



2010 MEDICAL PLAN COMPARISON SHEET

	Express 2500	Express 1500	Express 750	Express 500
Monthly Medical Premium Rates for ages 2 to 18 years	\$75	\$83	\$90	\$139
Primary Care Doctor Office Visit	\$30	\$30	\$30	\$30
Specialist Office Visit	\$50	\$50	\$50	\$50
Eye Exam	\$30	\$30	\$30	\$30
Immunizations (age appropriate)	No Charge			
Standard Lab & X-Ray	No Charge			
Preventive Services	No Charge			
Diagnostic Radiology	20% after deductible			
Outpatient Surgery	20% after deductible			
Inpatient Hospitalization	20% after deductible			
Emergency Room	20% after deductible			
Contract Year Deductible	\$2,500	\$1,500	\$750	\$500
Contract Year Out-of-Pocket Maximum *	\$5,500	\$4,500	\$3,750	\$3,500

*Contract year deductible, co-pays, and co-insurance apply to Contract Year Out-of-Pocket (OOP) Maximum

EXAMPLE: A member has the Express 500 plan. They are treated and released from the Emergency Room (ER). Total expenses for the ER visit is \$20,000. They member will pay: \$500 Deductible (\$20,000 - \$500 = \$19,500) plus 20% co-insurance (\$19,500 x 20% = \$3,900). Since the OOP Maximum is \$3,500, the member will pay their OOP Maximum of \$3,500 (\$500 Contract Year Deductible and \$3,000). Once the OOP Maximum has been satisfied, the member will not pay a co-pay or co-insurance for the remainder of the contract year. The member will still be responsible for plan premiums .

Young Texan



Texas Friendly

2010 OPTIONAL BENEFITS

Optional Prescription Plans	RX 1000	RX 3000
Additional Monthly Premium	\$12	\$18
<i>Retail Quantity (all network pharmacies; up to 34-day supply or 100 units, whichever is less)</i>		
Contract Year Benefit Maximum	\$1,000	\$3,000
Contract Year Deductible	\$250	\$200
Generic (<i>deductible waived</i>)*	\$10	\$10
Brand (<i>after deductible</i>)	\$30	\$30
Non-Preferred Brand (<i>after deductible</i>)	Lesser of \$50 or 50%	Lesser of \$50 or 50%
Non-Formulary (<i>after deductible</i>)	Greater of \$50 or 50%	Greater of \$50 or 50%
<i>Maintenance Quantity (SWHP pharmacies only; up to a 90-day supply or 100 units, whichever is less)</i>		
Generic (<i>deductible waived</i>)*	\$20	\$20
Brand (<i>after deductible</i>)	\$60	\$60
Non-Preferred Brand (<i>after deductible</i>)	Lesser of \$100 or 50%	Lesser of \$100 or 50%
Non-Formulary	Not Covered	Not Covered

*If a brand name drug is dispensed when a generic is available, 50% co-pay applies

**Optional Dental / Additional Monthly Premium	\$27
** Additional Life / Additional Monthly Premium	\$1

** Dental and Life insurance coverage is underwritten by MetLife (Metropolitan Life Co., New York, NY 10010).

All prices are subject to change with notice.

REV 1/28/10