

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST



TO: NEWLY ELIGIBLE EMPLOYEES

RE: ENROLLMENT OPPORTUNITY

On behalf of the Egyptian Trust we wish to welcome you as a newly eligible employee. The Egyptian Trust, founded in 1984, has continued to provide excellent health insurance coverage and other insurance options to school district employees every year since. Currently the Egyptian Trust serves in excess of 180 school districts and more than 10,000 employees in those districts.

We understand that enrolling in a new insurance plan can sometimes be confusing and intimidating for some. **As with any insurance options, there are enrollment requirements and specific enrollment periods that must be adhered to. Typically, you must enroll within 31 days of your first date of active employment or the date you are first eligible in order to take advantage of the offerings and maximize the benefits available to you.** Therefore, we are enclosing some information that we think will be helpful to you as you consider the choices available to you. Included in this packet is the following information:

Health Plan(s) – Summary of Benefits and associated monthly premium for the Platinum, Gold, Silver, and Bronze Health Plans. Check with your employer for which of the plans are being offered to you and if your employer is contributing to the cost of your health insurance. If you have questions about the benefits you may contact your District Office or:

Meritain Health Customer Service Department
(800) 844-7979

Each of the Health Plans offer the HealthLink Open Access III network to provide discounted services when using a participating provider (Tier 1 or Tier 2). When using a Tier 1 or Tier 2 provider, your calendar year deductible and out of pocket maximum are reduced and the reimbursement percentage is increased. Included is an informational brochure from Healthlink explaining how to use their web site to find participating (Tier I and Tier II) doctors and hospitals in your area. If you have questions about whether your current providers participate in the network or how to find a participating provider you may contact:

HealthLink
(800)624-2358
www.healthlink.com

Beginning September 1, 2011 – When you enroll in any of the Health Plans, you will gain access to the Consult A Doctor program. This program affords you access to a medical doctor 24/7. When you enroll in one of the Health Plans you will receive a member packet from Consult A Doctor.

Dental Plan(s) – Summary of Benefits and associated monthly premium for both the Low and the High Plan options. If you have questions about the benefits you may contact your District Office or:

Delta Dental Customer Service Department
(800) 323-1743

Life Insurance – When you enroll in any of the Health Plans, included is a \$10,000 basic term life insurance. Employees under age 60 also have the opportunity to purchase up to \$75,000 additional term life insurance on a guaranteed issue basis. Guaranteed issue means that you cannot be turned down for this coverage. You also have the opportunity to purchase up to half of the coverage you select for yourself for your spouse, with \$25,000 of that on a guaranteed issue basis. A brochure containing the age rated tables and requirements is included. If you have questions about the benefits you may contact your District Office.

Vision Plan – Summary of Benefits and associated monthly premium for the voluntary vision insurance. If you have questions about the benefits you may contact your District Office or:

UniView Vision Customer Service Department
(888) 884-8428

The answers to many questions you may have can also be found on the Egyptian Trust web site at www.egtrust.org. When you are ready to enroll please retrieve a copy of the enrollment form at www.egtrust.org by clicking on “Administrative Forms” and then “Enrollment Form – All Products”. Be sure to take this completed form to your District Office to finalize enrollment. If you have questions that remain unanswered after visiting the web site, you may contact Leo Hefner at lhfnr@htc.net or 618-973-8221, or Tom Dahncke at tdahncke@charter.net or 618-791-5541.



ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION (Employer Representative – Unsigned or incomplete forms will be returned and may delay enrollment)

(For Employer Use Only)- Employers retain a copy for your records.
Confirmation No. _____

Employer Name	Group Number	Department Number	Certified Staff <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date / /
Enrollment Event: <input type="checkbox"/> Open Enrollment- Applies to medical plan only <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Change in Family Status Reason _____		<input type="checkbox"/> Annual Enrollment- Applies to dental plan only <input type="checkbox"/> Late Enrollment		Employee Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other

Will Employee be Medicare Eligible at Age 65? Yes No

Certified by (Authorized Representative) _____ Date / / Employer Telephone () -

Employers please indicate which Health Plan options your district offers:

Platinum Gold Silver Bronze All Plans

Enter information at www.meritain.com or Mail to: MERITAIN HEALTH
300 CORPORATE PARKWAY
AMHERST, NEW YORK 14226

EMPLOYEE INFORMATION: COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)
Submit a copy of Certificate of Creditable Coverage with this form. Please check if no prior coverage.

