



EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
SUMMARY BENEFIT SCHEDULES AS OF JANUARY 1, 2020
 Check with your employer for plans offered and monthly premiums.

| Description of Services | Plan A BCBS Group No. 240874 | | | Plan B BCBS Group No. 240875 | | | Plan C BCBS Group No. 240876 | | | Plan D* BCBS Group No. 240877 | | | Plan E BCBS Group No. 240878 | | | Plan AB1 BCBS Group No. 240879 | | |
|--|--|---|-----------------------------|--|---|-----------------------------|--|---|-----------------------------|----------------------------------|---|-----------------------------|--|---|-----------------------------|--|---|-----------------------------|
| | NETWORK | NON-NETWORK | | NETWORK | NON-NETWORK | | NETWORK | NON-NETWORK | | NETWORK | NON-NETWORK | | NETWORK | NON-NETWORK | | NETWORK | NON-NETWORK | |
| Deductible | | | | | | | | | | | | | | | | | | |
| Individual | \$400 | \$800 | | \$600 | \$1,200 | | \$1,100 | \$2,200 | | \$1,400 | \$2,800 | | \$1,100 | \$2,200 | | \$400 | \$1,200 | |
| Family | \$1,200 | \$2,400 | | \$1,800 | \$3,600 | | \$3,300 | \$6,600 | | \$2,800 | \$5,600 | | \$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 Card | | | | | | | | | | | | | | | | | | |
| | Retail 30 days | Retail 90 day Maintenance Drug after first 2 fills | Home Delivery up to 90 days | Retail 30 days | Retail 90 day Maintenance Drug after first 2 fills | Home Delivery up to 90 days | Retail 30 days | Retail 90 day Maintenance Drug after first 2 fills | Home Delivery up to 90 days | Retail 30 days | Retail 90 day Maintenance Drug after first 2 fills | Home Delivery up to 90 days | Retail 30 days | Retail 90 day Maintenance Drug after first 2 fills | Home Delivery up to 90 days | Retail 30 days | Retail 90 day Maintenance Drug after first 2 fills | Home Delivery up to 90 days |
| Generic | \$12 | \$36 | \$30 | \$12 | \$36 | \$30 | \$12 | \$36 | \$30 | \$12 | \$36 | \$30 | \$12 | \$36 | \$30 | \$12 | \$36 | \$30 |
| Formulary | \$25 | \$85 | \$55 | \$25 | \$85 | \$55 | \$25 | \$85 | \$55 | \$25 | \$85 | \$55 | \$25 | \$85 | \$55 | \$25 | \$85 | \$55 |
| Non-Formulary | \$40 | \$130 | \$100 | \$40 | \$130 | \$100 | \$40 | \$130 | \$100 | \$40 | \$130 | \$100 | \$40 | \$130 | \$100 | \$40 | \$130 | \$100 |

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.