



Egyptian Area Schools Employee Benefit Trust



2022-2023 BENEFIT ENROLLMENT GUIDE



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New Enrollee and Change Enrollment forms are available on the last two pages of this Guide. They are perforated for easy removal.

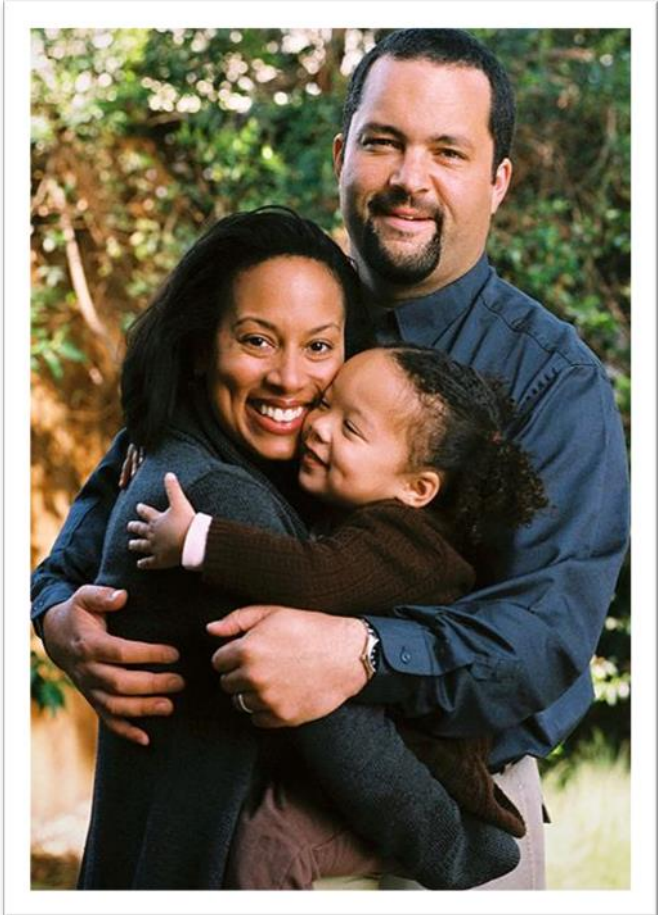
Welcome to 2022-2023 Open Enrollment

This Benefit Enrollment guide contains information about medical, dental, vision, life and Teladoc programs available to you and your dependents. In the following pages you will find details about each benefit program including key points to consider, whether you are making first-time enrollment decisions or changes to current coverage elections.

Please check with your Employer for the plans and rates offered in your district. Benefit summaries for all plans offered by the Trust are available on the Egyptian Trust website (www.eqtrust.org). See page 9 for examples of the medical plan summaries available and links to access them on the website. Voluntary dental, vision and life benefit summaries are included in the appropriate sections of this guide.

Review this guide carefully as you make your enrollment decisions and choose the plans that best meet the needs of you and your family. Keep the guide on hand to reference throughout the year. If you have questions about any program, please reach out to the proper contact as noted in the Member Communication Guide near the back of this book.

Here's to your health!
Egyptian Area Schools Employee Benefit Trust



Note: Some Employers do not offer all health and voluntary plan options described in this booklet. Please contact your Employer for the specific plans and premiums offered by your district.

BENEFIT PROGRAM CHANGES AS OF SEPTEMBER 1, 2022

Health Plan	The \$20,000 lifetime maximum for <i>Assisted Reproductive Technologies</i> removed from all Trust health plans.
EAP	ComPsych Employee Assistance Program (EAP) added as a voluntary option for district participation. Please check with your district to determine if your district is participating.

OPEN ENROLLMENT—WHAT YOU NEED TO DO



If you are a new employee and wish to enroll, complete the New Enrollee Form at the back of this guide and return it to your Employer to complete the enrollment process.



If you are a new employee and wish to waive coverage, you will need to complete the New Enrollee Form at the back of this guide and return it to your Employer. You will not be able to enroll until the next Open Enrollment unless you have a qualifying life event.



If you are currently enrolled and do not wish to make any changes to your coverage or plan elections during Open Enrollment, you don't need to do anything. Your current coverage will remain in effect until the next Open Enrollment period.



If you are currently enrolled and wish to make changes to your current plan elections, complete the Change Enrollment Form at the back of this guide and return it to your Employer to complete the enrollment process.

Enrollment forms are available:

- At the back of this guide,
- From your Employer, and
- On the Trust website at www.egtrust.org



OPEN ENROLLMENT AUGUST 1—SEPTEMBER 30!

Open Enrollment takes place **August 1—September 30, 2022**. That is when you will be able to select or make changes to health, dental, and vision plans for you and your family. Elections made during Open Enrollment are irrevocable until the next Open Enrollment period unless there is a qualifying life event. The effective date of your changes will either be September 1 or October 1 as determined by your Employer.

When you submit enrollment changes, please be sure to update your contact information so we can reach you if needed.

Important Note for Employees Opting Out

If you are opting out of any of the products offered, you must complete the waiver portion of the Enrollment Form and return it to your Employer.

Note: New supplemental life insurance elections or volume increases (except for newly eligible employees who enroll at the guarantee issue amount) are subject to Evidence of Insurability (EOI). Approval must be received before any new life insurance or increased volume will be put into effect. *See the Life Insurance section of this guide for more information.*

General Plan Information

When can you enroll or make changes?

NEW ACTIVE EMPLOYEES

New active employees need to enroll in health, dental, vision, and life insurance plans within 31 days of their first date of active employment (or the date they are first eligible). Elections are irrevocable until the next Open Enrollment period unless there is a qualifying life event.*

CURRENT ACTIVE EMPLOYEES

All current active employees have the opportunity to make changes to their existing elections during Open Enrollment. Elections are irrevocable until the next Open Enrollment period unless there is a qualifying life event.*

Note: Supplemental Life Insurance elections or volume increases for current active employees are subject to Evidence of Insurability (EOI). See the *Life Insurance* section of this guide for more information.

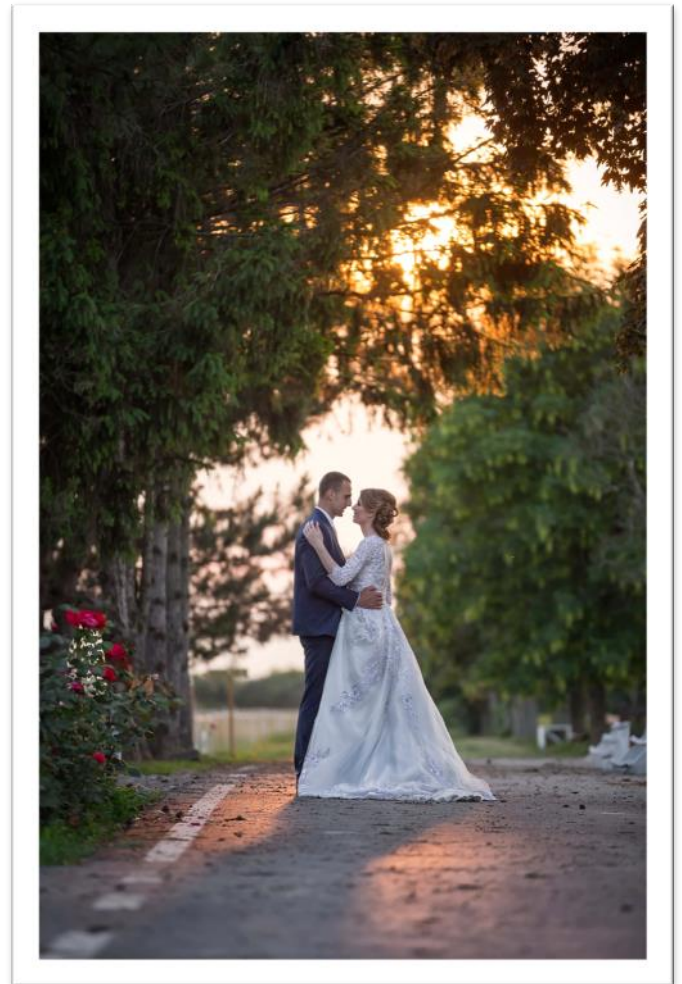
SPECIAL ENROLLMENT DUE TO A QUALIFYING EVENT

If you experience a Qualifying Life Event, you may be eligible for Special Enrollment allowing you to change your previous benefit elections. Your requested change must be consistent with the life event which has occurred. You must notify your Employer within **31 days** of your qualifying life event to add, drop, or change your benefit elections. If you do not provide timely notification of the qualifying event, you must wait until the next Open Enrollment period to change your benefit elections.

Exception: Employees or dependents who gain or lose eligibility for Medicaid or SCHIP coverage must notify their Employer within **60 days** of that event to be eligible for a Special Enrollment opportunity.

*QUALIFYING LIFE EVENTS

- Marriage
- Divorce or termination of civil union
- Birth or adoption of a child
- Changes in a child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Commencement or termination of adoption proceedings
- Change in spouse's or dependent child's benefits or employment status



MEDICAL BENEFITS



BlueCross BlueShield of Illinois



The Egyptian Trust offers a variety of medical plan options. All plan options cover the same services, including prescription drugs. Blue Cross Blue Shield (BCBSIL) is the health claims administrator. Prime Therapeutics is the pharmacy benefit manager. The plans provide discounted rates when you obtain medical care from participating hospitals, doctors, and other healthcare providers in the BCBSIL PPO network, one of the largest networks in the country. However, you have the flexibility to use any provider you choose. If you use a non-network provider, be aware that deductibles and out-of-pocket amounts are significantly increased, and you will have greater patient responsibility.

Benefits Value Advisors (BVA)

Benefits Value Advisor (BVA) customer service representatives are available to assist you with questions about claims, benefit coverage, finding network providers, navigating digital tools and resources, getting cost estimates, and even scheduling appointments.

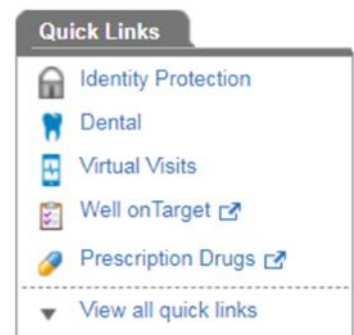
The BVA can help you save money on health procedures and tests by providing cost estimates for common procedures performed by providers in your area. This can help you understand and use your benefits more wisely.

If you have questions or need assistance, they are available 24/7. Contact the BVA at 855-686-8517.