Employee Name Last First MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Social Security Number - -
Employee Home Address Street/Apt. City State Zip + four County	Home Phone () -		Business Phone () -	
Mailing Address if Different From Home Address	Occupation: _____	Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually		
	Average Hours Worked per Week: _____			

EMPLOYEES: You must check one box in each section below. **EMPLOYEES: Check all boxes that apply:**

Medical Plan Includes Rx Coverage <input type="checkbox"/> Platinum <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Bronze	Voluntary Dental Plan <input type="checkbox"/> High <input type="checkbox"/> Low	Vision	Basic Life (Basic Life is automatic when enrolling in Health Plan) <input type="checkbox"/> Basic Life <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	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Deps <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Deps <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Optional Employee Life Volume _____ * Amounts over \$75,000 require completion of Evidence of Insurability Form <input type="checkbox"/> Optional Spouse Life Volume _____ * Limited to 50% of Emp Life – Amounts over \$25,000 require completion of Evidence of Insurability Form <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000 * Covers all eligible children <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 for coverage.)	Full-Time Student? (Y or N)	You must mark the coverage chosen or decline coverage for each dependent listed.
1.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
2.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
3.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
4.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
5.			/ /	- -		<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline
6.			/ /	- -		<input type="checkbox"/> Health <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 _____

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)				Lincoln Financial Group P.O. Box 2616, Omaha NE 68103-2616 (800) 423-2765 fax: (877) 573-6177		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE BASIC GROUP LIFE BENEFITS indicated above and, if my application is approved by Lincoln Financial Group, 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"/> "I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS indicated above and, if my application is approved by Lincoln Financial Group, 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"/> "WAIVER OF 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"/> "WAIVER OF 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"/> "WAIVER OF 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 Lincoln Financial Group, and the initial premium is paid to Lincoln Financial Group. 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 (HEALTH PLAN)				Administered by Meritain Health		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by Egyptian Area Schools Employee Benefit Trust, 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"/> "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 DENTAL)				Delta Dental of Illinois Group Number 20204		
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:						
<input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by Delta Dental of Illinois, 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"/> "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)				Administered by UniView		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by UniView, I authorize deductions from my pay for any required contributions.						
<input type="checkbox"/> "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	
<ul style="list-style-type: none"> • 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the other coverage COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2011

DESCRIPTION OF SERVICES	PLATINUM				GOLD				SILVER				BRONZE <small>All charges except charges for preventive care are subject to the Calendar Year Deductible. Calendar Year Deductible must be satisfied before Copays apply.</small>			
	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS
DEDUCTIBLE																
INDIVIDUAL	\$400	\$600	\$600	\$600	\$600	\$900	\$900	\$900	\$1,100	\$1,600	\$1,600	\$1,600	\$1,200	\$1,600	\$1,600	\$1,600
FAMILY	\$1,200	\$1,800	\$1,800	\$1,800	\$1,800	\$2,700	\$2,700	\$2,700	\$3,300	\$4,800	\$4,800	\$4,800	\$2,400	\$3,200	\$3,200	\$3,200
OUT OF POCKET MAXIMUM																
INDIVIDUAL	\$1,200	\$1,800	\$3,300	None	\$1,300	\$1,900	\$3,500	None	\$2,300	\$3,300	\$5,800	None	\$3,600	\$4,800	\$5,950	None
FAMILY	\$2,400	\$3,600	\$6,600	None	\$3,900	\$5,700	\$10,500	None	\$6,900	\$9,900	\$17,400	None	\$7,200	\$9,600	\$11,900	None
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
WELLNESS BENEFIT*	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
INPATIENT HOSPITAL (ILLNESS OR INJURY)	\$250 Copay Then 90%	\$250 Copay Then 85%	\$550 Copay Then 70%	\$550 Copay Then 60%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 80%	\$250 Copay Then 75%	\$550 Copay Then 60%	\$550 Copay Then 50%	\$250 Copay Then 80%	\$250 Copay Then 75%	\$550 Copay Then 60%	\$550 copay Then 50%
OUTPATIENT SURGERY	\$250 Copay Then 90%	\$250 Copay Then 85%	\$550 Copay Then 70%	\$550 Copay Then 60%	\$250 Copay Then 85%	\$250 Copay Then 80%	\$550 Copay Then 65%	\$550 Copay Then 55%	\$250 Copay Then 80%	\$250 Copay Then 75%	\$550 Copay Then 60%	\$550 Copay Then 50%	\$250 Copay Then 80%	\$250 Copay Then 75%	\$550 Copay Then 60%	\$550 copay Then 50%
DR OFFICE VISIT BY PRIMARY CARE PHYSICIAN	\$25 Copay Then 100%	\$25 Copay Then 100%	70%	60%	\$25 Copay Then 100%	\$25 Copay Then 100%	65%	55%	\$25 Copay Then 100%	\$25 Copay Then 100%	60%	50%	\$25 Copay Then 80%	\$25 Copay Then 75%	60%	50%
DR OFFICE VISIT BY SPECIALIST	\$40 Copay Then 100%	\$40 Copay Then 100%	70%	60%	\$40 Copay Then 100%	\$40 Copay Then 100%	65%	55%	\$40 Copay Then 100%	\$40 Copay Then 100%	60%	50%	\$40 Copay Then 80%	\$40 Copay Then 75%	60%	50%
EMERGENCY ROOM	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 85% No deductible	\$300 Copay Then 80% No deductible	\$300 Copay Then 80% No deductible	\$300 Copay Then 80% No deductible	\$300 Copay Then 80% No deductible
URGENT CARE FACILITY	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 90% No deductible	\$40 Copay Then 80% No deductible	\$40 Copay Then 80% No deductible	\$40 Copay Then 80% No deductible	\$40 Copay Then 80% No deductible
DRUG CARD Effective January 1, 2011	Retail 30 days	MDN Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Retail 30 days	MDN Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Retail 30 days	MDN Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Retail 30 days	MDN Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Retail 30 days	MDN Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Home Delivery up to 90 days
GENERIC	\$12	\$36	\$30	\$12	\$36	\$30	\$12	\$36	\$30	\$12	\$36	\$30	\$12	\$36	\$30	\$30
FORMULARY	\$25	\$85	\$55	\$25	\$85	\$55	\$25	\$85	\$55	\$30	\$85	\$70	\$30	\$85	\$70	\$70
NON-FORMULARY	\$40	\$130	\$100	\$40	\$130	\$100	\$45	\$130	\$110	\$45	\$130	\$110	\$45	\$130	\$110	\$110
RATES (Includes \$10,000 Basic Life)																
Employee Only			\$632				\$571				\$493				\$420	
Employee + Spouse			\$1,305				\$1,178				\$1,022				\$864	
Employee+child or children			\$1,260				\$1,136				\$985				\$848	
Family			\$1,405				\$1,266				\$1,100				\$933	

