



HEALTH PLAN COMPARISON

PLAN YEAR

2007



EMPLOYEES
Benefits Council



Medical Plans Comparison Chart Active and New Employees of the State of Oklahoma	HMO Standard OPTION Aetna CommunityCare GlobalHealth PacifiCare	HMO ALTERNATIVE OPTION Aetna	HMO ALTERNATIVE OPTION CommunityCare	HMO ALTERNATIVE OPTION GlobalHealth
CHOICE OF PROVIDER	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	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	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	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
CALENDAR YEAR DEDUCTIBLE	None	None	None	None
ANNUAL OUT-OF-POCKET MAXIMUM	Individual: \$1,500 Family : \$3,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000
OFFICE VISITS (PROFESSIONAL SERVICES)	Copays \$20 PCP \$35 Specialist Does NOT include preventive benefits for Well Baby Care, immunizations, contraceptive services, hearing screening or periodic health exams.	Copays \$25 PCP \$40 Specialist	Copays \$25 PCP \$40 Specialist	Copays \$25 PCP \$40 Specialist
PRESCRIPTION DRUGS	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. The HMO can provide drugs at no copay.	\$15/\$35/\$60 Retail, \$30/\$70/\$120 Mail Order	Up to \$0 select generic formulary Up to \$10 generic formulary Up to \$35 brand formulary (when no generic is available) Up to \$60 brand formulary (when generic is available) Up to \$60 non formulary	\$10/\$35/\$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. The HMO can provide drugs at no copay.

Disclaimer:

This comparison chart is only intended to be a brief summary of certain provisions of the State of Oklahoma flexible benefit plans. The contracts between the State and the individual carriers control the benefits that each carrier will offer during the Plan Year.

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK	HealthChoice BASIC	NOTES:
No referral is necessary from your contracting PCP, in order to see a contracted specialist when the specialist is in PacifiCare's HMO network. New Hires & New Enrollees must indicate PCP on Enrollment Form.	Choice of Network Provider, contracted allowable fee schedule for medically necessary services	Choice of any Provider, non-contracted fee schedule for medically necessary services Member responsible for amount that exceeds the allowed charge and all ineligible expenses	Segment A - Choice of any Provider, non-contracted fee schedule for medically necessary services Member responsible for amount that exceeds the allowed charge and all ineligible expenses	
None	\$500: Individual \$1,500: Family NO YEAR-END CARRY OVER See Emergency Health Care and Hospital Inpatient for additional per service deductible	\$500: Individual \$1,500: Family plus \$300 per confinement hospital deductible NO YEAR-END CARRY OVER See Emergency Health Care and Hospital Inpatient for additional per service deductible	Just as with the HealthChoice High Option Plan, the HealthChoice Basic Plan offers an <u>unlimited lifetime maximum</u> on eligible health benefits. The HealthChoice <u>Basic Plan pays 100% of the first \$500</u> of allowed amount for covered services.	
Individual: \$2,000 Family: \$4,000	Individual: \$2,800 (includes deductible) Non-covered services, copays & ER deductible do not apply NO YEAR-END CARRY OVER	Individual: \$3,300 (includes deductible) plus Member is responsible for amount that exceeds the allowed charges, inpatient deductible, ER deductible & charges over maximum benefit limitations NO YEAR-END CARRY OVER	Then the member pays the <u>next \$500</u> of covered charges as a deductible. After the first \$1,000 of eligible health expenses, the member and the Plan split the next \$10,000 on a 50/50 cost-sharing basis. Once a member has spent \$5,500 out-of-pocket, the Basic Plan will pay 100% of all other eligible, covered charges for that Plan Year. Family deductible is \$1,000 with a maximum annual family out-of-pocket of \$11,000.	
Copays \$20 PCP \$50 Specialist	\$25 copay per office visit; on other professional services the individual calendar year deductible applies first; member pays 20% of allowed charges	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses	OK Health Program benefit: No charge one time per plan year for network provider visits, biometric measurements and labwork as specified by OK Health Program (must meet OK Health Program participant requirements)	
\$5 copay for formulary generic drug / \$25 copay for formulary brand name drug / \$45 non-formulary generic and brand drug 30-day supply or 100 units; certain medications have restricted quantities	Generic Mandate: Member pays cost of medication up to a maximum dollar amount for Preferred & Non-Preferred medications. The greater of 34-day supply or 100 units (pills or capsules) as prescribed by physician. For more details visit www.healthchoiceok.com or www.sib.ok.gov	Generic Mandate: Member pays cost of medication up to a maximum dollar amount + dispensing fee for Preferred & Non-Preferred medications. The greater of 34-day supply or 100 units (pills or capsules) as prescribed by physician. For more details visit www.healthchoiceok.com or www.sib.ok.gov	(Go to Segment B) Using Network providers will maximize your benefits.	

