HMOS DO NOT APPLY A PREEXISTING CONDITION LIMITATION.]** You should show your HIPAA certificate to the proper enrolling official at your new place of employment. (Your covered dependents may also

receive their own HIPAA certificates if their coverage dates differ from yours.)

THE HIPAA CERTIFICATES ARE ISSUED BY EBC.

Exception: If you have a break in health coverage of at least 63 days, then the credits of prior coverage cannot be applied to reduce any preexisting condition limitations. **(TIP:**

COBRA IS ONE WAY TO AVOID ANY BREAK IN COVERAGE.)

If you elect **COBRA** coverage, you will also receive a Certificate of Creditable Coverage to show when **COBRA** coverage terminated. (Post-**COBRA** certificates are issued by OSEEGIB - The Oklahoma State and Education Employees Group Insurance Board.) Keep both certificates to show to a new employer as verification of all prior coverage.

HIPAA CERTIFICATES ARE NOT REQUIRED OF STATE NEW HIRES. WHEN ACTIVE EMPLOYEES AND/OR DEPENDENTS TERMINATE STATE COVERAGE, HIPAA CERTIFICATES ARE ISSUED BY THE STATE EMPLOYEES BENEFITS COUNCIL.

HIPAA EXEMPTION FOR HEALTHCHOICE PARTICIPANTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans with plan year anniversary dates occurring on or after January 1, 1998. **HIPAA** provides that the plan sponsor of a self-funded nonfederal governmental plan may elect to exempt the plan from any or all of the following requirements. The Oklahoma State and Education Employees Group Insurance Board has elected and been approved for exemption from these requirements for January 1, 2004 to December 31, 2004. The HealthChoice Plans currently have comparable benefits for requirements involving limiting the time period for preexisting conditions, enrollment periods, health coverage available without medical evidence, benefits for mothers and newborns, providing mental health benefits and breast reconstructive surgery following mastectomies.

EMPLOYEE NOTICE UNDER HIPAA LAW

If you are declining enrollment for your dependents (including your spouse) because of other group health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days of the other coverage ending. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your

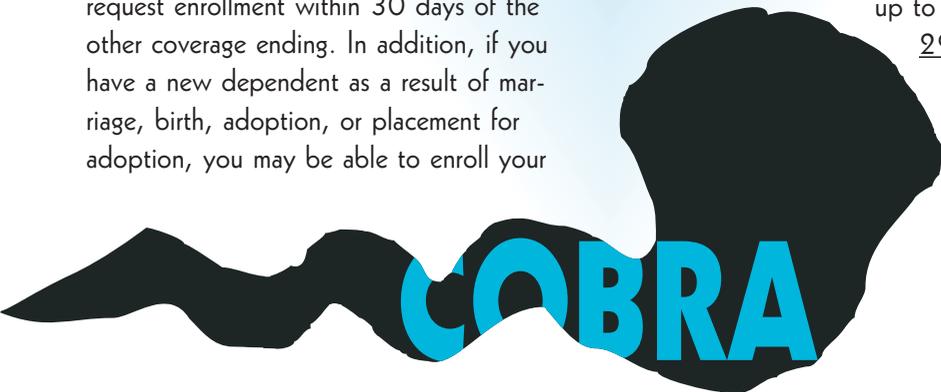
dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

[26 CFR § 54.9801-6T (c).]

[Consolidated Omnibus Budget Reconciliation Act of 1985.]

To continue coverage under **COBRA** law, there must be a **COBRA** “qualifying event.” You have 60 days from the event to elect **COBRA** plus 45 days to pay. (A 2% administrative fee is added to the premium.)

- If employment terminates and an employee wishes to continue eligible coverages on self or other eligible **COBRA** beneficiaries, he/she may do so by applying for **COBRA** continuation and paying monthly premiums directly for up to 18 months.
- Dependents are eligible for up to 36 months of coverage after death of employee, divorce or reaching age 25 or 19 if not a student, if they had coverage the day before the event. Newborns and adoptees may qualify as **COBRA** beneficiaries under HIPAA.
- If an employee or eligible dependent is disabled on the date of the qualifying event OR becomes disabled within the first 60 days after that **COBRA** event, he/she may apply to continue **COBRA** up to a maximum of 29 months (must qualify through Social Security Disability).

