



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.

PLAN PROVISIONS

Annual Deductible	\$1500 Individual***
Annual Out-of-Pocket Maximum	\$3000 Individual
Lifetime Maximum	\$5,000,000

OUTPATIENT SERVICES

Primary Care Office Visit	\$30 Copay
Specialty Care Office Visit	\$30 Copay
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
Day 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	\$30 Copay
Physical Therapy	\$30 Copay
Occupational Therapy	\$30 Copay
(Benefit maximum of 20 visits per contract year, based upon medical necessity)	

DURABLE MEDICAL EQUIPMENT/PROSTHESES

DME/Prosthetics	50% after deductible
(\$1000 maximum annual benefit)	

DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

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

MENTAL HEALTH/CHEMICAL ABUSE SERVICES

Outpatient

Visits 1-20	50% after deductible
Over 20 Visits	No Coverage
Alcohol and Drug Dependency (Covered as a physical illness, lifetime maximum of (1) series of treatment)	\$30 Copay

Inpatient

Days 1-20	50% after deductible
Over 20 Days	No Coverage
Alcohol and Drug Dependency (Covered as a physical illness, lifetime maximum of (1) series of treatment)	20% after deductible

HOME HEALTH SERVICES

Home Health	\$30 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

Annual Benefit Maximum	\$1000
Deductible (separate from Medical Deductible)	\$75 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.

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

South Loop
2601 Thornton Ln., Suite A
Temple, TX 76502
(254) 742-1100
(800) 344-2301

TEMPLE

CDM
1605 South 31st 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

ADMINISTRATIVE OFFICES & MEMBER SERVICE CENTERS

WACO

Scott & White Health Plan
American Plaza
200 W. Hwy 6, Suite 300
Waco, TX 76712
(254) 756-8000
(800) 684-7947

TEMPLE

Scott & White Health Plan
2401 South 31st Street
Temple, TX 76508-3000
(254) 298-3000
(800) 321-7947

BRYAN/COLLEGE STATION

Scott & White Health Plan
3000 Briarcrest, Suite 422
Bryan, TX 77802
(979) 268-7947
(800) 791-8777

GEORGETOWN

Scott & White Health Plan
204 South IH 35, Suite 100
Georgetown, TX 78628
(512) 930-6040
(800) 758-3012