Note:

All charges are subject to the calendar year deductible unless otherwise specified.
 Inpatient Hospital and Outpatient Surgery copays are limited to 3 copays in any calendar year and do not count toward deductible or out of pocket maximum.
 *WELLNESS BENEFIT refers to routine diagnostic lab & x-ray wellness charges. For a complete list of Wellness Benefits, refer to the Schedule of Benefits.

BRONZE PLAN:

The Bronze Plan is a High Deductible Health Plan (HDHP), designed to qualify for use with a Health Savings Account (HSA). All benefits except benefits for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. Under the HDHP, all eligible charges are subject to the Calendar Year Deductible. If you are enrolled for Individual health coverage, you must pay 100% of the discounted charge for each covered service until you satisfy the Individual Calendar Year Deductible. If you are enrolled for Employee + Spouse, Employee + Child(ren) or Employee + Family health coverage, you must pay 100% of the discounted charge until your covered family members satisfy the Family Calendar Year Deductible. After you satisfy the applicable Calendar Year Deductible, you will pay the copayments shown in the following table until your out of pocket expenses satisfy the appropriate Calendar Year Out of Pocket Maximum. The Plan will then pay 100% of the cost of your covered charges for the remainder of the year.

ABOUT HEALTH SAVINGS ACCOUNTS:

- Rules require first dollar payment by the covered individual except for wellness benefit.
- Those with individual coverage must pay the full discounted cost of prescriptions (except those considered preventive) and health care services (except wellness benefits) until the individual deductible is met, then the copays and coinsurance will apply.
- Those with more than individual coverage must pay the full discounted cost of prescriptions (except those prescriptions considered preventive) and health care services (other than wellness benefits) until the family deductible is met, then the copays will apply. All covered costs by the family members covered will count collectively towards the family deductible and the family maximum out of pocket. If one family member reaches the individual maximum out of pocket costs the plan will pay 100% of the health care costs for that individual.
- Individual Deductible in Tier 1 and Maximum Out of Pocket for Tiers 1-4 will be adjusted January 1 each year as per the IRS rules.
- Individual Deductible in Tiers 2-4 will always be \$400 more than Tier 1.
- Family Deductible will be 2 times the Individual Deductible in Tiers 1-4.



