EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2011

	PLATINUM				GOLD				SILVER				BRONZE (All charges except charges for preventive care are subject to the Calendar Year Deductible. Calendar Year Deductible must be satisfied before Copays apply.)			
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**	**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	$1,200	$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	$2,400	$3,200	$3,200	$3,200
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	$3,600	$4,800	$5,950	None
FAMILY	$2,400	$3,600	$6,600	None	$3,900	$5,700	$10,500	None	$6,900	$9,900	$17,400	None	$7,200	$9,600	$11,900	None
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	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	$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%	$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%	$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%	$25 Copay, Then 80%	$25 Copay, Then 75%	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%	$40 Copay Then 80%	$40 Copay Then 75%	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	$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 80%
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	$40 Copay Then 80%	$40 Copay Then 80%	$40 Copay Then 80%	$40 Copay Then 80%
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**	**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	$12	$36		$30
FORMULARY	$25	$85		$55	$25	$85		$55	$30	$85		$70	$30	$85		$70
NON-FORMULARY	$40	$130		$100	$40	$130		$100	$45	$130		$110	$45	$130		$110
RATES (Includes $10,000 Basic Life)																
Employee Only	**$632**				**$571**				**$493**				**$420**			
Employee + Spouse	**$1,305**				**$1,178**				**$1,022**				**$864**			
Employee+child or children	**$1,260**				**$1,136**				**$985**				**$848**			
Family	**$1,405**				**$1,266**				**$1,100**				**$933**			

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.

BRONZE PLAN:

The Bronze Plan is a High Deductible Health Plan (HDHP), 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. Under the HDHP, all eligible charges are subject to the Calendar Year Deductible. If you are enrolled for Individual 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 Employee + 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 shown in the following table until your out of pocket expenses satsify 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.

ABOUT HEALTH SAVINGS ACCOUNTS:

a) Rules require first dollar payment by the covered individual except for wellness benefit.
b) Those with individual coverage must pay the full discounted cost of prescriptions (except those considered preventive) and health care services (except wellness benefits) until the individual deductible is met, then the copays and coinsurance will apply.
c) Those with more than individual coverage must pay the full discounted cost of prescriptions (except those prescriptions considered preventive) and health care services (other than wellness benefits) until the family deductible is met, then the copays will apply. All covered costs by the family members covered will count collectively towards the family deductible and the family maximum out of pocket. If one family member reaches the individual maximum out of pocket costs the plan will pay 100% of the health care costs for that individual.

d) Individual Deductible in Tier 1 and Maximum Out of Pocket for Tiers 1-4 will be adjusted January 1 each year as per the IRS rules.
e) Individual Deductible in Tiers 2-4 will always be $400 more than Tier 1.
f) Family Deductible will be 2 times the Individual Deductible in Tiers 1-4.