

The details below give a general idea of how the policy works. To be covered, expenses must be medically necessary and listed as covered in your policy. A policy is the document that outlines the benefits, provisions, and limitations of your plan.

| Plan Provisions | In Network | Out of Network ¹ |
|---|------------|-----------------------------|
| Individual calendar year deductible | \$7,500 | \$15,000 |
| Family calendar year deductible | \$15,000 | \$30,000 |
| Individual calendar year Out of Pocket Maximum ² | \$10,500 | \$21,000 |
| Family calendar year Out of Pocket Maximum ² | \$21,000 | \$42,000 |
| Lifetime Maximum Benefit | Unlimited | |
| Pre-existing condition limitation | 12/12 | |

| | You Pay... | You Pay... |
|---|---|---------------------|
| Office Visits | | |
| Primary/Specialist care | \$25 primary / \$50 specialist | Deductible then 50% |
| Preventive Health Services | Deductible waived then 0% | Deductible then 50% |
| Standard Lab & X-Ray | Deductible then 20% | Deductible then 50% |
| Diagnostic/Radiology Procedures Limited to angiograms, CT scans, MRIs, myelography, PET scans, stress tests | First \$300 are covered in full Deductible then 20% first 3 tests, then deductible and 50% for additional tests | Deductible then 50% |
| Outpatient Surgery | Deductible then 20% | Deductible then 50% |
| Other Outpatient Services | Deductible then 20% | Deductible then 50% |
| Inpatient Hospitalization | Deductible then 20% | Deductible then 50% |
| Allergy Serum | Deductible then 20% | Deductible then 50% |
| Eye Exam (1 refraction annually) | Deductible then 20% | Deductible then 50% |
| Maternity | Not covered | Not covered |
| Outpatient Specialty Drugs | | |
| Level 1 | Deductible then 10% | Deductible then 40% |
| Level 2 (preferred) | Deductible then 20% | Deductible then 40% |
| Level 3 (premium preferred) | Deductible then 30% | Deductible then 40% |
| Level 4 (non-preferred) ³ | Deductible then 50% | Deductible then 50% |
| Speech & Hearing Therapy (20 visits per calendar year) | Deductible then 20% | Deductible then 50% |
| Physical Therapy (20 visits per calendar year, 10 visits in home) | Deductible then 20% | Deductible then 50% |
| Durable Medical Equipment/Prostheses \$1,000 benefit maximum per calendar year | Deductible then 20% | Deductible then 50% |
| Mental Health / Chemical Abuse Services | Not covered | Not covered |
| Home Health Services (up to 60 days per calendar year) Deductible waived in-network when approved by care coordination. | Deductible then 20% | Deductible then 50% |
| Emergency Room In-Area and Out-of-Area | Deductible then 20% | Deductible then 20% |
| Urgent Care In-Area and Out-of-Area | \$75 | Deductible then 20% |

¹Some services require authorization from ICSW. If you utilize a non-network provider, it is your responsibility to coordinate authorization with ICSW.

²Out of network deductibles and coinsurance amounts will count toward satisfying in network deductible and coinsurance amounts.

³Level 4 deductible and coinsurance amounts do not apply to out of pocket maximums.

My Plan 80 Prescription Drug Benefit

| <u>Prescription Drug Benefit</u> | <u>In network Pharmacy</u> Up to a 34-day supply or 100 units, whichever is less | <u>Maintenance Quantity from a Scott & White Pharmacy²</u> Up to a 90-day supply or 360 units, whichever is less | <u>Out of Network pharmacy³</u> |
|---|--|---|---|
| Calendar year drug deductible The prescription drug deductible is separate from the major medical deductible. | \$250 per person | | Out of network major medical deductible, then 50% of allowed charges. |
| Preferred generic | \$3 co-pay, deductible waived for generic | \$6 co-pay, deductible waived for generic | |
| All other drugs¹ | Deductible then 50% | Deductible then 50% | |
| Annual Benefit Maximum per person | Unlimited | | Unlimited |

¹ If a brand name is dispensed when a generic is available, 50% co-pay applies

² Scott & White pharmacies will dispense up to a 90-day supply of preferred generic medications for \$6 co-pay.

³ You must submit a claim for reimbursement when using out of network pharmacies.

IN NETWORK AND OUT OF NETWORK PROVIDERS

When you go to a network provider, the amount you pay is based on the agreed-upon amount. The provider cannot “balance bill” you for charges greater than that amount. Network providers agree to accept an agreed-upon amount as payment in full. When you go to an out-of-network provider, the amount you pay is based on ICSW’s allowable amount. The provider can “balance bill” you for charges greater than the allowed amount. These charges don’t apply to your out-of-pocket limit or deductible. Your policy explains your share of the cost for network and out-of-network providers.

PREEXISTING CONDITION LIMITATION

“Preexisting Condition(s)” means any medical or physical condition for which the Member sought or received medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the Effective Date. ICSW will not deny, exclude, or limit benefits for services for Preexisting conditions when expenses for Covered Services are incurred more than twelve (12) months following the Effective Date. Genetic information in the absence of a diagnosis of a relevant condition shall not be considered a Preexisting Condition. Preexisting Conditions do not apply to Covered Dependents age 18 or under.

LIMITATIONS & EXCLUSIONS

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| <ul style="list-style-type: none"> • Abortions • Altered Sexual Characteristics • Blood and Blood Products • Breast Implants • Chiropractic Care • Cosmetic or Reconstructive Procedures or Treatments • Court-Ordered Care • Injuries sustained in commission of a felony • Custodial Care • Dental Care • Disaster or Epidemic • Elective Treatment or Elective Surgery • Services Exceeding Benefit Maximum or limits • Experimental or Investigational Treatment • Services Provided by a Family Member • Family Planning Treatment • Genetic Testing | <ul style="list-style-type: none"> • Household Equipment such as exercise cycles, air purifiers, allergenic pillows, etc. • Household Fixtures such as escalators, elevators, saunas, etc. • Infertility Diagnosis and Treatment • Maternity Care • Mental Health • Miscellaneous; Artificial aids, corrective appliances, and medical supplies, such as batteries, crutches, condoms, canes, dressings, syringes (other than diabetic syringes), braces, prosthetic devices, dentures, hearing aids, eyeglasses and corrective lenses • Non-Covered Benefits/Services • Payment for Charges exceeding Allowed Amount • Personal Comfort Items | <ul style="list-style-type: none"> • Physical and Mental Exams for obtaining insurance, maintaining employment, licenses, etc. • Preexisting Conditions • Over the counter prescription drugs • Refractive Keratotomy • Rehabilitation Services • Reimbursement • Routine Foot Care • Self-Inflicted Injury • Speech and Hearing Loss • Storage of Bodily Fluids and Body Parts • Temporomandibular Joint (TMJ) • Transplants • Treatment Received in State or Federal Facilities or Institutions • Vision Corrective Surgery, including Laser Application • War, Insurrection or Riot • Weight Loss • Work Related Injury |
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