EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2025

Check with your employer for plans offered and monthly premiums.

	Plan A BCS Group No. 0MD746 BCBS Group No. 240874		Plan B BCS Group No. 0MD747 BCBS Group No. 240875		Plan C BCS Group No. 0MD748 BCBS Group No. 240876		Plan D* BCS Group No. 0MD749 BCBS Group No. 240877 *(HSA Qualified Plan)*		Plan E BCS Group No. 0MD750 BCBS Group No. 240878	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible										
Individual	$900	$1,800	$1,100	$2,200	$1,600	$3,200	$2,150	$4,300	$1,600	$3,200
Family	$2,700	$5,400	$3,300	$6,600	$4,800	$9,600	$4,300	$8,600	$4,800	$9,600
Out of Pocket Maximum										
Individual	$2,700	$8,100	$2,800	$8,400	$3,800	$11,400	$5,550	$11,100	$3,300	$9,900
Family	$5,400	$24,300	$8,400	$25,200	$11,400	$34,200	$11,100	$22,200	$9,900	$29,700
Cost Share Maximum										
Individual	$6,600	N/A	$6,600	N/A	$6,600	N/A	N/A	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
Reimbursement	85%	65%	80%	60%	75%	55%	75%	55%	80%	60%
Inpatient Hospital (Illness or Injury)	$350 Copay Then 85%	$750 Copay Then 65%	$350 Copay Then 80%	$750 Copay Then 60%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 80%	$750 Copay Then 60%
Outpatient Surgery	$350 Copay Then 85%	$750 Copay Then 65%	$350 Copay Then 80%	$750 Copay Then 60%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 80%	$750 Copay Then 60%
Primary Doctor (PCP) Office Visit	$35 Copay Then 100% No deductible	65%	$35 Copay Then 100% No deductible	60%	$35 Copay Then 100% No deductible	55%	$35 Copay, Then 75%	55%	$35 Copay Then 100% No deductible	60%
Specialist Office Visit	$40 Copay Then 100% No deductible	65%	$40 Copay Then 100% No deductible	60%	$40 Copay Then 100% No deductible	55%	$40 Copay Then 75%	55%	$40 Copay Then 100% No deductible	60%
Services other than Office Visit at time of visit	85%	65%	80%	60%	75%	55%	75%	55%	80%	60%
Emergency Room	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 75%	$400 Copay Then 75%	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible
Urgent Care Facility	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 75%	$70 Copay Then 75%	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible
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****	**Retail 30 days**	**Home Delivery 90 days****
Generic	$15	$38	$15	$38	$15	$38	$15	$38	$15	$38
Formulary Brand	$30	$75	$30	$75	$30	$75	$30	$75	$30	$75
Non-Formulary Brand	$50	$125	$50	$125	$50	$125	$50	$125	$50	$125
Specialty Drugs	Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400	

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.

** 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.