INTRODUCING A NEW BENEFIT BEGINNING SEPTEMBER 1, 2011! 24/7 PHYSICIAN CONSULTATIONS

Welcome to Consult A Doctor!

The Egyptian Trust has partnered with Consult A Doctor to provide you with a truly revolutionary healthcare benefit. You and your family can now **consult with a physician 24/7 via telephone or secure e-mail.**

What is Consult A Doctor?

You can call or e-mail a doctor at *anytime*, from *anywhere*. Consult A Doctor's services can be used in a variety of ways:

- ✓ Free around-the-clock physician care
- ✓ Request prescriptions¹ or get refills

Why Use Consult A Doctor?

You can call or e-mail a doctor at *anytime*, from *anywhere*. Consult A Doctor's services can be used in a variety of ways:

- ✓ On-demand healthcare – Wherever and whenever you need, as often as you need.
- ✓ Save money – Costs less than going to your doctor or an ER.
- ✓ Save time - Avoid waiting for an appointment or sitting in the doctor's office.

When to Use Consult A Doctor

- Cold/Flu
 - Allergies
 - Sinus infections
 - Bronchitis
 - Headaches/Migraines
 - Stomach ache/Diarrhea
 - Respiratory Infections
 - Urinary Tract Infections
 - Prescription Refills¹
- ...and many other conditions

How much will Consult A Doctor Cost You?

Your enrollment in one of the Egyptian Trust Health Plans entitles you to **free and unlimited** access to all of Consult A Doctor's services.

Here's a breakdown of the services:

- ✓ **On Call Consultation** (talk to a doctor immediately for general advice and questions)
- ✓ **E-Consult** (e-mail a doctor for general advice and questions)
- ✓ **By Appointment Consultation** (schedule a time to talk to a doctor, request prescription medication¹)
- ✓ **Priority Consultation** (talk to a doctor within 1-3 hours, request prescription medication¹)
- ✓ **Personal Health Manager** (online health portal)

This great new benefit is available to you beginning September 1, 2011. You can consult with a doctor by calling **1-800-DOC-CONSULT (800-362-2667)** or by going online to www.MyDrConsult.com.

Best of Health!

Egyptian Area Schools Employee Benefit Trust



4 GREAT WAYS TO CONSULT BY PHONE or ONLINE



BY PHONE

1. **On Call:** Connect with a doctor immediately - Just pick up the phone, dial the toll free number and get connected to a doctor within minutes. The On Call Service should be used when you are seeking information on medical conditions, want advice or recommendations for common conditions. (Does not require a completed medical assessment.)

CONSULT WITH A DOCTOR BY PHONE IMMEDIATELY!

Dial 1-800-DOC-CONSULT (800-362-2667)

Step 1: Select "On Call" Consultation

Step 2: Enter your Member ID

Step 3: Enter your Date of Birth

Connect to a licensed U.S. Physician

2. **Priority:** A Doctor will call you back within 3 hours - Get diagnosis and treatment, potentially including prescription medication¹. (Requires a completed Medical Assessment form prior to consult.)
3. **By Appointment:** Set a time to talk to a doctor - Get diagnosis and treatment, potentially including prescription medication¹. (Requires a completed Medical Assessment form prior to consult.)

CONSULT ONLINE

www.MyDrConsult.com



4. **E-Consult:** E-mail your questions to a doctor via our secure messaging system and receive your response usually within 2-3 hours and guaranteed within 24 hours. The E-Consult Service should be used when you are seeking information on medical conditions, want advice or recommendations for common conditions. (Does not require a completed medical assessment.)

How to complete your Medical Assessment

In order for our physicians to perform either a By Appointment or Priority Tele-Consult, you are required to complete a Medical Assessment form. The Medical Assessment form allows you to document any existing conditions, drug allergies, family medical history, and anything that your doctor should know about your health. You can choose to fill out your Medical Assessment online or over the phone.

Complete your Medical Assessment online

- Visit www.MyDrConsult.com
- Create your Username and Password
- Click on "My Health Records"
- Update your medical information

Complete your Medical Assessment by phone

- Call 1-800-DOC-CONSULT (800-362-2667)
- Press "0" and get connected to Member Services
- Ask to have your Medical Assessment completed by phone
- Answer questions about your medical and family history

¹There is no guarantee that you will be prescribed medication. Consult A Doctor physicians do not prescribe controlled medications. Consult A Doctor is not insurance. During a By Appointment and Priority Consultation you will be speaking with a physician licensed in your state. Members that consult frequently, there is no guarantee that you will consult with the same physician every time.

