

	CHOICE OF PROVIDER 1	CALENDAR YEAR DEDUCTIBLE 2	ANNUAL OUT-OF-POCKET MAXIMUM 3	OFFICE VISITS (PROFESSIONAL SERVICES) 4	PRESCRIPTION DRUGS 5		HOSPITAL INPATIENT 6	HOSPITAL OUTPATIENT 7	EMERGENCY HEALTH CARE 8	AFTER HOURS URGENT CARE 9	DIAGNOSTIC X-RAY & LAB 10	ALLERGY TREATMENT & TESTING 11		WELL-BABY CARE 12	IMMUNIZATIONS 13	MATERNITY 14	CONTRACEPTIVE SERVICES 15	CONTRACEPTIVE DRUGS 16	INFERTILITY SERVICES 17		MENTAL HEALTH INPATIENT 18	MENTAL HEALTH OUTPATIENT 19	SUBSTANCE ABUSE INPATIENT 20	SUBSTANCE ABUSE OUTPATIENT 21	HEARING SCREENING 22	HEARING AIDS 23
Standard HMO HIGH OPTION CommunityCare GlobalHealth	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for all care received outside PCP office	None	Individual: \$1,000 Family: \$2,000	COPAYS \$10 PCP \$25 Specialist Does NOT include preventive benefits in columns 12,13,15, 22, or 29	Tier 1: \$10 Tier 2: \$25 Tier 3: \$45 Greater of 30-day supply or 100 units as determined by physician. Select medications may have restricted quantities because the recommended therapy is less than 30 days or 100 units or dosage form is not a tablet or capsule.	Standard HMO HIGH OPTION CommunityCare GlobalHealth	\$100 per admission Precertification from PCP required	\$100 per visit As authorized by PCP	\$75 copay which is waived if hospitalized	\$10 per visit You must contact your PCP and use plan authorizations	No charge except for MRI, MRA, PET or CAT Scan which requires \$100 copay per scan All must be preauthorized	\$10 per series of tests w/PCP \$25 w/specialist \$10 per 6 weeks of Antigen, including shots (No additional charge for administration of shots)	Standard HMO HIGH OPTION CommunityCare GlobalHealth	\$0 per exam for Well-Care visits during first two years of life	No copay for ages birth through 18 years \$10 copay per visit for ages over 18	\$10 for initial visit \$100 per admission Precertification required	\$10 for consultation \$10 per surgical procedure	Tier 1: \$10 Tier 2: \$25 Tier 3: \$45 Greater of 30-day supply or 100 units Select medications may have restricted quantities One copay per injectable contraceptive	25% of costs plus the office visit copay of \$10 - PCP \$25 - Specialist Limited to diagnosis and some treatment See exclusions in member materials	Standard HMO HIGH OPTION CommunityCare GlobalHealth	\$50 per admission Limited to 30 days per Plan Year Must be preauthorized Except for the biologically based diagnoses that are treated as other illnesses	\$10 per visit - PCP \$25 per visit - Specialist Single or group therapy 26 visits per Plan Year Must be preauthorized Except for the biologically based diagnoses that are treated as other illnesses	\$50 per admission Limited to 30 days per Plan Year Must be preauthorized	\$10 per visit - PCP \$25 per visit - Specialist Single or group therapy 26 visits per Plan Year Must be preauthorized	\$10 copay per visit for a basic hearing screening (does not include a comprehensive hearing exam) Limit one visit per year	Not a covered benefit—Except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment—see column #26) No benefits for ages 18 & over
Standard HMO LOW OPTION CommunityCare GlobalHealth	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for all care received outside PCP office	None	Individual: \$2,000 Family: \$4,000	COPAYS \$25 PCP \$40 Specialist Does NOT include preventive benefits in columns 12, 13, 15, 22, or 29	Tier 1: \$10 Tier 2: \$35 Tier 3: \$60 Greater of 30-day supply or 100 units as determined by physician. Select medications may have restricted quantities because the recommended therapy is less than 30 days or 100 units or dosage form is not a tablet or capsule.	Standard HMO LOW OPTION CommunityCare GlobalHealth	\$250 per admission Precertification from PCP required	\$150 per visit As authorized by PCP	\$100 copay which is waived if hospitalized	\$25 per visit You must contact your PCP and use plan authorizations	No charge except for MRI, MRA, PET or CAT Scan which requires \$100 copay per scan All must be preauthorized	\$25 per series of tests w/PCP \$40 w/specialist \$25 per 6 weeks of Antigen, including shots (No additional charge for administration of shots)	Standard HMO LOW OPTION CommunityCare GlobalHealth	\$0 per exam for Well-Care visits during first two years of life	No copay for ages birth through 18 years \$25 copay per visit for ages over 18	\$25 for initial visit \$250 per admission Precertification is required	\$25 for consultation \$25 per surgical procedure	Tier 1: \$10 Tier 2: \$35 Tier 3: \$60 Greater of 30-day supply or 100 units Select medications may have restricted quantities One copay per injectable contraceptive	50% of costs plus the office visit copay of \$25 - PCP \$40 - Specialist Limited to diagnosis and some treatment See exclusions in member materials	Standard HMO LOW OPTION CommunityCare GlobalHealth	\$250 per admission Limited to 30 days per Plan Year Must be preauthorized Except for the biologically based diagnoses that are treated as other illnesses	\$25 per visit - PCP \$40 per visit - Specialist Single or group therapy 26 visits per Plan Year Must be preauthorized Except for the biologically based diagnoses that are treated as other illnesses	\$250 per admission Limited to 30 days per Plan Year Must be preauthorized	\$25 per visit - PCP \$40 per visit - Specialist Single or group therapy 26 visits per Plan Year Must be preauthorized	\$25 copay per visit for a basic hearing screening (does not include a comprehensive hearing exam) Limit one visit per year	Not a covered benefit—Except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment—see column #26) No benefits for ages 18 & over
