

**EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST  
SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2013**

**Plan E High Deductible Options**

DESCRIPTION OF SERVICES	OPTION 1 DEDUCTIBLE \$1,100 - MAX OOP \$1,600				OPTION 2 DEDUCTIBLE \$1,600 - MAX OOP \$2,100				OPTION 3 DEDUCTIBLE \$2,100 - MAX OOP \$2,600				OPTION 4 DEDUCTIBLE \$2600 - MAX OOP \$3,100							
	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				
<b>Deductible</b>																				
INDIVIDUAL	\$1,100	\$1,400	\$1,400	\$1,400	\$1,600	\$1,900	\$1,900	\$1,900	\$2,100	\$2,400	\$2,400	\$2,400	\$2,600	\$2,900	\$2,900	\$2,900				
FAMILY	\$3,300	\$4,200	\$4,200	\$4,200	\$4,800	\$5,700	\$5,700	\$5,700	\$6,300	\$7,200	\$7,200	\$7,200	\$7,800	\$8,700	\$8,700	\$8,700				
<b>Out of Pocket Maximum</b>																				
INDIVIDUAL	\$1,600	\$2,200	\$3,800	None	\$2,100	\$2,700	\$4,300	None	\$2,600	\$3,200	\$4,800	None	\$3,100	\$3,700	\$5,300	None				
FAMILY	\$4,800	\$6,600	\$11,400	None	\$6,300	\$8,100	\$12,900	None	\$7,800	\$9,600	\$14,400	None	\$9,300	\$11,100	\$15,900	None				
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited				
<b>Wellness Benefit*</b>	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100				
<b>Inpatient Hospital (Illness or Injury)</b>	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%				
<b>Outpatient Surgery</b>	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%				
<b>Primary Doctor (PCP) Office Visit</b>	\$25 Copay Then 100%	\$25 Copay Then 100%	65%	55%	\$25 Copay Then 100%	\$25 Copay Then 100%	65%	55%	\$25 Copay Then 100%	\$25 Copay Then 100%	65%	55%	\$25 Copay Then 100%	\$25 Copay Then 100%	65%	55%				
<b>Specialist Office Visit with Primary Doctor Referral/Notification</b>	\$30 Copay Then 100%	\$30 Copay Then 100%	65%	55%	\$30 Copay Then 100%	\$30 Copay Then 100%	65%	55%	\$30 Copay Then 100%	\$30 Copay Then 100%	65%	55%	\$30 Copay Then 100%	\$30 Copay Then 100%	65%	55%				
<b>Specialist Office Visit without Primary Doctor Referral/Notification</b>	\$40 Copay Then 100%	\$40 Copay Then 100%	65%	55%	\$40 Copay Then 100%	\$40 Copay Then 100%	65%	55%	\$40 Copay Then 100%	\$40 Copay Then 100%	65%	55%	\$40 Copay Then 100%	\$40 Copay Then 100%	65%	55%				
<b>Emergency Room</b>	\$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 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible				
<b>Urgent Care Facility</b>	\$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 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible				
<b>Drug Card</b>	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					
FORMULARY	\$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					
<b>Effective 9/1/2013</b>																				
<b>RATES</b> (Includes \$10,000 Basic Life)		<b>9/1/2013</b>					<b>9/1/2013</b>					<b>9/1/2013</b>					<b>9/1/2013</b>			
Employee Only		<b>\$554</b>					<b>\$532</b>					<b>\$512</b>					<b>\$492</b>			
Employee + Spouse		<b>\$1,141</b>					<b>\$1,096</b>					<b>\$1,055</b>					<b>\$1,014</b>			
Employee + Child or Children		<b>\$1,100</b>					<b>\$1,053</b>					<b>\$1,014</b>					<b>\$974</b>			
Family		<b>\$1,227</b>					<b>\$1,176</b>					<b>\$1,208</b>					<b>\$1,087</b>			

**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.  
THESE PLANS ONLY AVAILABLE ON DISTRICT WIDE BASIS, NO INDIVIDUAL SELECTION ALLOWED.