

# OKLAHOMA

## 1907-2007



*A Unique History. An Extraordinary Future.*

PLAN YEAR  
2008

**EMPLOYEES**  
**Benefits Council**



HEALTH PLAN COMPARISON

*Active and New Employees of the State of Oklahoma*

Medical Plans Comparison Chart Active and New Employees of the State of Oklahoma	<b>HMO Standard OPTION</b> Aetna CommunityCare GlobalHealth PacifiCare	<b>HMO ALTERNATIVE OPTION</b> Aetna	<b>HMO ALTERNATIVE OPTION</b> CommunityCare	<b>HMO ALTERNATIVE OPTION</b> GlobalHealth
<b>CHOICE OF PROVIDER</b>	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for 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
<b>CALENDAR YEAR DEDUCTIBLE</b>	None	None	None	None
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>	Individual: \$1,500 Family : \$3,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000	Individual: \$2,000 Family: \$4,000
<b>OFFICE VISITS (PROFESSIONAL SERVICES)</b>	Copays \$20 PCP \$35 Specialist	Copays \$25 PCP \$40 Specialist	Copays \$25 PCP \$40 Specialist	Copays \$25 PCP \$40 Specialist
<b>PRESCRIPTION DRUGS</b>	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.

**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.

<b>HMO ALTERNATIVE OPTION PacifiCare</b>	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
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, allowable fee schedule for medically necessary services	Choice of any Provider, allowable fee schedule for medically necessary services Member responsible for amount that exceeds the allowed charge when using a non-network provider and all ineligible expenses	<b>Segment A</b> - Choice of any Provider, allowable fee schedule for medically necessary services Member responsible for amount that exceeds the allowed charge when using a non-network provider and all ineligible expenses	Choice of Network Provider, allowable fee schedule for medically necessary services
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</u> pays <u>100%</u> of the <u>first \$500</u> of allowed charges for covered services. Then the member pays the <u>next \$500</u> of allowed 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.	\$1,500 individual \$3,000 family Applies to medical and pharmacy
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	The HealthChoice <u>Basic Plan</u> pays <u>100%</u> of the <u>first \$500</u> of allowed charges for covered services. Then the member pays the <u>next \$500</u> of allowed 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.	\$4,000 individual \$8,000 family
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 visit, biometric measurements and labwork as specified by OK Health Program (must meet OK Health Program participant requirements)	\$25 copay after deductible
\$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, not to exceed the FDA's approved "usual" dosing for a 100-day supply. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a>	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, not to exceed the FDA's approved "usual" dosing for a 100-day supply. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a>	for network provider visit, biometric measurements and labwork as specified by OK Health Program (must meet OK Health Program participant requirements)  <b>(Go to Segment B)</b>  <b>Using Network providers will maximize your benefits.</b>	After the \$1,500 individual or \$3,000 family deductible has been met, the pharmacy benefits are: Generic mandate, member pays cost of medication up to a maximum dollar amount for Preferred and non-Preferred medications. The greater of 34-day supply or 100 units, whichever is greater, not to exceed the FDA approved usual dosing for a 100 day supply.

<b>Medical Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard OPTION</b> Aetna CommunityCare GlobalHealth PacifiCare	<b>HMO ALTERNATIVE OPTION</b> Aetna	<b>HMO ALTERNATIVE OPTION</b> CommunityCare	<b>HMO ALTERNATIVE OPTION</b> GlobalHealth
<b>OK HEALTH PROGRAM</b> (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
<b>HOSPITAL INPATIENT</b>	\$200 copay per admission  Precertification from PCP required	\$500 copay per admission	\$250 copay per admission  Precertification from PCP required	\$250 copay per inpatient stay  Precertification from PCP required
<b>HOSPITAL OUTPATIENT</b>	\$150 per visit copay  As authorized by PCP	\$250 per visit copay	\$150 copay per visit outpatient surgical facility	\$150 per visit copay  As authorized by PCP
<b>EMERGENCY HEALTH CARE</b>	\$100 per visit copay (waived if admitted)			
<b>AFTER HOURS URGENT CARE</b>	\$20 copay per visit  You must contact your PCP and use plan authorizations	\$75 per visit copay	\$25 copay per visit (prior authorization required)	\$25 PCP/\$40 all other providers copay  You must contact your PCP and plan authorizations