HealthChoice HIGH OPTION IN NETWORK	Choice of Network Provider, contracted allowable fee schedule for medically necessary services	\$300: Individual \$900: Family NO YEAR-END CARRY OVER	Individual: \$2,800 (\$2,500 + \$300 deductible) Non-covered services, copays & ER deductible do not apply NO YEAR-END CARRY OVER	\$25 copay per office visit; on other professional services the individual calendar year deductible applies first; member pays 20% of fee schedule	Generic Mandate: Member pays cost of medication up to a maximum dollar amount as determined by physician. The greater of 34 day supply or 100 units (pills or capsules) as determined by physician. For more details visit www.healthchoiceok.com	HealthChoice HIGH OPTION IN NETWORK	Member pays 20% of fee schedule after the individual calendar year deductible Precertification required	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible	HealthChoice HIGH OPTION IN NETWORK	\$25 copay per exam (no deductible applies)	Well-Baby and Adult immunizations paid at 100% Office visit is subject to copay; administration charge subject to deductible and coinsurance	Member pays 20% of fee schedule after the individual calendar year deductible Includes one postpartum home visit (must meet criteria) Precertification is required	Member pays 20% of fee schedule after the individual calendar year deductible	Generic Mandate: Member pays cost of medication up to a maximum \$ amount for Preferred & Non-Preferred medications. The greater of 34 day supply or 100 units (pills or capsules) as determined by physician. For more details visit www.healthchoiceok.com	Member pays 20% of fee schedule after the individual calendar year deductible	HealthChoice HIGH OPTION IN NETWORK	Member pays 20% of fee schedule after the individual calendar year deductible Limited to 30 days per year Precertification required except for the biologically based diagnoses that are treated as other illnesses	Member pays 20% of fee schedule after the individual calendar year deductible Requires prior approval after 15 visits or penalty will apply 26 visits per year	Member pays 20% of fee schedule after the individual calendar year deductible 30 days per year Precertification required	Member pays 20% of fee schedule after the individual calendar year deductible Requires prior approval after 15 visits or penalty will apply 26 visits per year	Copay per visit for a basic hearing screening (does not include a comprehensive hearing exam) One per year	Not a covered benefit—Except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment—see column #26) No benefits for ages 18 and over; prior authorization required
HealthChoice HIGH OPTION NON NETWORK	Choice of any Provider, non-contracted fee schedule for medically necessary services Member responsible for amount that exceeds the fee schedule and all ineligible expenses	\$300: Individual \$900: Family plus \$300 per confinement hospital deductible NO YEAR-END CARRY OVER	Individual: \$3,300 (\$3,000 + \$300 deductible) Member is responsible for amount that exceeds the fee schedule, ER deductible, ER deductible & charges over maximum benefit limitations NO YEAR-END CARRY OVER	Member pays 25% of fee schedule after the individual calendar year deductible and \$300 per confinement hospital deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Generic Mandate: Member pays cost of medication up to a maximum dollar amount as determined by physician. The greater of 34 day supply or 100 units (pills or capsules) as determined by physician. For more details visit www.healthchoiceok.com	HealthChoice HIGH OPTION NON NETWORK	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses Precertification required	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses Precertification required for outpatient surgery	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses Limit: Battery of 60 tests every 24 months	HealthChoice HIGH OPTION NON NETWORK	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	Generic Mandate: Member pays cost of medication up to a maximum \$ amount for Preferred & Non-Preferred medications. The greater of 34 day supply or 100 units (pills or capsules) as determined by physician. For more details visit www.healthchoiceok.com	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses	HealthChoice HIGH OPTION NON NETWORK	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses 30 days per year Precertification required See exception above	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses 26 visits per year See exception above	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses 30 days per year Precertification required	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses Requires prior approval after 15 visits or penalty will apply 26 visits per year	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount that exceeds the fee schedule and all ineligible expenses Basic hearing screening only	Not a covered benefit—Except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment—see column #26) No benefits for ages 18 and over; prior authorization required

