

OKLAHOMA BEAUTIFUL



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Plan Year 2009

HEALTH PLAN COMPARISON

Active and New Employees of the State of Oklahoma

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 (Members can self-refer for initial visit)	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for all care received outside PCP office
CALENDAR YEAR DEDUCTIBLE	None	None	None	None
ANNUAL OUT-OF-POCKET MAXIMUM	Individual: \$2,000 Family: \$4,000	Individual: \$3,000 Family: \$6,000	Individual: \$2,500 Family: \$5000	Individual: \$3,000 Family: \$5,000
OFFICE VISITS (PROFESSIONAL SERVICES)	Copays \$25 PCP \$35 Specialist	Copays \$30 PCP \$45 Specialist	Copays \$30 PCP \$45 Specialist	Copays \$25 PCP \$50 Specialist
PRESCRIPTION DRUGS	Tier 1: \$10 Tier 2: \$30 Tier 3: \$50 Greater of 30-day supply or 100 units as determined by physician. Selected 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.	\$20/\$40/\$70 Retail, \$40/\$80/\$140 Mail Order	Up to \$0 select generic formulary Up to \$10 generic formulary Up to \$40 brand formulary (when no generic is available) Up to \$65 brand formulary (when generic is available) Up to \$65 non formulary	\$10/\$50/\$75 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.

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF- NETWORK	HealthChoice BASIC	HealthChoice S-ACCOUNT
Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) However, no referral from your contracted specialist when the specialist is in PacifiCare's HMO network	Choice of Network Provider 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 Choice	Segment A - 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 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 unlimited lifetime maximum on eligible health benefits.	\$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 Basic Plan pays 100% of the first \$500 of Allowed Charges for covered services. Then the member pays the next \$500 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.	\$4,000 individual \$8,000 family
Copays \$30 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	Once a member has spent \$5,500 out-of-pocket, the Basic Plan will pay 100% of all other Allowed Charges for that Plan Year. Family deductible is \$1,000 with a maximum annual family out-of-pocket of \$11,000.	\$25 copay after deductible
\$10 copay for formulary generic drug / \$30 copay for formulary brand name drug / \$50 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 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, not to exceed the FDA's approved "usual" dosing for a 100-day supply. For more details visit www.healthchoiceok.com or www.sib.ok.gov	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) (Go to Segment B) Using Network providers will maximize your benefits.	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.

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
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 lab work as specified by OK Health Program	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program
HOSPITAL INPATIENT	\$250 copay per admission Precertification from PCP required	\$500 copay per admission	\$350 copay per admission Precertification from PCP required	\$250 copay per inpatient day Precertification from PCP required \$750 max. per admission
HOSPITAL OUTPATIENT	\$175 per visit copay As authorized by PCP	\$300 per visit copay	\$200 copay per visit outpatient surgical facility	\$250 per visit copay As authorized by PCP
EMERGENCY HEALTH CARE	\$125 per visit copay (Waived if admitted)	\$150 per visit copay (Waived if admitted)	\$150 per visit copay (waived if admitted)	\$150 per visit copay (waived if admitted)
AFTER HOURS URGENT CARE	\$35 copay per visit You must contact your PCP and use plan authorizations	\$75 per visit copay	\$35 copay per visit (prior authorization required)	\$25 PCP/\$50 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	HealthChoice S-ACCOUNT
No charge one time per plan year for PCP visits biometric measurements and lab work related to the OK Health Program. If any other services are provided during this PCP office visit, member will be charged an Office Visit copay.	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	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.	No charge one time per plan year for Network physician visits, biometric measurements, and labwork as specified by OK Health Program
\$1000 admit	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.	Member pays 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, 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, not to exceed the FDA's approved "usual" dosing for a 100-day supply whichever is greater. Certain medications have a maximum quantity limit. For details on specific medications, use the web site at www.healthchoiceok.com or www.sib.ok.gov (Go to Segment C)	Member pays 20% of Allowed Charges after deductible. Precertification required for certain surgeries
\$200 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	Using Network providers will maximize your benefits. 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. identical between the HealthChoice High Option Plan and the HealthChoice Basic Plan.	Member pays 20% of Allowed Charges after deductible \$100 ER deductible; waived if admitted
\$30 PCP copay per visit \$50 Specialist	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	Using Network providers will maximize your benefits. Plan pays 100% of the first \$500 of allowed charges for eligible covered services.	Member pays 20% of Allowed Charges after deductible