HealthLink Customized Directories Available On-Line!

Find the results you need by searching HealthLink networks of participating physicians, hospitals and other health care professionals. Create a customized directory that you can instantly print or save to your computer in an easy-to-read PDF file.

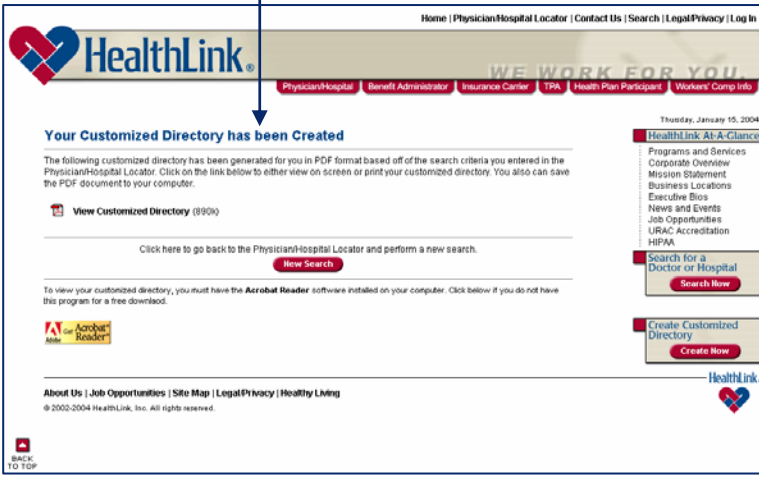
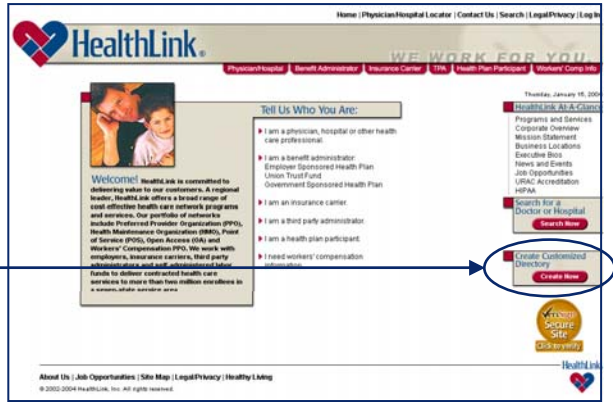
Here's how it works:

1 Log onto HealthLink's web site at www.healthlink.com. Click on the "Create Customized Directory" button to your right.

2 Enter your search criteria by following the Physician/Hospital Locator steps. Click on the "Search" button to obtain your results.

3 Once your results are listed, you are able to create a customized directory by clicking on the "Create Customized Directory" button.

4 A PDF file is generated and you are able to print or save the file instantly to your computer.



Customized Directories in an Easy-to-Read Format!



EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
VOLUNTARY
DENTAL PLAN DESCRIPTION

As of September 1, 2010

Effective September 1, 2010 Delta Dental of Illinois will become the carrier for the Voluntary Dental Plan. You can continue to visit any dentist without a change in benefits. However, you can realize significant savings by choosing a Delta Dental Network Provider. Please visit www.deltadentalil.com.

Dental Coverage	Low Plan	High Plan
Calendar Year Deductible		
Per Individual	\$50	\$50
Per Family	\$150	\$150
Waived for Preventive Services?	Yes	Yes
Percentage Payable (of covered charges)		
Preventive Services (<i>such as oral exams, routine teeth cleaning, fluoride treatments, x-rays</i>)	80%	100%
Basic Services (<i>such as simple extractions, basic fillings, repair of bridges & dentures, recementing crowns & bridges, surgical extractions, general anesthesia & intravenous sedation, endodontics, periodontics</i>)	70%	80%
Major Services (<i>such as crowns, implants, bridges, dentures</i>)	Not Covered	50%
Calendar Year Maximum	\$750	\$1500
Dependent Child Orthodontia	Not Covered	Children Only Covered
Calendar Year Deductible		\$0/\$0
Percentage Payable (of covered charges)		50%
Lifetime Maximum		\$1000

Rates Effective September 1, 2010 through August 31, 2012

RATES

COVERAGE TYPE	HIGH PLAN	COVERAGE TYPE	LOW PLAN
Emp. Only	\$27.94	Emp. Only	\$11.80
Emp. + 1 Dependent	\$51.16	Emp. + 1 Dependent	\$21.44
Emp. + 2 or more Dependents	\$74.26	Emp. + 2 or more Dependents	\$40.38

Egyptian Area Schools Employee Benefit Trust Term Life Insurance Program



Ask yourself this question: If I were to die prematurely, would my basic life insurance be enough to provide for my dependents? To pay for the mortgage — the car payments — my children's educations?