BLUE ACCESS FOR MEMBERS (BAM)

Once you have your BCBSIL Member ID card, go to <https://www.bcbsil.com> to register for Blue Access for Members (BAM). Current members will use the same ID card. You and all covered dependents age 18 and older can create a BAM account. Use this secure website from your desktop or mobile device to:

- Check the status of a medical claim
- View or print Explanation of Benefits (EOB) statements
- View prescription history using Quick Links
- Request or print your ID Card
- Use the Provider Finder tool to search for providers
- Use the Cost Estimator tool to find the price of hundreds of tests, treatments and procedures
- Download the BAM mobile app
- Sign up for text or email alerts



PREAUTHORIZATION/ PRE-CERTIFICATION

Preauthorization is required for certain services to ensure the treatment meets medical necessity criteria. Failure to pre-certify will result in a benefit reduction up to \$250.

PREDETERMINATION

Predetermination is a **written request** for verification of benefits prior to receiving treatment. This is recommended when the treatment may be considered experimental or investigational in nature. You may ask your provider to request a predetermination for any proposed treatment. Approvals or denials will be based on BCBSIL medical policies.

Preauthorization and predetermination do not guarantee payment of benefits. Coverage is always subject to other requirements of the plan, such as medical necessity, limitations and exclusions, payment of contributions, and eligibility at the time services are provided.

Please share this list with your health care provider as the following services **require Preauthorization**:

- All inpatient hospital admissions
 - Coordinated home care program services
 - Home hemodialysis
 - Home hospice
 - Home infusion therapy
 - All home health services
 - Outpatient infusion drugs
 - Private duty nursing
 - Transplant & transplant evaluations
 - Lipid apheresis
- Ear, Nose and Throat (ENT)**
- Bone conduction hearing aids
 - Cochlear implants
 - Nasal and sinus surgery
- Gastroenterology (Stomach)**
- Gastric electrical stimulation (GES)
- Neurological**
- Deep brain stimulation
 - Sacral nerve neuromodulation/stimulation
 - Vagus nerve stimulation (VNS) (morbid obesity)
 - Surgical deactivation of headache trigger sites
- Surgical Procedures**
- Orthognathic surgery; face reconstruction
 - Mastopexy, breast lift
 - Reduction mammoplasty; breast reduction
- Wound Care**
- Hyperbaric Oxygen (HBO2) therapy
- Specialty Pharmacy**
- Medical benefit specialty drugs (administered by your provider)

Musculoskeletal

- Artificial intervertebral disc
- Autologous Chondrocyte Implantation (ACI) for focal articular cartilage lesions
- Femoroacetabular Impingement (FAI) Syndrome
- Functional Neuromuscular Electrical Stimulation (FNMES)
- Lumbar spinal fusion
- Meniscal allografts and other meniscal implants
- Orthopedic application of stem cell therapy

Pain Management

- Occipital nerve stimulation
- Percutaneous and implanted nerve stimulation and neuromodulation
- Spinal cord stimulation

Non-Emergency Fixed-Wing Ambulance Transportation

- Non-emergency fixed-wing ambulance transportation

Behavioral Health

- Inpatient (acute and rehab)
- Residential
- Partial hospital confinement
- Intensive outpatient
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Electroconvulsive Therapy (ECT)
- Applied Behavioral Analysis (ABA)

List of services requiring preauthorization is subject to change.

MEDICAL PLAN SUMMARIES REFERENCE GUIDE

The Trust has a variety of summary documents available that explain each of the medical plans offered. All plan benefit summaries can be found on the Trust website at <https://www.egtrust.org/>.



Before you begin to review these summaries, **please confirm with your Employer which medical plans are offered at your district** to ensure you are reviewing the appropriate plan information. Your Employer will also provide the premiums associated with the plans offered.

BENEFIT PLAN COMPARISONS

<https://www.egtrust.org/medical-benefits/traditional-plans/>

These side-by-side comparisons have multiple health plans in each document. The comparisons include key plan details, such as deductible, out of pocket maximum, ACA cost share maximum, office visit and prescription drug copays, etc.

Description of Benefits	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F	
	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573	ACA Group No. 248573
Hospitalization	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Prescription	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Vision	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Hearing	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000

Benefit Maximum	Amount
Lifetime Maximum Benefits	Assisted Reproduction Techniques - \$20,000
Calendar Year Maximum Benefits	Chiropractic and Osteopathic Manipulation - \$750
Deductible and Out-of-Pocket Maximum	Network: \$800 (Individual), \$1,200 (Family); Non-Network: \$2,400 (Individual), \$3,600 (Family)
ACA Cost Share Maximum	Individual: \$800, Family: \$1,200

SCHEDULES OF BENEFITS (SOB)

<https://www.egtrust.org/schedule-of-benefits/>

Each Schedule of Benefits document is a handy reference guide that outlines a **single** health plan. This schedule includes key plan details, such as deductible, out of pocket maximum, and ACA cost share maximum. In addition, the SOB provides expanded explanations of plan coverage based on common medical procedures, supplies, and services.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

<https://www.egtrust.org/schedule-of-benefits/>

Each 8-page document provides an easy to read summary to compare coverage and expected patient out of pocket expense for a **single** health plan. The SBC explains key plan details like deductible, out of pocket maximum, and limitations or exceptions which may apply. In addition, the SBC provides coverage examples using three common claims.

Important Questions	Answers
What is the overall deductible?	For In-Network: \$800 Individual/\$1,200 Family; For Out-of-Network: \$2,400 Individual/\$3,600 Family
Are there services covered before you meet your deductible?	Yes. Certain preventive care, services that change a course of medical diagnosis and emergency care services are covered before you meet your deductible.
Are there other deductibles for specific services?	No.
What is the out-of-pocket limit for this plan?	For In-Network: \$1,200 Individual/\$2,400 Family; For Out-of-Network: \$3,600 Individual/\$5,400 Family
What is not included in the out-of-pocket limit?	Prescription, Out-of-Pocket charges, copays, coinsurance, and other services are not included in the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.egtrust.org or call 1-800-488-8877 for a list of network providers.
Do you need a referral to see a specialist?	No.

Use these resources to select the medical plan which will best suit the needs of you and your family.



Blue Access for MembersSM

Health care at your fingertips.

Blue Cross and Blue Shield of Illinois (BCBSIL) helps you get the most from your health care benefits with Blue Access for Members (BAMSM). You and all covered dependents age 18 and up can create a BAM account.

With BAM, you can:

- Find care – search for in-network doctors, hospitals, pharmacies and other health care providers
- Request or print your ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Download our app
- Sign up for text or email alerts

It's Easy to Get Started!

1. Go to **bcbsil.com**
2. Click **Register Here**
3. Use the information on your BCBSIL ID card to sign up

Or, text* **BCBSIL** to **33633** to get the BCBSIL app and use BAM while you're on the go.

*Message and data rates may apply.

Find what you need with Blue Access for Members

NATHAN SMITH Settings **9** Language Assistance En Español Log Out

BlueCross BlueShield of Illinois

8 CURRENTLY VIEWING MY PLAN
PPO
View My Plans

1 Home **2** My Coverage **3** Claims Center **4** My Health **5** Doctors & Hospitals **6** Forms & Documents

Welcome NATHAN SMITH!

6 Message Center
You have no messages
View all messages

7 Quick Links
Stop receiving paper statements
Connect
Member Discount Program
Manage preferences
Verification of Coverage

MY COVERAGE
Plan Type: PPO Group Number: 098765
ID Number: ABC123456789

MEDICAL BENEFITS
Preferred Network

Individual Deductible	N/A
Family Deductible	N/A
Family Out of Pocket Maximum	\$8,500.00
Coinsurance	N/A

My Care Profile
Blue Button
Learn how to get your health care profile electronically
Get Started »

10 **11**
Important Information | Non-Discrimination Notice | Help | Contact Us

- 1 My Coverage:** Review benefit details for you and family members covered under your plan.
- 2 Claims Center:** View and organize details such as payments, dates of service, provider names, claims status and more.
- 3 My Health:** Make more informed health care decisions by reading about health and wellness topics and researching specific conditions.
- 4 Doctors & Hospitals:** Use Provider Finder® to locate a network doctor, hospital or other health care provider, and get driving directions.
- 5 Forms & Documents:** Use the form finder to get medical, dental, pharmacy and other forms quickly and easily.
- 6 Message Center:** Communicate with a Customer Service Advocate here. You can also learn about updates to your benefit plan and receive promotional information via secure messaging.
- 7 Quick Links:** Go directly to some of the most popular pages, such as medical coverage, replacement ID cards, manage preferences and more.
- 8 View My Plan:** See the details of your current health plan, as well as other plans you've had in the past.
- 9 Settings:** Set up notifications and alerts to receive updates via text and email, review your member information and change your secure password at anytime.
- 10 Help:** Look up definitions of health insurance terms, get answers to frequently asked questions and find Health Care School articles and videos.
- 11 Contact Us:** Here you can find contact information to reach a Customer Service Advocate with any questions you may have about your plan.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Your Doctor Is In... Provider Finder[®]



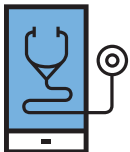
It's now easier to find a provider and manage health care expenses.

Provider Finder from Blue Cross and Blue Shield of Illinois (BCBSIL) is a fast, easy-to-use tool that improves members' experience when they're looking for in-network health care providers. Plus, it can help them manage their out-of-pocket costs.

The updated Provider Finder platform has undergone intensive testing. The result is a better experience that will help members be smarter consumers of health care.

By going to **bcbsil.com**, members can login or create an account on Blue Access for MembersSM (BAMSM) and use Provider Finder to:

- Find in-network providers, clinics, hospitals and pharmacies.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Compare quality awards for doctors, hospitals and more.
- Read or add reviews for providers.
- Estimate the out-of-pocket costs for more than 1,700 health care procedures, treatments and tests.*
- Find cost savings opportunities using the Medication Finder tool.



Go Mobile with BCBSIL

Even on the go members can manage their ID cards and stay on top claims activity, coverage information and prescription refill reminders. It's easy: Log into or create a BAM account at **bcbsil.com** or text BCBSIL to 33633** to download our mobile app.

* Not all plans provide this information.

** Message and data rates may apply. Terms and conditions and privacy policy are available at bcbsil.com/mobile/text-messaging.

