

# STATE PLAN SUMMARY

McAllen Independent School District

Group #2048700

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<b>Calendar Year Deductible</b> Individual Family  <b>Out-of-Pocket Limit</b> (excludes Calendar Year Deductible) Individual Family NOTE: The plan pays 100% for most covered services after the out-of-pocket expense is reached.  <b>Maximum</b> (while covered under the plan except as noted below) NOTE: In-Network and Out-of-Network maximums are combined.	\$0 \$0  \$1,000 N/A  Unlimited	\$500 \$1,500  \$3,000 N/A  \$1,000,000
Covered Services	In-Network (The plan pays the % shown after any copay and/or the calendar year deductible)	Out-of-Network (The plan pays the % shown after any copay and/or the calendar year deductible)
<b>Doctor and Lab Services</b> Doctor office visits (includes immunizations, injections, diagnostic X-rays and lab tests when performed during an office visit) <ul style="list-style-type: none"> <li>- Primary Care Physician</li> <li>- Specialist</li> </ul> Immunizations, diagnostic X-rays and lab tests (when no office visit is billed) Allergy injections (when no office visit is billed) Office Surgery Outpatient Surgery Maternity Care (doctor charges only; see Hospital/Facility Services for inpatient charges)  Inpatient doctor visits	\$20 copay each visit, then 100% \$30 copay each visit, then 100% 85 %  85% 85% \$20 copay for Primary \$30 copay for Specialist (Copay applies to initial visit, then delivery charges are paid at 85%) 85%	65% 65% 65%  65% 65% 65%  65%
<b>Preventive Care</b> Office visit copay includes all preventive care services billed with an office visit by a network doctor. Preventive care visits – network or out-of-network – are limited to one physical exam per plan year for age two and over; one OB/GYN well-woman exam per plan year; and one routine mammogram per plan year. Network services billed without an office visit will be paid at 85%.  Office Visit (including lab, X-rays, immunizations) <ul style="list-style-type: none"> <li>- Primary Care Physician</li> <li>- Specialist</li> </ul> Routine Eye Exam (one per plan year) <ul style="list-style-type: none"> <li>- Primary Care Physician</li> <li>- Specialist</li> </ul> Hearing Exams <ul style="list-style-type: none"> <li>- Primary Care Physician</li> <li>- Specialist</li> </ul> Lab and X-ray (without an office visit) Immunizations (without an office visit) Routine mammograms (without an office visit)	\$20 copay each visit, then 100% \$30 copay each visit, then 100%  \$20 copay each visit, then 100% \$30 copay each visit, then 100%  \$20 copay each visit, then 100% \$30 copay each visit, then 100%  85% 85% 85%	65% 65%  65% 65%  65% 65% 65%
<b>Hospital/Facility Services</b> Inpatient hospital (semi-private room and board or intensive care unit) Other inpatient charges (including surgery) Outpatient hospital/facilities Emergency room care within 48 hours of accident or medical emergency  Emergency room care for all other conditions	85% 85% 85% \$50 copay per visit, (waived if admitted) then 85% \$50 copay per visit, (waived if admitted) then 85%	65% 65% 65% 65%  65%

# STATE PLAN SUMMARY

McAllen Independent School District

Group #2048700

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<b>Extended Care Services</b> Skilled Nursing facility (\$10,000 plan year maximum; up to \$7,000 can be out-of-network charges.) Home Health Care (\$10,000 plan year maximum; up to \$7,000 can be out-of-network charges.) Hospice (\$20,000 lifetime maximum; up to \$14,000 can be out-of-network charges.)	85%	65%
<b>Other Medical Services</b> Physical Therapy - Office visit - All other services Chiropractic Care (up to \$1,500 maximum per plan year) - Office visit - All other services Home Infusion Therapy Hearing Aids (up to \$1,000 per 36-month period) Durable Medical Equipment Prosthetics Ambulance Services (ground or air)	\$20 copay for Primary \$30 copay for Specialist 85%  \$30 copay for Specialist 85% 85% 85% 85% 85%	65% 65% 65% 65% 65% 85% 65% 85%
<b>Mental and Nervous Disorders</b> Inpatient facility (up to 30 days per plan year) Inpatient physician charges (up to 30 visits per plan year) Outpatient/Office visits (up to 30 visits per plan year; out-of-network limited to \$60 allowable per visit)  <b>Chemical Dependency</b> (maximum of two separate series per lifetime) Inpatient facility Inpatient physician charges Outpatient Office visits  <b>Serious Mental Illness</b> Inpatient facility Inpatient physician charges Outpatient Office visits  Pre-Certification is required for mental health and substance abuse treatment, inpatient hospitalization and other services listed in Plan document.	85% 85% 85%  85% 85% 85%  85% 85% 85%  \$20 copay for Primary \$30 copay for Specialist	65% 65% 65%  65% 65% 65%  65% 65% 65%  65%
<b>Prescription Drugs</b> Retail (up to a 30-day supply) Generic Preferred Non-Preferred  Home Delivery Pharmacy Service Generic Preferred Non-Preferred	\$ 5 copay per prescription \$25 copay per prescription \$40 copay per prescription  \$10 copay per prescription \$50 copay per prescription \$80 copay per prescription	You will be reimbursed the amount that would have been charged by a network pharmacy less the required copay.  N/A