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OK HEALTH PROGRAM (Only for State employees participating in OK Health Program, dependents do not qualify.)	No charge one time per plan year for PCP visits, biometric measurements and labwork as specified by OK Health Program	No charge one time per plan year for PCP visits, biometric measurements and labwork as specified by OK Health Program	No charge one time per plan year for PCP visits, biometric measurements and labwork as specified by OK Health Program	No charge one time per plan year for PCP visits, biometric measurements and labwork as specified by OK Health Program
HOSPITAL INPATIENT	\$200 copay per admission Precertification from PCP required	\$500 copay	\$250 copay per admission Precertification from PCP required	\$250 copay per inpatient stay Precertification from PCP required
HOSPITAL OUTPATIENT	\$150 per visit As authorized by PCP	\$250 copay	\$150 Copay per visit outpatient surgical facility	\$150 copay per visit As authorized by PCP
EMERGENCY HEALTH CARE	\$100 copay (waived if hospitalized)	\$100 copay	\$100 copay per visit (waived if admitted)	\$100 copay (waived if admitted)
AFTER HOURS URGENT CARE	\$20 copay per visit You must contact your PCP and use plan authorizations	\$75 copay	\$25 copay per visit (prior authorization required)	\$25 PCP/\$40 all other providers copay You must contact your PCP and plan authorizations

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK	HealthChoice BASIC	NOTES:
No charge one time per plan year for PCP visits, biometric measurements and labwork as specified by OK Health Program	No charge one time per plan year for physician visits, biometric measurements and labwork as specified by OK Health Program	Not covered for out-of-network	Segment B - Pharmacy Benefits The HealthChoice Basic Plan offers the same pharmacy benefits as the HealthChoice High Option. Pharmacy benefits under both plans are separate from any other health benefits offered. Each covered member has a lifetime pharmacy benefit of \$2 million which began accruing on January 1, 2004.	
\$500 copay per day \$1,500 out-of-pocket maximum	Member pays 20% of allowed charges after the individual calendar year deductible Precertification required	Member pays 50% of allowed charges after the individual calendar year deductible and \$300 per confinement hospital deductible, plus amount that exceeds the allowed charges and all ineligible expenses (Precertification required)	The pharmacy program has a Generic Mandate with a Preferred Medication list offering the member an opportunity to save money by choosing a generic alternative. Copays and out-of-pocket expenses are reduced by using the Pharmacy Network and by choosing the generic alternatives available on the HealthChoice Select Medication List.	
\$500 copay per Outpatient Surgery visit	Member pays 20% of allowed charges after the individual calendar year deductible Precertification required for certain outpatient surgeries	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses Precertification required for certain outpatient surgeries	The benefit available per copay is 34-day or 100 units (pills or capsules) whichever is greater. Certain medications have a maximum quantity limit. For details on specific medications, use the web site at	
\$100 copay per visit (waived if admitted as an inpatient from emergency room)	Member pays 20% of allowed charges after the individual calendar year deductible \$100 ER copay is waived if hospitalized	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses \$100 ER copay is waived if hospitalized	The benefit available per copay is 34-day or 100 units (pills or capsules) whichever is greater. Certain medications have a maximum quantity limit. For details on specific medications, use the web site at	
\$50 copay per visit	Member pays 20% of allowed charges after the individual calendar year deductible	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses	www.healthchoiceok.com or www.sib.ok.gov (Go to Segment C) Using Network providers will maximize your benefits.	