How to Navigate Provider Finder

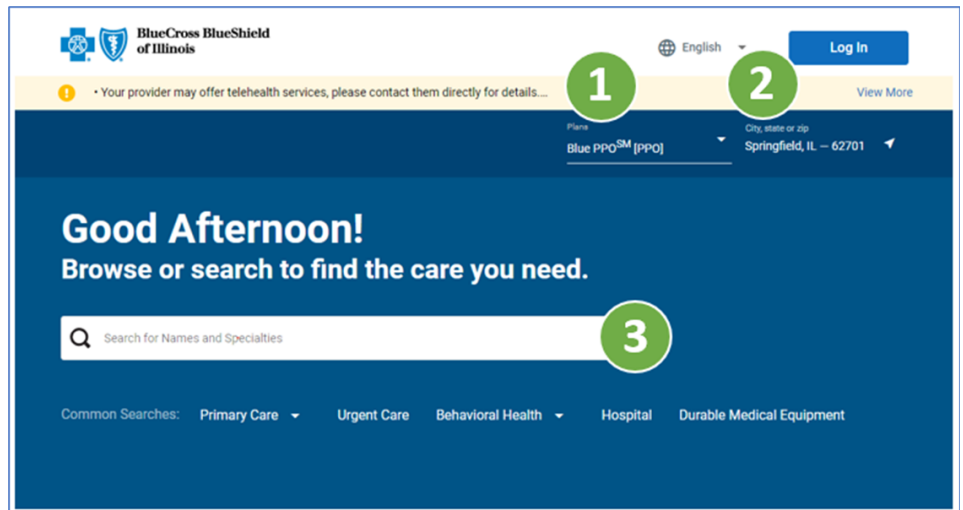
The Provider Finder tool is available on the BlueCross BlueShield of Illinois (BCBSIL) website. Provider Finder's improved search results helps you easily find in-network physicians, specialists and other health care providers. Below is a step-by-step guide to aid you in navigating Provider Finder.

Getting Started

- Log in to Blue Access for Members (BAM)
- Find and select Provider Finder

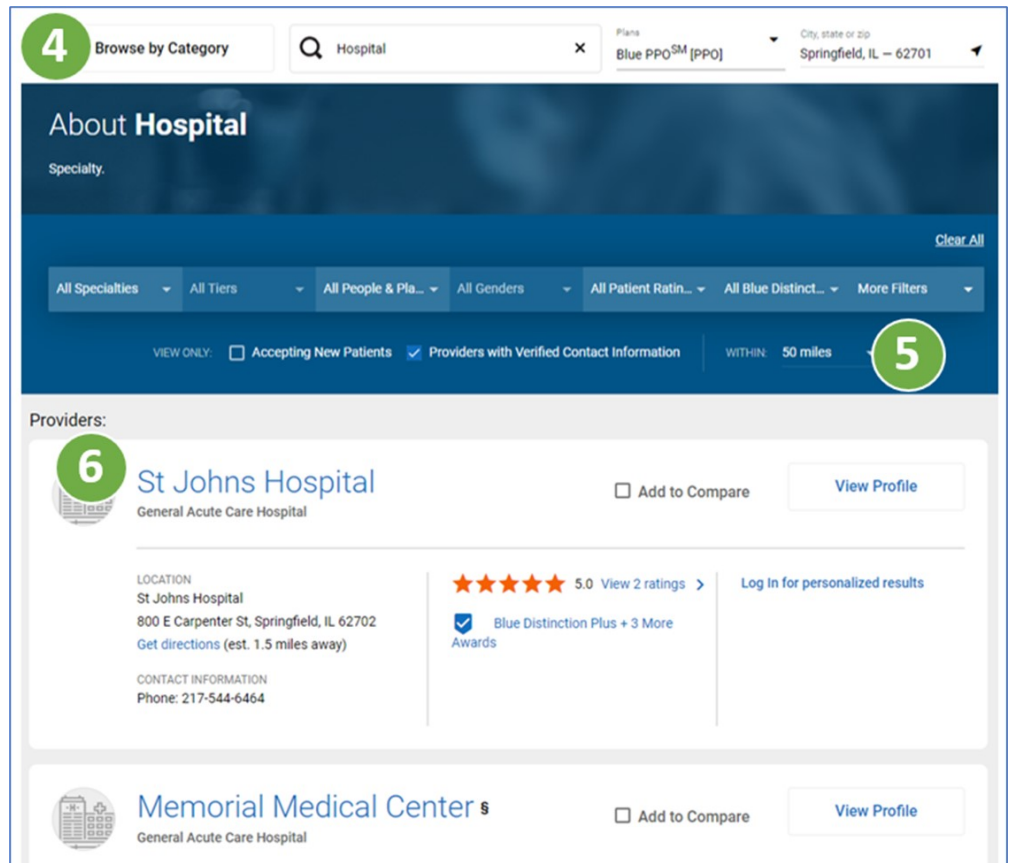
Enter your Location into Provider Finder

1. If PLAN is not filled in, Select **Blue PPO**
2. Enter your **City, State** or **Zip**
3. Enter a **Provider Name** or **Specialty**



Refine your Search or View Results

4. Revise the **Category** to search for other Provider Types
5. Enter the **Distance**
6. View your **Provider Results**





Understanding Your Explanation of Benefits



Your **Explanation of Benefits (EOB)** lets you know when and how we process your claims. It isn't a bill. It gives you a detailed look at the covered services and shows how much you may owe your provider after we apply your benefits.

Page One Covers the Basics

- A. Confirm your policy ID.
- B. Learn how to download the mobile app and access your claims online.
- C. Find helpful contacts and a glossary.

BlueCross BlueShield of Illinois
 PO Box 7344
 Chicago, IL 60680-7344

John Smith
 1234 Cedar Road
 APT #2
 Any Town, IL 76065

Sample

EXPLANATION OF BENEFITS

- B** Log into **Blue Access for MembersSM** at bcsil.com
 - View plan and claim details
 - Contact us through our secure Message Center
 - Sign up for digital health plan info
 - Search for health care providers
- C** Text* **GOBCBSIL** to 33633 to download the mobile app.
- C** Have questions about this EOB? Customer Advocates are here to help! **XXX-XXX-XXXX**

SUBSCRIBER INFORMATION
GROUP NAME
 Member ID#: XXXXXXXXX777V Group #: 000012345

Dear John Smith,

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

HELPFUL INFORMATION

Want Your Health Care Info Digitally?

To get this EOB and other health care info on our mobile app, text* GOBCBSIL to 33633 to download the app. You can also go digital by logging in at bcsil.com/member. Once logged in, navigate to Settings, click Preferences, then select Go Paperless.

Health Care Fraud Hotline: 800-543-0867

Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Illinois (BCBSIL), please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to bcsil.com.

GLOSSARY OF TERMS - We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.

Amount Billed: The amount your provider billed for the service(s) rendered.

Amount Covered (Allowed): Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

Coinsurance: The percentage of the allowed amount you pay as your share of the bill. For example, if your plan pays 80% of the allowed amount, 20% would be your coinsurance.

Copay Amount (Also known as Copayment): The set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit (Maximum): Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this

*Message and data rates may apply. Terms & Conditions and Privacy Policy bcsil.com/text-messaging
Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

F SUBSCRIBER INFORMATION
GROUP NAME
 Member ID#: XXXXXXXXX777V Group #: 000012345
 Customer Advocates are here to help! XXX-XXX-XXXX

CLAIM DETAIL (1 OF X)

PATIENT: John Smith **D**
PROVIDER: Ralph Johnston M.D. **E**

Sample

CLAIM # XXXXXXXXXXXXXXXX **DATE PROCESSED:** 06/20/2020

We reviewed the claim for this patient based on the additional information received regarding other group health care coverage involvement. Blue Cross and Blue Shield of Illinois (BCBSIL) has negotiated discounts with this provider. The following shows how this claim was adjusted.

O²

Amount Billed	\$7,850.00
Discounts and Reductions	-\$3,930.00
Health Plan Responsibility	-\$2,219.00
You may owe your health care provider for these services	\$1,701.00

Service Description	Service Dates	YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				
		Amount Billed G	Discounts and Reductions H	Amount Covered (Allowed) I	Health Plan Responsibility J	Deductible Amount K	Copay Amount L	Coinsurance M	Amount Not Covered N	Your Total Costs O
Surgical Charges	04/04/2020	4,000.00	(1) 1,800.00	2,200.00	960.00	1,000.00		240.00		1,240.00
Recovery Room	04/04/2020	900.00	(1) 410.00	490.00	392.00			98.00		98.00
Med/Surg Supplies	04/04/2020	300.00	(1) 140.00	160.00	128.00			32.00		32.00
Med/Surg Supplies	04/04/2020	100.00							(2) 100.00	100.00
Laboratory Services	04/04/2020	1,200.00	(1) 820.00	380.00	304.00			76.00		76.00
Laboratory Services	04/04/2020	400.00	(1) 270.00	130.00	72.00		50.00	8.00		58.00
MRI Outpatient	04/04/2020	950.00	(1) 490.00	460.00	363.00		15.00	82.00		97.00
CLAIM TOTALS		\$7,850.00	\$3,930.00	\$3,820.00	\$2,219.00	\$1,000.00	\$65.00	\$536.00	\$100.00	\$1,701.00

Total covered benefits approved for this claim: \$2,219.00 to Ralph Johnston M.D. on 06-20-20. **J²**

Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"

(1) The amount billed is greater than the amount allowed for this service. Based on our agreement with this provider, you will not be billed the difference.

(2) Your Health Care Plan does not provide benefits for surgical assistant services when billed by the same physician who performed the surgery or administered the anesthesia. No payment can be made.

Your health care plan has a calendar year maximum for x-rays and laboratory services performed in the outpatient department of a hospital, a clinic or a doctor's office. When this maximum has been reached, the balance is eligible under your major medical benefits, subject to a yearly deductible and a coinsurance share.

For your up-to-date Medical Spending summary, visit Blue Access for MembersSM on our website, the BCBSIL Mobile App or call the phone number on the back of your ID card.

JOHN SMITH - For benefit period 01-01-20 through 12-31-20 to date this patient has met \$4,515.02 of her/his \$7,350.00 Out-of-Pocket Expense Limit.

242384.0421

2

On Page Two You Can:

At a glance, confirm the:

D. Patient **E.** Provider **F.** Policy Information

Get the Details

YOUR BENEFITS APPLIED—This section shows your list of services and how they're covered.

- G.** Amount Billed is the total amount your provider billed for the services.
- I.** Amount Covered (Allowed) is the amount billed (G) minus any discounts or reductions (H).
- J.** Health Plan Responsibility is the portion we paid to your provider.

See Your Cost Share

YOUR RESPONSIBILITY—This section shows your member cost-share amounts, including:

K. Deductible **L.** Copays **M.** Coinsurance

- O.** Your Total Costs is the sum of your copay, deductible and coinsurance. You may owe less if your provider collected any of these payments before beginning services. It also includes any amounts not covered by your health plan. The total cost in this column details the amount shown in the claim summary (O²). It does not include any amounts that a non-participating provider may bill you.

Get More Information

Your EOB may include a little more information about:

- J².** Total covered benefits approved – This is the amount and the date we paid your provider. The total matches the total in the Health Plan Responsibility column (J).
- P.** Numbered notes give more details about discounts and reductions (H) and any amounts that aren't covered (N).
- Q.** Health care plan maximums help you track your yearly out-of-pocket totals so you'll know when your patient cost-shares are met.

Sign up to get your EOBs online on **Blue Access for MembersSM** or Text* **GOBCBSIL to 33633** to download the mobile app.