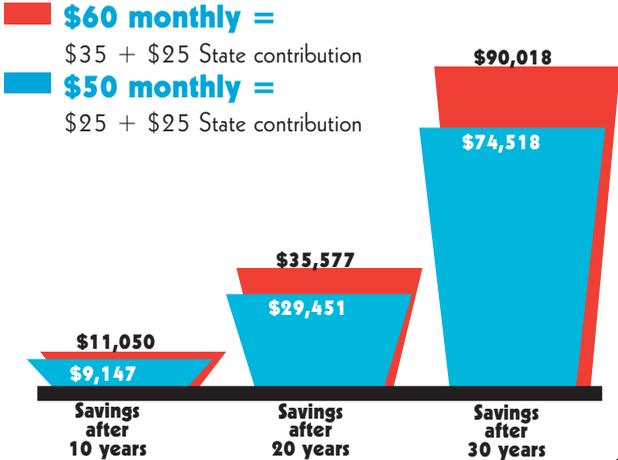


COBRA

Prepare for retirement...wisely

If you are one of the more than 32,000 state employees already taking advantage of the SoonerSave 457 Deferred Compensation & 401(a) Match Incentive Plans, now is a great time to consider increasing your contribution to SoonerSave! Look at how just a small increase of as little as \$10 per month may impact the value of your account over time and when you retire.

How What You Save Adds Up¹



Changing your contribution amount has never been easier.

If you have your PIN, simply visit the SoonerSave Website. If you don't have a PIN, call KeyTalk® at (877) 538-3457 and press zero to speak to a client service representative.²



If you're not a SoonerSave participant, now is a perfect time to join! Here are just a few of the advantages of being a SoonerSave participant:

- **Easy enrollment**
Enrollment forms are available on the Website or from your Agency Coordinator
- **\$25 contribution from the State of Oklahoma**
- **Tax deferred savings**
- **Investment option choice**



1. FOR ILLUSTRATIVE PURPOSES ONLY. DOES NOT REPRESENT THE PERFORMANCE OF ANY SPECIFIC INVESTMENT OPTION. DOES NOT REFLECT ANY CHARGES OR FEES ASSOCIATED WITH YOUR PLAN. THE ACCUMULATIONS ILLUSTRATED HERE WOULD BE REDUCED IF THESE FEES HAD BEEN DEDUCTED. ASSUMES 8% ANNUAL RETURN COMPOUNDED MONTHLY AND NO WITHDRAWALS.
2. ACCESS TO KEYTALK® AND THE WEB SITE MAY BE LIMITED OR UNAVAILABLE DURING PERIODS OF PEAK DEMAND, MARKET VOLATILITY, SYSTEMS UPGRADES/MAINTENANCE, OR OTHER REASONS.
FOR MORE INFORMATION ABOUT AVAILABLE INVESTMENT OPTIONS, INCLUDING FEES AND EXPENSES, YOU MAY OBTAIN APPLICABLE PROSPECTUSES AND/OR DISCLOSURE DOCUMENTS FROM YOUR REGISTERED REPRESENTATIVE AT (877) 538-3457. READ THEM CAREFULLY BEFORE INVESTING. SECURITIES (EXCEPT FOR THE SELF-DIRECTED BROKERAGE ACCOUNT OPTION), WHEN OFFERED, ARE OFFERED THROUGH BENEFITSCORP EQUITIES, INC., A WHOLLY OWNED SUBSIDIARY OF GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY.

2004 BENEFIT ALLOWANCE

EMPLOYER MONEY FOR YOUR BENEFIT			
TOTAL	Monthly	Yearly	
Employee-Only receives	\$371.46	\$4457.52	
Employee with Family receives amounts below			
\$371.46	Plus	= Monthly =	Yearly
a Child	\$146.02	= \$517.48	= \$6,209.76
Children	\$204.66	= \$576.12	= \$6,913.44
a Spouse	\$282.62	= \$654.08	= \$7,848.96
a Spouse & Child	\$428.64	= \$800.10	= \$9,601.20
a Spouse & Children	\$487.28	= \$858.74	= \$10,304.88

Your Premiums + Your Out-of-Pocket costs do *not* cover the total cost of your medical care. Surprised???



The State's Benefits Allowance provides employees with a great deal of financial assistance toward the premiums for themselves and for a Health plan for spouse and dependents.