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DIAGNOSTIC X-RAY AND LAB	No charge except for MRI, MRA, PET or CAT Scan which requires \$100 copay per scan All must be preauthorized	\$40 copay	No additional copay for Laboratory services or Outpatient Radiology \$100 copay per scan for MRI, CT, MRA and PET Scan	No additional copay for Laboratory services or Outpatient Radiology \$100 per -CT, PET, SPECT, CT, MRI
ALLERGY TREATMENT AND TESTING	\$20 per series of tests w/PCP \$35 w/specialist \$20 per 6 weeks of Antigen, including shots (No additional charge for administration of shots)	\$20 copay per visit	\$25 copay per visit to PCP \$40 copay per visit to Specialist \$25 copay for Allergy Serum (six week supply - including shots)	\$25 PCP \$40 Specialist \$25 per 6 week supply of antigen (including shots)
WELL-BABY CARE	\$0 per exam for Well-Care visits during first two years of life	\$0 copay	No copay up to age 2	No copay under age 2, \$25 PCP copay over age 2
IMMUNIZATIONS	No copay for ages birth through 18 years \$10 copay per visit for ages over 19 and over	\$10 copay for adults and \$0 copay for child	No copay for childhood immunizations \$25 copay per visit for ages 19 and over	No copay children to age 18, \$25 per PCP/\$40 per Specialist for adults over age 18
MATERNITY	\$20 for initial visit \$200 per admission Precertification required	\$500 per hospital admission and \$40 copay for initial OB visit (covered 100% thereafter)	\$25 copay for initial visit only (includes prenatal and postnatal care) No copay for Prenatal Classes Amniocentesis (medically necessary; outpatient surgical facility copay may apply) \$250 per admission	\$25 physician services copay for initial visit only \$250 per hospital admission

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK	HealthChoice BASIC	NOTES:
<p>Standard Laboratory and Radiology: \$0 copay</p> <p>Specialized scanning and imaging (MRI, MRA, PET, CAT): \$250 copay per scan</p>	<p>Member pays 20% of allowed charges after the individual calendar year deductible</p>	<p>Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses</p>	<p>Segment C - A Consumer-Oriented Program All services, benefits, exceptions, limitations and conditions are identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan. Using Network providers will maximize your benefits.</p>	
<p>See copay for professional services per testing series</p>	<p>Member pays 20% of allowed charges after the individual calendar year deductible Limit: Battery of 60 tests every 24 months</p>	<p>Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses Limit: Battery of 60 tests every 24 months</p>	<p>Plan pays 100% of the first \$500 of allowed charges for eligible covered services.</p> <p>Member pays 100% of the next \$500 of eligible, covered expenses.</p>	
<p>No copay</p>	<p>\$25 copay per exam (no deductible applies)</p>	<p>Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses</p>	<p>Plan and Member share on a 50/50 basis, the next \$10,000 of eligible, covered expenses.</p> <p>(Individual Member's maximum out-of-pocket cost per year: \$5,500)</p>	
<p>\$25 copay for ages 19 and over; No copay from birth through age 18 (if no other service is rendered)</p>	<p>Well-baby and adult immunizations paid at 100%</p> <p>Office visit is subject to \$25 copay</p> <p>Administration charge is subject to deductible and coinsurance</p>	<p>Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses</p>	<p>(Family maximum out-of-pocket cost per year: \$11,000)</p> <p>The Plan pays 100% of all eligible, covered expenses after the annual maximum out-of-pocket limits have been reached. (Pharmacy expenses are not included in these maximums)</p>	
<p>\$25 copay for initial visit once diagnosis of pregnancy is confirmed; \$500 copay per day \$1,500 out-of-pocket maximum</p>	<p>Member pays 20% of allowed charges after the individual calendar year deductible</p> <p>Includes one postpartum home visit (must meet criteria)</p> <p>Also see Hospital Inpatient Benefits</p>	<p>Member pays 50% of allowed charges after the individual calendar year deductible and \$300 per confinement hospital deductible, plus amount that exceeds the allowed charges and all ineligible expenses. Includes one postpartum home visit (must meet criteria)</p> <p>Also see Hospital Inpatient Benefits</p>		