	PHYSICAL OCCUPATIONAL, OR SPEECH THERAPY 24	CHIROPRACTIC & MANIPULATIVE THERAPY 25	DURABLE MEDICAL EQUIPMENT (DME) 26	BLOOD & BLOOD PRODUCTS 27	SKILLED NURSING FACILITY 28		PERIODIC HEALTH EXAMS 29	TEMPORO-MANDIBULAR JOINT (TMD) DYSFUNCTION 30	HOME HEALTH SERVICES 31	MEDICAL TRANSPORTATION 32	TRANSPLANTS 33	HOSPICE 34	
Standard HMO HIGH OPTION CommunityCare GlobalHealth	Inpatient—No charge Outpatient \$10 per visit - PCP \$25 per visit - Specialist 60 treatment days per course of therapy	\$10 per visit - PCP \$25 per visit - Specialist PCP can refer for chiropractic or manipulative therapy up to 15 visits per year Additional visits only with approved treatment plan	20% of cost for equipment 20% of cost for repair and replacement Must be preapproved by the HMO	No charge if medically necessary	No charge Limit: 100 days per Plan Year Must be prescribed by a PCP	Standard HMO HIGH OPTION CommunityCare GlobalHealth	\$10 copay per exam	\$50 copay with a \$1,500 lifetime maximum non-surgical benefit Must be medically necessary	No charge Must be prescribed by a PCP	No charge but subject to prior authorization if not an emergency	No charge Preapproval & precertification required	No charge For terminal illness of six months or less Preapproval required	
Standard HMO LOW OPTION CommunityCare GlobalHealth	Inpatient—No charge Outpatient—Per visit \$25 - PCP \$40 - Specialist 60 treatment days per course of therapy	Per visit \$25 - PCP \$40 - Specialist PCP can refer for chiropractic or manipulative therapy up to 15 visits per year Additional visits only with approved treatment plan	20% of cost for equipment 20% of cost for repair and replacement Must be preapproved by the HMO	No charge if medically necessary	No charge Limit: 100 days per Plan Year Must be prescribed by a PCP	Standard HMO LOW OPTION CommunityCare GlobalHealth	\$25 copay per exam	\$100 Copay with a \$1,500 lifetime maximum non-surgical benefit Must be medically necessary	No charge Must be prescribed by a PCP	No charge but subject to prior authorization if not an emergency	No charge Preapproval & precertification required	No charge For terminal illness of six months or less Preapproval required	
HealthChoice HIGH OPTION IN NETWORK	Physical/Occupational Therapy: 20% of allowed charges after the deductible. 15 visits per calendar year (max 3 services/visits; over 15 visits must be preapproved or penalty applies) Speech therapy: 20% of allowed charges after plan year deductible	20% of allowed charges after the plan year deductible. 15 visits per calendar year (maximum 3 services/visit) Extended treatment (over 15 visits) must be preapproved or penalty applies	Member pays 20% of fee schedule after the individual calendar year deductible for covered items Purchase, rental, repair or replacement must be preapproved or penalty applies	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible Precertification required Limit: 100 days per year (in a facility)	HealthChoice HIGH OPTION IN NETWORK	\$25 copay per exam (no deductible applies) No copay for mammograms for women age 40 and over	Member pays 20% of fee schedule after the individual calendar year deductible Preapproval required	Member pays 20% of fee schedule after the individual calendar year deductible Preapproval required; penalty applies if not precertified Limit: 100 visits per calendar year	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible	Member pays 20% of fee schedule after the individual calendar year deductible For terminal illness of six months or less Must be preapproved or penalty applies Subject to Home Health 100 visit maximum
HealthChoice HIGH OPTION NON NETWORK	Physical/Occupational Therapy: 25% of allowed charges after the deductible. 15 visits per calendar year (max 3 services/visits; over 15 visits must be preapproved or penalty applies) Speech therapy: 25% of allowed charges after the plan year deductible	25% of allowed charges after the plan year deductible. 15 visits per calendar year (maximum 3 services/visit) Extended treatment (over 15 visits) must be preapproved or penalty applies	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses. Purchase, rental, repair or replacement must be preapproved or penalty applies	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses Precertification required Limit: 100 days per year (in a facility)	HealthChoice HIGH OPTION NON NETWORK	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses Some Guidelines apply	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses Preapproval required \$1500 lifetime maximum non-surgical benefit	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses Preapproval required or penalty applies Limit: 100 visits per calendar year	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses Subject to preapproval if not an emergency	Member pays 25% of fee schedule after the individual calendar year deductible, plus amount above fee schedule and all ineligible expenses Precertification required	

