

# Health Plus



Texas Friendly

## SUMMARY OF BENEFITS HEALTH PLUS PORTFOLIO 5000

This insert attempts to summarize the principal benefits of Scott & White Health Plan and is not a contract. Details of benefits are subject to the terms, conditions and limitations of the Individual Evidence of Coverage. The following benefits are available at SWHP designated facilities when medically necessary and provided, authorized, ordered or arranged by a Scott and White Health Plan network provider.

### PLAN PROVISIONS

|                                        |                                         |
|----------------------------------------|-----------------------------------------|
| Contract Year Deductible               | \$5000/\$10000**<br>(Individual/Family) |
| Contract Year Out-of-Pocket<br>Maximum | \$10000/\$20000<br>(Individual/Family)  |
| Lifetime Maximum                       | \$5,000,000/member                      |

### OUTPATIENT SERVICES

|                                                                                                                                               |                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Primary Care Office Visit                                                                                                                     | \$30 Copay              |
| Specialty Care Office Visit                                                                                                                   | \$50 Copay              |
| Preventive Services                                                                                                                           | No Charge               |
| Standard Lab & X-Ray                                                                                                                          | No Charge               |
| Diagnostic/Radiology Procedures<br>(limited to the following procedures: angiograms, CT scans, MRIs,<br>myelography, PET scans, stress tests) | 20% after deductible    |
| Outpatient Surgery                                                                                                                            | 20% after deductible    |
| Allergy Serum                                                                                                                                 | \$25/vial               |
| Eye Exam (1 refraction annually)                                                                                                              | \$30 Copay              |
| Family Planning                                                                                                                               | \$30 Copay              |
| Immunizations (age appropriate)                                                                                                               | No Charge               |
| Maternity - Pre- and Post-Natal Care                                                                                                          |                         |
| Primary Care-Family Practice                                                                                                                  | \$30 Copay per visit    |
| Specialty Care-Obstetrician                                                                                                                   | \$50 Copay per visit    |
| Outpatient Specialty Drugs<br>(Requires Approval of Medical Director)                                                                         |                         |
| Level 1                                                                                                                                       | 10% after deductible    |
| Level 2 (preferred)                                                                                                                           | 20% after deductible    |
| Level 3 (premium preferred)                                                                                                                   | 30% after deductible    |
| Level 4 (non-preferred)                                                                                                                       | 50% after deductible*   |
| Other Outpatient Services                                                                                                                     | 20% after deductible*** |

### INPATIENT SERVICES

|                                                          |                      |
|----------------------------------------------------------|----------------------|
| Hospital Room, Semi-private                              | 20% after deductible |
| Intensive Care Unit                                      | 20% after deductible |
| Surgery/Physician Services                               | 20% after deductible |
| Other Hospital Services                                  | 20% after deductible |
| Skilled Nursing Facility<br>(Pre-Certification Required) | 20% after deductible |

### THERAPEUTIC SERVICES

|                                                                                |            |
|--------------------------------------------------------------------------------|------------|
| Speech & Hearing                                                               | \$50 Copay |
| Physical Therapy                                                               | \$50 Copay |
| Occupational Therapy                                                           | \$50 Copay |
| (Benefit maximum of 20 visits per contract year, based upon medical necessity) |            |

### DURABLE MEDICAL EQUIPMENT/PROSTHESES

|                                                      |                      |
|------------------------------------------------------|----------------------|
| DME/Prosthetics<br>((\$1000 maximum annual benefit)) | 50% after deductible |
|------------------------------------------------------|----------------------|

### DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

|                                |                             |
|--------------------------------|-----------------------------|
| Supplies                       | 20% Copay after deductible  |
| Equipment                      | 20% Copay after deductible  |
| Education/Nutrition Counseling | \$50 Copay after deductible |

### MENTAL HEALTH/CHEMICAL ABUSE SERVICES

#### Outpatient

|                                                                         |                      |
|-------------------------------------------------------------------------|----------------------|
| Visits 1-20                                                             | 50% after deductible |
| Over 20 Visits                                                          | No Coverage          |
| Alcohol and Drug Dependency<br>(Coverage for acute detoxification only) | \$50 Copay           |

#### Inpatient

|                                                                         |                      |
|-------------------------------------------------------------------------|----------------------|
| Days 1-20                                                               | 50% after deductible |
| Over 20 Days                                                            | No Coverage          |
| Alcohol and Drug Dependency<br>(Coverage for acute detoxification only) | 20% after deductible |

### HOME HEALTH SERVICES

|             |            |
|-------------|------------|
| Home Health | \$50 Copay |
| Hospice     | No Charge  |

### EMERGENCY CARE SERVICES

|                                  |                      |
|----------------------------------|----------------------|
| In-Area and Out-of-Area          | 20% after deductible |
| Urgent Care (in and out of area) | 20% after deductible |
| Ambulance                        | 20% after deductible |

\* Level 4 Copayment does not count toward Out-of-Pocket Maximum

\*\* Deductible applies to Out-of-Pocket Maximum

\*\*\* Including other services, treatments, or procedures received at time of office visit.

