EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2025

Check with your employer for plans offered and monthly premiums.

2025-2026 Medical Plans M3, M5, M6, M7, M8

	Plan M3 BCS Group No. 0MD752 BCBS Group No. M240880		Plan M5 (HRA) BCS Group No. 0ME538 BCBS Group No. 398348		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	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible*										
Individual	$3,000	$6,000	$5,000	$10,000	$900	$1,800	$1,100	$2,200	$1,600	$3,200
Family	$6,000	$12,000	$10,000	$20,000	$2,700	$5,400	$3,300	$6,600	$4,800	$9,600
Out of Pocket Maximum*										
Individual	$5,000	$15,000	$10,000	$25,000	$2,700	$8,100	$2,800	$8,400	$3,800	$11,400
Family	$10,000	$30,000	$20,000	$50,000	$5,400	$16,200	$8,400	$25,200	$11,400	$34,200
Cost Share Maximum										
Individual	N/A	N/A	N/A	N/A	$4,000	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	$8,000	N/A	N/A	N/A	N/A	N/A
Reimbursement	80%	60%	100%	50%	85%	65%	80%	60%	75%	55%
Inpatient Hospital (Illness or Injury)	80%	60%	$350 then 100%	$750 then 50%	$350 then 85%	$750 then 65%	$350 then 80%	$750 then 60%	$350 then 75%	$750 then 55%
Outpatient Surgery	80%	60%	$350 then 100%	$750 then 50%	$350 then 85%	$750 then 65%	$350 then 80%	$750 then 60%	$350 then 75%	$750 then 55%
Primary Doctor (PCP) Office Visit	$35 copay then 100% no deductible	60%	$35 copay then 100% no deductible	50%	$35 copay then 100% no deductible	65%	$35 copay then 100% no deductible	60%	$35 copay then 100% no deductible	55%
Specialist Office Visit	$40 copay then 100% no deductible	60%	$40 copay then 100% no deductible	50%	$40 copay then 100% no deductible	65%	$40 copay then 100% no deductible	60%	$40 copay then 100% no deductible	55%
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 80%, no deductible	$400 Copay then 80% no deductible	$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 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible
Facility Charges										
Physician Charges	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
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	

The M-series plans on this sheet are not NOT HSA-compatible.

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.