20154.0121

bcbsil.com/text-messaging.
 *Message and data rates may apply. See terms and conditions and our privacy policy at Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

PRESCRIPTION DRUG BENEFITS



Prime Therapeutics, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit. Prime Therapeutics maintains the Balanced Drug List (also known as a preferred drug list) and manages a network of retail pharmacies. Prime Therapeutics, in consultation with the Plan, also provides related services that promote the appropriate use of prescription benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions and other safety measures.

The Balanced Drug List is a list of drugs available to Blue Cross and Blue Shield of Illinois (BCBSIL) members. How much you pay out-of-pocket for prescription drugs is determined by whether your medication is on the list and the tier designation of the drug. Generally, if you choose a drug that is generic or preferred, your out-of-pocket costs will be less. Your doctor should consult the Balanced Drug List when prescribing drugs for you. This may help lower your out-of-pocket costs. This list can be found at <https://www.bcbsil.com/docs/rx-drugs/drug-lists/il/rx-list-bal-il-2022.pdf> and is regularly updated as generic drugs become available and changes take place in the pharmaceuticals market. Some drugs are covered under your medical plan instead of your prescription benefits. These can include drugs that must be administered by a health care provider. These drugs are often given to you in a hospital, doctor's office or health care setting. Examples of these drugs are contraceptive implants and chemo infusion. If you are taking or prescribed a drug that is not on the Balanced Drug List, call a Benefits Value Advisor (BVA) customer service representative at **855-686-8517** to see if the drug may be covered by your medical plan.

Certain medications are subject to limitations and may require prior authorization for continued use. Covered members may use either network retail pharmacies or the home delivery option.

RETAIL PHARMACIES

Retail pharmacy service is most convenient for short-term prescription needs. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the Prime Advantage network. At retail, you can get up to a 30-day supply, or a 90-day supply for prescription drugs. Most major chain pharmacies participate in the Prime network except CVS pharmacies. If you are using an independent drugstore, you should confirm whether it participates in the network. To find out, visit www.myprime.com or call a Benefits Value Advisor (BVA) at **855-686-8517**.

EXTENDED SUPPLY NETWORK (ESN) RETAIL PHARMACIES

If you need medication on long-term basis you can ask your doctor to prescribe up to a 90-day supply, plus refills if appropriate. Examples include ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. You may buy your maintenance drugs at any Prime ESN retail pharmacy or through the home delivery service. Copays are higher if you choose to use an ESN retail pharmacy instead of home delivery for maintenance drugs. Not all Prime retail pharmacies participate in the network that allows 90 day retail fills. To find Prime ESN pharmacies, visit www.myprime.com and look for pharmacies that indicate "90-day supply available". You can also call a Benefits Value Advisor (BVA) at **855-686-8517** for assistance.

EXPRESS SCRIPTS (ESI) HOME DELIVERY

Home Delivery service is a convenient way to have your maintenance medications delivered to you and can save you money.

- Medications are shipped in discreet packaging via standard delivery at no additional cost.
- First-time orders are usually delivered within 10 days after receipt and confirmation of your order.
- You can receive notification by phone or email when your orders are shipped. You will be contacted, if needed, to complete your order.
- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines and other important details.
- You can request refills online or over the phone. You can also choose to receive refill reminder notices by phone or email.
- Copayments for the home delivery option are less than 90-day retail.

To start using ESI home delivery pharmacy services, visit <https://www.express-scripts.com/rx> and follow the instructions to register and create a profile. Once you have registered, your doctor can send new 90-day prescriptions electronically to the pharmacy.



ACCREDO SPECIALTY PHARMACY

Specialty medications that are self-administered generally must be filled through an in-network specialty pharmacy. You may have coverage for a first fill at some other pharmacy prior to being required to use an in-network option. Specialty medications are limited to a 30-day supply.

- At no additional charge, you get one-on-one support in managing your therapy, including help dealing with any side effects you may experience.
- You have access to around-the-clock customer service and educational materials about your particular diagnosis.
- Medications are delivered directly to you or your doctor's office. Each shipment for self-injectable drugs also includes syringes, sharps containers and other supplies.
- You can register for online refills, if applicable, and sign up for email notifications.

To start using the Accredo Specialty Pharmacy, call **833-721-1619**. An Accredo representative will work with your doctor on the rest. Once registered, you can manage your prescriptions on [accredo.com](https://www.accredo.com) or through their mobile app.



Prescription Drug Program Questions & Answers

Q: Will members receive a separate pharmacy identification card from Prime Therapeutics?

A: No, the BCBSIL member ID card should be used for both medical services and when filling a prescription.

Q: What are my prescription copays?

A: Following are the copayments for the traditional plans (A, B, C, D, E, AB1) and M plans. In Plan D (HDHP), you must meet the calendar year deductible before these copayments apply, except for IRS-approved maintenance and preventive drugs. There are no prescription drug copayments in the H plans. H plans have a 100 % benefit for covered prescription drugs after the calendar year deductible and out-of-pocket amount is met.

Prescription Drug Copayments	Retail 30 day supply	ESN Retail 90 day supply after first 2 fills	Home Delivery up to 90 day supply
Generic	\$12	\$36	\$30
Preferred Brand	\$25	\$85	\$55
Non-Preferred	\$40	\$130	\$100
Oral & Injectable Specialty Drugs	Copay plus 3%*	Copay plus 3%*	Copay plus 3%*

*Most specialty drugs (oral and injectable) will have a maximum copay of \$150 per month.

Note: Not all retail pharmacies participate in the ESN network that allows 90-day retail fills.

Q: Where can I view the Balanced Drug List?

A: The 2022 drug list can be found at <https://www.bcbsil.com/docs/rx-drugs/drug-lists/il/rx-list-bal-il-2022.pdf>.

Q: How do I know if my medication is preferred or non-preferred on the Balanced Drug List?

A: Preferred brands are marked with a “P” in the Tier Designation column and shown in all CAPITAL letters. Non-preferred brands are marked with a “NP” in the Tier Designation column and shown in all CAPITAL letters.

Preferred generics are marked with a “p” and shown in lower-case **boldface** type. Non-preferred generics are marked with a “np” and shown in lower-case **boldface** type.

Specialty medications are marked with a dot in the Specialty column.

Q: What if my medication is not covered on the Balanced Drug List?

A: If your medication is not covered, ask your doctor about therapeutic alternatives. Your doctor can also request a drug list coverage exception from BCBSIL (unless there is a benefit exclusion). Your doctor can call **855-686-8517** to start this process.

Q: CVS is not a network pharmacy. How will my prescriptions be paid if I choose to use CVS?

A: The prescription will be rejected at the CVS pharmacy and you will be responsible for paying the entire cost of the drug at point of sale. You can access www.myprime.com to find a network pharmacy near you.

As always, treatment decisions are between you and your doctor. Coverage is based on the terms and limits of your health plan.



A home delivery (mail order) pharmacy service you can trust.

Express Scripts® Pharmacy delivers your long-term (or maintenance) medicines right where you want them. No driving to the pharmacy. No waiting in line for your prescriptions to be filled.

Savings and Convenience

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines.¹
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.
- You can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy.
- Tamper-evident, unmarked packaging protects your privacy.

Support and Service

- You can receive notices by phone, email or text — your choice — when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at [express-scripts.com/rx](https://www.express-scripts.com/rx) or call **833-715-0942**.
- 24/7 access to a team of knowledgeable pharmacists and support staff.
- Choose to receive refill reminder notices by phone or email.
- Multiple pharmacy locations are located across the U.S., for fast processing and dispensing.



Medicines may take up to 5 business days to deliver after Express Scripts® Pharmacy receives and verifies your order.

Getting Started with Express Scripts® Pharmacy Mail Order

Online and Mobile

You have more than one option to fill or refill a prescription online or from a mobile device:

- Visit [express-scripts.com/rx](https://www.express-scripts.com/rx). Follow the instructions to register and create a profile. See your active prescriptions and/or send your refill order.
- Log in to [myprime.com](https://www.myprime.com) and follow the links to Express Scripts® Pharmacy.

Over the Phone

Call **833-715-0942**, 24/7, to refill, transfer a current prescription or get started with mail order. Please have your member ID card, prescription information and your doctor's contact information ready.

Through the Mail

To send a prescription order through the mail, visit [bcbsil.com](https://www.bcbsil.com) and log in to Blue Access for MembersSM (BAMSM). Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

Talk to Your Doctor

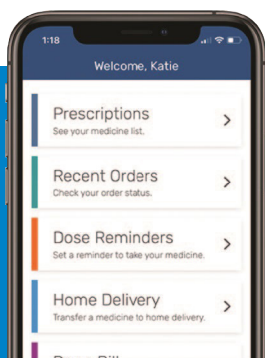
Ask your doctor for a prescription for up to a 90-day supply of each of your long-term medicines.¹ You can ask your doctor to send your prescription electronically to Express Scripts® Pharmacy, call **888-327-9791** for faxing instructions or call the pharmacy at **833-715-0942**. If you need to start your medicine right away, request a prescription for up to a one-month supply you can fill at a local retail pharmacy.

Refills Are Easy

Refill dates are shown on each prescription label. You can choose to have Express Scripts® Pharmacy remind you by phone or email when a refill is due. Choose the reminder option that best suits you.

Questions?

Visit [bcbsil.com](https://www.bcbsil.com). Or call the phone number listed on your member ID card.



Use the mobile app to manage your prescriptions

- Refill prescriptions
- Track your order
- Make payments
- Set reminders to take medicines and more

1. Prescriptions of up to a 90-day supply, or the most amount allowed by the benefit plan.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Illinois. The relationship between Express Scripts® Pharmacy and Blue Cross and Blue Shield of Illinois is that of independent contractors. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by BCBSIL to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC. MyPrime.com is an online resource offered by Prime Therapeutics, LLC.

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Do You Need Specialty Medications?



Blue Cross and Blue Shield of Illinois (BCBSIL) supports members who need self-administered specialty medication and helps them manage their therapy. Accredo® is the specialty pharmacy chosen to do just that.¹

Specialty drugs are often prescribed to treat complex and/or chronic conditions, such as multiple sclerosis, hepatitis C and rheumatoid arthritis.

Specialty drugs often call for carefully following a treatment plan (or taking them on a strict schedule). These medications have special handling or storage needs and may only be stocked by select pharmacies.

Some specialty drugs must be given by a health care professional, while others are approved by the FDA for self-administration (given by yourself or a care giver). Medications that call for administration by a professional are often covered under your medical benefit plan. Your doctor will order these medications. Coverage for self-administered specialty drugs is usually provided through your pharmacy benefit plan. Your doctor should write or call in a prescription for self-administered specialty drugs to be filled by a specialty pharmacy.