Monthly Premium Rates & Benefit Allowance

Plan Year 2005 (January 2005 through December 2005)	Employee	Employee & Spouse	Employee, Spouse & Child	Employee & One Child	Employee & Two or More Children	Employee, Spouse & Children
HealthChoice High	\$313.86	\$764.08	\$ 921.18	\$470.96	\$564.26	\$1,014.48
HealthChoice Basic	271.12	659.30	794.48	406.30	486.58	874.76
CommunityCare High	458.92	913.26	1,188.62	734.28	826.06	1,280.40
CommunityCare Low	345.02	686.60	893.62	552.04	621.04	962.62
CommunityCare Alternative	316.04	628.92	818.54	505.66	568.88	861.76
GlobalHealth High	367.06	730.46	950.70	587.30	660.72	1,024.12
GlobalHealth Low	313.96	624.78	813.16	502.34	565.14	875.96
GlobalHealth Alternative	277.96	553.14	719.92	444.74	500.34	775.52
HealthChoice Dental	\$21.96	\$43.92	\$61.44	\$39.48	\$67.42	\$89.38
Assurant Heritage Prepaid	11.74	20.60	28.20	19.34	26.94	35.80
Assurant Freedom	22.78	45.44	62.44	39.78	68.48	91.14
CIGNA Dental Prepaid	8.99	14.87	21.75	15.87	23.87	29.75
Delta Preferred DPO	23.84	47.68	67.32	43.48	75.27	99.11
Delta Choice DPO	17.44	34.88	49.26	31.82	55.08	72.52
CompBenefits	\$6.98	\$12.04	\$15.61	\$10.55	\$11.44	\$16.50
Primary Vision Care Svc.	9.00	16.50	24.50	17.00	19.00	26.50
Spectera	7.79	13.30	17.67	12.16	14.44	19.95
Superior Vision Services	6.98	13.88	20.46	13.56	13.56	20.46
Vision Service Plan (VSP)	9.14	14.62	20.40	14.92	20.40	25.88