This Plan Summary provides a brief description of the features and benefits of the Plan. This summary is not a contract. For complete plan benefits and exclusions refer to the McAllen Independent School District Employee Benefit Plan Document.

## EMPLOYEE PAYS

EMPLOYEE ONLY	\$188
EMPLOYEE & ONE CHILD	\$432
EMPLOYEE & SPOUSE	\$561
2 PERSONS EMPLOYED-FAMILY	\$671
EMPLOYEE & FAMILY	\$836

# HIGH PLAN SUMMARY

McAllen Independent School District

Group #2048700

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<b>Calendar Year Deductible</b> Individual Family <b>NOTE:</b> Covered expenses applied to the deductible October through December may be applied to satisfy the individual deductible for the following calendar year. <b>Out-of-Pocket Limit</b> (excludes Calendar Year Deductible) Individual Family <b>NOTE:</b> The plan pays 100% for most covered services after the out-of-pocket expense is reached. <b>Maximum</b> (while covered under the plan except as noted below) <b>NOTE:</b> In-Network and Out-of-Network maximums are combined.	\$300 \$900  \$2,500 \$7,500  \$1,000,000	\$300 \$900  \$5,000 \$15,000  \$1,000,000
Covered Services	In-Network (The plan pays the % shown after any copay and/or the calendar year deductible)	Out-of-Network (The plan pays the % shown after any copay and/or the calendar year deductible)
<b>Physician Services</b> Office Visits/Consultations only  Other Physician Services Maternity Services – includes prenatal, delivery and postnatal physician services  Physician Surgical Services - Inpatient - Outpatient Nonsurgical Services Routine Physical Exam (age 18 or older) which includes Routine Mammogram and Prostate Screening Vision (one exam per calendar year) Hearing (one exam per calendar year)  Routine Preventive Care (through age 17)  Immunization	\$20 copay each visit, then 100%, deductible waived 80%, deductible waived 80%  80% 80% 80% \$20 copay each visit, then 100%, deductible waived 80%, deductible waived 80%, deductible waived  \$20 copay each visit, then 100%, deductible waived 100%, deductible waived	60%  60% 60%  60% 60% 60% 60%  60%
<b>Hospital Services</b> Room & Board and Services & Supplies	80%	\$250 copay per admission then 60% after the calendar year deductible
<b>Emergency Care</b> Accident/Medical Emergency Room Facility (each visit copay waived if admitted to the hospital)  Physician Non-Emergency Situations Facility Physician Urgent Care Center Ambulance Services	\$50 copay each visit, then 80%, deductible waived 80%, deductible waived  \$50 copay each visit, then 80% 80% 80% 80%, deductible waived	\$50 copay each visit, then 80%, deductible waived 60%, deductible waived  \$50 copay each visit, then 60% 60% 60% 80%, deductible waived
<b>Mental and Nervous Disorders</b> Outpatient Visit (up to 25 visits each calendar year) Inpatient Stay (up to 30 days each calendar year)	80% 80%	60% 60%
<b>Alcohol &amp; Drug Abuse and/or Substance Abuse</b> Outpatient Visit Inpatient Stay	80% 80%	60% 60%