<b>HMO ALTERNATIVE OPTION</b> PacifiCare	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
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 visit, biometric measurements and labwork as specified by OK Health Program	Not covered for out-of-network	<b>Segment B - Pharmacy Benefits</b> 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.	No charge one time per plan year for Network physician visits, biometric measurements, and labwork as specified by OK Health Program
\$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, <b>plus</b> 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.	20% of Allowed Charges after deductible Precertification required Additional \$300 deductible non-Network
\$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, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses Precertification required for certain outpatient surgeries	The member can choose 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.	20% of Allowed Charges after deductible Precertification required for certain surgeries
\$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, <b>plus</b> 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, not to exceed the FDA's approved "usual" dosing for a 100-day supply whichever is greater. Certain medications have a maximum quantity limit.	20% of Allowed Charges after deductible \$100 ER deductible; waived if admitted
\$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, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses	For details on specific medications, use the web site at <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a> <b>(Go to Segment C)</b>  <b>Using Network providers will maximize your benefits.</b>	20% of Allowed Charges after deductible

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<b>DIAGNOSTIC X-RAY AND LAB</b>	No charge except for MRI, MRA, PET or CAT Scan which requires \$100 copay per scan  All must be preauthorized	\$40 per visit 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, MRI Scan
<b>ALLERGY TREATMENT AND TESTING</b>	\$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 series of tests  \$20 per 6 weeks of antigen, including shots  Copay is waived for services with no office 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)
<b>WELL-BABY CARE</b>	\$0 per exam for Well-Care visits during first two years of life	No copay for well-care visits during first 2 years of life	No copay up to age 2	No copay up to age 2, \$25 PCP copay over age 2
<b>IMMUNIZATIONS</b>	No copay for ages birth through 18 years  \$10 copay per visit for ages over 19 and over	No copay for ages birth through age 18  \$10 copay per visit for ages 19 and over	No copay for childhood immunizations  \$25 copay per visit for ages 19 and over	No copay for ages birth through 18 years  \$25 per PCP/\$40 per Specialist for adults over age 18
<b>MATERNITY</b>	\$20 for initial visit  \$200 per admission  Precertification required	\$40 copay for initial OB visit (covered 100% thereafter)  \$500 copay per admission	\$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

<b>HMO ALTERNATIVE OPTION</b> PacifiCare	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
<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, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses</p>	<p><b>Segment C - A Consumer-Oriented Program</b> 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>20% of Allowed Charges after deductible</p>
<p>See copay for professional services per testing series</p>	<p>Member pays 20% of allowed charges after the individual calendar year deductible <b>Limit:</b> Battery of 60 tests every 24 months</p>	<p>Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses <b>Limit:</b> 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 allowed charges for eligible covered expenses.</p>	<p>20% of Allowed Charges after deductible Limit: Battery of 60 tests every 24 months</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, <b>plus</b> 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 allowed charges for eligible covered expenses.</p>	<p>20% of Allowed Charges after deductible</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, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses</p>	<p>(Individual Member's maximum out-of-pocket cost per year: \$5,500)</p> <p>(Family maximum out-of-pocket cost per year: \$11,000)</p>	<p>20% of Allowed Charges after deductible</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, <b>plus</b> 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>	<p>The Plan pays 100% of all allowed charges for eligible covered expenses after the annual maximum out-of-pocket limits have been reached. (Pharmacy expenses are not included in these maximums)</p>	<p>20% of Allowed Charges after deductible</p> <p>Includes 1 postpartum home visit - criteria must be met</p> <p>Precertification is required for inpatient services</p>

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<b>CONTRACEPTIVE SERVICES</b>	\$20 for consultation  \$20 per surgical procedure  Excludes reversal and voluntary sterilization	\$25 PCP per visit copay  \$40 Specialist per visit copay  Excludes reversal of voluntary sterilization	\$25 copay for Family Planning consultation  \$25 copay for surgical procedure (in office)	\$25 physician services, \$25 per surgical procedure (in office)
<b>CONTRACEPTIVE DRUGS</b>	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  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.	Covered under formulary Outpatient Prescription Drug Benefits	Covered under prescription drug benefit  Tier 1: \$10 Tier 2: \$35 Tier 3: \$60
<b>INFERTILITY SERVICES</b>	25% of costs <b>plus</b> the office visit copay of \$20 - PCP \$35 - Specialist  Limited to diagnosis and <u>some treatment</u>  See exclusions in member materials	25% of cost <b>plus</b> \$25 PCP/\$40 Specialist copay  Limited to diagnosis and treatment of the underlying medical condition. See exclusions in member materials	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.
<b>MENTAL HEALTH INPATIENT</b>	\$150 per admission <b>Limited to 30 days per Plan Year</b>  Must be preauthorized, except for the biologically based diagnoses that are treated as other illnesses	\$500 copay per admission. Must be pre-authorized  Limited to 30 days per Plan Year Except for the biologically-based diagnoses treated as other illnesses	\$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
<b>MENTAL HEALTH OUTPATIENT</b>	\$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	\$25 PCP per visit copay \$40 Specialist per visit copay Single or Group Therapy <b>(Limited to 26 visits per year)</b> Except for the biologically-based diagnoses treated as other illnesses	\$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