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CONTRACEPTIVE SERVICES	\$20 for consultation \$20 per surgical procedure Excludes reversal and voluntary sterilization	\$25 PCP copay \$40 Specialist copay	\$25 copay for Family Planning consultation \$25 copay for surgical procedure (in office)	\$25 physician services, \$25 per surgical procedure
CONTRACEPTIVE DRUGS	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	Retail: Tier 1: \$15 Tier 2: \$35 Tier 3: \$60 Mail Order Drug (MOD) Tier 1: \$30 Tier 2: \$70 Tier 3: \$120	Covered under formulary Outpatient Prescription Drug Benefits	Covered under prescription drug benefit Tier 1: \$10 Tier 2: \$35 Tier 3: \$60
INFERTILITY SERVICES	25% of costs plus the office visit copay of \$20 - PCP \$35 - Specialist Limited to diagnosis and <u>some treatment</u> See exclusions in member materials	Testing Only - If identifiable (25% after applicable copay)	Office visit copays apply Fertility medications (require prior authorization) are subject to a 50% copay	50% co-insurance, office visit copays apply Limited to diagnosis and <u>some treatment</u> See exclusions in member materials Requires prior authorization.
MENTAL HEALTH INPATIENT	\$150 per admission Limited to 30 days per Plan Year Must be preauthorized Except for the biologically based diagnoses that are treated as other illnesses	\$500 copay/ per admission (Limited to 30 days per year)	\$250 copay per admission (requires preauthorization and approval through CCOK HMOs Behavioral Health Services) Limited to 30 days per Plan Year	\$250 Inpatient copay Must be preauthorized Limited to 30 days per Plan Year except for the biologically based diagnoses that are treated as other illnesses
MENTAL HEALTH OUTPATIENT	\$20 per visit - PCP \$35 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	\$40 copay (Limited to 26 visits per year)	\$25 copay per visit to PCP \$40 copay per visit to Specialist (requires preauthorization and approval through CCOK HMOs Behavioral Health Services) 26 visits per year	\$40 per visit limited to 26 visits Must be preauthorized Limited to 26 visits per Plan Year except for the biologically based diagnoses that are treated as other illnesses

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK		NOTES:
Consultation, \$25 copay (PCP), \$50 copay (Specialist); Vasectomy - \$500 Copay (Physician's Office), \$500 copay (outpatient facility); Tubal Ligation - \$500 copay (outpatient facility) \$500 copay per day (3 day max) (inpatient facility)	Member pays 20% of allowed charges after the individual calendar year deductible	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses		
Please refer to prescription drug benefit; \$50 copay for Depo-Provera Injection	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 prescribed by physician. For more details visit www.healthchoiceok.com or www.sib.ok.gov	Generic Mandate. Member pays cost of medication up to a maximum dollar amount and dispensing fee for Preferred & Non-Preferred medications. The greater of 34-day supply or 100 units (pills or capsules) as prescribed by physician. For more details visit www.healthchoiceok.com or www.sib.ok.gov		
50% of Total Charges (Basic Services)	Member pays 20% of allowed charges after the individual calendar year deductible Benefits available for diagnosis and limited treatment	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds allowed charges and all ineligible expenses Limited to diagnosis and <u>some treatment</u> See exclusions in member materials		
\$500 copay per admission; 30 days per calendar year	Member pays 20% of allowed charges after the individual calendar year deductible Limited to 30 days per calendar year* Precertification required *Except for the biologically based diagnoses that are treated as other illnesses	Member pays 50% of allowed charges after the individual calendar year deductible plus \$300 per confinement deductible, plus amount that exceeds allowed charges and all ineligible expenses 30 days per calendar year* Precertification required See exception under In-Network		
See copay for professional services; 26 visits per year	Member pays 20% of allowed charges after individual calendar year deductible Requires prior authorization after 15 visits or penalty will apply. Limit 26 visits per calendar year* *Except for the biologically based diagnoses that are treated as other illnesses	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount that exceeds the allowed charges and all ineligible expenses Requires prior authorization after 15 visits or penalty will apply. Limit 26 visits per year* See exception under In-Network		