Your plan may require you to get your self-administered specialty drugs through Accredo or another in-network pharmacy. If you do not use these pharmacies, you may pay higher out-of-pocket costs.² Your doctor may also order select specialty drugs that must be given to you by a health professional through Accredo.

Do You Need Specialty Medications?

Examples of Self-administered Specialty Medications

This chart shows some conditions self-administered specialty drugs may be used to treat, along with sample medications. This is not a complete list and may change from time to time. Visit bcbsil.com to see the up-to-date list of specialty drugs.

Condition	Sample Medications ³
Autoimmune Disorders	Cosentyx, Enbrel, Humira, Xeljanz
Osteoporosis	Forteo, Tymlos
Cancer (oral)	Gleevec, Nexavar, Sprycel, Sutent, Tarceva
Growth Hormones	Norditropin Flexpro, Nutropin AQ, Omnitrope
Hepatitis C	Daklinza, Eplclusa, Harvoni, Mavyret, Sovaldi, Vosevi
Multiple Sclerosis	Betaseron, Copaxone, Rebif

Support in Managing Your Condition: Accredo

Accredo carries roughly 99% of specialty drugs, which means you're more likely to get all of your specialty drugs from one pharmacy. Through Accredo, you can have your covered, self-administered specialty drugs delivered straight to you. When you get your specialty drugs through Accredo, you get:

- One-on-one counseling from 500+ condition-specific pharmacists and 600+ nurses
- Simple communication, including refill reminders, by your choice of phone, email, text or web⁴
- An online member website to order refills, check order status and track shipments, view order and medication history, set profile preferences and learn more about your condition
- A mobile app that lets you refill and track prescriptions, make payments and set reminders to take your medicine⁴
- Free standard shipping
- 24/7 support

1. Blue Cross and Blue Shield of Illinois (BCBSIL) contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

2. The BCBSIL specialty pharmacy network includes Accredo as well as other in-network specialty pharmacies for select specialty drugs. Based on the benefit plan, members may be responsible for the full cost of the specialty drug for not using an in-network specialty pharmacy. You can log in to your Blue Access for MembersSM (BAMSM) account to find an in-network specialty pharmacy near you.

3. Third-party brand names are the property of their respective owners.

4. Not all medicines can be refilled on the app, by text or email.

5. Treatment decisions are between you and your doctor.

Accredo is contracted to provide services for BCBSIL. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Ordering Through Accredo

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo. **To start using Accredo, call 833-721-1619.**

An Accredo representative will work with your doctor on the rest.

Once registered, you can manage your prescriptions on accredo.com or through the mobile app.

Receiving Specialty Medications

Since many specialty drugs have unique shipping or handling needs, shipments will be arranged with you through Accredo. Medications are shipped in plain, secure, tamper-evident packaging.

Before your scheduled fill date, you will be contacted to:

- Confirm your drugs, dose and the delivery location
- Check any prescription changes your doctor may have ordered⁵
- Discuss any changes in your condition or answer any questions about your health⁵

One-on-One Support

Accredo has 15 Therapeutic Resource Centers[®] (TRCs), each focused on a specific specialty condition. Through your one-on-one counseling sessions, they'll discuss how to reduce your disease progression and achieve your treatment goals, manage any side effects from your drugs, help you stick to your regimen and monitor your progress. They can also offer support with any financial or insurance concerns you may have.

Certain coverage exclusions and limits may apply, based on your health plan. For some medicines, members must meet certain criteria before prescription drug benefit coverage may be approved. Check your benefit materials for details, or call the customer service number listed on your ID card with questions.

Your Teladoc⁺ Program

The Teladoc program is free of charge and available to you and your family members enrolled in one of the Egyptian Trust Health Plans. Or, if you are not enrolled in one of the health plans, but wish to participate in the Teladoc program, employees may enroll for a small monthly fee.

Get the medical advice you need, when you need it.

Sometimes you need to speak with a doctor when it's not possible to attend an office visit. That's why the Teladoc program is available to you and your family, and can be used in a variety of ways:

- During weekends, holidays, or after business hours, when general practitioners don't typically schedule appointments.
- When you can't attend a medical appointment, such as when traveling or at work.
- If you need a prescription medication or refill for a common condition.

The Teladoc program provides more than just on-demand medical support.

This convenient program is available, free of charge, and can help you to:

- **Save time.** Avoid waiting for an appointment or sitting in a doctor's office.
- **Save money.** You'll realize dramatic savings compared with an office or ER visit.
- **Get healthier.** Our network of U.S. based, board-certified doctors are on-hand to provide you with the best medical care and advice available.
- **Gain peace of mind.** Get medical support, when you need it, as often as you need it.

There's more than one way to contact a physician.

Doctors can be reached by phone at 1-800-362-2667. If you prefer, you can also email a doctor or request a video consultation through the online health portal, My Personal Health Manager. Simply login at www.teladoc.com to set up your personal account.

In addition, you can access online health tools such as:

- **Health Library.** Research the latest health articles, then click to consult with a doctor.
- **Personal Health Record.** Store your consultation and medical history within a single, secure location. Share it with your primary care physician.
- **Symptom Checker.** User interactive tools, designed to help you get well.
- **Health Centers.** Comprehensive resource guides for every medical condition, with medical tests, drug reference libraries, and corresponding links to community reference forums.

Contact a Teladoc physician at 1-800-362-2667, or by visiting www.teladoc.com.

Common conditions treated

- Cold/flu
- Allergies
- Sinus infections
- Bronchitis
- Headaches/migraines
- Stomach ache/diarrhea
- Respiratory infections
- Urinary tract infections
- Prescription refills*
- Many other conditions

**Teladoc makes no warranty as to the content of any treatment response. You and your physician are solely responsible for all information and/or communication sent during a teleconsultation or other communication. Teladoc is not health insurance. Its services do not replace your primary care doctor or regular office visits. You agree to contact your Primary Care Physician should your condition change or your symptoms worsen. Priority and By Appointment Tele-Consults do not guarantee prescriptions as requested. Teladoc is not a prescription distribution center. Teladoc's physicians do not prescribe DEA-controlled medications or lifestyle drugs. If you require urgent care, you should contact your local emergency services immediately or dial 911. Teladoc, at its sole discretion, reserves the right to cancel your membership at any time.*



VOLUNTARY DENTAL PROGRAM



Met Life is the administrator of the fully insured voluntary dental program. The Egyptian Trust offers two dental plan options. Benefit highlights for the High and Low dental plans begin on the next page.

Why dental insurance makes sense?

Dental problems can be unpredictable and expensive. For example, did you know that a crown can cost more than \$1,500? With MetLife Dental Insurance, you can reduce your out-of-pocket expenses and maintain your smile with preventive care. When your preventive care is covered, you're more likely to go for cleanings and checkups — this can help you avoid problems before they become too costly or complicated.

Frequently asked questions

Q: How do I find a participating dentist?

A: There are thousands of general dentists and specialists to choose from nationwide. Look for a list of participating dentists online at www.metlife.com. Select "Find a Dentist". Next, choose the **PDP Plus** network, and enter your City, State, or Zip.

Q: May I choose a non-participating dentist?

A: You are always free to select any general dentist or specialist. However you usually save when you visit a participating dentist. Participating dentists have agreed to accept negotiated fees as payment in full for covered services. Negotiated fees typically range from 30-45% below the average fees charged in a dentist's community for similar services. Non-participating dentists have not agreed to accept these negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and the plan's benefit payment.

Q: What types of services do the dental plans cover?

A: These dental plans cover exams and cleanings, X-rays, fillings, root canals, and more. See the detailed High and Low plan summaries on the following pages for more details.

Q: How does a dental plan save me money?

A: Think about this: Having a good dental plan in place can help you save money every year on your preventive dental services. You also get protection against costly emergency dental treatments that may run into the hundreds of dollars. See the detailed High and Low plan summaries for specifics on covered services.

Q: Will I receive a dental ID card?

A: Dental ID cards can be downloaded or printed from metlife.com/mybenefits. In the **Access MyBenefits** box (see example) enter **Egyptian Area Schools Employee Benefit Trust** to log-in or register.

Access MyBenefits

Type and select your organization.

Egyptian Area Schools Employee Benefit Tr

Remember my selection

Next

If you have any questions about the MetLife dental benefits, call Customer Service at
1-800-ASK-4MET
(1-800-275-4638)
Monday through Friday
7:00 AM to 10:00 PM (CT)

Dental - High Plan Summary*

Metropolitan Life Insurance Company

Plan Design for: Egyptian Area Schools Employee Benefit Trust

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	In-Network ¹ % of PDP Fee ²	Out-of-Network ¹ % of R&C Fee ⁴
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$1500	\$1500
Orthodontia Lifetime Maximum - Ortho applies to Child Only	Up to dependent age limit	
	\$1000 per Person	\$1000 per Person

- "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
- Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
- Applies to Type B and C services only.
- Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
 - the dentist's actual charge (the 'Actual Charge'),
 - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
 - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

We're here to help

Find a Dental provider at
www.metlife.com/dental

For general questions go to
www.metlife.com/mybenefits or
 call 1-800-275-4638

Monthly Premium Payment	
Employee	\$35.56
Employee + 1 Dependent	\$67.12
Employee + 2 or more Dependents	\$98.46

Note: The monthly rates above have been adjusted by the Egyptian Trust as approved by the Board of Managers. These rates will remain in effect for dental participants through August 31, 2023.

*This information provides highlights of this dental program only. Full benefit details are available at:

<http://www.egtrust.org/voluntary-benefits/dental/>

Dental - Low Plan Summary*

Metropolitan Life Insurance Company

Plan Design for: Egyptian Area Schools Employee Benefit Trust

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	In-Network ¹ % of PDP Fee ²	Out-of-Network ¹ % of R&C Fee ⁴
Type A - Preventive	80%	80%
Type B - Basic Restorative	70%	70%
Type C - Major Restorative	Not Covered	Not Covered
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$750	\$750

- "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
- Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
- Applies to Type B and C services only.
- Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
 - the dentist's actual charge (the 'Actual Charge'),
 - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
 - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

We're here to help

Find a Dental provider at
www.metlife.com/dental

For general questions go to
www.metlife.com/mybenefits or
 call 1-800-275-4638

Monthly Premium Payment	
Employee	\$14.60
Employee + 1 Dependent	\$28.50
Employee + 2 or more Dependents	\$54.88

Note: The monthly rates above have been adjusted by the Egyptian Trust as approved by the Board of Managers. These rates will remain in effect for dental participants through August 31, 2023.