The state employee can help control the rise in these premiums by adopting a healthy lifestyle, eating right, increasing physical activity, educating him/herself on how to prevent high-risk medical conditions, obtaining preventive and routine health exams, etc. Healthy employees are at work more than unhealthy ones; healthy employees are more productive and happier than unhealthy ones.

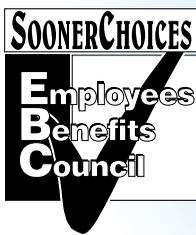
Your out-of-pocket costs such as deductibles and copayments, are paid as you use your health care benefits. Those who go to the doctor more, have more surgeries and take more prescription drugs pay more as they use these services. However, your out-of-pocket costs often do not even come close to the "real costs" for that care.

When you use the Emergency Room and pay a \$100 copay, your health plan may get billed three times that amount. When you pay a \$20 copay for a doctor's office visit, your health plan may pay two or three times that. When you have a \$100 copay for an MRI or CTScan, your health plan may pay eight to ten times what you did. These are the "real costs" of medical care. If you pay a pharmacy copay of \$60, the drug itself may be costing the health plan ten times that amount. Some plans charge a member -0- for a transplant; yet some of these procedures can cost up to \$300,000.

JUST SOME FOOD FOR THOUGHT BEFORE YOU TURN THE PAGE AND REVIEW NEXT YEAR'S RATES . . . *Your insurance coverage is a valuable employee benefit. Choose wisely and Use wisely. Seek information to help you elect coverage that best suits your needs.* Bonita McCoy, Deputy Director, Benefits Administration

HEALTH RATES.MONTHLY.PY 2004

PLAN NAME	Employee	Spouse	Child	Children
HMOs				
CommunityCare (Hi)	\$369.20	\$365.50	\$221.52	\$295.36
CommunityCare (Lo)	\$265.08	\$262.42	\$159.04	\$212.06
PacifiCare (Hi)	\$371.56	\$367.84	\$222.94	\$297.26
PacifiCare (Lo)	\$304.84	\$301.80	\$182.90	\$243.86
PacifiCare Alternative	\$263.12	\$260.48	\$157.88	\$210.50
HealthChoice (Hi)	\$292.54	\$397.12	\$139.62	\$226.02
HealthChoice Basic	\$256.16	\$347.18	\$121.58	\$197.66



AMERICANS ARE BECOMING “SUPER SIZED.” Anyone eating on the run or at restaurants has probably noticed that food portions have gotten larger. Some portions are called “SUPER SIZE,” while others have simply grown in size and provide enough food for at least two people. With this growth have come increases in waistlines and body weight.

PLAN NAME	Employee	+Child	+Children	+Spouse	+Spouse Child	+Spouse Children
HMOs						
CommunityCare (Hi)	\$369.20	\$590.72	\$664.56	\$734.70	\$956.22	\$1030.06
CommunityCare (Lo)	\$265.08	\$424.12	\$477.14	\$527.50	\$686.54	\$ 739.56
PacifiCare (Hi)	\$371.56	\$594.50	\$668.82	\$739.40	\$962.34	\$1036.66
PacifiCare (Lo)	\$304.84	\$487.74	\$548.70	\$606.64	\$789.54	\$ 850.50
PacifiCare Alternative	\$263.12	\$421.00	\$473.62	\$523.60	\$681.48	\$ 734.10
HChoice (Hi)	\$292.54	\$432.16	\$518.56	\$689.66	\$829.28	\$ 915.68
HChoice Basic	\$256.16	\$377.74	\$453.82	\$603.34	\$724.92	\$ 801.00

DENTAL.VISION.OTHER MONTHLY.PY 2004

HEALTHCHOICE DEPENDENT LIFE INSURANCE

(Optional Benefit, Coverage for Spouse & Children)

Dependent Status	Low Option	High Option
Spouse	\$6000	\$10000
Child (6 months to 25)	\$3000	\$5000
Child (Birth to 6 months)	\$1000	\$1000
Premium (per family unit)	\$2.16	\$3.60

DENTAL MONTHLY PREMIUM amounts for each category.

Plan Name	Employee	Spouse	Child	Children
HealthChoice	\$21.96	\$21.96	\$17.52	\$45.46
Fortis/UDC	\$11.74	\$8.86	\$7.60	\$15.20

VISION MONTHLY PREMIUM amounts for each category.