# HIGH PLAN SUMMARY

McAllen Independent School District

Group #2048700

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<b>Other Covered Services</b> (NOTE: In-Network and Out-of-Network maximums and limitations are combined.)		
High End Radiology (MRIs, PET Scans, CT Scans, etc)	\$20 copay then 80%, deductible waived	60%
Independent Radiology Center (i.e., x-rays, etc.)	\$20 copay then 80%, deductible waived	60%
Independent Pathology Center (i.e., labs, etc.)	100%, deductible waived	60%
Outpatient Facility Services	80%	60%
Speech and/or Physical Therapy Services	80%	60%
Occupational Therapy (up to \$2,000 maximum per calendar year)	80%	60%
Chiropractic Services (up to \$500 maximum per calendar year)		
Office visit only	\$20 copay each visit, then 100%, deductible waived	60%
Other chiropractic Services (includes modalities/ manipulations/X-rays)	\$20 copay each visit, then 80%, deductible waived	60%
Skilled Nursing Facility (up to \$10,000 maximum each calendar year)	80%, deductible waived	60%, deductible waived
Home Health Care (up to \$30,000 maximum each calendar year)	80%, deductible waived	60%, deductible waived
Hospice Care (up to \$20,000 maximum per calendar year)		
Inpatient	80%, deductible waived	60%, deductible waived
Outpatient	80%, deductible waived	60%, deductible waived
Durable Medical Equipment	80%	60%
Prosthetics	80%	60%
Orthognathic Services (only dependents under age 23) up to a \$5,000 plan maximum	80%	60%
TMJ (Temporomandibular Joint Syndrome) up to a \$750 maximum while covered.	80%	60%
Specialty Pharmacy Drugs and Medicines (provided in the office)	80%	60%
Transplant Benefit	80%, may utilize Medical Specialty Network or the Mutually Preferred PPO Network	60%
Non Pre-Certification Penalty	\$500	\$500
Admission Copay	No	250
Second Surgical opinion required	Yes	Yes
Maximum Out of Pocket	\$2,500	\$10,000
Travel Expenses allowed	Yes	No
Fees for Waiting List Allowed	Yes	No
Supplies and Non-Surgical Treatment of Feet (up to \$250 maximum per calendar year)	80%	60%
Pre-Certification is required for mental health and substance abuse treatment, inpatient hospitalization and other services listed in Plan document.		
<b>Prescription Drugs ( Oral Contraceptives are included)</b>		
<b>Retail (up to a 30-day supply)</b>		
Generic Drugs	Plan pays 100% after: \$2.50 copay per prescription	No Benefit
Preferred	\$20.00 copay per prescription	
Non-Preferred	\$35.00 copay per prescription	
<b>*Mail Order (up to a 90-day supply)</b>		
Generic Drugs	\$3.75 copay per prescription	No Benefit
Preferred	\$30.00 copay per prescription	
Non-Preferred	\$52.50 copay per prescription	
A voluntary generic substitution program applies.		
*90 Day Supply also available at select retail pharmacies. Contact SunRx at 1-800-786-1791 for a pharmacy listing.		
PPI (Gastric) & Allergy prescription strength medications will be covered at the preferred brand co-payment + 50% of the cost of the product. If a member converts to the Over the Counter Equivalent (OTC), the OTC product will be covered at 100%. The employee will have \$0 co-payment.		

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# HIGH PLAN SUMMARY

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McAllen Independent School District

Group #2048700

## EMPLOYEE PAYS

EMPLOYEE ONLY	\$83
EMPLOYEE & ONE CHILD	\$201
EMPLOYEE & SPOUSE	\$384
2 PERSONS EMPLOYED-FAMILY	\$312
EMPLOYEE & FAMILY	\$472