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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	\$45 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 \$250 copay per scan for MRI, CT, MRA and PET Scan
ALLERGY TREATMENT AND TESTING	\$25 per series of tests w/PCP \$35 w/specialist \$25 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	\$30 copay per visit to PCP \$45 copay per visit to Specialist \$30 copay for Allergy Serum (six week supply - including shots)	\$25 PCP /\$50 Specialist \$30 per 6-week supply of antigen (including shots)
WELL-BABY CARE	\$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
IMMUNIZATIONS	No copay for ages birth through age 18 \$10 copay per visit for ages 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/ \$50 per Specialist for adults over age 18
MATERNITY	\$25 for initial visit \$250 per admission Precertification required	\$45 copay for initial OB visit (covered 100% thereafter) \$500 copay per admission	\$30 copay for initial visit only (includes prenatal and postnatal care) No copay for Prenatal Classes Amniocentesis (medically necessary; outpatient surgical facility copay may apply) \$350 per admission	\$25 physician services copay for initial visit only \$250 per day hospital admission \$750 max. per admission

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF- NETWORK	HealthChoice BASIC	HealthChoice S-ACCOUNT
Standard Laboratory and Radiology: \$0 copay Specialized scanning and imaging (MRI, MRA, PET, CAT): \$250 copay per scan	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	Member pays 100% of the next \$500 of Allowed Charges for eligible covered expenses. Plan and Member share on a 50/50 basis, the next \$10,000 of Allowed Charges for eligible covered expenses.	Members Pay 20% of Allowed Charges after deductible
\$30 PCP \$50 Spec. Serum and shots including a six (6) week supply of antigen and administration	Member pays 20% of Allowed Charges after the individual calendar year deductible Limit: Battery of 60 tests every 24 months	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	(Individual Member's maximum out-of-pocket cost per year: \$5,500) (Family maximum out-of-pocket cost per year: \$11,000)	Members Pay 20% of Allowed Charges after deductible Limit: Battery of 60 tests every 24 months
No copay	\$25 copay per exam (no deductible applies)	Member pays 50% of Allowed Charges after the individual calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses	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)	Members Pay 20% of Allowed Charges after deductible
\$30 / \$50 copay for ages 19 and over; No copay from birth through age 18 (if no other service is rendered)	Well-baby and adult immunizations paid at 100% Office visit is subject to \$25 copay Administration charge is subject to deductible and coinsurance	Member pays 50% of Allowed Charges after the individual calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses		Members Pay 20% of Allowed Charges after deductible
\$30 PCP \$50 Spec. copay for initial visit once diagnosis of pregnancy is confirmed; \$1000 copay per admit for Hospitalization	Member pays 20% of Allowed Charges after the individual calendar year deductible Includes one postpartum home visit (must meet criteria) Also see Hospital Inpatient Benefits	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) Also see Hospital Inpatient Benefits		Members Pay 20% of Allowed Charges after deductible Includes 1 postpartum home visit - criteria must be met Precertification is required for inpatient services