Plan Name	Employee	Spouse	Child	Children
Ameritas	\$4.28	\$3.68	\$3.68	\$6.80
CompBenefits	\$6.98	\$5.06	\$3.57	\$4.46
PVCS	\$9.00	\$7.50	\$8.00	\$10.00
Spectera	\$8.20	\$5.80	\$4.60	\$7.00
Superior	\$6.98	\$6.90	\$6.58	\$6.58
VSP	\$8.88	\$5.33	\$5.62	\$10.95

SOONERCHOICES

**Employees
Benefits
Council**

HEALTHCHOICE SUPPLEMENTAL LIFE INSURANCE

Active State Employees Only

STEP ONE

\$20,000 Life/AD&D **\$3.90 monthly rate**

STEP TWO

Age-Rated Life Insurance (No AD&D Coverage)	Current Age	Per \$1000	Per \$20,000
<25	<25	.06	1.20
25-29	25-29	.06	1.20
30-34	30-34	.06	1.20
35-39	35-39	.09	1.80
40-44	40-44	.13	2.60
45-49	45-49	.21	4.20
50-54	50-54	.35	7.00
55-59	55-59	.58	11.60
60-64	60-64	.67	13.40
65-69	65-69	1.10	22.00
70-74	70-74	1.86	37.20
75+	75+	2.89	57.80

Supplemental Life: Each employee is automatically enrolled in the \$20,000 Basic life coverage at \$3.90/month. The employee may elect Supplemental Life. The first step costs the same as the Basic Coverage, but additional purchases in units of \$20,000 are age-rated per the chart above. Additional amounts of insurance require an EOI. The maximum amount that can be purchased is five times annual salary or \$300,000, whichever is less.

*Monthly Premium Rates per \$1,000 and \$20,000 Please see the Life Insurance section of this Guide for details on page 44.

DENTAL CUMULATIVE PREMIUMS based on the number of covered dependents.

Plan Name	Employee	+Child	+Children	+Spouse	+Spouse & Child	+Spouse & Children
HealthChoice	\$21.96	\$39.48	\$67.42	\$43.92	\$61.44	\$89.38
Fortis	\$11.74	\$19.34	\$26.94	\$20.60	\$28.20	\$35.80

VISION CUMULATIVE PREMIUMS based on the number of covered dependents.

Plan Name	Employee	+Child	+Children	+Spouse	+Spouse & Child	+Spouse & Children
Ameritas	\$4.28	\$7.96	\$11.08	\$7.96	\$11.64	\$14.76
CompBenefits	\$6.98	\$10.55	\$11.44	\$12.04	\$15.61	\$16.50
PVCS	\$9.00	\$17.00	\$19.00	\$16.50	\$24.50	\$26.50
Spectera	\$8.20	\$12.80	\$15.20	\$14.00	\$18.60	\$21.00
Superior	\$6.98	\$13.56	\$13.56	\$13.88	\$20.46	\$20.46
VSP	\$8.88	\$14.50	\$19.83	\$14.21	\$19.83	\$25.16

HEALTH RATES.BIWEEKLY.PY 2004

PLAN NAME	Employee	Spouse	Child	Children
HMOs				
CommunityCare (Hi)	\$170.40	\$168.69	\$102.24	\$136.32
CommunityCare (Lo)	\$122.34	\$121.12	\$ 73.40	\$ 97.87
PacifiCare (Hi)	\$171.49	\$169.77	\$102.90	\$137.20
PacifiCare (Lo)	\$140.70	\$139.29	\$ 84.42	\$112.55
PacifiCare Alternative	\$121.44	\$120.22	\$ 72.87	\$ 97.15
HealthChoice (Hi)	\$135.02	\$183.29	\$ 64.44	\$104.32
HealthChoice Basic	\$118.23	\$160.24	\$ 56.11	\$ 91.23

WEIGHTY NUMBERS

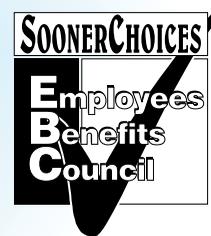
14 EQUALS the number of CALORIES in a POTATO CHIP.