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SUBSTANCE ABUSE INPATIENT	\$150 per admission Limited to 30 days per Plan Year Must be preauthorized	\$500 copay/Admission Limited to 30 days per calendar year Must be preauthorized	\$250 copay per admission (maximum of 30 days per calendar year and requires preauthorization and approval through CCOK HMO's Behavioral Health Services)	\$250 Inpatient copay limited to 30 days Must be preauthorized
SUBSTANCE ABUSE OUTPATIENT	\$20 per visit - PCP \$35 per visit -Specialist Single or group therapy 26 visits per Plan Year Must be preauthorized	\$40 per visit copay (limited to 26 visits per calendar year) Must be preauthorized	\$25 per visit PCP \$40 per visit specialist (26 visit limit per calendar year and requires preauthorization and approval through CCOK HMO's Behavioral Health Services)	\$40 per visit limited to 26 visits per calendar year Must be preauthorized
HEARING SCREENING	\$20 copay per visit for a basic hearing screening (does not include a comprehensive hearing exam) Limit one visit per year	\$10 copay per visit	\$25 copay per visit (covered under preventive care services and limited to one per year)	\$25 per visit limited to 1 per year
HEARING AIDS	Not a covered benefit—except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment) No benefits for ages 18 & over	Not covered for adults (Covered for children up to 18 years of age)	20% copay for children up to age 18	Covered for children up to age 18 only 20% coinsurance Limited to \$5,000 combined DME, orthotics, and prosthetics
PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY	Inpatient— No charge Outpatient \$20 per visit - PCP \$35 per visit - Specialist 60 treatment days per course of therapy	Inpatient-no charge Outpatient-\$40 copay Treatment over a 60 day consecutive period per incident of illness or injury beginning with the first day of treatment.	No copay for Inpatient Rehabilitation \$40 copay for Outpatient Physical, Occupational or Speech Therapy (up to 60 treatment days per disability)	No copay for Inpatient rehabilitation \$40 copay for Outpatient Physical, Occupational or Speech Therapy Limited to 60 days per illness or injury

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK		NOTES:
\$500 copay per admission; 30 days per calendar year	Member pays 20% of allowed charges after the individual calendar year deductible Limit 30 days per year Precertification required	Member pays 50% of allowed charges after the individual calendar year deductible and \$300 per confinement hospital deductible, <u>plus</u> amount above the allowed charges and all ineligible expenses Limit 30 days per year Precertification required		
See copay for professional services; 26 visits per year	Member pays 20% of allowed charges after the individual calendar year deductible Requires prior authorization after 15 visits or penalty will apply Limit 26 visits per year	Member pays 50% of allowed charges after the individual calendar year deductible, <u>plus</u> amount that exceeds the allowed charges & all ineligible expenses Requires prior authorization after 15 visits or penalty will apply Limit 26 visits per year		
\$20 copay per visit (PCP); \$50 copay per visit (Specialist)	\$25 Copay per visit for a basic hearing screening (does not include a comprehensive hearing exam) One per calendar year	Member pays 50% of allowed charges after the individual calendar year deductible, <u>plus</u> amount that exceeds the allowed charges and all ineligible expenses Basic hearing screening only		
Not covered except for mandated coverage for children up to age eighteen (18)	Benefit limited to children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment Benefit) No benefits for ages 18 and over; prior approval required	Benefit limited to children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment Benefit) No benefits for ages 18 and over; prior approval required		
Inpatient \$500 per day (3 day maximum); Outpatient \$50 copay per visit - Combined limit of 60 treatment days per medical episode	Physical/Occupational Therapy: 20% of allowed charges after calendar year deductible. 15 visits per calendar year (max 3 services per visit; over 15 visits must be preauthorized or penalty applies) Speech therapy: 20% of allowed charges after calendar year deductible Prior authorization required	Physical/Occupational Therapy: 50% of allowed charges after calendar year deductible. 15 visits per calendar year (max 3 services per visit; over 15 visits must be preauthorized or penalty applies) Speech therapy: 50% of allowed charges after calendar year deductible Prior authorization required		