<b>HMO ALTERNATIVE OPTION PacifiCare</b>	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
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, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses	<b>Refer to previous pages</b>	20% of Allowed Charges after deductible
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, not to exceed the FDA's approved "usual" dosing for a 100-day supply as prescribed by physician. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a>	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, not to exceed the FDA's approved "usual" dosing for a 100-day supply as prescribed by physician. For more details visit <a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a>		See Pharmacy Benefits
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, <b>plus</b> amount that exceeds allowed charges and all ineligible expenses  Limited to diagnosis and <u>some treatment</u> See exclusions in member materials		20% of Allowed Charges after deductible Benefits for diagnosis and limited treatment
\$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, <b>plus</b> amount that exceeds allowed charges and all ineligible expenses <b>30 days per calendar year*</b> Precertification required See exception under In-Network		20% of Allowed Charges after deductible Limit: 30 days/year Precertification required
See copay for professional services; 26 visits per year	Member pays 20% of allowed charges after individual calendar year deductible <b>Requires prior authorization after 15 visits or penalty will apply. Limit 26 visits per calendar year*</b> *Except for the biologically based diagnoses that are treated as other illnesses	Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses <b>Requires prior authorization after 15 visits or penalty will apply. Limit 26 visits per year*</b> See exception under In-Network		20% of Allowed Charges after deductible Limit: 26 visits per year More than 15 visits require prior authorization or penalty applies

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<b>SUBSTANCE ABUSE INPATIENT</b>	\$150 per admission  <b>Limited to 30 days per Plan Year</b>  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
<b>SUBSTANCE ABUSE OUTPATIENT</b>	\$20 per visit - PCP \$35 per visit -Specialist  Single or group therapy  <b>26 visits per Plan Year</b>  Must be preauthorized	\$40 specialist per visit copay single or group therapy <b>(limited to 26 visits per calendar year)</b> <b>Must be preauthorized</b>	\$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
<b>HEARING SCREENING</b>	\$20 copay per visit for a basic hearing screening (does not include a comprehensive hearing exam)  <b>Limit one visit per year</b>	\$10 per visit copay for basic hearing screening (does not include comprehensive hearing exam) Limit one visit per year	\$25 copay per visit (covered under preventive care services and limited to one per year)	\$25 per visit limited to 1 per year
<b>HEARING AIDS</b>	Not a covered benefit—except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment)  <b>No benefits for ages 18 &amp; over</b>	Not covered except for children up to 18 years of age; Audiological services and hearing aids are covered (as durable medical equipment)	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
<b>PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY</b>	Inpatient— No charge  Outpatient \$20 per visit - PCP \$35 per visit - Specialist  <b>60 treatment days per course of therapy</b>	Inpatient-no copay Outpatient-\$40 Specialist copay  Treatment over a 60 day consecutive period per incident or 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

<b>HMO ALTERNATIVE OPTION</b> PacifiCare	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
\$500 copay per admission; 30 days per calendar year	Member pays 20% of allowed charges after the individual calendar year deductible  <b>Limit 30 days per year</b> Precertification required	Member pays 50% of allowed charges after the individual calendar year deductible and \$300 per confinement hospital deductible, <b>plus</b> amount above the allowed charges and all ineligible expenses  <b>Limit 30 days per year</b> Precertification required	<b>Refer to previous pages</b>	20% of Allowed Charges after deductible 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  <b>Requires prior authorization after 15 visits or penalty will apply</b>  <b>Limit 26 visits per year</b>	Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount that exceeds the allowed charges & all ineligible expenses  <b>Requires prior authorization after 15 visits or penalty will apply</b>  <b>Limit 26 visits per year</b>		20% of Allowed Charges after deductible Limit: 26 visits per year More than 15 visits require prior authorization or penalty applies
\$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)  <b>One per calendar year</b>	Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount that exceeds the allowed charges and all ineligible expenses  Basic hearing screening only		20% of Allowed Charges after deductible Basic hearing screening Does not include comprehensive exam Limit: 1 per year
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		20% of Allowed Charges after deductible Covered for children up to age 18; hearing aids covered as durable medical equipment No benefits for adults 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		20% of Allowed Charges after deductible Prior authorization required for all home services More than 15 visits requires prior authorization or penalty applies

