EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2011

	PLATINUM				GOLD				SILVER			
DESCRIPTION OF SERVICES	**TIER 1 HMO**	**TIER 2 PPO**	**TIER 3 NON NETWORK**	**TIER 4 NON NETWORK METRO ST LOUIS**	**TIER 1 HMO**	**TIER 2 PPO**	**TIER 3 NON NETWORK**	**TIER 4 NON NETWORK METRO ST LOUIS**	**TIER 1 HMO**	**TIER 2 PPO**	**TIER 3 NON NETWORK**	**TIER 4 NON NETWORK METRO ST LOUIS**
DEDUCTIBLE												
INDIVIDUAL	$400	$600	$600	$600	$600	$900	$900	$900	$1,100	$1,600	$1,600	$1,600
FAMILY	$1,200	$1,800	$1,800	$1,800	$1,800	$2,700	$2,700	$2,700	$3,300	$4,800	$4,800	$4,800
OUT OF POCKET MAXIMUM												
INDIVIDUAL	$1,200	$1,800	$3,300	None	$1,300	$1,900	$3,500	None	$2,300	$3,300	$5,800	None
FAMILY	$2,400	$3,600	$6,600	None	$3,900	$5,700	$10,500	None	$6,900	$9,900	$17,400	None
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
WELLNESS BENEFIT*	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100
INPATIENT HOSPITAL (ILLNESS OR INJURY)	$250 Copay Then 90%	$250 Copay Then 85%	$550 Copay Then 70%	$550 Copay Then 60%	$250 Copay Then 85%	$250 Copay Then 80%	$550 Copay Then 65%	$550 Copay Then 55%	$250 Copay Then 80%	$250 Copay Then 75%	$550 Copay Then 60%	$550 Copay Then 50%
OUTPATIENT SURGERY	$250 Copay Then 90%	$250 Copay Then 85%	$550 Copay Then 70%	$550 Copay Then 60%	$250 Copay Then 85%	$250 Copay Then 80%	$550 Copay Then 65%	$550 Copay Then 55%	$250 Copay Then 80%	$250 Copay Then 75%	$550 Copay Then 60%	$550 Copay Then 50%
DR OFFICE VISIT BY PRIMARY CARE PHYSICIAN	$25 Copay Then 100%	$25 Copay Then 100%	70%	60%	$25 Copay Then 100%	$25 Copay Then 100%	65%	55%	$25 Copay Then 100%	$25 Copay Then 100%	60%	50%
DR OFFICE VISIT BY SPECIALIST	$40 Copay Then 100%	$40 Copay Then 100%	70%	60%	$40 Copay Then 100%	$40 Copay Then 100%	65%	55%	$40 Copay Then 100%	$40 Copay Then 100%	60%	50%
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 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
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 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
DRUG CARD Effective January 1, 2011	**Retail 30 days**	**MDN Retail 90 day Maintenance Drug after first 2 fills**		**Home Delivery up to 90 days**	**Retail 30 days**	**MDN Retail 90 day Maintenance Drug after first 2 fills**		**Home Delivery up to 90 days**	**Retail 30 days**	**MDN 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
FORMULARY	$25	$85		$55	$25	$85		$55	$30	$85		$70
NON-FORMULARY	$40	$130		$100	$40	$130		$100	$45	$130		$110
RATES (Includes $10,000 Basic Life)												
Employee Only	**$632**				**$571**				**$493**			
Employee + Spouse	**$1,305**				**$1,178**				**$1,022**			
Employee+child or children	**$1,260**				**$1,136**				**$985**			
Family	**$1,405**				**$1,266**				**$1,100**			

Note:

All charges are subject to the calendar year deductible unless otherwise specified.

Inpatient Hospital and Outpatient Surgery copays are limited to 3 copays in any calendar year and do not count toward deductible or out of pocket maximum.

*WELLNESS BENEFIT refers to routine diagnostic lab & x-ray wellness charges. For a complete list of Wellness Benefits, refer to the Schedule of Benefits.