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
CONTRACEPTIVE SERVICES	\$25 for consultation \$35 per surgical procedure Excludes reversal and voluntary sterilization	\$30 PCP Copay per visit \$45 Specialist Copay per visit \$45 Surgical Procedures Excludes reversal of voluntary sterilization	\$30 copay for Family Planning consultation \$45 copay for surgical procedure (in office)	\$25 PCP \$50 Specialist physician services,
CONTRACEPTIVE DRUGS	Tier 1: \$10 Tier 2: \$25 Tier 3: \$45 Greater of 30-day supply of 100 units Selected medications may have restricted quantities One copay per injectable contraceptive	Retail: Tier 1: \$20 Tier 2: \$40 Tier 3: \$70 Mail Order Drug (MOD) Tier 1: \$40 Tier 2: \$80 Tier 3: \$140 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: \$50 Tier 3: \$75
INFERTILITY SERVICES	25% of costs plus the office visit copay of \$25 – PCP \$35 – Specialist Limited to diagnosis and some treatment See exclusions in members materials	25% of cost plus \$30 PCP/\$45 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 some treatment See exclusions in member materials Requires prior authorization.
MENTAL HEALTH INPATIENT	\$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	\$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	\$400 copay per admission (requires preauthorization and approval through CCOK HMOs Behavioral Health Services) Limited to 30 days per Plan Year	\$250 per Inpatient day copay (750 max. per admission) 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 Including gambling addiction (NEW for 2009)	\$25 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	\$45 Specialist copay Single or Group Therapy (Limited to 26 visits per calendar year) Except for the biologically-based diagnoses treated as other illnesses	\$30 copay per visit to PCP \$45 copay per visit to Specialist (requires preauthorization and approval through CCOK HMOs Behavioral Health Services) 26 visits per year	\$50 per visit 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	HealthChoice BASIC	HealthChoice S-ACCOUNT
Consultation, \$30 copay (PCP), \$50 copay (Specialist); Vasectomy - \$500 Copay (Physician's Office), \$500 copay (outpatient facility); Tubal Ligation - \$500 copay (outpatient facility) \$1000 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	Refer to previous pages	Member pays 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 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, not to exceed the FDA's approved "usual" dosing for a 100-day supply 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 amount for Preferred and 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 after the combined medical and pharmacy deductible 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 some treatment See exclusions in member materials		Member pays 20% of Allowed Charges after deductible Benefits for diagnosis and limited treatment
\$1000 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		Member pays 20% of Allowed Charges after deductible Limit: 30 days/year Precertification required
\$30 PCP \$50 Spec 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		Member pays 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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SUBSTANCE ABUSE INPATIENT	\$250 copay/Admission Limited to 30 days per calendar year Must be preauthorized	\$500 copay/Admission Limited to 30 days per calendar year Must be preauthorized	\$400 copay per admission (maximum of 30 days per calendar year and requires preauthorization and approval through CCOK HMO's Behavioral Health Services)	\$250 Per Inpatient day copay \$750 max. per admission limited to 30 days Must be preauthorized
SUBSTANCE ABUSE OUTPATIENT	\$25 PCP per visit \$35 Specialist per visit Single or group Therapy 26 visits per Plan Year Must be preauthorized	\$45 specialist per visit copay single or group therapy (Limited to 26 visits per calendar year) Must be preauthorized	\$45 per visit PCP \$40 per visit specialist (26 visit limit per calendar year and requires preauthorization and approval through CCOKHMO's Behavioral Health Services)	\$50 per visit Limited to 26 visits per calendar year Must be preauthorized
HEARING SCREENING	\$25 copay per visit for a basic hearing screening (does not include a comprehensive hearing exam) Limit one visit per year	\$10 per visit copay for basic hearing screening (does not include comprehensive hearing exam) Limit one visit per calendar year	\$30 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 covered benefit Except for children up to age 18; audiological services and hearing aids are covered (as Durable Medical Equipment)	Not covered except for children up to 18 years of age; Audiological services and hearing aids are covered (As durable medical equipment) Limited 1 hearing aid per ear every 48 months.	20% copay for children up to age 18	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- \$25 PCP – per visit \$35 Specialist Per visit 60 treatment days per course of therapy	Inpatient-no copay Outpatient-\$45 Specialist copay Limited to 60 days per course of therapy.	No copay for Inpatient Rehabilitation \$45 copay for Outpatient Physical, Occupational or Speech Therapy (up to 60 treatment days per disability)	No copay for Inpatient Rehabilitation \$50 copay per visit for outpatient Limited to 60 days per illness or injury

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF- NETWORK	HealthChoice BASIC	HealthChoice S-ACCOUNT
\$1000 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, plus amount above the Allowed Charges and all ineligible expenses Limit 30 days per year	Refer to previous pages	Member pays 20% of Allowed Charges after deductible Limit: 30 days per year Precertification required
\$30 PCP \$50 Spec 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, plus amount that exceeds the Allowed Charges & all ineligible expenses Requires prior authorization after 15 visits or penalty will apply Limit 26 visits per year		Member pays 20% of Allowed Charges after deductible Limit: 26 visits per year More than 15 visits require prior authorization or penalty applies
\$30 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, plus amount that exceeds the Allowed Charges and all ineligible expenses Basic hearing screening only		Member pays 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		Member pays 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 \$1000 admit Outpatient \$30 PCP \$50 Spec. copay per visit - Combined limit of 60 treatment days per medical episode	For speech and occupational therapy, member pays 20% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year For physical therapy/physical medicine, member pays 20% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year	For speech and occupational therapy, member pays 50% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year For physical therapy/physical medicine, member pays 50% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year		For speech and occupational therapy, member pays 20% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year For physical therapy/physical medicine, member pays 20% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year

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CHIROPRACTIC & MANIPULATIVE THERAPY	\$25 PCP per visit \$35 Specialist per visit PCP can refer for chiropractic or manipulative therapy up to 15 visits per year. Additional visits only with approved treatment plan	\$45 specialist per visit copay PCP can refer for chiropractic or manipulative therapy up to 15 visits per calendar year Additional visits only with approved treatment plan	\$45 copay per visit (15 visits per year)	\$50 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 for the initial device, repair and replacement	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 co pay
SKILLED NURSING FACILITY	No Charge Limited: 100 days per Plan Year Must be prescribed by a PCP	No copay (Limited to 100 days per plan year)	No copay Limit: 60 consecutive treatment days per disability)	Limit: 100 days per Plan Year \$250 / day \$750 max. per admission
PERIODIC HEALTH EXAMS	\$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