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CHIROPRACTIC & MANIPULATIVE THERAPY	\$20 per visit - PCP \$35 per visit - Specialist PCP can refer for chiropractic or manipulative therapy up to 15 visits per year Additional visits only with approved treatment plan	\$40 copay per visit (Limited to 15 visits per calendar year)	\$40 copay per visit (15 visits per year)	\$40 per visit limited to 15 visits per calendar year Must be preauthorized
DURABLE MEDICAL EQUIPMENT (DME)	20% of cost for equipment 20% of cost for repair and replacement Must be preapproved by the HMO	20% of contracted rate	20% copay	20% coinsurance limited to \$5,000 combined DME, orthotics, and prosthetics per calendar year
BLOOD AND BLOOD PRODUCTS	No charge if medically necessary	Covered 100% if medically necessary	No copay	No copay
SKILLED NURSING FACILITY	No charge Limit: 100 days per Plan Year Must be prescribed by a PCP	No copay (limited to 100 days per calendar year)	No copay (Limit: 60 consecutive treatment days per disability)	No copay Limit: 100 days per Plan Year
PERIODIC HEALTH EXAMS	\$10 copay per exam	\$10 copay for adults	\$25 copay per visit for Routine Physicals	\$0 Ok Health Benefit, \$25 per PCP limited to 1 per year

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK		NOTES:
\$20 copay per visit; 15 visits per calendar year, limited to treatments of neurological and orthopedic conditions	20% of allowed charges after the calendar year deductible. 15 visits per calendar year (limit 3 services per visit) Extended treatment (over 15 visits) must be prior authorized or penalty applies	50% of allowed charges after the calendar year deductible. 15 visits per calendar year (limit 3 services per visit) Extended treatment (over 15 visits) must be prior authorized or penalty applies		
20% copay; \$10,000 per calendar year	Member pays 20% of allowed charges after the individual calendar year deductible for covered items Purchase, rental, repair or replacement must be prior authorized or 10% penalty applies	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses. Purchase, rental, repair or replacement must be prior authorized or 10% penalty applies		
Autologous, donor directed, and donor designated blood processing costs are limited to \$120 per unit and must be for a scheduled procedure	Member pays 20% of allowed charges after the individual calendar year deductible	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses		
\$500 copay per admission; 100 consecutive calendar days	Member pays 20% of allowed charges after the individual calendar year deductible Precertification required Limit: 100 days per year (in a facility)	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses Precertification required Limit: 100 days per year (in a facility)		
\$20 copay per visit (PCP); \$50 copay per visit (Specialist)	\$25 copay per exam (no deductible applies) No copay for one mammogram per calendar year for women age 40 and over Some guidelines apply	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses No copay or deductible for one mammogram per calendar year for women age 40 and over, member pays charges over \$115 Some guidelines apply		

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TEMPORO- MANDIBULAR JOINT (TMD) DYSFUNCTION	\$50 copay with a \$1,500 lifetime maximum nonsurgical benefit Must be medically necessary	\$50 copay per treatment (if identifiable) (\$1,500 lifetime maximum, not surgical.)	\$100 copay per treatment plan (lifetime non-surgical maximum of \$1,500)	\$100 copay per treatment plan (limited to \$1,500 non-surgical care)
HOME HEALTH SERVICES	No charge Must be prescribed by a PCP	Covered 100%	No copay	No copay Must be prescribed by PCP
MEDICAL TRANSPORTATION	No charge but subject to prior authorization if not an emergency	Ambulance covered 100% (must have prior authorization except for emergencies)	No copay for ambulance services (must have prior authorization, except for emergencies)	No copay
TRANSPLANTS	No charge Preapproval & precertification required	\$40 copay (coverage provided at IOE contract facility only)	No copay, (all transplant services, including evaluations must be preauthorized)	No copay Preapproval and precertification required
HOSPICE	No charge For terminal illness of six months or less Preapproval required	No copay	No copay	No copay for terminal illness of six months or less Preapproval required