# BASIC PLAN SUMMARY

**McAllen Independent School District**

**Group #2048700**

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<p><b>Calendar Year Deductible</b></p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul> <p><b>NOTE:</b> Covered expenses applied to the deductible October through December may be applied to satisfy the individual deductible for the following calendar year.</p> <p><b>Out-of-Pocket Limit</b> (excludes Calendar Year Deductible)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul> <p><b>NOTE:</b> The plan pays 100% for most covered services after the out-of-pocket expense is reached.</p> <p><b>Maximum</b> (while covered under the plan except as noted below) <b>NOTE:</b> In-Network and Out-of-Network maximums are combined.</p>	<ul style="list-style-type: none"> <li>\$500</li> <li>\$1,500</li>   <li>\$3,500</li> <li>\$10,500</li>   <li>\$1,000,000</li> </ul>	<ul style="list-style-type: none"> <li>\$500</li> <li>\$1,500</li>   <li>\$7,000</li> <li>\$21,000</li>   <li>\$1,000,000</li> </ul>
Covered Services	In-Network (The plan pays the % shown after any copay and/or the calendar year deductible)	Out-of-Network (The plan pays the % shown after any copay and/or the calendar year deductible)
<p><b>Physician Services</b></p> <ul style="list-style-type: none"> <li>Office Visits/Consultations only</li> <li>Other Physician Services</li> <li>Maternity Services – includes prenatal, delivery and postnatal physician services</li> <li>Physician Surgical Services               <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul> </li> <li>Nonsurgical Services</li> <li>Routine Physical Exam (age 18 or older) which includes Routine Mammogram and Prostate Screening</li> <li>Vision (one exam per calendar year)</li> <li>Hearing (one exam per calendar year)</li> <li>Routine Preventive Care (through age 17)</li> </ul>	<ul style="list-style-type: none"> <li>\$30 copay each visit, then 100%, deductible waived</li> <li>70%, deductible waived</li>   <li>70%</li>   <li>70%</li> <li>70%</li> <li>70%</li> <li>\$30 copay each visit, then 100%, deductible waived</li> <li>70%, deductible waived</li> <li>70%, deductible waived</li> <li>\$30 copay each visit, then 100%, deductible waived</li> </ul>	<ul style="list-style-type: none"> <li>50%</li> <li>50%</li>   <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> </ul>
<ul style="list-style-type: none"> <li>Immunization</li> </ul>	<ul style="list-style-type: none"> <li>100%, deductible waived</li> </ul>	<ul style="list-style-type: none"> <li>50%</li> </ul>
<p><b>Hospital Services</b></p> <ul style="list-style-type: none"> <li>Room &amp; Board and Services &amp; Supplies</li> </ul>	<ul style="list-style-type: none"> <li>70 %</li> </ul>	<ul style="list-style-type: none"> <li>\$500 copay per admission then 50% after the calendar year deductible</li> </ul>
<p><b>Emergency Care</b> Accident/Medical Emergency Room</p> <ul style="list-style-type: none"> <li>Facility (each visit copay waived if admitted to the hospital)</li> <li>Physician</li> </ul> <p>Non-Emergency Situations</p> <ul style="list-style-type: none"> <li>Facility</li> <li>Physician</li> <li>Urgent Care Center</li> <li>Ambulance Services</li> </ul>	<ul style="list-style-type: none"> <li>\$75 copay each visit, then 70%, deductible waived</li> <li>70% deductible waived</li>   <li>\$75 copay each visit, then 70%</li> <li>70%</li> <li>70%</li> <li>70%, deductible waived</li> </ul>	<ul style="list-style-type: none"> <li>\$75 copay each visit, then 70%, deductible waived</li> <li>50% deductible waived</li>   <li>\$75 copay each visit, then 50%</li> <li>50%</li> <li>50%</li> <li>70%, deductible waived</li> </ul>