29 EQUALS the number of POUNDS you would GAIN from eating ONE EXTRA POTATO CHIP A DAY FOR 20 YEARS.

19.8 EQUALS the PERCENTAGE OF PEOPLE who say they are OBESE.

30.5 EQUALS the PERCENTAGE OF PEOPLE who really are MEDICALLY OBESE.

DO THE MATH



PLAN NAME	Employee	+Child	+Children	+Spouse	+Spouse Child	+Spouse Children
HMOs						
CommunityCare (Hi)	\$170.40	\$272.64	\$306.72	\$339.09	\$441.33	\$475.41
CommunityCare (Lo)	\$122.34	\$195.74	\$220.21	\$243.46	\$316.86	\$341.33
PacifiCare (Hi)	\$171.49	\$274.39	\$308.69	\$341.26	\$444.16	\$478.46
PacifiCare (Lo)	\$140.70	\$225.12	\$253.25	\$279.99	\$364.41	\$392.54
PacifiCare Alternative	121.44	\$194.31	\$218.59	\$241.66	\$314.53	\$338.81
HChoice (Hi)	\$135.02	\$199.46	\$239.34	\$318.31	\$382.75	\$422.63
HChoice Basic	\$118.23	\$174.34	\$209.46	\$278.47	\$334.58	\$369.70

DENTAL.VISION.OTHER BIWEEKLY.PY 2004

HEALTHCHOICE DEPENDENT LIFE INSURANCE

(Optional Benefit, Coverage for Spouse & Children)

Dependent Status	Low Option	High Option
Spouse	\$6000	\$10000
Child (6 months to 25)	\$3000	\$ 5000
Child (Birth to 6 months)	\$1000	\$ 1000
Premium (per family unit)	\$ 1.00	\$ 1.66

DENTAL BIWEEKLY PREMIUM amounts for each category.

Plan Name	Employee	Spouse	Child	Children
HealthChoice	\$10.14	\$10.14	\$ 8.09	\$20.98
Fortis/UDC	\$ 5.42	\$ 4.09	\$ 3.51	\$ 7.02

VISION BIWEEKLY PREMIUM amounts for each category.

Plan Name	Employee	Spouse	Child	Children
Ameritas	\$1.98	\$1.70	\$1.70	\$3.14
CompBenefits	\$3.22	\$2.34	\$1.65	\$2.06
PVCS	\$4.15	\$3.46	\$3.69	\$4.62
Spectera	\$3.78	\$2.68	\$2.12	\$3.23
Superior	\$3.22	\$3.18	\$3.04	\$3.04
VSP	\$4.10	\$2.46	\$2.59	\$5.05



HEALTHCHOICE SUPPLEMENTAL LIFE INSURANCE Active State Employees Only

STEP ONE \$20,000 Life/AD&D

\$1.80
monthly rate

STEP TWO Age-Rated Life Insurance (No AD&D Coverage)

Current Age	Per \$1000	Per \$20,000
<25	.03	.55
25-29	.03	.55
30-34	.03	.55
35-39	.04	.83
40-44	.06	1.20
45-49	.10	1.94
50-54	.16	3.23
55-59	.27	5.35
60-64	.31	6.18
65-69	.51	10.15
70-74	.86	17.17
75+	1.33	26.68

Supplemental Life: Each employee is automatically enrolled in the \$20,000 Basic life coverage at \$1.80/month. The employee may elect Supplemental Life. The first step costs the same as the Basic Coverage, but additional purchases in units of \$20,000 are age-rated per the chart above. Additional amounts of insurance require an EOI. The maximum amount that can be purchased is five times annual salary or \$300,000, whichever is less.

*Monthly Premium Rates per \$1,000 and \$20,000 Please see the Life Insurance section of this Guide for details on page 44.

DENTAL CUMULATIVE PREMIUMS based on the number of covered dependents.

Plan Name	Employee	+Child	+Children	+Spouse	+Spouse & Child	+Spouse & Children
HealthChoice	\$10.14	\$18.23	\$31.12	\$20.28	\$28.37	\$41.26
Fortis	\$ 5.42	\$ 8.93	\$12.44	\$ 9.51	\$13.02	\$16.53

VISION CUMULATIVE PREMIUMS based on the number of covered dependents.

