

Gold Benefit Level	Hillcrest Baptist Medical Center, Select Hillcrest Medical Staff, Scott & White Hospital (Temple & Round Rock), Scott & White Clinic Physicians.		
Silver Benefit Level	Providers include select contracted area providers, college students out of the area, and services for which Hillcrest Baptist Medical Center or Scott & White Hospital refer out to another provider.		
Bronze Benefit Level	Includes all other providers.		
Effective January 1, 2012	GOLD	Silver	Bronze
Plan Provisions (Usual and Customary Charges will apply to Out-of-Network benefits)			
Annual Deductible (Deductible applies to Out-of-Pocket Maximum)	None	\$1,000 individual \$3,000 family	\$3,500 individual \$7,500 family
Annual Out-of-Pocket Maximum (Includes Deductible, Copays and Coinsurance)	\$3,000 individual \$6,000 family	\$5,500 individual \$12,500 family	\$10,000 individual \$25,000 family
Outpatient Services			
Primary Care Office Visit (Includes examination, treatment, tests and supplies provided by and billed by Physician at the time of the office visit, except Select Diagnostic Medical Procedures)	\$25 copay	80% after deductible	50% after deductible
Specialty Care Office Visit (Includes examination, treatment, tests and supplies provided by and billed by Physician at the time of the office visit, except Select Diagnostic Medical Procedures)	\$45 copay	80% after deductible	50% after deductible
Preventive Services (including associated lab and x-ray)	100% coverage	80% after deductible	No Coverage
Standard Lab and X-Ray	100% coverage	80% after deductible	50% after deductible
Diagnostic/Radiology (Limited to the following procedures: angiograms, CT scans, MRIs, myelography, PET scans, stress tests, ultrasound)	\$150 copay (\$200 copay for MRI) (\$50 for ultrasound)	80% after deductible	50% after deductible
Outpatient Surgery/Procedures Ambulatory Surgical Center	\$250 copay	80% after deductible	50% after deductible
Allergy Injections	\$10 copay	80% after deductible	50% after deductible
Allergy Serum (dispensed by Physician's office)	80% coverage	80% after deductible	50% after deductible
Routine Immunizations (including flu shots/pneumonia shots)	100% coverage (no age limit)	100% coverage	Not Covered
Maternity (Physician Services Pre- and Post-Natal Care)	100% coverage	80%, deductible waived	50%, deductible waived
Inpatient Services (Notification of Health Services Division of Claims Administrator required)			
Hospital Room, Semi-private	\$200 copay/day (\$1,000 max per admission)	80% after deductible	50% after deductible
Skilled Nursing Facility (Pre-Certification Required) 100 covered days per calendar year combined between all benefit levels.	\$200 copay /day (\$1,000 max per admission)	80% after deductible	50% after deductible
Therapeutic Services			
Speech and Hearing Office Visit, Testing and Treatment	\$25 copay	80% after deductible	50% after deductible
Hearing Aids Maximum Benefit per Ear (1 hearing aid every 36 months) Combined between all Benefit Levels	100% coverage up to \$500 per ear	80% after deductible up to \$500 per ear	50% after deductible up to \$500 per ear
Physical Therapy *Combined between Silver and Bronze Benefit	\$25 copay	80% after deductible (*limited to 60 visits per calendar year)	50% after deductible (*limited to 60 visits per calendar year)
Durable Medical Equipment			
DME	80% coverage	80% after deductible	50% after deductible
Diabetic Supplies, Equipment and Self-Management Training (Unlimited Benefit)			
Supplies	80% coverage	Same as DME or Rx, as appropriate	Same as DME or Rx, as appropriate
Annual Diabetic Eye Exam (1 refraction annually)	100% coverage	Not Covered	Not Covered
Education/Nutrition Counseling	\$45 copay	80% after deductible	50% after deductible

Effective January 1, 2012	GOLD	Silver	Bronze
Mental Health/Chemical Abuse Services			
Office Visit	\$25 copay	80% after deductible	50% after deductible
Outpatient Day Treatment	\$45 copay	80% after deductible	50% after deductible
Inpatient	\$200/day (\$1,000 max per admission)	80% after deductible	50% after deductible
Serious Mental Illness			
Office Visit	\$25 copay	80% after deductible	50% after deductible
Outpatient Day Treatment	\$45 copay	80% after deductible	50% after deductible
Inpatient	\$200/day (\$1,000 max per admission)	80% after deductible	50% after deductible
Home Infusion Therapy <i>(requires authorization)</i>			
Home Infusion Therapy	100% coverage	80% after deductible	50% after deductible
Home Health Services <i>(requires authorization)</i>			
Home Health (100 covered days)	100% coverage	Not Covered	Not Covered
Hospice	100% coverage	Not Covered	Not Covered
Sleep Disorders <i>(requires authorization)</i>			
Office Visit/Outpatient	\$45 copay	Not Covered	Not Covered
Sleep Studies/Diagnostic Testing, Devices, and all other covered services	80% coverage	Not Covered	Not Covered
Emergency Care Services <i>(Emergency Care Services copayments do not apply to In-Network deductible and Out-of-Pocket maximum)</i>			
Emergency Room (all related charges) Copay waived if admitted inpatient	\$200 copay/visit	\$200 copay/visit	\$200 copay/visit
Urgent Care	\$75 copay	\$75 copay	\$75 copay
Ambulance (per trip)	\$75 copay	\$75 copay	\$75 copay

Prescription Plan (all plans)	Network
Annual Benefit Maximum	Unlimited
Annual Deductible	\$50 Individual \$150 Family
Retail Quantity <i>(Up to a 30-day supply)</i>	
Preferred Generic	\$5 copay <i>(deductible waived)</i>
Non-Preferred Generic	\$10 copay
Preferred Brand	30% copay
Non-Preferred Brand	50% copay
Maintenance Quantity <i>(Up to a 90-day supply) Maintenance quantities must be obtained from a Scott & White Health Plan pharmacy.</i>	
Preferred Generic	\$10 <i>(deductible waived)</i>
Non-Preferred Generic	Available through retail only
Preferred Brand	30% (\$100 max)
Non-Preferred Brand	Available through retail only
Self-Administered Injectable Pharmacy Drugs <i>(Up to a 30-day supply) (requires authorization)</i>	
Generic	30% copay / \$150 maximum per prescription
Brand	30% copay / \$150 maximum per prescription

For more information, please refer to your SPD. To view a complete list of providers in the Gold and Silver categories, simply go to www.Hillcrest.swhp.org.
Customer Service 1-877-819-9171