# BASIC PLAN SUMMARY

McAllen Independent School District

Group #2048700

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<b>Mental and Nervous Disorders</b> <ul style="list-style-type: none"> <li>Outpatient Visit (up to 25 visits each calendar year)</li> <li>Inpatient Stay (up to 30 days each calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>70%</li> <li>70%</li> </ul>	<ul style="list-style-type: none"> <li>No Benefit unless determined to be medical emergency</li> <li>No Benefit unless determined to be medical emergency</li> </ul>
<b>Alcohol &amp; Drug Abuse and/or Substance Abuse</b> <ul style="list-style-type: none"> <li>Outpatient Visit</li> <li>Inpatient Stay</li> </ul>	<ul style="list-style-type: none"> <li>70%</li> <li>70%</li> </ul>	<ul style="list-style-type: none"> <li>50%</li> <li>50%</li> </ul>
<b>Other Covered Services</b> <i>(NOTE: In-Network and Out-of-Network maximums and limitations are combined.)</i> <ul style="list-style-type: none"> <li>High End Radiology (MRIs, PET Scans, CT Scans, etc)</li> <li>Independent Radiology Center (i.e., x-rays, etc.)</li> <li>Independent Pathology Center (i.e., labs, etc.)</li> <li>Outpatient Facility Services</li> <li>Speech and/or Physical Therapy Services</li> <li>Occupational Therapy (up to \$2,000 maximum per calendar year)</li> <li>Chiropractic Services (up to \$500 maximum per calendar year)               <ul style="list-style-type: none"> <li>Office visit only</li> <li>Other chiropractic Services (includes modalities/manipulations/X-rays)</li> </ul> </li> <li>Skilled Nursing Facility (up to \$10,000 maximum each calendar year)</li> <li>Home Health Care (up to \$30,000 maximum each calendar year)</li> <li>Hospice Care (up to \$20,000 maximum per calendar year)               <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul> </li> <li>Durable Medical Equipment</li> <li>Prosthetics</li> <li>Orthognathic Services (only dependents under age 23) up to a \$5,000 plan maximum</li> <li>TMJ (Temporomandibular Joint Syndrome) up to a \$750 maximum while covered.</li> <li>Specialty Pharmacy Drugs and Medicines (provided in the office)</li> <li>Transplant Benefit               <ul style="list-style-type: none"> <li>Non Pre-Certification Penalty</li> <li>Admission Copay</li> <li>Second Surgical opinion required</li> <li>Maximum Out of Pocket</li> <li>Travel Expenses allowed</li> <li>Fees for Waiting List Allowed</li> </ul> </li> </ul> <p>Pre-Certification is required for mental health and substance abuse treatment, inpatient hospitalization and other services listed in Plan document.</p>	<ul style="list-style-type: none"> <li>\$30 copay then 70%, deductible waived</li> <li>\$30 copay then 70%, deductible waived</li> <li>100%, deductible waived</li> <li>70%</li> <li>70 %</li> <li>70%</li> <li>\$30 copay each visit, then 100%, deductible waived</li> <li>\$30 copay each visit, then 70%, deductible waived</li> <li>70%, deductible waived</li> <li>70%, deductible waived</li> <li>70 % deductible waived</li> <li>70% deductible waived</li> <li>70%</li> <li>70%</li> <li>70%</li> <li>70%</li> <li>70%</li> <li>70%</li> <li>70%, may utilize Medical Specialty Network or the Mutually Preferred PPO Network</li> <li>\$500</li> <li>No</li> <li>Yes</li> <li>\$3,500</li> <li>Yes</li> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%, deductible waived</li> <li>50%, deductible waived</li> <li>50% deductible waived</li> <li>50% deductible waived</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>50%</li> <li>\$500</li> <li>250</li> <li>Yes</li> <li>\$14,000</li> <li>No</li> <li>No</li> </ul>

# BASIC PLAN SUMMARY

**McAllen Independent School District**

**Group #2048700**

Plan Effective Date: October 1, 2007	In-Network	Out-of-Network
<p><b>Prescription Drugs ( Oral Contraceptives are included)</b></p> <p><b>Retail (up to a 30-day supply)</b></p> <ul style="list-style-type: none"> <li>• Generic Drugs</li> <li>• Preferred</li> <li>• Non-Preferred</li> </ul> <p><b>*Mail Order (up to a 90-day supply)</b></p> <ul style="list-style-type: none"> <li>• Generic Drugs</li> <li>• Preferred</li> <li>• Non-Preferred</li> </ul> <p>A voluntary generic substitution program applies.</p> <p>*90 Day Supply also available at select retail pharmacies. Contact SunRx at 1-800-786-1791 for a pharmacy listing.</p> <p>PPI (Gastric) &amp; Allergy prescription strength medications will be covered at the preferred brand co-payment + 50% of the cost of the product. If a member converts to the Over the Counter Equivalent (OTC), the OTC product will be covered at 100%. The employee will have \$0 co-payment.</p>	<p>Plan pays 100% after:</p> <ul style="list-style-type: none"> <li>• \$2.50 copay per prescription</li> <li>• \$25.00 copay per prescription</li> <li>• \$45.00 copay per prescription</li> </ul> <ul style="list-style-type: none"> <li>• \$3.75 copay per prescription</li> <li>• \$37.50 copay per prescription</li> <li>• \$67.50 copay per prescription</li> </ul>	<ul style="list-style-type: none"> <li>• No Benefit</li> </ul> <ul style="list-style-type: none"> <li>• No Benefit</li> </ul>

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### Employee Pays

Employee Only	\$24
Employee & One Child	\$168
Employee & Spouse	\$292
2 Persons Employed-Family	\$171
Employee & Family	\$350

# ALTERNATE PLAN SUMMARY

McAllen Independent School District

Group #2048700

Effective Date: October 1, 2007	
Covered Services	Benefit Level
<b>Inpatient Hospital (benefit payable per day)</b> Inpatient Hospitalization shall mean only those days for which charges are made for Room and Board in a covered Hospital facility.	\$250
<b>Outpatient Surgical/Ambulatory Surgical Center (benefit payable per procedure)</b> 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.	\$100
<b>Outpatient Cancer Treatment (benefit payable per day)</b> Outpatient Cancer treatment means only outpatient administration of chemotherapy and/or radiation therapy.	\$100
<b>Routine and Preventive Care</b> Certain covered expenses for Routine and/or Preventive Medical care (with no symptoms of illness or injury) will be considered. Charges exceeding the calendar year maximum will not be an eligible expense under any provision of this plan.  Covered expenses will include the following: 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 exam per calendar year for persons age forty (40) and older. Routine vision examinations Routine hearing examinations	Paid at 100% up to a \$200 maximum per calendar year
<b>Prescription Drug Benefit (benefit payable per calendar year)</b>  This plan will pay 100% of prescription drug expenses incurred on an Outpatient basis up to a maximum of \$500 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.	\$500

