

# Health Plus



## SUMMARY OF BENEFITS HEALTH PLUS VI

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 Health Care 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

Annual Deductible	\$250/\$500** (Individual/Family)
Annual Out-of-Pocket Maximum	200% of total annual premium
Pre-Existing Conditions	Covered
Lifetime Maximum	\$5,000,000

### OUTPATIENT SERVICES

Primary Care Office Visit	\$30 Copay
Specialty Care Office Visit	\$30 Copay
Lab & X-Ray	No Charge
Day Surgery	\$100 Copay
Allergy Injections	\$30/vial
Family Planning	\$30 Copay
Well Child Care	\$30 Copay
Immunizations	\$30 Copay
Routine Physical (excluding employment, insurance, etc.)	\$30 Copay
Maternity	
Pre- and Post-Natal Care	\$30 Copay (Or flat fee of \$360)

### INPATIENT SERVICES

Pre-admission Tests	No Charge
Lab & X-Ray	No Charge
Hospital Room, Semi-private	\$200/day Copay*
Intensive Care Unit	\$200/day Copay*
Surgery	No Charge
Other Hospital Services	No Charge
Skilled Nursing Facility (Pre-Certification Required)	\$200/day Copay*

### DIAGNOSTIC/THERAPEUTIC SERVICES

(Limited to combined total of 20 visits per contract year; benefit limitation based upon medical necessity)

Speech & Hearing	\$30 Copay
Physical Therapy	\$30 Copay
Occupational Therapy	\$30 Copay

### DURABLE MEDICAL EQUIPMENT/PROSTHESES

DME/Prosthetics	20% Copay after deductible (\$1,000.00 maximum annual benefit)
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### DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

Supplies	20% Copay after deductible
Equipment	20% Copay after deductible
Education/Nutrition Counseling	\$30 Copay

### MENTAL HEALTH/CHEMICAL ABUSE SERVICES

Outpatient	
Visits 1-20	50% Copay after deductible
Over 20 Visits	No Coverage
Alcohol and Drug Dependency (Detoxification only)	50% Copay after deductible
Inpatient	
Days 1-20	50% Copay after deductible
Over 20 Days	No Coverage
Alcohol and Drug Dependency (Detoxification only)	50% Copay after deductible

### HOME HEALTH SERVICES

Home Health	\$30 Copay
Hospice	No Charge

### EMERGENCY CARE SERVICES

In-Area and Out-of-Area	\$100/Visit Copay (copay waived if admitted within 24 hours)
Urgent Care (in and out of area)	\$40/Visit Copay
Ambulance	\$40 Copay (copay waived if transported)

\* **\$1,000 maximum copayment per confinement**

\*\* **\$250 deductible per person must be met before benefits are paid.**

## EXCLUSIONS

- Altered sexual characteristics including sex change operations or any related services
- Blood, blood plasma, and other blood products
- Breast augmentation
- 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
- Cost of services in excess of the usual, customary, and reasonable charges
- Court ordered care
- 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
- Family planning treatment
- Infertility diagnosis and 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
- Miscellaneous aids, corrective appliances, supplies
- Non-covered benefits or services
- Non-emergent treatment provided by non-participating providers
- Personal comfort items
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs
- Purchase or rental of household equipment or fixtures
- Reversal of voluntary surgically-induced sterility, artificial insemination, in-vitro fertilization or family planning therapies
- Reimbursement for which member has no obligation to pay in absence of coverage
- Residential treatment center for children or adolescents
- Routine foot care
- Routine eye exams
- Services provided by a family member
- Take-home prescription drugs
- 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 and radial keratotomy
- War, insurrection, riot, disaster or epidemic

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

## ADMINISTRATIVE OFFICES & MEMBER SERVICE CENTERS

### **WACO**

Scott & White Health Plan  
American Plaza  
200 W. State 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