In addition to the Basic Life/AD&D insurance that is part of your Egyptian Trust benefit plan, all full-time employees regularly working 10 hours or more per week on a regular basis will have the option to purchase *Term Life and Accidental Death & Dismemberment (AD&D) Insurance* at competitive group rates. This coverage is provided by Jefferson Pilot Financial Insurance Company, a Lincoln Financial Group affiliate. With \$171 billion in consolidated assets*, Lincoln Financial Group has a stellar reputation for financial strength and stability. Here are some program highlights:

- You can purchase optional life insurance in the following options:
OPTION 1: \$10,000 OPTION 2: \$25,000
OPTION 3: \$50,000 OPTION 4: \$75,000
OPTION 5: \$100,000 but less than \$500,000 (not to exceed 5 times your salary) in increments of \$10,000. You must provide Evidence of Insurability in order to choose an amount in OPTION 5.
- Premiums are conveniently deducted from your paycheck.
- You can also purchase optional life insurance for your spouse and children when you participate in the optional life insurance plan. A spouse will have the option of up to 50% of the covered employee's approved amount in \$5,000 increments. Your spouse must provide Evidence of Insurability for amounts over \$25,000.
- Portability - you may be able to take your coverage with you if you leave the District. Your premiums will increase under the Portability provision.
- All coverage terminates at retirement. At that time, coverage can be converted to an individual policy but not ported.
- Should you become totally disabled for at least six consecutive months prior to age 60, your premium is waived during your disability until age 65 if proof satisfactory to us is submitted.
- Accelerated Death Benefit - You can collect up to 75% of your death benefit (to a maximum of \$250,000) if you become terminally ill with a life expectancy of 12 months or less. You must satisfy actively-at-work requirements and must be insured under this policy for 12 months.
- AD&D equals the life insurance benefit or a percentage of that for dismemberment. AD&D benefits are not payable for any loss to which a contributing cause is any of the following: intentional self-inflicted injury; a disease or the medical treatment of it; participation in a riot or while committing a felony; military service; war or any act of war; use of drugs, except as prescribed by a doctor; voluntary inhalation of gas; travel in any aircraft, except as a fare-paying passenger on a regularly scheduled flight; or driving while intoxicated.

In order to provide you with all the information you need when considering your life insurance needs, we have arranged for these informational packets to be provided to each employee.



* As of September 30, 2006. Liabilities for the same period were \$159 billion.

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

Optional Group Life and AD&D: Rate Page Benefit Options and Costs Based on Employee Age

Finding your cost is easy! These tables give you the cost for most age groups and benefit options. Simply find your age group and the amount of coverage you need. We have calculated the deduction for you. Please note that AD&D coverage is not available for children.

Monthly cost shown 12 payments per year

Employee Age Under 25		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$0.85	\$1.28
\$25,000	\$2.13	\$3.19
\$50,000	\$4.25	\$6.38
\$75,000	\$6.38	\$9.56*
\$100,000 + Per \$10,000	\$0.85**	\$1.28**

Employee Age 25 - 29		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$0.95	\$1.43
\$25,000	\$2.38	\$3.56
\$50,000	\$4.75	\$7.13
\$75,000	\$7.13	\$10.69*
\$100,000 + Per \$10,000	\$0.95**	\$1.43**

Employee Age 30 - 34		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$1.05	\$1.58
\$25,000	\$2.63	\$3.94
\$50,000	\$5.25	\$7.88
\$75,000	\$7.88	\$11.81*
\$100,000 + Per \$10,000	\$1.05**	\$1.58**

Employee Age 35 - 39		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$1.35	\$2.03
\$25,000	\$3.38	\$5.06
\$50,000	\$6.75	\$10.13
\$75,000	\$10.13	\$15.19*
\$100,000 + Per \$10,000	\$1.35**	\$2.03**

Employee Age 40 - 44		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$1.95	\$2.93
\$25,000	\$4.88	\$7.31
\$50,000	\$9.75	\$14.63
\$75,000	\$14.63	\$21.94*
\$100,000 + Per \$10,000	\$1.95**	\$2.93**

Employee Age 45 - 49		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$3.05	\$4.58
\$25,000	\$7.63	\$11.44
\$50,000	\$15.25	\$22.88
\$75,000	\$22.88	\$34.32*
\$100,000 + Per \$10,000	\$3.05**	\$4.58**

