

COLLIN COUNTY
Medical Plan Comparison Sheet
January 1, 2012

	ADVANTAGE		ADVANTAGE PLUS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre-existing Condition Limitations	None		None	
Plan Year Deductible (Individual/Family)	\$750/\$1,500	\$1,250/\$2,500	\$250/\$500	\$500/\$1,000
Out-of-Pocket Maximum (Individual/Family)	\$3,000/\$6,000	Does not apply	\$2,000/\$4,000	Does not apply
Physician Office Visit	\$20 Co-pay	Not Covered	\$15 Co-pay	Not Covered
Specialist Office Visit	\$50 Co-pay	Not Covered	\$40 Co-pay	Not Covered
Diabetes Related Physician Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Diabetes Related Specialist Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Urgent Care Center Services	\$25 Co-pay	Not Covered	\$25 Co-pay	Not Covered
Chiropractic Care	\$50 Co-pay	Not Covered	Plan pays 75%* (\$1,000 plan year max)	Not Covered
Lifetime Maximum	No Lifetime Maximum		No Lifetime Maximum	
Pharmacy Generic/Brand Name/Non-Preferred Generic/Brand Name & Non-Preferred	Retail Pharmacy \$10/\$25/\$50 Mail Order \$25/\$50	Not Covered	Retail Pharmacy \$10/\$25/\$50 Mail Order \$25/\$50	Not Covered
Diabetes Related Pharmacy Generic/Brand Name/Non-Preferred Generic/Brand Name & Non-Preferred	Retail Pharmacy \$0/\$0/\$0 Mail Order \$0/\$0	Not Covered	Retail Pharmacy \$0/\$0/\$0 Mail Order \$0/\$0	Not Covered
Well Care Benefits	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Emergency Health Services	Plan pays 80%*		Plan pays 75%*	
Durable Medical Equipment	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Inpatient Hospital Co-Payment: 3 person maximum	Plan pays 80%*	Not Covered	Plan pays 100% after a \$100 per day/\$500 co-payment maximum per admission*	Not Covered
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Surgery	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Diagnostic Laboratory and X-ray	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Diagnostic/Therapeutic Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Hospice Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Home Health Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Ambulance Services	Plan pays 80%*		Plan pays 75%*	
Mental Health Services- Inpatient	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Mental Health Services- Outpatient	\$50 Co-pay (Individual) \$45 Co-pay (Group)	Plan pays 60%*	\$40 Co-pay	Plan pays 60%*
Allergy Shots, Serum and Testing	\$20 or \$50 Co-pay	Not Covered	Plan pays 75%*	Not Covered
Lasik Surgery	Plan pays 50%*, limited to \$2,000 per lifetime		Plan pays 50%*, limited to \$2,000 per lifetime	
Vision Care (part of medical plan)	See attached sheet		See attached sheet	
	Premium Discount Full-Time		Employee Monthly Contribution	
Employee Only	\$0.00		\$25.00	
Employee & Child(ren)	\$120.00		\$180.00	
Employee & Spouse	\$160.00		\$225.00	
Employee & Family	\$220.00		\$305.00	
	Premium Surcharge Full-Time		Employee Monthly Contribution	
Employee Only	\$50.00		\$75.00	
Employee & Child(ren)	\$170.00		\$230.00	
Employee & Spouse	\$210.00		\$275.00	
Employee & Family	\$270.00		\$355.00	

This document is intended as a convenient summary of the major points of these benefits plans. This document does not cover all provisions, limitations and exclusions. The official plan documents, policies and certificates of insurance govern in all cases.

*Subject to plan year deductible