<b>Medical Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard OPTION</b> Aetna CommunityCare GlobalHealth PacifiCare	<b>HMO ALTERNATIVE OPTION</b> Aetna	<b>HMO ALTERNATIVE OPTION</b> CommunityCare	<b>HMO ALTERNATIVE OPTION</b> GlobalHealth
<b>CHIROPRACTIC &amp; MANIPULATIVE THERAPY</b>	\$20 per visit - PCP \$35 per visit - Specialist  PCP can refer for chiropractic or manipulative therapy <b>up to            15 visits per year</b> Additional visits only with approved treatment plan	\$40 specialist per visit copay  PCP can refer for chiropractic or manipulative therapy <b>up to            15 visits per year</b> Additional visits only with approved treatment plan	\$40 copay per visit (15 visits per year)	\$40 per visit limited to 15 visits per calendar year Must be preauthorized
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	20% of cost for equipment  20% of cost for repair and replacement  Must be preapproved by the HMO	20% of contracted rate for the initial device, repair and replacement	20% copay	20% coinsurance limited to \$5,000 combined DME, orthotics, and prosthetics per calendar year
<b>BLOOD AND BLOOD PRODUCTS</b>	No charge if medically necessary	Covered 100% if medically necessary	No copay	No copay
<b>SKILLED NURSING FACILITY</b>	No charge  <b>Limit: 100 days per Plan Year</b>  Must be prescribed by a PCP	No copay (limited to 100 days per plan year)	No copay (Limit: 60 consecutive treatment days per disability)	No copay Limit: 100 days per Plan Year
<b>PERIODIC HEALTH EXAMS</b>	\$10 copay per exam	\$10 per exam copay for ages 19 and over	\$25 copay per visit for Routine Physicals	\$25 per PCP limited to 1 per year

<b>HMO ALTERNATIVE OPTION</b> PacifiCare	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
\$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	<b>Refer to previous pages</b>	20% of Allowed Charges after deductible Limit: 15 visits per year; 3 services/visit More than 15 visits requires prior authorization 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  <b>Purchase, rental, repair or replacement must be prior authorized or 10% penalty applies</b>	Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount above allowed charges and all ineligible expenses.  <b>Purchase, rental, repair or replacement must be prior authorized or 10% penalty applies</b>		20% of Allowed Charges after deductible For purchase, rental, repair, or replacement Prior authorization required or 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, <b>plus</b> amount above allowed charges and all ineligible expenses		20% of Allowed Charges after deductible
\$500 copay per admission; 100 consecutive calendar days	Member pays 20% of allowed charges after the individual calendar year deductible Precertification required <b>Limit:</b> 100 days per year (in a facility)	Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount above allowed charges and all ineligible expenses Precertification required <b>Limit:</b> 100 days per year (in a facility)		20% of Allowed Charges after deductible Precertification required Limit: 100 inpatient days per year
\$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, <b>plus</b> 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		20% of Allowed Charges after deductible 1 mammogram at no charge for women age 40 and over

<b>Medical Plans Comparison Chart Active and New Employees of the State of Oklahoma</b>	<b>HMO Standard OPTION</b> Aetna CommunityCare GlobalHealth PacifiCare	<b>HMO ALTERNATIVE OPTION</b> Aetna	<b>HMO ALTERNATIVE OPTION</b> CommunityCare	<b>HMO ALTERNATIVE OPTION</b> GlobalHealth
<b>TEMPORO- MANDIBULAR JOINT (TMD) DYSFUNCTION</b>	\$50 copay with a \$1,500 lifetime maximum nonsurgical benefit  Must be medically necessary	\$50 per visit copay  (with a \$1,500 lifetime maximum, not surgical benefit)  Must be medically necessary	\$100 copay per treatment plan (lifetime non-surgical maximum of \$1,500)	\$100 copay per treatment plan (limited to \$1,500 non-surgical care)
<b>HOME HEALTH SERVICES</b>	No charge  Must be prescribed by a PCP	No copay  Covered for terminal illness of six months or less  Pre-approval required	No copay	No copay Must be prescribed by PCP
<b>MEDICAL TRANSPORTATION</b>	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
<b>TRANSPLANTS</b>	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
<b>HOSPICE</b>	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