Plan Name	Employee	+Child	+Children	+Spouse	+Spouse & Child	+Spouse & Children
Ameritas	\$1.98	\$ 3.68	\$ 5.12	\$ 3.68	\$ 5.38	\$ 6.82
CompBenefits	\$3.22	\$ 4.87	\$ 5.28	\$ 5.56	\$ 7.21	\$ 7.62
PVCS	\$4.15	\$ 7.84	\$ 8.77	\$ 7.61	\$11.30	\$12.23
Spectera	\$3.78	\$ 5.90	\$ 7.01	\$ 6.46	\$ 8.58	\$ 9.69
Superior	\$3.22	\$ 6.26	\$ 6.26	\$ 6.40	\$ 9.44	\$ 9.44
VSP	\$4.10	\$ 6.69	\$ 9.15	\$ 6.56	\$ 9.15	\$11.61

ATTENTION : POTENTIAL RETIRED/VESTED EMPLOYEES

Option Period changes are effective January 1st. If you leave employment before January 1, 2004, Option Period enrollments or changes will not be in effect, nor can they be made at the time of retirement. If you have plan changes or dependents to add prior to your leaving employment, the increased coverage must be in effect (premiums paid for a minimum of one [1] month) in order to contin-

OPERS RETIREMENT

Use the coverage into retirement or as a vested member. Only enrollments within thirty (30) days of certain allowable midyear changes (see page 11 for a list) following the previous year's Option Period ensure this. If you have any questions about available benefit plan options, please contact your Benefits Coordinator prior to leaving employment.

OPERS/SoonerSave
(800) 733.9008 &
405) 858.6737

WWW.OPERS.STATE.OK.US
WWW.SOONERSAVE.COM

The Oklahoma Public Employees Retirement System (OPERS) serves many state and local government employees.

This Option Period is a great time to update the beneficiaries you have named for each of your retirement plans especially if you have recently been married, divorced, experienced the birth of a child, or death in your family.

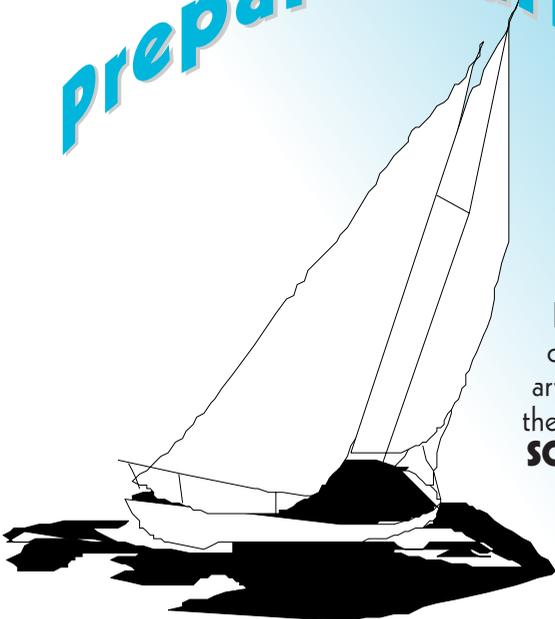
Updating your beneficiaries is easy.

Employees of

state and local governments can obtain beneficiary designation forms from their **OPERS & SOONERSAVE** Coordinators.

Retirees can call (800) 733.9008 to request beneficiary designation forms.

Prepare Early to SAIL AWAY



RETIREE.NON-ACTIVE.PY 2004 HEALTH RATES.MONTHLY

This retiree/nonactive vested rate information is provided as a courtesy of EBC for any state employee who may be anticipating retirement during Plan Year 2004.

MONTHLY RATES PRE-MEDICARE

Name of Plan	Employee	Spouse	Child	Children
CommunityCare HMO (Hi)	459.20	413.28	183.68	367.36
CommunityCare HMO (Lo)	355.08	319.56	142.02	284.06

PacifiCare HMO (Hi)	461.56	415.40	184.62	369.24
PacifiCare HMO (Lo)	394.84	355.36	157.94	315.86

PacifiCare HMO

Alternative Nonstandard	353.12	317.80	141.26	282.50
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HealthChoice (Hi)	382.54	507.52	139.62	226.02
HealthChoice Basic	346.16	445.44	121.58	197.66

MONTHLY RATES MEDICARE ELIGIBLE

Name of Plan	Employee	Spouse	Child	Children
HealthChoice (Hi)	251.84	261.40	139.62	226.02
HealthChoice (Lo)	166.02	171.36	124.98	203.00

PacifiCare (Hi)	244.50	244.50	134.46	212.72
PacifiCare (Lo)	164.24	164.24	90.34	142.88

MEDICARE + CHOICE RATES

Name of Plan	Employee
PacifiCare Secure Horizons	\$164.76
CommunityCare Senior	\$145.60



WEIGHTY NUMBERS

510 equals the number of calories in a cinnamon crunch bagel
2 hours equals the number of hours needed for a 160 lb. person to walk off a plain cinnamon crunch bagel.