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EFF. 3/2010

## EXCLUSIONS

- Altered sexual characteristics including sex change operations or any related services
- Blood, blood plasma, and other blood products
- Chiropractic care
- Cosmetic and reconstructive procedures and treatments undertaken to improve or modify a Member's appearance except for mastectomy reconstruction following breast cancer surgery
- Custodial or domiciliary care
- Dental care
- Elective abortions, which are not necessary to preserve the health of the Member
- Elective treatment or elective surgery
- Experimental or investigational treatment
- Genetic testing
- Infertility treatment including any drug whose primary purpose is the treatment of infertility
- Mental health services or disorders are limited to those described in your evidence of coverage
- Non-covered benefits or services
- Cost of services in excess of the usual, customary, and reasonable charges
- Personal comfort items
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs
- Reversal of voluntary surgically-induced sterility; artificial insemination, in-vitro fertilization or family planning therapies
- Rehabilitation services and therapies are limited to those recommended by a Participating or Referral Physician as medically necessary
- Storage of bodily fluids and other body parts
- Experimental organ transplants and associated donor/procurement costs and artificial organs; e.g., heart
- Treatment received in State or Federal facilities or institutions or services or supplies provided by an employer or governmental agency or entity
- Vision corrective surgery including laser application
- War, insurrection, riot, disaster or epidemic
- Weight reduction surgery

See the Exclusions and Limitations section of the Scott and White Health Plan Evidence of Coverage for specific information.

## SCOTT & WHITE HEALTH PLAN PHARMACIES

### **TEMPLE**

Canyon Creek  
937 Canyon Creek Drive  
Temple, TX 76502  
(254) 774-1600

### **TEMPLE**

CDM  
1605 South 31<sup>st</sup> Street  
Temple, TX 76508  
(254) 215-9100

### **BRYAN/COLLEGE STATION**

1110 Earl Rudder Freeway S.  
College Station, TX 77840  
(979) 691-3900

### **GEORGETOWN/SUN CITY**

4945 Williams Drive  
Georgetown, TX 78628  
(512) 942-3302

### **WACO**

Town West Shopping Center  
1412 North Valley Mills  
Suite 116  
Waco, TX 76710  
(254) 761-5200

### **KILLEEN**

2500 Cross Drive  
Killeen, TX 76543  
(254) 953-7777

### **MAIL ORDER PRESCRIPTIONS**

Express Home Prescription Services  
PO Box 1287  
Salado, TX 76571  
(254) 947-7555 (800) 707-3477

### **BELTON**

2805 N. Loop 121  
Suite E  
Belton, TX 76513  
(254) 933-6000

### **SALADO**

3525 FM 2484  
Salado, TX 76571  
(254) 947-7555

### **NORTHSIDE**

514 West Adams  
Temple, TX 76501  
(254) 774-1050

## ADMINISTRATIVE OFFICES & MEMBER SERVICE CENTERS

### **WACO**

Scott & White Health Plan  
American Plaza  
200 W. Hwy 6, Suite 300  
Waco, TX 76712  
(254) 756-8000  
(866) 522-2515

### **TEMPLE**

Scott & White Health Plan  
2401 South 31<sup>st</sup> Street  
Temple, TX 76508-3000  
(254) 298-3000  
(866) 522-2515

### **BRYAN/COLLEGE STATION**

Scott & White Health Plan  
3000 Briarcrest, Suite 422  
Bryan, TX 77802  
(979) 268-7947  
(866) 522-2515

### **GEORGETOWN**

Scott & White Health Plan  
204 South IH 35, Suite 100  
Georgetown, TX 78628  
(512) 930-6040  
(866) 522-2515

### **SAN ANGELO**

Scott & White Health Plan  
2030 Pulliam, Suite 1  
San Angelo, TX 76905  
(325) 659-7591  
(800) 782-5068