

# Young Texan



## SCOTT & WHITE HEALTH PLAN

### Texas Friendly

## SUMMARY OF BENEFITS Young Texan Express 1500

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 Young Texan Evidence of Coverage. The following benefits are applied to medically necessary care received at Scott and White Health Plan (SWHP) designated facilities and provided, authorized, ordered or arranged by a SWHP network provider.

### PLAN PROVISIONS

Annual Deductible	\$1500 Individual***
Annual Out-of-Pocket Maximum	\$4500 Individual
Lifetime Maximum	\$5,000,000

### OUTPATIENT SERVICES

Primary Care Office Visit	\$30 Copay
Specialty Care Office Visit	\$50 Copay
Other Outpatient Services	20% after deductible*****
Preventive Services	No Charge
Standard Lab & X-Ray	No Charge
Diagnostic/Radiology Procedures (limited to the following procedures: angiograms, CT scans, MRIs, myelography, PET scans, stress tests)	20% after deductible
Outpatient Surgery	20% after deductible
Allergy Serum	\$25/vial
Eye Exam (1 refraction annually)	\$30 Copay
Immunizations (age appropriate)	No Charge
Outpatient Specialty Drugs (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**

### 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 (Pre-Certification Required)	20% after deductible

### THERAPEUTIC SERVICES

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

### DURABLE MEDICAL EQUIPMENT/PROSTHESES

DME/Prosthetics ((\$1000 maximum annual benefit))	50% after deductible
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### DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

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

### MENTAL HEALTH/CHEMICAL ABUSE SERVICES

#### **Outpatient**

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

#### **Inpatient**

Days 1-20	50% after deductible
Over 20 Days	No Coverage
Alcohol and Drug Dependency (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

### PRESCRIPTIONS - OPTIONAL

Annual Benefit Maximum	\$1000
Deductible	\$250 annually****

#### **Retail Quantity (All Network Pharmacies)**

(Up to 34-day supply or 100 units, whichever is less)

Generic*	\$10 Copay
Brand	\$30 Copay
Non-preferred brand	Lesser of \$50 or 50%
Non-Formulary	Greater of \$50 or 50%

#### **Maintenance Quantity (SWHP Pharmacies only)**

(Up to a 90-day supply or 360 units, whichever is less)

Generic*	\$20 Copay
Brand	\$60 Copay
Non-preferred brand	Lesser of \$100 or 50%
Non-Formulary	Not Covered

\* If a brand name drug is dispensed when a generic is available, 50% Copay applies.

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

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

\*\*\*\* Deductible on brand name drugs, alternate choice brand name drugs and non-formulary drugs. There is no deductible for generic drugs.

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

## **EXCLUSIONS**

- Altered sexual characteristics including sex change operations or any related services
- Blood, blood plasma, and other blood products
- Breast augmentation
- Chiropractic care
- Chronic pain relief
- Cosmetic and reconstructive procedures and treatments undertaken to improve or modify a Member's appearance except for mastectomy reconstruction following breast cancer surgery
- Cost of services in excess of the usual, customary and reasonable charges
- 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
- Immunizations for purposed of travel
- 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
- Non-emergent treatment or non-emergency services provided by non-participating providers
- Orthotics and protective equipment for sports participation
- Personal comfort items
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs
- Pregnancy and related care and conditions
- 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
- Reimbursement for which Legal Guardian has no obligation to pay in absence of coverage
- Residential treatment center for children or adolescents
- Routine foot care
- Services provided by a family member
- Social services that are not covered services
- 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
- Unauthorized services
- 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) 699-1133

### **MAIL ORDER PRESCRIPTIONS**

Express Home Prescription Services  
PO Box 3690  
Temple, TX 76505  
(254) 742-0550 (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

## **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) 522-2516

### **TEMPLE**

Scott & White Health Plan  
2401 South 31<sup>st</sup> Street  
Temple, TX 76508-3000  
(254) 298-3000  
(866) 522-2516

### **BRYAN/COLLEGE STATION**

Scott & White Health Plan  
3000 Briarcrest, Suite 422  
Bryan, TX 77802  
(979) 268-7947  
(866) 522-2516

### **GEORGETOWN**

Scott & White Health Plan  
204 South IH 35, Suite 100  
Georgetown, TX 78628  
(512) 930-6040  
(866) 522-2516