RETIREE.NON-ACTIVE.PY 2004 DENTAL.LIFE.MONTHLY

DENTAL Monthly premium amounts for each category.

Plan Name	Employee	Spouse	Child	Children
HealthChoice	\$21.96	\$21.96	\$17.52	\$45.46
Fortis	\$11.74	\$ 8.86	\$ 7.60	\$15.20

VISION Monthly premium amounts for each category.

Plan Name	Employee	Spouse	Child	Children
Ameritas	\$4.28	\$3.68	\$3.68	\$ 6.80
CompBenefits	\$6.98	\$5.06	\$3.97	\$ 4.46
PVCS	\$9.00	\$7.50	\$8.00	\$10.00
Spectera	\$8.20	\$5.80	\$4.60	\$ 7.00
Superior	\$6.98	\$6.90	\$6.58	\$ 6.58
VSP	\$8.88	\$5.33	\$5.62	\$10.95

Monthly Life Insurance Rates

Per guidelines established by the State and Education Employees Group Insurance Board, eligible former employees may retain in \$5,000 increments a portion of their life insurance up to a maximum of the \$20,000 Basic Life. From \$35,000 up the employee may also continue in force any of the remaining Supplemental HealthChoice Life coverage in effect at the time of termination.

\$5,000 TO \$35,000 costs \$2.16 per \$1,000 in \$5,000 increments

COVERAGE MAY NEVER BE ADDED OR INCREASED AFTER RETIREMENT. FROM \$36,000 UP, THE AGE-RATED LIFE IS AS FOLLOWS:

Current Retiree	Age-Rated	Current
	Age	
	< 30	.06
	30-34	.06
	35-39	.09
	40-44	.13
	45-49	.21
	50-54	.35
	55-59	.58
	60-64	.67
	65-69	1.10
	70-74	1.86
	75+	2.89

Dependent Life

For Dependents of Retiree (Spouse and/or Children)
\$1.08 (per \$500 unit, per dependent)



k **EAP**

h e a l t h y

The **EMPLOYEE ASSISTANCE PROGRAM (OAC 530:10-21)**

provides professional consultation,

Health Robert Dennis (OK City) (405) 947.7591
Corporate Assistance Program (800) 677.2729 or 947.2688

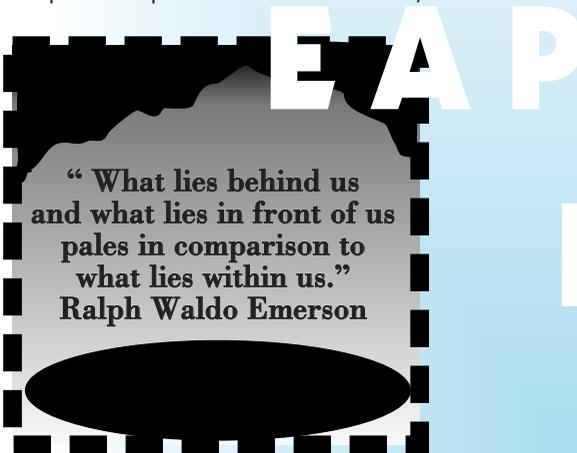
Human Services Corporate Assistance Program (800) 677.2729 or 947.2688

Mental Health & Substance Abuse
Rob Lewis (Tulsa) (918) 581.2805

Public Safety Joe Elam, Director of Psychological Services (405) 425.2445
Transportation Nancy Graham-Owen (405) 522.3709

Personnel Management (handles all other state agencies without an EAP) Bob Stevens, Warren Thompson, Blanche Longoria, Deanna Miller (OK City) (405) 947.7576
After-hours Emergencies Pager (888) 870.3759

Oklahoma Transportation Authority
Shirley Fuller (405) 425.3621
(877) 347.5917



confidential assessment, short-term problem resolution and referral service for employees, family members and supervisors.

EAP services are absolutely confidential and free of charge. Participation is voluntary except where participation is required by other state or federal law such as a positive drug and/or alcohol test. The employee shall not be disciplined or otherwise prejudiced in employment by participating in the **EAP**.

