

Frates Benefit Administrators

SCHEDULE OF MEDICAL EXPENSE BENEFITS - ALTERNATE PLAN

Sharyland ISD Plan Benefits Effective: May 1, 2005

FOR COVERED PERSONS ENROLLED IN THE ALTERNATE PLAN

The Alternate plan is available to employees only. The Alternate plans purpose is to provide minimal coverage to employee with medical coverage elsewhere. Specified Benefits are considered "cash" benefits and are not subject to all of the Medical Plan provisions. Assignment of Benefits is not eligible for this plan. In no event can an employee be enrolled in the alternate plan with a dependent enrolled in a medical plan. Employees in the Alternate plan may enroll in another medical option with a qualifying event (loss of coverage) during This Plan year or anniversary date. Any pre-existing limitation condition will apply once an employee enrolls himself and his dependents in a medical plan.

The effective date of the Plan change will be the first day of the month following or coinciding with the qualifying event (loss of coverage).

This schedule represents a summary of benefits. For complete details of benefits and requirements please refer to the Medical Benefits Booklet. To Verify Coverage: 1-866-471-6048 / www.healthsmart.com

BENEFITS UNDER THE ALTERNATE PLAN – PAID DIRECT TO THE EMPLOYEE ONLY

	BENEFIT
Inpatient Hospital (<i>benefit payable per day</i>)	\$250
Inpatient Hospitalization shall mean only those days for which charges are made for Room and Board in a covered Hospital facility.	
Outpatient Surgical/Ambulatory Surgical Center (<i>benefit payable per service date</i>)	\$100
Surgical Procedure means only cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general Anesthesia, tapping (paracentesis), electrocauterization, application of plaster Cast, endoscopy, administration of artificial pneumothorax, or injection of Sclerosing solution. The benefit includes coverage for facility and professional benefits payable.	
Outpatient Cancer Treatment (<i>benefit payable per day</i>)	\$100
Outpatient Cancer treatment means only outpatient administration of chemotherapy and/or radiation therapy.	
Specified Routine/Preventive Care Services (<i>benefit payable per calendar year</i>)	\$200
Charges for certain Routine/Preventive Care Expenses, up to a maximum benefit \$200 per Participant, per Calendar Year, will be considered eligible. Covered Expenses for Routine and/or Preventive Medical Care (with no symptoms of illness or injury) will be considered and processed at 100% up to the \$200 Calendar Year Maximum Benefit. Charges exceeding this Calendar Year Maximum are not Eligible Expenses under any provision of this Plan. For the purpose of this Special Provision, Covered Expenses shall include the following:	
<ul style="list-style-type: none">• Routine physical examinations and associated lab and/or X-ray screening procedures; including, but not limited to, one mammography screening per Calendar Year for persons age thirty-five (35) and older; and one prostate examination per Calendar year for persons age forty (40) and older.• Routine vision examinations• Routine hearing examinations.	
To receive benefits under the Alternate Plan, the Participant must submit copies of eligible bills for Inpatient Hospitalization, Outpatient Surgery, Outpatient Cancer Treatment, and/or Routine/Preventive Care Services.	
Prescription Drug Benefit (<i>benefit payable per calendar year</i>)	\$600
For persons enrolled in the Alternate Benefit Plan, the Plan will pay 100% of prescription drug expenses incurred on an Outpatient basis up to a maximum benefit of \$600 per Covered Person per Calendar Year.	

NOTE: Charges incurred for medication which is to be taken or administered (in whole or in part) to an individual while in a Hospital, rest home, extended care facility, convalescent hospital or any other similar institution are not covered under this provision.

To file a claim: Include itemized bills from the health care provider printed on their letterhead and showing the services performed, dates of service, itemized charges, diagnosis, and the name of the patient. Submit itemed along with employee's social security number.

MAIL ALTERNATE CLAIMS TO:

**Frates Benefits Administrators
Mail or Fax to Address or Fax Number
on the Alternate Plan Claim Form**