HMO ALTERNATIVE OPTION PacifiCare	HealthChoice HIGH OPTION IN-NETWORK	HealthChoice HIGH OPTION OUT-OF- NETWORK	HealthChoice BASIC	HealthChoice S-ACCOUNT
\$20 copay per visit; 15 visits per calendar year, limited to treatments of neurological and orthopedic conditions	For chiropractic services only , member pays 20% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year For manipulative therapy, see physical, occupational, or speech therapy	For chiropractic services only , member pays 50% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year For manipulative therapy, see physical, occupational, or speech therapy	Refer to previous pages	For chiropractic services only , member pays 20% of Allowed Charges after calendar year deductible 20 visits per calendar year without prior authorization Each service limited to 60 visits per year For manipulative therapy, see physical, occupational, or speech therapy
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		Member pays 20% of Allowed Charges after deductible For purchase, rental, repair, or replacement Prior authorization required or penalty applies
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		Member pays 20% of Allowed Charges after deductible
\$1000 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)		Member pays 20% of Allowed Charges after deductible Precertification required Limit: 100 inpatient days per year
\$30 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		Member pays 20% of Allowed Charges after deductible 1 mammogram at no charge for women age 40 and over

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
TEMPORO-MANDIBULAR JOINT (TMD) DYSFUNCTION	\$50 copay with a \$1,500 lifetime maximum nonsurgical benefit Must be medically necessary	\$50 per treatment plan (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)
HOME HEALTH SERVICES	No Charge Must be prescribed by a PCP	No copay Covered for terminal illness of six months or less Pre-approval required	No copay	\$25 copay per visit 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)	Ambulance covered 100% (must have prior authorization except for emergencies)	\$100 copay
TRANSPLANTS	No charge Preapproval & precertification required	\$45 copay (coverage provided at IOE contract facility only)	No copay (all transplant services, including evaluations must be preauthorized)	Inpatient co pay applies 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	HealthChoice BASIC	HealthChoice S-ACCOUNT
\$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	Refer to previous pages	Member pays 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. 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		Member pays 20% of Allowed Charges after deductible. Prior authorization required or penalty applies. Limit: 100 visits per year
\$200 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		Member pays 20% of Allowed Charges after deductible. Medically necessary transport. Requires approval
\$1000 per 3 day maximum Per Admit / Inpatient	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		Member pays 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 prior authorization 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		Member pays 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 All areas (866) 447-0436
Health, Dental & Life Claims.....	(405) 499-4920
Toll Free	(800) 782-5218
Health & Dental ID cards;	OKC area(405)416-1800 — All other areas: (800) 782-5218
TDD.....	OKC area (405) 416-1525 — All other areas (800) 941-2160
Pharmacy Claims / Pharmacy ID cards.....	(800)903-8113
Pre-certification / Emergencies Toll Free.....	All areas (800) 848-8121
TDD.....	All other areas(877) 267-6367
Web.....	www.sib.ok.gov or www.healthchoiceok.com
Disability Plan.....	OKC area (405) 841-9686 — All areas (800) 752-9475
HealthChoice USA, Customer Service & Claims.....	(877) 877-0715,ext 4059
TDD.....	All areas (800) 257-8595
Web:	www.choicecarenetwork.com
Aetna, Inc. All Areas.....	(800) 949-3104
Web:	www.aetna.com/okstateemployees/
TDD.....	(800) 628-3323
CommunityCare HMO All area	(800) 777-4890
TTY / TDD.....	(800) 722-0353
Web:	www.ccok.com
GlobalHealth HMO.....	All areas (405) 280-5600
Web:	www.globalhealth.cc
Toll-Free	(877) 280-5600
TY/TDD/Voice	(800) 522-8506
PacifiCare of Oklahoma All Areas.....	(800) 825-9355
TDHI.....	(800) 577-7595
Web:	www.pacificare.com

DENTAL

HealthChoice Dental Plan Oklahoma City Metro	(405) 717-8780
Web:	www.healthchoiceok.com or www.sib.ok.gov
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:	www.assurantemployeebenefits.com
CIGNA Dental Prepaid	(800) 367-1037
Web:	www.cigna.com
Delta Dental of Oklahoma Oklahoma City Metro.....	(405) 607-2100
Web:	www.deltadentalok.org
Toll Free.....	(800) 522-0188

VISION

Humana/CompBenefits	(800) 865-3676
Web:	www.visioncare.com
Primary Vision Care Services (PVCS).....	(888) 357-6912
Web:	www.pvcs-usa.com
United HealthCare Vision/Spectera	(800) 638-3120
Web:	www.uhcvision.com or www.spectera.com
Superior.....	(800) 507-3800
Web:	www.superiorvision.com
VSP Service Plan (VSP)	(800) 877-7195
Web:	www.vsp.com

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