Young Texan
SCOTT&WHITE HEALTH PLAN
Texas Friendly

SUMMARY OF BENEFITS
Young Texan Express 750

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	$750 Individual***
Annual Out-of-Pocket Maximum	$3,750 Individual
Lifetime Maximum	$5,000,000

OUTPATIENT SERVICES / MEMBER PAYS

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	20% after deductible
(limited to the following procedures: angiograms, CT scans, MRIs, myelography, PET scans, stress tests)	
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	20% after deductible
(Pre-Certification Required)	

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	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	$50 Copay

MENTAL HEALTH/CHEMICAL ABUSE SERVICES

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

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.

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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 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

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 31st 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