EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2024

Check with your employer for plans offered and monthly premiums.

	Plan A BCS Group No. 0MD746 BCBS Group No. 240874		Plan B BCS Group No. 0MD747 BCBS Group No. 240875		Plan C BCS Group No. 0MD748 BCBS Group No. 240876		Plan D* BCS Group No. 0MD749 BCBS Group No. 240877		Plan E BCS Group No. 0MD750 BCBS Group No. 240878		Plan AB1 BCS Group No. 0MD751 BCBS Group No. 240879	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible							See footnote					
Individual	$400	$800	$600	$1,200	$1,100	$2,200	$1,600	$3,200	$1,100	$2,200	$400	$1,200
Family	$1,200	$2,400	$1,800	$3,600	$3,300	$6,600	$3,200	$6,400	$3,300	$6,600	$1,200	$3,600
Out of Pocket Maximum												
Individual	$1,200	$3,700	$1,300	$4,100	$2,300	$6,900	$4,050	$7,900	$1,800	$5,100	$1,300	$4,100
Family	$2,400	$11,100	$3,900	$12,300	$6,900	$20,700	$8,100	$15,800	$5,400	$15,300	$3,900	$12,300
Cost Share Maximum												
Individual	$6,600	N/A	$6,600	N/A	$6,600	N/A	N/A	N/A	$6,600	N/A	$6,600	N/A
Family	$13,200	N/A	$13,200	N/A	$13,200	N/A	N/A	N/A	$13,200	N/A	$13,200	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Reimbursement	90%	70%	85%	65%	80%	60%	80%	60%	85%	65%	85%	65%
Inpatient Hospital (Illness or Injury)	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 80%	$550 Copay Then 60%	$250 Copay, Then 80%	$550 Copay Then 60%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 85%	$550 Copay Then 65%
Outpatient Surgery	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 80%	$550 Copay Then 60%	$250 Copay, Then 80%	$550 Copay, Then 60%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 85%	$550 Copay Then 65%
Primary Doctor (PCP) Office Visit	$25 Copay Then 100% No deductible	70%	$25 Copay Then 100% No deductible	65%	$25 Copay Then 100% No deductible	60%	$25 Copay, Then 80%	60%	$25 Copay Then 100% No deductible	65%	$25 Copay Then 100% No deductible	65%
Specialist Office Visit	$30 Copay Then 100% No deductible	70%	$30 Copay Then 100% No deductible	65%	$30 Copay Then 100% No deductible	60%	$30 Copay Then 80%	60%	$30 Copay Then 100% No deductible	65%	$30 Copay Then 100% No deductible	65%
Services other than Office Visit at time of visit	90%	70%	85%	65%	80%	60%	80%	60%	85%	65%	85%	65%
Emergency Room	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible
Urgent Care Facility	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 80%	$40 Copay Then 80%	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible
Drug Type	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****
Generic	$12	$30	$12	$30	$12	$30	$12	$30	$12	$30	$12	$30
Formulary Brand	$25	$55	$25	$55	$25	$55	$25	$55	$25	$55	$25	$55
Non-Formulary Brand	$40	$100	$40	$100	$40	$100	$40	$100	$40	$100	$40	$100
Specialty Drugs	Copay plus 3% to maximum of $150		Copay plus 3% to maximum of $150		Copay plus 3% to maximum of $150		Copay plus 3% to maximum of $150		Copay plus 3% to maximum of $150		Copay plus 3% to maximum of $150	

Notes:

Network and Non-Network deductibles and out of pockets will accumulate separately

* Plan D is a High Deductible Health Plan, designed to qualify for use with a Health Savings Account (HSA). All benefits except benefits for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. If you enrolled for Employee Only health coverage, you must pay 100% of the discounted charge for each covered service until you satisfy the Individual Calendar Year Deductible. If you are enrolled for Employee + Spouse, Employee + Child(ren) or Family health coverage you must pay 100% of the discounted charge until your covered family members satisfy the Family Calendar Year Deductible. After you satisfy the applicable Calendar Year Deductible, you will pay the copayments/coinsurance shown in the above table until your out of pocket expenses satisfy the appropriate Calendar Year Out of Pocket Maximum. The Plan will then pay 100% of the cost of your covered charges for the remainder of the year.
Effective 1/1/2025 Plan D Network deductible will be $1,650 Individual / $3,300 Family to comply with IRS guidelines; and Non-Network deductible will be $3,300 Individual / $6,600 Family.

** You may fill the first two months of a newly prescribed **Brand Name** maintenance medication at a Prime network retail pharmacy. Subsequent fills must be obtained through Home Delivery (90-day supply). Other prescriptions can remain at retail with 30-day supplies.