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## EMPLOYEE PAYS

EMPLOYEE ONLY

\$0.00-Provided by the District

The Alternate Plan offers limited benefits to covered Participants and may be elected instead of the Basic Plan, High Plan or State Plan. Dependents are not eligible for benefits under the Alternate Plan. Specified Benefits are considered "cash" benefits and are not subject to the following Plan provisions: Deductible, Benefit Percentage, Maximum Out of Pocket, Special Provisions, Pre-Existing Conditions, Subrogation and Coordination of Benefits. All other Plan provisions including Eligibility for Coverage and Termination of Coverage provisions will apply to persons covered under the Alternate Plan.

## LIFE/AD&D INSURANCE

LIFE/AD&D INSURANCE (Basic, High or State Health Plan)		
Term Life Insurance	\$15,000 (Alternate Health Plan-\$50,000)	
Accidental Death & Dismemberment Benefit Reduction	Additional \$15,000 (Alternate Health Plan-\$50,000)	Employee Only \$0.00
Age 65	35% Reduction	Provided by District
Age 75 +	50% Reduction and will terminate upon retirement	
Employment Termination, Retirement or Disability	Eligible for Conversion to Individual Policy	

# DENTAL PLAN SUMMARY

## McAllen Independent School District

<b>Benefit Waiting Period(s):</b>	<b>Class</b>	<b>Months</b>
All Employees	A B C Orthodontia	None None 12 12
<b>Calendar Year Deductible</b>		<b>Other Providers</b>
<b>Class A</b> <b>Classes B &amp; C (combined)</b> Individual Family <b>Orthodontia</b> Individual Family		Deductible Waived  \$75 \$225  \$0 \$0
<b>Maximums</b> <b>Classes A, B &amp; C (Calendar Year Maximum)</b>  <b>Orthodontia (Lifetime Maximum)</b>		\$2,000  \$1,000
<b>Covered Services</b> (The plan pays the % shown after the Calendar Year Deductible and any Benefit Waiting Period(s) are satisfied)		<b>Other Providers</b>
<b>Class A – Preventive &amp; Diagnostic</b> Oral Examinations, including prophylaxis (scaling and cleaning of teeth), but not more than twice (2) per Calendar Year Topical application of sodium or stannous fluoride, but not more than twice per Calendar Year, and only for covered individuals under nineteen (19) years of age Dental X-rays required in connection with the diagnosis of a specific condition requiring treatment. Dental X-rays not more than one (1) full-mouth X-ray or series in any period of thirty-six (36) consecutive months and not more than two (2) sets of supplementary bitewing X-rays per Calendar Year		80% 80% 80%
<b>Class B – Basic Services</b> Tests & Laboratory Examinations Oral Surgery Amalgam Periodontics Endodontics Space Maintainers Services & Supplies to include: Emergency palliative treatment General anesthetics and the administration thereof, including intravenous Sedation, related to cutting procedures in the oral cavity Antibiotic drug injection by attending dentist		80% 80% 80% 80% 80% 80% 80%
<b>Class C – Major Services</b> Inlays, Onlays, gold fillings or Crowns Bridgework Dentures		50% 50% 50%
<b>Orthodontics (Child(ren))</b> Treatment is available to Covered Persons under age 19 only  <i>Benefits for Orthodontia treatment will be payable in equal monthly amounts during the first twelve (12) months of orthodontia treatment. Such monthly installments will terminate on the date the Covered Person is no longer eligible for coverage under the Plan.</i>		50%

This Plan Summary provides a brief description of the features and benefits of the Plan. This summary is not a contract. For complete plan benefits and exclusions refer to the McAllen Independent School District Employee Benefit Plan Document.

### EMPLOYEE PAYS

EMPLOYEE ONLY	\$0.00-Provided by the District
2 PERSONS EMPLOYED-FAMILY	\$17.82
EMPLOYEE & FAMILY	\$36.00