*This information provides highlights of this dental program only. Full benefit details are available at:
<http://www.egtrust.org/voluntary-benefits/dental/>

Selected Covered Services and Frequency Limitations*

Type A - Preventive (HIGH & LOW PLAN)

How Many/How Often:

Oral Examinations	2 in a year
Full Mouth X-rays	1 in 36 months
Bitewing X-rays (Adult/Child)	2 in a year
Prophylaxis - Cleanings	2 in a year
Topical Fluoride Applications	1 in a year - Children to age 19

Type B - Basic Restorative (HIGH & LOW PLAN)

How Many/How Often:

Sealants	1 in 60 months - Children to age 19
Space Maintainers	1 per lifetime per tooth area - Children up to age 19
Amalgam and Composite Fillings	1 in 12 months
Prefabricated Crowns	1 per tooth in 60 months
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 12 months per quadrant
Periodontal Scaling & Root Planing	1 in 12 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery (Simple Extractions)	
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	
Emergency Palliative Treatment	
General Anesthesia	
Consultations	1 in 12 months

Type C - Major Restorative (HIGH PLAN ONLY)

How Many/How Often:

Crowns/Inlays/Onlays	1 per tooth in 60 months
Repairs	1 in 12 months
Bridges	1 in 60 months
Dentures	1 in 60 months
Implant Services	1 service per tooth in 60 months - 1 repair per 12 months

Type D – Orthodontia (HIGH PLAN ONLY)

- Dependent children up to age 26. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

***Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

VOLUNTARY VISION PROGRAM

Met Life is the administrator of the fully insured voluntary vision program. Vision plan highlights begin on the next page.



Why is having a good vision plan so important?

Because taking good care of your eyes can help you take better care of your body. Regular visits to your eye care professional do more than just protect your eyesight. They can help protect your overall health. Through a routine exam, eye doctors can spot serious health problems like diabetes, high blood pressure, heart disease, certain cancers and other conditions.

That's why, even if you have perfect vision, yearly exams are important. Don't let preventable health and vision problems sneak up on you. Vision benefits are there to help you stay on top of your care.

Frequently asked questions

Q: *Can I choose my own eye care professional?*

A: You can go to any licensed eye care professional. Choose an ophthalmologist, optometrist or optician in private practice or use popular retail locations like Costco® Optical, America's Best, Cohen's Fashion Optical, Eyeglass World, For Eyes Optical, Walmart and Sam's Club, Visionworks and more.

Q: *How do I find participating providers?*

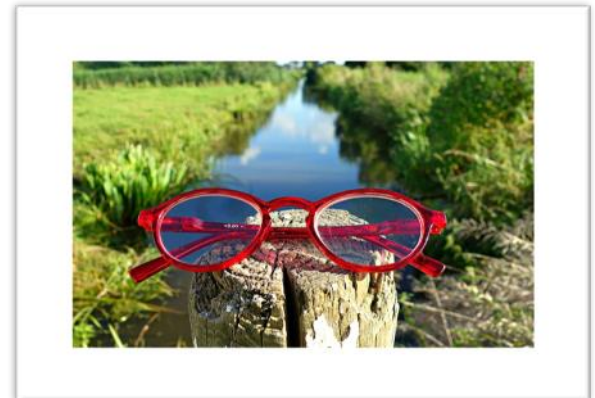
A: Look for participating locations online at www.metlife.com. Select "Find a Vision Provider". Next, choose the **MetLife Vision PPO** network, and enter your City, State, or Zip.

Q: *How does a vision plan save me money?*

A: Eyeglasses and routine eye exams can be more expensive than you may think. With MetLife's low copays, you can save up to 60% on vision wear and services. Lens options like polycarbonate (shatter-resistant) lenses for children up to age 18, ultraviolet (UV) coating, progressive standard and scratch-resistant coatings are covered in full after a flat dollar eyewear copay. You also enjoy fixed copays for many other lens enhancements.

Q: *Will I receive a vision ID card?*

A: Vision ID cards are not required to be presented at time of service. You can download or print an ID card from metlife.com/mybenefits. In the **Access MyBenefits** box (see example) enter **Egyptian Area Schools Employee Benefit Trust** to log-in or register.



Access MyBenefits

Type and select your organization.

 Remember my selection

If you have any questions about the MetLife vision benefits, call Customer Service at 1-855-MET-EYE1 (1-855-638-3931)
Monday-Friday
7:00 AM - 4:00 PM (CT)
and Saturday-Sunday
9:00 AM - 3:00 PM (CT)

Vision Plan Summary*

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.¹

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.¹

Laser vision correction:² Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

We're here to help

Find a Vision provider at www.metlife.com/vision

Download a claim form at www.metlife.com/mybenefits

For general questions go to www.metlife.com/mybenefits or call 1-855-MET-EYE1 (1-855-638-3931)

VI-STAND Vision Benefit Summary

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam	Once every 12 months
<ul style="list-style-type: none"> • Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a \$15 copay. • Retinal imaging: Up to a \$39 copay on routine retinal screening when performed by a private practice provider. 	

Frame

Once every 24 months

- Allowance: **\$130** after **\$15** eyewear copay.
- Costco, Walmart and Sam's Club: **\$70** allowance after **\$15** eyewear copay. You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.

Standard corrective lenses

Once every 12 months

- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **\$15** eyewear copay.

Standard lens enhancements*

Once every 12 months

- Polycarbonate (child up to age 18), Ultraviolet (UV) coating, Progressive Standard and Scratch-resistant coatings: Covered in full after **\$15** eyewear copay.
- Progressive Premium/Custom, Polycarbonate (adult), Photochromic, Anti-reflective and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits.

Contact lenses instead of eye glasses

Once every 12 months

- Contact fitting and evaluation: Covered in full with a maximum copay of **\$40**.
- Elective lenses: **\$130** allowance.
- Necessary lenses: Covered in full after eyewear copay.

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

- | | |
|--------------------------------|--|
| • Eye exam: up to \$45 | • Single vision lenses: up to \$30 |
| • Frames: up to \$70 | • Lined bifocal lenses: up to \$50 |
| • Contact lenses: | • Lined trifocal lenses: up to \$65 |
| • Elective up to \$105 | • Lenticular lenses: up to \$100 |
| • Necessary up to \$210 | • Progressive lenses: up to \$50 |

Monthly Premium Payment	
Employee	\$ 8.02
Employee + 1 Dependent	\$11.54
Employee + 2 or more Dependents	\$20.84

*This information provides highlights of this vision program only. Full benefit details are available at: <http://www.egtrust.org/voluntary-benefits/vision/>

200 Park Ave., New York, NY 10166
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Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments:

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.

- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

Treatments

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

Medications

- Prescription and non-prescription medication

¹ All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart and Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

² Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M130D-15/15-C/E

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

LIFE INSURANCE AND AD&D COVERAGE



BlueCross BlueShield
of Illinois

Life insurance is the tool most people use to financially protect their families in the event of death. If you were to pass away unexpectedly, would you want your family's financial standard of living to be better, worse, or the same as it is today? The life insurance options offered through the Egyptian Trust provide that financial security for your family.

Life Insurance, Supplemental Life Insurance, and Accidental Death and Dismemberment (AD&D) plans are available from Blue Cross Blue Shield of Illinois (BCBSIL), previously Dearborn National. You may see either of these companies listed on various life insurance forms and documentation.

Helpful Tips For Your Life Insurance

Life insurance is one of those things that we purchase, file away, and often forget about it until we need it.

Here are some general life insurance tips and terminology to help you understand this important coverage. Remember to always refer to the certificate for actual terms and conditions. Your life insurance certificate is available at <https://www.egtrust.org>.

GUARANTEE ISSUE AMOUNT

For new entrants enrolled within 31 days of being eligible, the following guarantee issue amounts are available without Evidence of Insurability (EOI):

Employee: \$100,000 (under age 60); or \$25,000 (age 60-69)
Spouse: \$37,500 (under age 60)

EVIDENCE OF INSURABILITY (EOI)

EOI is an application process to provide information on the condition of your health or your dependent's health in order to be considered for life insurance coverage. The completed EOI application needs to be reviewed and approved by BCBSIL before coverage becomes effective. EOI is required if:

- 1) you apply for an amount of coverage higher than the guarantee issue amount,
- 2) you are currently enrolled and want to increase your insurance amount, or
- 3) you declined coverage previously.



WAIVER OF PREMIUM

The Life Insurance policy has a Waiver of Premium provision. If an employee is younger than age 60, becomes totally disabled and is unable to work for at least six months, the employee is no longer required to submit life insurance premium for the duration of the disability. A *Waiver or Premium claim form must be submitted to BCBSIL for review to determine if the employee meets the definition of total disability.* If the Waiver of Premium benefit is approved, the employee's life insurance will continue while he or she is not at work. Waiver of Premium terminates at the employee's Social Security Normal Retirement Age or when the employee is no longer considered totally disabled.

PORTABILITY

At termination of employment, an employee has the option to retain life insurance coverage through this Portability provision. Portability premiums must be submitted timely and rates increase as the employee's age increases. If the employee ports his or her coverage, a covered spouse and any covered children may also port their coverage. Portability coverage ends at age 65. Portability application form must be completed and submitted to the carrier within 31 days of coverage termination. Rates are found on the Portability application.

CONVERSION

If an employee is terminating employment or if the Waiver of Premium benefit is ending, the employee can convert life insurance coverage to a whole life policy. The rates are age-based, and as long as premiums are paid on time, coverage can stay in effect until age 100. Conversion application form must be completed and submitted to the carrier within 31 days of coverage termination. Rates are found on the Conversion application.

Where do I find Life Insurance forms?

All necessary life insurance forms and applications are available on the Egyptian Trust website at <https://www.egtrust.org/voluntary-benefits/life-insurance/>.

The image shows two forms from Blue Cross Blue Shield of Illinois. The first form is titled 'Coverage Election Summary for BCB' and includes sections for 'Employee Information', 'Employer Information', and 'Coverage Election Summary'. The second form is titled 'Request for Portability' and includes sections for 'Employee Information', 'Employer Information', and 'Request for Portability'.

The image shows a form from Dearborn Life Insurance Company titled 'Application to Convert Group Life Insurance'. It includes sections for 'Employee Information', 'Employer Information', and 'Application to Convert Group Life Insurance'.

Many of these forms have portions to be completed by both the employer and the employee. Forms should be submitted to BCBSIL at the address or fax number indicated on the form.



