



EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2024

2024-2025 Medical Plans M3, M6, M7, M8

Description of Services	Plan M3 BCS Group No. 0MD752 BCBS Group No. M240880		Plan M6 BCS Group No. 0MD753 BCBS Group No. M240881		Plan M7 BCS Group No. 0MD754 BCBS Group No. M240882		Plan M8 BCS Group No. 0MD755 BCBS Group No. M240883	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible*								
Individual	\$2,500	\$5,000	\$400	\$800	\$600	\$1,200	\$1,100	\$2,200
Family	\$5,000	\$10,000	\$1,200	\$2,400	\$1,800	\$3,600	\$3,300	\$6,600
Out of Pocket Maximum*								
Individual	\$3,500	\$10,500	\$1,200	\$4,500	\$1,300	\$4,100	\$2,300	\$6,900
Family	\$7,000	\$21,000	\$2,400	\$9,000	\$3,900	\$12,300	\$6,900	\$20,700
Cost Share Maximum								
Individual	N/A	N/A	\$2,500	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	\$5,000	N/A	N/A	N/A	N/A	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Reimbursement	85%	65%	90%	70%	85%	65%	80%	60%
Inpatient Hospital (Illness or Injury)	85%	65%	\$250 then 90%	\$550 then 70%	\$250 then 85%	\$550 then 65%	\$250 then 80%	\$550 then 60%
Outpatient Surgery	85%	65%	\$250 then 90%	\$550 then 70%	\$250 then 85%	\$550 then 65%	\$250 then 80%	\$550 then 60%
Primary Doctor (PCP) Office Visit	\$25 copay then 100% no deductible	65%	\$25 copay then 100% no deductible	70%	\$25 copay then 100% no deductible	65%	\$25 copay then 100% no deductible	60%
Specialist Office Visit	\$30 copay then 100% no deductible	65%	\$30 copay then 100% no deductible	70%	\$30 copay then 100% no deductible	65%	\$30 copay then 100% no deductible	60%
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
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
Facility Charges								
Physician Charges	90%	90%	90%	90%	90%	90%	90%	90%
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**
Generic	\$12	\$30	\$12	\$30	\$12	\$30	\$12	\$30
Formulary	\$25	\$55	\$25	\$55	\$25	\$55	\$25	\$55
Non-Formulary	\$40	\$100	\$40	\$100	\$40	\$100	\$40	\$100

Notes:

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

** 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.