All insurance plans provide mental health and substance abuse treatment now referred to as "behavioral health." The **EAP** can help with explaining and accessing this benefit.

EAP Agency Contacts

Corrections Curtis Gilley, Ken Skidmore, Debbie Payne (Shawnee)
(405) 275.1997 (800) 522.7031

EAP can help when sometimes our lives can become overwhelming. We hit a bump in the road - divorce, depression, alcohol/drugs, stress, and we may need help putting the pieces back together. It is important to know you do not have to do it alone.

EAP can help with a variety of issues including: family, marriage, forced change, drugs/alcohol, trauma, grief, finances, depression, anxiety, and eldercare. Contact your **EAP** professional for more information or a referral. Remember: we are here to help you help yourself.

**Visit EBC's redesigned Website at
www.ebc.state.ok.us**



Employees 
Benefits Council

- About EBC
- BAS
- BENEFITS
- FLEXIBLE Spending
- OkHEALTH
- WELLNESS



**You
may enroll
online or with a paper form.**

Check the online ENROLLMENT TIP SHEET and complete the authorization form which must be returned to your agency Benefits Coordinator. Upon submitting the authorization form, you will receive a personal letter with an initial ID and temporary password. Follow instructions on the ENROLLMENT TIP SHEET to complete your 2004 SoonerChoices enrollment.



EBC ~~2004~~ online www.ebc.state.ok.us

RETIREMENT SYSTEMS

Public Employees Retirement System
(OPERS)(405) 858-6737
Toll-Free(800) 733-9008
Webwww.opers.state.ok.us
Law Enforcement Retirement
.(405) 522-4931
Firefighters Pension & Retirement
.(405) 522-4600
Toll-Free(800) 525-7461
Wildlife Retirement(405) 521-4656
Teachers Retirement(405) 521-2387
OESC Retirement(405) 557-7217
Uniform Retirement System for Justices &
Judges(405) 858-6737
Toll-Free(800) 733-9008

OTHER

HealthChoice Disability Information
Member Service Life
.(405) 841-9686
Toll-Free(800) 722-2567
SoonerSave Account Line
.(877) 538-3457
Webwww.soonersave.com
Deferred Compensation
.(405) 858-6737
Toll Free(800) 733-9008
Webwww.opers.state.ok.us
EAP Numberslisted on page 63

EMPLOYEES BENEFITS COUNCIL

Toll Free(800) 219-8115
Benefits/ Wellness Fax
.(405) 232-1324
Administration Fax(405) 232-3158

Finance Fax(405) 232-1729
TDD(405) 235-4625
Flexible Spending Accounts
.(405) 232-1190 x301
Toll Free(800) 219-8115 x301
Fax(405) 232-1729
HIPAA(405) 232-1190
Benefits Reps(405) 232-1190 x300
Wellness .(405) 232-1190 x120 & x131

(405) 232.1190
PHONES.FAXES
WEBSITES



HEALTH

HealthChoice (State Plan)

Oklahoma City Metro

.....(405) 717-8780

Toll Free(800) 752-9475

Health, Dental & Life

.....(405) 499-4920

Toll-Free(800) 782-5218

Pharmacy Claims(800) 903.8113

Precertification/On-line Directory/Emergencies

Toll-Free(800) 848-8121

COBRA(405) 717-8824

Toll-Free(800) 543-6044 x8824

Webwww.heathchoiceok.com

CommunityCare HMO

All Areas(800) 777-4890

Webwww.ccok.com

PacifiCare HMO

All Areas(800) 825-9355

Webwww.pacificare.com

DENTAL

HealthChoice (State) Dental Plan

Oklahoma City Metro

.....(405) 717-8780

Toll Free(800) 752-9475

Fortis Pinnacle Dental

All Areas(800) 443-2995

Webwww.fortisbenefitsdental.com

VISION

Ameritas(800) 877-7195

Webwww.ameritasgroup.com

CompBenefits(800) 365-3676

Webwww.visioncare.com

SOONERCHOICES

Employees
Benefits
Council

Primary Vision Care Service

.....(888) 357-6912

Webwww.pvcs-usa.com

Spectera(800) 638-3120

Webwww.spectera.com

Superior(800) 507-3800

Webwww.superiorvision.com

Vision Service Plan ... (800) 877-7195

Webwww.vsp.com

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Benefits Reps(405) 232-1190 x300