Employee Age 50 - 54		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$4.95	\$7.43
\$25,000	\$12.38	\$18.56
\$50,000	\$24.75	\$37.13
\$75,000	\$37.13	\$55.69*
\$100,000 + Per \$10,000	\$4.95**	\$7.43**

Employee Age 55 - 59		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$7.95	\$11.93
\$25,000	\$19.88	\$29.81
\$50,000	\$39.75	\$59.63
\$75,000	\$59.63	\$89.44*
\$100,000 + Per \$10,000	\$7.95**	\$11.93**

Employee Age 60 - 64		
Employee Amount	Employee Only	Employee with 50% Spouse
\$10,000	\$9.85	\$14.78*
\$25,000	\$24.63	\$36.94*
\$50,000	\$49.25**	\$73.88*
\$75,000	\$73.88**	\$110.81*
\$100,000 + Per \$10,000	\$9.85**	\$14.78**

Employee Ages 65+***		
Rates per \$10,000 of employee coverage.		
Age	Employee Only	Employee with 50% Spouse
65-69	\$16.85	\$25.28*
70-74	\$27.25	\$40.88
75-79	\$41.85	not available

Child Coverage	
Child Amount	Cost (all children)
\$5,000	\$0.47
\$10,000	\$0.94

* Amounts over guarantee issue will require medical underwriting for the spouse.

** Amounts over guarantee issue will require medical underwriting for the employee (and spouse, if applicable).

*** Age reductions apply.

EMPLOYEE COVERAGE

Eligibility — All active employees working for the district at least 10 hours per week on a regular basis.

Amount of Insurance —

OPTION 1: \$10,000 OPTION 2: \$25,000

OPTION 3: \$50,000 OPTION 4: \$75,000

OPTION 5: \$100,000 but less than \$500,000 (not to exceed 5 times your salary) in increments of \$10,000.

You must provide Evidence of Insurability in order to choose an amount in OPTION 5.

Guarantee Issue:

Employees under 60: \$75,000

Employees 60 - 69: \$25,000

No guarantee issue for employees age 70 and over

Reduction — Life benefits reduce to 65% on the employee's 65th birthday. Further reduction of 50% at age 70.

All coverage terminates at retirement.

SPOUSE COVERAGE

Eligibility — Under age 75, non-confined to home or hospital and performing normal daily activities.

Amounts of Insurance — up to 50% of the employee amount in the following increments:

OPTION 1: \$5,000

OPTION 2: \$12,500

OPTION 3: \$25,000

OPTION 4: \$37,500

OPTION 5: \$50,000 but less than \$250,000 in increments of \$10,000.

You must provide Evidence of Insurability in order to choose an amount in OPTION 4 and 5.

Guaranteed Issue:

Spouses of employees under age 60: \$25,000

Spouses of employees ages 60 - 74: All amounts require evidence

Spouses of employees ages 75+: No coverage available

Reduction — Spouse coverage reduces at the same rate as the employee's.

DEPENDENT CHILD(REN) COVERAGE

Eligibility: A dependent means a person who meets the definition of a dependent of the insured person under the provision of the U.S. Internal Revenue Code; and is an insured person's: Unmarried dependent children age 19 or younger, or up to age 25 if a full-time student performing normal daily activities and not confined to home or hospital.

Amounts of Insurance — \$5,000 or \$10,000

Guaranteed Issue: All amounts are guaranteed issue

IMPORTANT NOTES

Insurance will be delayed for an employee if he/she is not actively employed because of an injury, sickness, temporary layoff or leave of absence on the date that insurance would otherwise be effective. For dependents a delayed effective date applies if they are confined or not able to perform the normal activities of a healthy person of the same age and sex.

Guarantee issue amounts are only available during a designated Term Life open enrollment period or your first 31 days of employment.

A suicide exclusion will apply to any medically underwritten amount or increased amount of insurance during the first two years of coverage.

PLEASE NOTE: If you decline coverage during an open enrollment period or when you are first eligible within the first 31 days of employment, you must submit to medical questions/exams if you wish to become covered at a later time.

STEPS TO ENROLL

1. Read this brochure to learn about your Life and AD&D options.
2. Look at the rate page to determine your monthly cost.
3. Fill out the application.
 - Complete the employee section and check the box that states "I apply for the group benefits."
 - You and your spouse complete Evidence of Insurability form if needed (see below).
 - Sign and date the employee's signature line at the bottom of the page.
 - **Note: You must complete this application even if you do not elect coverage.** Please check the "Waiver of Coverage" box if you do not want to participate.