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF-NETWORK		NOTES:
\$50 copay, \$1,500 lifetime maximum for nonsurgical benefits	Member pays 20% of allowed charges after the individual calendar year deductible. Prior authorization required	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses Prior authorization required		
\$50 copay per visit	Member pays 20% of allowed charges after the individual calendar year deductible Prior authorization required or 10% penalty applies Limit: 100 visits per calendar year	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses Prior authorization required or 10% penalty applies Limit: 100 visits per calendar year		
\$100 copay per medical episode	Member pays 20% of allowed charges after the individual calendar year deductible If not an emergency, medically necessary services are subject to prior approval	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses If not an emergency, medically necessary services are subject to prior approval		
\$500 copay per day (3 day maximum)	Member pays 20% of allowed charges after the individual calendar year deductible Precertification required	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses Precertification required		
\$50 copay per visit	Member pays 20% of allowed charges after the individual calendar year deductible For life expectancy of six months or less Must be preauthorized or 10% penalty applies	Member pays 50% of allowed charges after the individual calendar year deductible, plus amount above allowed charges and all ineligible expenses For life expectancy of six months or less Prior authorization required or 10% penalty applies		

HEALTH

HealthChoice (Member Services and Telephone Provider Directory) Oklahoma City Metro . . .	(405) 717-8780
Toll Free	(800) 752-9475
TDD	(405) 949-2281 or (866) 447-0436
Website	www.healthchoiceok.com or www.sib.ok.gov
Health, Dental & Life Claims.	(405) 499-4920
Toll-Free	(800) 782-5218
Pharmacy Claims/ID Cards.	(800) 903-8113
Pre-certification.	(800) 848-8121
COBRA	(405) 717-8780
Toll-Free	(800) 752-9475
Website	www.healthchoiceok.com or www.sib.ok.gov
Aetna HMO All Areas	(800) 949-3104
TDD.	(800) 628-3323
Website	www.aetna.com/okstateemployees/
CommunityCare HMO All Areas	(800) 777-4890
TTY/TDD	(800) 722-0353
Website	www.ccok.com
GlobalHealth HMO OKC Metro	(405) 280-5600
Toll-Free	(877) 280-5600
TTY/TDD/Voice	(800) 522-8506
Website	www.globalhealth.cc
PacificCare HMO All Areas	(800) 825-9355
TDHI	(800) 557-7595
Website	www.pacificare.com
TRICARE Supplement (ASI Corporation)	(800) 638-2610
Website	www.asicorptricare.com

DENTAL

HealthChoice Dental Plan Oklahoma City Metro	(405) 717-8780
Toll Free	(800) 752-9475
Website	www.healthchoiceok.com or www.sib.ok.gov
Assurant Heritage Plus Prepaid Dental	(800) 443-2995
Assurant Freedom Preferred Indemnity	(800) 442-7742
Website	www.assurantemployeebenefits.com
CIGNA Dental Prepaid.	(800) 367-1037
Website	www.cigna.com
Delta Dental of Oklahoma, Oklahoma City Metro	(405) 607-2100
Toll Free	(800) 522-0188
Website	www.deltadentalok.org

VISION

CompBenefits	(800) 865-3676
Website	www.visioncare.com
Primary Vision Care Services	(888) 357-6912
Website	www.pvcs-usa.com
Spectera	(800) 638-3120
Website	www.spectera.com
Superior	(800) 507-3800
Website	www.superiorvision.com
Vision Service Plan	(800) 877-7195
Website	www.vsp.com

EMPLOYEES BENEFITS COUNCIL

Main	(405) 232-1190
Toll Free	(800) 219-8115
Benefits Fax	(405) 609-3474
Administration Fax	(405) 609-3477
Finance Fax.	(405) 609-3476
Wellness Fax	(405) 609-3475
TDD	(405) 609-3473
Flexible Spending Accounts	(405) 232-1190 x301
Toll Free.	(800) 219-8115 x301