GROUP LIFE BENEFIT PROGRAM SUMMARY
For Egyptian Area Schools Employee Benefit Trust
Policy Number #F019133

All Classes as Defined by your School District

Eligibility	All full-time employees working 10 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.
Group Term Life/AD&D Benefit:	Benefit amount as defined by your School District
Supplemental Life/AD&D Benefit: Employee Options	Options of \$10,000 - \$25,000 - \$50,000 - \$75,000 - \$100,000 or \$10,000 increments to a maximum of \$500,000, not to exceed 5 times annual salary.
Supplemental Life/AD&D Benefit: Spouse - (Includes Domestic Partners) Employee must elect coverage for dependent to be eligible.	\$5,000 - \$250,000, in increments of \$2,500, not to exceed 50% of the employee benefit amount. (minimum \$5,000)
Supplemental Life Benefit: Child(ren) Employee must elect coverage for dependent to be eligible.	Live Birth to 14 days: \$0 Age 15 days to Age 26: \$5,000 or \$10,000
Age Reduction Schedule	Life and AD&D benefits reduce by 50% at age 70.
Guarantee Issue Amount – Employee	\$100,000 under age 60, \$25,000 Ages 60-69
Guarantee Issue Amount – Spouse	\$37,500 under age 60.
Accelerated Death Benefit (ADB)	Upon the employee's request, this benefit pays a lump sum up to 75% of the employee's Life insurance, if diagnosed with a terminal illness and has a life expectancy of 24 months or less. Minimum: \$7,500. Maximum: \$250,000. The amount of group term life insurance otherwise payable upon the employee's death will be reduced by the ADB.
Portability Feature (Life coverage)	Included. (Employee & Spouse Supplemental Life)
Conversion Privilege (Life coverage)	Included.
Guarantee Issue	For timely entrants enrolled within 31 days of being eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense.
Beneficiary Resource Services	Includes grief, legal and financial counseling for beneficiaries, funeral planning; and online legal library, including templates to create a legal will and other legal documents.
Travel Resource Services	Helps travelers deal with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance, and access to other critical services and resources available via the internet.
Exclusions	One-year suicide exclusion applies to Supplemental Group Term Life coverage. AD&D exclusions are the same as Basic AD&D exclusions.

This piece is for illustrative purposes only. The disability and life insurance policies referenced may not be available in all states. All policies are subject to issue limitations, exclusions and other coverage conditions, which may include a waiting period for pre-existing conditions. Only the policy can provide the actual terms of coverage.

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



Egyptian Area Schools Employee Benefit Trust - #F019133

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

Supplemental Life/AD&D Insurance

Employee Benefit: **Options of \$10,000 - \$25,000 - \$50,000 - \$75,000 - \$100,000 or \$10,000 increments to a maximum of \$500,000, not to exceed 5 times earnings**

Spouse Benefit: **\$5,000 - \$250,000 in \$2,500 increments, but not to exceed 50% of the employee benefit.**

Note: Spouse may not have coverage unless the employee has coverage.

Child Coverage (Life Only)

Live Birth to 14 Days: \$0
Age 15 days to Age 26: \$5,000 or \$10,000

Employee/Spouse: Life and AD&D benefits reduce by 50% of the original amount at age 70. All benefits terminate at retirement.

Guarantee Issue: New Hires Only

Employee: **\$100,000 (Under age 60); \$25,000 (age 60-69)**
Spouse: **\$37,500 (Under age 60)**

Supplemental Life/AD&D Insurance

Monthly Premium Cost (Based on 12 payroll deductions per year)

EMPLOYEE & SPOUSE	
Supplemental Life/AD&D	
Monthly rates per \$1,000	
<u>Age</u>	<u>Rates</u>
Under 25	\$0.085
25-29	\$0.095
30-34	\$0.105
35-39	\$0.135
40-44	\$0.195
45-49	\$0.305
50-54	\$0.495
55-59	\$0.795
60-64	\$0.985
65+	\$1.685

Dependent Life (Children)	
Monthly Premium per Family	
	<u>Life</u>
\$5,000	\$0.47
\$10,000	\$0.94

EMPLOYEE Benefit Amount	EMPLOYEE ATTAINED AGE										
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	
\$10,000	\$0.85	\$0.95	\$1.05	\$1.35	\$1.95	\$3.05	\$4.95	\$7.95	\$9.85	\$16.85	
\$25,000	\$2.13	\$2.38	\$2.63	\$3.38	\$4.88	\$7.63	\$12.38	\$19.88	\$24.63	\$42.13	
\$50,000	\$4.25	\$4.75	\$5.25	\$6.75	\$9.75	\$15.25	\$24.75	\$39.75	\$49.25	\$84.25	
\$75,000	\$6.38	\$7.13	\$7.88	\$10.13	\$14.63	\$22.88	\$37.13	\$59.63	\$73.88	\$126.38	
\$100,000	\$8.50	\$9.50	\$10.50	\$13.50	\$19.50	\$30.50	\$49.50	\$79.50	\$98.50	\$168.50	

SPOUSE (Employee Attained Age)											
Monthly Premium Cost (Based on 12 payroll deductions per year)											
\$5,000	\$0.43	\$0.48	\$0.53	\$0.68	\$0.98	\$1.53	\$2.48	\$3.98	\$4.93	\$8.43	
\$10,000	\$0.85	\$0.95	\$1.05	\$1.35	\$1.95	\$3.05	\$4.95	\$7.95	\$9.85	\$16.85	
\$25,000	\$2.13	\$2.38	\$2.63	\$3.38	\$4.88	\$7.63	\$12.38	\$19.88	\$24.63	\$42.13	
\$30,000	\$2.55	\$2.85	\$3.15	\$4.05	\$5.85	\$9.15	\$14.85	\$23.85	\$29.55	\$50.55	
\$35,000	\$2.98	\$3.33	\$3.68	\$4.73	\$6.83	\$10.68	\$17.33	\$27.83	\$34.48	\$58.98	
\$37,500	\$3.19	\$3.56	\$3.94	\$5.06	\$7.31	\$11.44	\$18.56	\$29.81	\$36.94	\$63.19	

This piece is for illustrative purposes only and is not a contract. It is intended to provide only a brief summary of the type of policy and insurance coverage advertised. The policy provides the actual terms of coverage, including any exclusions, conditions and limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period. Refer to your certificate for complete details and limitations of coverage.

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Policy Provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations.

COVERED MEMBERS COMMUNICATION GUIDE



Important – Please read: Below is a contact list for covered members. We request members use this reference to contact the appropriate vendor or provider of service. Failure to contact the appropriate vendor or carrier will result in a delay of services to the member.

Note: Members **must** work with their district contacts to request enrollment or eligibility changes.

Program	Subject Matter	Vendor	Phone	Website
Health Plans	For any Health plan questions including: <ul style="list-style-type: none"> • Benefits • Precertification/Predetermination • Request Health Plan ID cards • Find a network provider 	BCBS of IL	1-855-686-8517	www.bcbsil.com
Prescription Drugs	For any Prescription questions including: <ul style="list-style-type: none"> • Benefits • Eligibility • Prescription Drug Plan • Claim questions • Find a network provider 	Prime Therapeutics	1-800-423-1973	www.myprime.com
Teladoc	Health plan and voluntary Teladoc participants have 24/7 access to medical consults for common conditions.	Teladoc	1-800-DOC-CONSULT 1-800-362-2667	www.teladoc.com
Voluntary Dental	For any Dental plan questions including: <ul style="list-style-type: none"> • Benefits • Eligibility • Claim questions • Find a network provider 	MetLife	1-800-ASK-4MET 1-800-275-4638	www.metlife.com
Voluntary Vision	For any Vision plan questions including: <ul style="list-style-type: none"> • Benefits • Eligibility • Claim questions • Find a network provider 	MetLife	1-855-MET-EYE1 1-855-638-3931	www.metlife.com
Basic or Supplemental Life Insurance	Member questions concerning: <ul style="list-style-type: none"> • Portability or Conversion • Claim issues • Travel or Beneficiary Resources 	BCBS of IL	1-877-442-4207 Option 4	www.egtrust.org

If you need contact information for vendors who are not listed, please email us at egtrust@healthscopebenefits.com.

IMPORTANT LEGAL NOTICES

COBRA

Under certain circumstances, you and your enrolled dependents have the right to continue coverage under the medical, dental and vision plans, beyond the time coverage would have ordinarily ended. You may elect continuation coverage for yourself and your dependents if you lose coverage under the Trust plan(s) because of one of the following qualifying events:

- Termination (for reasons other than gross misconduct)
- Reduction in employment hours
- Retirement
- You become entitled to Medicare

Upon a qualifying event, a COBRA election packet will be mailed to your home address by our COBRA administrator.

In addition, continuation coverage may be available to your eligible dependents if:

- You die
- You and your spouse divorce or legally separate
- A covered child ceases to be an eligible dependent
- You become entitled to Medicare

To initiate a COBRA continuation coverage offer, you or a dependent must notify your Employer within 60 days of a qualifying life event. You and/or your dependents must pay the full cost of COBRA coverage. Under the law, COBRA must be offered to eligible individuals at group rates. These rates are subject to change annually.

The full General Notice of Continuation Coverage Rights under COBRA is available on the Egyptian Trust website at www.egtrust.org. You may also request a printed copy of this full notice by contacting:

Egyptian Trust

P.O. Box 2034

Loves Park, IL 61130

Email: egtrust@healthscopebenefits.com

Phone: 1-800-397-9598

HIPAA Privacy Notice

This summary notice is a reminder of how medical information about you may be used and disclosed and how you can get access to this information. You are receiving this Notice summary because you are eligible for benefit plans (“Health Plan”) offered through the Egyptian Area Schools Employee Benefit Trust. The “Health Plan” includes medical, dental and vision programs. The Health Plan is committed to protecting the confidentiality of any health information it receives, maintains, uses or discloses. This notice describes how the Health Plan may use and disclose your “protected health information” (PHI). PHI is any health information that identifies the individual or may reasonably be used to identify the individual; that is created or received by a health care provider, health plan, employer or health care clearing house; and that relates to your past, present or future physical or mental health conditions, or provision of or payment for health care.

The Trust administers and manages this Health Plan and may use your PHI only for appropriate plan purposes (such as for payment of claims or health care plan operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes. The Trust and all business associates must comply with the same requirements that apply to the Health Plan to safeguard your PHI and protect the confidentiality of your PHI.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide a notice explaining how the Health Plan may use your PHI. Copies of BCBSIL's Notice of Privacy Practices and the Trust's Notice of Privacy Practices are on the Trust website at [HIPAA Authorization Notice & Form | EG Trust](#).

Should you have questions about the Privacy Notices, if you want more information about the privacy practices of the Health Plan, or to request a printed copy of the Privacy Notice, please contact the Trust's Privacy Officer at:

Egyptian Trust Privacy Officer

P.O. Box 2034

Loves Park, IL 61130

Email: egtrust@healthscopebenefits.com

Phone: 1-800-397-9598

HIPAA Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan in the following circumstances:

- If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage);
- If you or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage. However, you must request enrollment within 60 days after the loss of such coverage; or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP. However, you must request enrollment within 60 days after you or your dependents become eligible for such assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Employer.

Essential Health Benefits Disclosure

Illinois employers, including school districts, are required to provide annual disclosure identifying Essential Health Benefits (EHB) covered by the health plan(s). This document, which applies to all Trust health plans, is available on the Trust website at: <https://www.egtrust.org/medical-benefits/essential-health-benefits-disclosure/>.

