

A&M MEDICAL STUDENT POLICY JULY 2012

This insert attempts to summarize the principal benefits of A&M Medical Student Blanket Accident and Sickness Plan and is not a contract. Details of benefits are subject to the terms, conditions and limitations of the Blanket Policy.

PLAN PROVISIONS MEMBER RESPONSIBILITY

| | |
|------------------------------|-----------------------------|
| Annual Deductible | \$250 ind/\$750 family |
| Annual Out-of-Pocket Maximum | \$5,000 ind/\$10,000 family |
| Lifetime Maximums | None |

MEDICAL SERVICES MEMBER PAYS

| | |
|---|-----------------------|
| Physician's Office Visit | \$25 Copay |
| Preventive Services | No Charge |
| - with Lab and Xray | No Charge |
| Lab & X-Ray | 30% after deductible |
| Infusion Therapy | 30% after deductible |
| Outpatient services and supplies | 30% after deductible |
| Office and Outpatient Surgery | 30% after deductible |
| Eye Exam (1 refraction annually) | \$25 Copay |
| Immunizations (Age Appropriate) | No Charge |
| Independent Lab/Freestanding Imaging Centers | 30% after deductible |
| 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* |

MATERNITY, FAMILY PLANNING, INFERTILITY

| | |
|--------------------------|----------------------|
| Physician's Office Visit | \$25 Copay |
| Pre- and Post-Natal Care | |
| Inpatient services | 30% after deductible |

HOSPITAL SERVICES

| | |
|-----------------------------|----------------------|
| Hospital Room, Semi-private | 30% after deductible |
|-----------------------------|----------------------|

MENTAL HEALTH CARE

| | |
|--------------------------------------|----------------------|
| Outpatient | |
| Visits 1 – 20 | 30% after deductible |
| Over 20 Visits | Not Covered |
| Serious Mental Illness | \$25 Copay |
| Limited to 60 days per contract year | |
| Inpatient | |
| Days 1 – 20 | 30% after deductible |
| Over 20 Visits | Not Covered |
| Serious Mental Illness | 30% after deductible |
| Limited to 45 days per contract year | |

TREATMENT FOR CHEMICAL DEPENDENCY

| | |
|--|----------------------|
| Outpatient facility | \$25 Copay |
| Inpatient facility | 30% after deductible |
| Must be precertified, provides lifetime maximum of 3 series of treatments. | |

EMERGENCY CARE SERVICES

| | |
|--------------------------------|----------------------|
| Physician and facility charges | 30% after deductible |
| Ambulance | 30% after deductible |

REHABILITATIVE THERAPY

| | |
|--|----------------------|
| Physical, Occupational, Speech, Respiratory and Manipulative Therapy | 30% after deductible |
| (Benefit maximum of 20 visits per contract year, based upon medical necessity) | |

HOME HEALTH SERVICES

| | |
|-----------------------------|----------------------|
| Home Health Care | 30% after deductible |
| Maximum Days /contract year | 60 |
| Skilled Nursing Facility | 30% after deductible |
| Maximum Days /contract year | 60 |
| Hospice Care | 30% after deductible |

DURABLE MEDICAL EQUIPMENT

| | |
|---------------------------|----------------------|
| Durable Medical Equipment | 30% after deductible |
| Contract year maximum | \$1,000 |

DIABETIC SUPPLIES, EQUIPMENT

| | |
|---------------------------------|--|
| Diabetic Equipment and Supplies | Covered under Prescription Drug Plan or DME benefit as applicable. |
|---------------------------------|--|

PRESCRIPTIONS

| | |
|---|-----------------|
| Annual Deductible (Separate From Medical Deductible) | |
| Tier 1 | \$0 |
| Tier 2-4 | \$75 |
| Annual Maximum Benefit | \$500, then 50% |
| (After you have used \$500 in benefits, you have 50% coverage after deductibles.) | |

Retail Quantity (All Network Pharmacies)

| | |
|---|------------------------|
| (Up to a 34-day supply or 100 units, whichever is less) | |
| Tier 1 - Generic** | \$10 |
| Tier 2 - Brand | \$30 |
| Tier 3 - Non-preferred brand | \$50 |
| Tier 4 - Non-Formulary | Greater of \$50 or 50% |

Maintenance Quantity

| | |
|---|-------------|
| (up to a 90-day supply or 360 units, whichever is less) | |
| Tier 1 - Generic** | \$20 |
| Tier 2 - Brand | \$60 |
| Tier 3 - Non-preferred brand | \$100 |
| Tier 4 - Non-Formulary | Not Covered |

* Level 4 copayment does not count toward the Out of Pocket Maximum

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

Note: All benefit payments are subject to the ICSW allowed amount schedule.

EXCLUSIONS

- Altered sexual characteristics including sex change operations or any related services
- Blood, blood plasma, and other blood products
- Breast implants
- Care provided by a family member
- 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
- Court Ordered Care
- Criminal Offenses
- 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
- Genetic testing
- Household Equipment and Fixtures
- 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
- Cost of services in excess of the allowed amount
- Personal comfort items
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs
- Pre-existing 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 Physician as medically necessary
- Refractive Keratotomy
- Routine Foot Care
- 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
- Vision corrective surgery including laser application
- War, insurrection, riot, disaster or epidemic
- Weight reduction surgery

See the Exclusions and Limitations section of the Insurance Company of Scott & White Evidence of Coverage for specific information.

SCOTT & WHITE HEALTH PLAN PHARMACIES

TEMPLE
Canyon Creek
937 Canyon Creek Dr
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 South
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) 953-7777

MAIL ORDER PRESCRIPTIONS
Express Home Prescription Services
PO Box 1287
Salado, TX 76571
(254) 947-7555 (800) 707-3477

BELTON
309 Lake Rd
Suite B
Belton, TX 76513
(254) 933-6000

SALADO
3525 FM 2484
Salado, TX 76571
(254) 947-7555

NORTHSIDE
514 West Adams
Temple, TX 76501
(254) 774-1050

CAMERON
101 Lafferty
Cameron, TX 76520
(254) 605-1150

ROUND ROCK
425 Univ. Blvd. Ste 165
Round Rock, TX 78665
(512) 509-3600

COLLEGE STATION
1296 Arrington Rd
College Station, TX 77845
(979) 361-6301

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
(800) 684-7947

TEMPLE
Scott & White Health Plan
1206 West Campus Drive
Temple, TX 76502
(254) 298-3000
(800) 321-7947

BRYAN/COLLEGE STATION
Scott & White Health Plan
3000 Briarcrest Dr., 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

SAN ANGELO
Scott & White Health Plan
1131-B Knickerbocker Rd
San Angelo, TX 76903
(325) 659-7591
(800) 782-5068