Life & Disability

Basic Life (20,000)	\$3.90
Supplemental Life (20,000)	3.90
Dependent Life Low Option	2.16
Dependent Life High Option	3.60
Disability	6.28
Addition Units of Supplemental Life Age Rated	<25 \$1.20 25-29 \$1.20 30-34 \$1.20 35-39 \$1.80 40-44 \$2.60 45-49 \$4.20 50-54 \$7.00 55-59 \$11.60 60-64 \$13.40 65-69 \$22.00 70-74 \$37.20 75+ \$57.80

Monthly Benefit Allowance

Employee	\$407.92
Plus Child	571.09
Plus Children	635.72
Plus Spouse	724.91
Spouse & Child	888.08
Spouse & Children	952.71

Bi-Weekly Premium Rates & Benefit Allowance

Plan Year 2005 (January 2005 through December 2005)	Employee	Employee & Spouse	Employee, Spouse & Child	Employee & One Child	Employee & Two or More Children	Employee, Spouse & Children
HealthChoice High	\$144.86	\$352.65	\$425.16	\$217.37	\$260.43	\$468.22
HealthChoice Basic	125.13	304.29	366.68	187.52	224.57	403.73
CommunityCare High	211.81	421.51	548.60	338.90	381.26	590.96
CommunityCare Low	159.24	316.89	412.44	254.79	286.63	444.28
CommunityCare Alternative	145.86	290.27	377.79	233.38	262.56	406.97
GlobalHealth High	169.41	337.13	438.78	271.06	304.95	472.67
GlobalHealth Low	144.90	288.36	375.30	231.84	260.83	404.29
GlobalHealth Alternative	128.29	255.30	332.28	205.27	230.93	357.94
HealthChoice Dental	\$10.14	\$20.28	\$28.37	\$18.23	\$31.12	\$41.26
Assurant Heritage Prepaid	5.42	9.51	13.02	8.93	12.44	16.53
Assurant Freedom	10.51	20.97	28.82	18.36	31.60	42.06
CIGNA Dental Prepaid	4.15	6.86	10.04	7.33	11.02	13.73
Delta Preferred DPO	11.00	22.00	31.06	20.06	34.74	45.74
Delta Choice DPO	8.05	16.10	22.74	14.69	25.42	33.47
CompBenefits	\$3.22	\$5.56	\$ 7.21	\$4.87	\$5.28	\$ 7.62
Primary Vision Care Svc.	4.15	7.61	11.30	7.84	8.77	12.23
Spectera	3.60	6.14	8.16	5.62	6.67	9.21
Superior Vision Services	3.22	6.40	9.44	6.26	6.26	9.44
Vision Service Plan (VSP)	4.22	6.75	9.42	6.89	9.42	11.95

Life & Disability

Basic Life (20,000)	\$1.80
Supplemental Life (20,000)	1.80
Dependent Life Low Option	1.00
Dependent Life High Option	1.66
Disability	2.90
Addition Units of Supplemental Life Age Rated	<25 \$.55 25-29 \$.55 30-34 \$.55 35-39 \$.83 40-44 \$1.20 45-49 \$1.94 50-54 \$3.23 55-59 \$5.35 60-64 \$6.18 65-69 \$10.15 70-74 \$17.17 75+ \$26.68

Bi-Weekly Benefit Allowance

Employee	\$188.27
Plus Child	263.58
Plus Children	293.41
Plus Spouse	334.57
Spouse & Child	409.88
Spouse & Children	439.71