<b>HMO ALTERNATIVE OPTION</b> PacifiCare	<b>HealthChoice HIGH OPTION IN-NETWORK</b>	<b>HealthChoice HIGH OPTION OUT-OF- NETWORK</b>	<b>HealthChoice BASIC</b>	<b>HealthChoice S-ACCOUNT</b>
\$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, <b>plus</b> amount above allowed charges and all ineligible expenses Prior authorization required	<b>Refer to previous pages</b>	20% of Allowed Charges after deductible
\$50 copay per visit	Member pays 20% of allowed charges after the individual calendar year deductible  Prior authorization required or 10% penalty applies  <b>Limit:</b> 100 visits per calendar year	Member pays 50% of allowed charges after the individual calendar year deductible, <b>plus</b> amount above allowed charges and all ineligible expenses  Prior authorization required or 10% penalty applies <b>Limit:</b> 100 visits per calendar year		20% of Allowed Charges after deductible Prior authorization required or penalty applies Limit: 100 visits per 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, <b>plus</b> amount above allowed charges and all ineligible expenses  If not an emergency, medically necessary services are subject to prior approval		20% of Allowed Charges after deductible Medically necessary transport Requires 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, <b>plus</b> amount above allowed charges and all ineligible expenses  Precertification required		20% of Allowed Charges after deductible 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, <b>plus</b> amount above allowed charges and all ineligible expenses For life expectancy of six months or less  Prior authorization required or 10% penalty applies		20% of Allowed Charges after deductible For terminal illness of six months or less Requires prior authorization or penalty applies

## HEALTH

HealthChoice (Member Services) Oklahoma City Metro	(405) 717-8780
Toll Free	(800) 752-9475
TDD	(405) 949-2281 or (866) 447-0436
Health, Dental & Life Claims	(405) 499-4920
Toll-Free	(800) 782-5218
Pharmacy Claims/ID cards	(800) 903-8113
Pre-certification/Emergencies Toll-Free	(800) 848-8121
COBRA	(405) 717-8780
Toll-Free	(800) 752-9475
Web:	<a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a>
Aetna, Inc. All Areas	(800) 949-3104
Web:	<a href="http://www.aetna.com/okstateemployees/">www.aetna.com/okstateemployees/</a>
TDD	(800)-628-3323
CommunityCare HMO All Areas	(800) 777-4890
TTY/TDD	(800) 722-0353
Web:	<a href="http://www.ccok.com">www.ccok.com</a>
GlobalHealth HMO All Areas	(405) 280-5600
Web:	<a href="http://www.globalhealth.cc">www.globalhealth.cc</a>
Toll-Free	(877) 280-5600
TY/TDD/Voice	(800) 522-8506
PacificCare of Oklahoma All Areas	(800) 825-9355
TDHI	(800) 577-7595
Web:	<a href="http://www.pacificare.com">www.pacificare.com</a>

## DENTAL

HealthChoice Dental Plan Oklahoma City Metro	(405) 717-8780
Web:	<a href="http://www.healthchoiceok.com">www.healthchoiceok.com</a> or <a href="http://www.sib.ok.gov">www.sib.ok.gov</a>
Toll Free	(800) 752-9475
TDD	(405) 949-2281 or (866) 447-0436
Assurant Prepaid Dental (Plus and Secure) All Areas	(800) 443-2995
Assurant Freedom Preferred Indemnity All Areas	(800) 442-7742
Web:	<a href="http://www.assurantemployeebenefits.com">www.assurantemployeebenefits.com</a>
CIGNA Dental Prepaid	(800) 367-1037
Web:	<a href="http://www.cigna.com">www.cigna.com</a>
Delta Dental of Oklahoma Oklahoma City Metro	(405) 607-2100
Web:	<a href="http://www.deltadentalok.org">www.deltadentalok.org</a>
Toll Free	(800) 522-0188

## VISION

CompBenefits	(800) 865-3676
Web:	<a href="http://www.visioncare.com">www.visioncare.com</a>
Primary Vision Care Services (PVCS)	(888) 357-6912
Web:	<a href="http://www.pvcs-usa.com">www.pvcs-usa.com</a>
Spectera	(800) 638-3120
Web:	<a href="http://www.spectera.com">www.spectera.com</a>
Superior	(800) 507-3800
Web:	<a href="http://www.superiorvision.com">www.superiorvision.com</a>
Vision Service Plan (VSP)	(800) 877-7195
Web:	<a href="http://www.vsp.com">www.vsp.com</a>

## EMPLOYEES BENEFITS COUNCIL

Main	(405) 232-1190
Toll Free	(800) 219-8115
Administration FAX	(405) 609-3477
Benefits FAX	(405) 609-3474
Finance FAX & Flexible Benefits 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
HIPAA	(405) 232-1190 x122