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of the above periods.

Women's Health & Cancer Rights Act

Group health plans that cover mastectomies must cover postmastectomy reconstructive breast surgery. Specifically, health plans must cover:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis and treatment of physical complications of all stages of mastectomy including lymphedemas.

Benefits required by law will be provided in consultation between the patient and attending physician. These benefits are subject to the health plan's regular plan provisions and benefits.





RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

Egyptian Area Schools Employee Benefit Trust

NEW ENROLLEE (Not Currently Covered)

EMPLOYER (OR PLAN SPONSOR) SECTION

EMPLOYER MUST COMPLETE THIS SECTION. Unsigned or incomplete forms will be returned and may delay enrollment.

Employer Name	Group Number	Effective Date
Enrollment Event: <input type="checkbox"/> Open Enrollment- Applies to medical, dental, vision only <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Change in Family Status Reason	<input type="checkbox"/> Late Enrollment	Employee Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other
Certified by (Authorized Representative)	Date	Employer Telephone () -
Special Instructions:		

EMPLOYEE INFORMATION: EMPLOYEE MUST COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)

Employee Name Last First MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union	Social Security Number
Employee Home Address Street/Apt. City State Zip	Home Phone _____ Business or Cell Phone _____		Email Address _____	Occupation: _____ Average Hours Worked per Week: _____
			Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	

EMPLOYEES: You must check one box in each section below.

EMPLOYEES: Check all boxes that apply:

Medical Plan <i>Instruction: Ask your Employer which Plans you are eligible for.</i> Enter Plan Name Here: _____	Voluntary Teladoc <input type="checkbox"/> Teladoc Only	Voluntary Dental <input type="checkbox"/> High <input type="checkbox"/> Low	Voluntary Vision	Basic Life – Basic Life is automatic when enrolling in Health Plan <input type="checkbox"/> Basic Life Amount _____ <input type="checkbox"/> Decline coverage
				Optional Life – When applying for more than guarantee issue amounts an Evidence of Insurability form must be completed. <input type="checkbox"/> Optional Employee Life Amount _____ Note: Evidence of Insurability Form required for amounts over \$100,000 <input type="checkbox"/> Optional Spouse Life Amount _____ Note: Limited to 50% of Employee Life – Evidence of Insurability required for amounts over \$37,500 <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000 Note: Covers all eligible children <input type="checkbox"/> Decline Coverage
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Decline Coverage NOTE: Includes Teladoc, Basic Life Insurance and Prescription Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Decline Coverage NOTE: Teladoc is included in Medical Plan.	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more depts <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more depts <input type="checkbox"/> Decline Coverage	

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number (Required when enrolling dependents.)	Please mark the coverage chosen or decline coverage for each dependent listed.
1.			/ /	- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
2.			/ /	- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
3.			/ /	- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
4.			/ /	- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
5.			/ /	- -	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline

OTHER INSURANCE COVERAGE

Are you or any of your dependents covered by another group, medical, dental or vision plan? Yes No If yes, type(s) of coverage: Medical Vision Dental

Name of individual with other coverage: _____ Effective Date of other coverage _____

Name of insurance carrier or TPA: _____ Group No. _____

Address: _____ Phone: _____

Name of employer providing coverage: _____

Is other coverage Medicare or Medicaid? Yes No Medicare/Medicaid Effective Date of coverage _____

EMPLOYER: RETAIN ORIGINAL FOR YOUR FILE

BASIC LIFE – Beneficiary Information						
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number	
Street Address			City	State	Zip	
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's Social Security Number	
Street Address			City	State	Zip	

OPTIONAL LIFE – Beneficiary Information						
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number	
Street Address			City	State	Zip	
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's Social Security Number	
Street Address			City	State	Zip	

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE)	Blue Cross Blue Shield of Illinois
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This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

<input type="checkbox"/> APPLY FOR THE BASIC GROUP LIFE BENEFITS indicated above and, if my application is approved by BCBSIL, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.	<input type="checkbox"/> APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS indicated above and, if my application is approved by BCBSIL I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.
<input type="checkbox"/> WAIVE COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.	<input type="checkbox"/> WAIVE COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
<input type="checkbox"/> WAIVE COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program. I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.	

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of BCBS of IL, and the initial premium is paid to BCBS of IL. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

REQUEST FOR COVERAGE (MEDICAL)	Administered By: Blue Cross Blue Shield of Illinois
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This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

 I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by my employer, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.
 WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program. I understand that if I apply for coverage at a later date all the rules of late enrollment will apply.

REQUEST FOR COVERAGE (VOLUNTARY TELADOC)

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

 I APPLY FOR THE GROUP BENEFITS indicated above and, I authorize deductions from my pay for any required contributions.
 WAIVER OF COVERAGE: I do NOT want to enroll myself in the Voluntary Teladoc Program.

REQUEST FOR COVERAGE (VOLUNTARY DENTAL)	Met Life
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Select Coverage. Confirm the options available to you by reviewing your benefit plan description or checking with your employer. Note: Except for COBRA continuance, dependent coverage may be elected only if employee coverage is elected.

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

 I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by my employer, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex.
 WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program. I understand that if I apply for coverage at a later date all the rules of late enrollment will apply.

REQUEST FOR COVERAGE (VOLUNTARY VISION)	Met Life
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This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

 I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved I authorize deductions from my pay for any required contributions.
 WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program.

Please read, sign, and date the following Authorization & Acknowledgement

- I have read and understand the information provided in the summary of benefits and other enrollment materials.
- On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law.
- Are you declining any coverage due to coverage in another plan? Yes No
 - If yes, is the other coverage COBRA? Yes No
 - Other (Please Explain) _____

To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.

Employee's Signature	Date:
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EMPLOYER: RETAIN ORIGINAL FOR YOUR FILE



RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

Egyptian Area Schools Employee Benefit Trust

CHANGE ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION –

EMPLOYER MUST COMPLETE THIS SECTION. Unsigned or Incomplete forms will be returned and may delay enrollment.

Employer Name	Group Number	Date of Hire	Effective Date of Change
Certified by (Authorized Representative)	Date	Employer Telephone	
Special Instructions:			

ENROLLMENT CHANGE SECTION Effective Date of Change _____ / _____ / _____ (indicate changes below)

EMPLOYEE INFORMATION – EMPLOYEE MUST COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)

Employee Name	Last	First	MI	Sex	Date of Birth	Social Security Number
				<input type="checkbox"/> M <input type="checkbox"/> F		

Employee Name From: _____ To: _____

Employee Address From: _____ To: _____

Employee Phone From: _____ To: _____

Employee Email From: _____ To: _____

Marital Status From: Single Married Civil Union Divorced. To: Single Married Civil Union Termination Divorced

<input type="checkbox"/> Termination Choose Reason	<input type="checkbox"/> Dependent Status (When adding or terminating a dependent you must complete Dependent Section on the reverse side.)
<input type="checkbox"/> Active <input type="checkbox"/> Reduction In Hours <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Lay Off <input type="checkbox"/> Medicare Entitlement <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Retired <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Add Dependent(s) Reason for Addition: <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible Dependent <input type="checkbox"/> Other _____
<input type="checkbox"/> Terminate Dependent(s) Reason for Termination: <input type="checkbox"/> Ineligible Child <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Death <input type="checkbox"/> Other _____	

You must enter a reason for termination in order to be offered the appropriate extension of coverage as dictated by COBRA Federal Law.

EMPLOYEES: You must check one box in each column below:

Medical Changes to health plan coverage may only be made during annual open enrollment period or within 31 days of a qualifying event. Instruction: Enter the Plan Name/Coverage Type in which you are selecting to enroll or change. Only populate if you are changing your medical plan option or coverage type. Check "No Change Medical" if no medical changes are being made. Enter Plan Name Here: _____	Voluntary Teladoc <input type="checkbox"/> Employee Only <input type="checkbox"/> Terminate <input type="checkbox"/> No Change	Voluntary Dental Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event. TO: <input type="checkbox"/> High <input type="checkbox"/> Low	Voluntary Vision Changes to voluntary vision plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event. TO: _____
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Terminate Medical <input type="checkbox"/> No Change Medical	<input type="checkbox"/> Employee Only <input type="checkbox"/> Terminate <input type="checkbox"/> No Change	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Dental <input type="checkbox"/> No Change Dental	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Vision <input type="checkbox"/> No Change Vision

Basic Life – All life insurance terminates upon employment termination or retirement. <input type="checkbox"/> Add Basic Life (Only available when employee is newly eligible.) <input type="checkbox"/> Term Basic Life <input type="checkbox"/> No Change	Optional Life – Changes in Optional Life coverage must be submitted using the BCBS Evidence of Insurability form unless you are terminating coverage. Form can be found at www.egtrust.org . EMPLOYEES: Check all boxes that apply: <input type="checkbox"/> Add Optional Employee (Evidence of Insurability REQUIRED) <input type="checkbox"/> Add Optional Spouse (Evidence of Insurability REQUIRED) <input type="checkbox"/> Add Optional Dependent (Evidence of Insurability REQUIRED) <input type="checkbox"/> No Change Optional Life	<input type="checkbox"/> Terminate Optional Employee <input type="checkbox"/> Terminate Optional Spouse <input type="checkbox"/> Terminate Optional Dependent
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DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number	You must check one box in each line below for each dependent listed.			
					Medical	Dental	Vision	
1.					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
2.				- -	<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
3.				- -	<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
4.				- -	<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
5.					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline
					<input type="checkbox"/> Add	<input type="checkbox"/> Term	<input type="checkbox"/> No Change	<input type="checkbox"/> Decline

BASIC LIFE – CHANGE Beneficiary Information

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number.
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's ID No.
Street Address			City	State	Zip

OPTIONAL LIFE – CHANGE Beneficiary

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Primary Beneficiary's Social Security Number.
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	DOB	Contingent Beneficiary's Social Security Number.
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

OTHER INSURANCE COVERAGE

Are you or any of your dependents covered by another group, medical, vision, or dental plan? Yes No
 If yes, type(s) of coverage: Medical Vision Dental

Name of individual with other coverage: _____ Name of insurance carrier or TPA: _____ Group No. _____

Name of employer providing coverage: _____ Address: _____

Is other coverage Medicare or Medicaid? Yes No
 Effective Date _____ Phone: _____ Effective Date of other coverage: _____

ADDITIONAL CHANGES – Please add any comments concerning your changes.

Please read, sign, and date the following Authorization & Acknowledgement

- I have read and understand the information provided in the summary of benefits and other enrollment materials.
- On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law.
- Are you declining any coverage due to coverage in another plan? Yes No
 If yes, is the other coverage COBRA? Yes No Other (Please Explain) _____

To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.

Employee's Signature	Date:
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