DO I NEED TO COMPLETE THE EVIDENCE OF INSURABILITY FORM FOR MYSELF OR MY SPOUSE?

- 1) IF THIS IS YOUR OPEN ENROLLMENT PERIOD (INITIAL PROGRAM OFFERING OR YOU ARE A NEW HIRE), COMPLETE THE EVIDENCE OF INSURABILITY FORM FOR YOU AND/OR YOUR SPOUSE IF YOU ARE REQUESTING ANY AMOUNT OVER THE GUARANTEE ISSUE AMOUNT.
- 2) IF THIS IS NOT YOUR OPEN ENROLLMENT PERIOD (YOU HAVE BEEN OFFERED THE PLAN BEFORE) COMPLETE THE EVIDENCE OF INSURABILITY FORM FOR YOU AND/OR YOUR SPOUSE IF YOU WISH TO INCREASE COVERAGE.

Insurance above the Guarantee Issue amount is not effective until the application is approved by Lincoln Financial Group. Both the employee and spouse must complete and sign the E of I form. Delayed effective date may apply.

4. Return the completed application and Evidence of Insurability form (if needed) to the District.

Remember, the completed application must be returned to your District during the designated open enrollment period or within the first 31 days of employment.

**IF YOU NEED ASSISTANCE, PLEASE CONTACT LINCOLN FINANCIAL GROUP AT:
800-423-2765 or www.LFG.com**

Questions and Answers

Q: When will my coverage become effective?

A: The plan effective date will be announced during the enrollment process. However, insurance for a particular individual above the Guarantee Issue amount is not effective until the application is approved by Lincoln Financial Group. Delayed effective date may apply.

Q: Can I delay my decision and enroll for coverage at a later date?

A: If you enroll more than 31 days after you are eligible for coverage, you'll need to satisfy Evidence of Insurability at your own expense.

Q: What is portability?

A: Portability allows you to continue the same (or lower) amount of insurance if you leave your employer. Portability rates are slightly higher and you will need to obtain those rates from Lincoln Financial Group at time of termination. The premiums must be paid quarterly and statements will be mailed directly to your residence. Some restrictions apply to this benefit. You are not eligible if you are terminating employment due to sickness, injury or retirement; however, you may be eligible to convert your policy to an individual policy (conversion benefit). Again, these rates are higher and you will need to obtain the rates from Lincoln Financial Group at time of conversion.

Q: Could coverage be delayed for any reason?

A: If you are not actively at work when coverage begins, your coverage will begin when you resume active, full-time work. If your dependent is disabled, coverage will begin when the person is able to perform the normal activities of a person in good health of the same age and sex.

Q: What happens if I become totally disabled while insured?

A: If the total disability occurs before age 60, life insurance coverage continues, upon our approval, without premium until age 65 while you remain disabled. Waiver of Premium forms must be completed for this benefit.

Q: Can I change the amount of insurance?

A: Your needs may change, so in addition to choosing your coverage amount now, you can change your amount of coverage at any time. You only need to complete an application for the new amount. If you increase the amount you need, you will need to complete the Evidence of Insurability form for yourself and/or your spouse. If you apply for additional insurance, all amounts of insurance that have already been approved by Lincoln Financial Group will be grandfathered.

This brochure is not intended as a complete description of Lincoln Financial Group insurance coverage. The controlling provisions are provided in the policy; and this brochure does not modify those provisions or the insurance in any way.

Group insurance products are underwritten by Jefferson Pilot Financial Insurance Company, a Lincoln Financial Group® company. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. ©2007 Lincoln National Corporation.

THE BENEFITS ARE CLEAR

Taking care of your vision is essential to your overall health and well-being. Having regular eye exams and wearing corrective eyewear can greatly reduce the risk of more serious, long-term diseases — and may even help detect other health conditions.* So be sure to take advantage of your UniView Vision's comprehensive vision benefits — including convenient routine eye exams and quick delivery of eyewear available through our national network of ophthalmologists and optometrists as well as the marquee retailers, LensCraftersSM, Target Optical, JCPenney Optical, Sears Optical and most Pearle Vision locations. Most are open on evenings and weekends, so you can easily arrange an appointment that fits your schedule.



(This is a brief review of benefits. See your Certificate for complete details including frequency exclusions and limitations.)

Locating a Provider

- Go to www.unicare.com
- Click Find a Doctor
- Click UniView Vision

BENEFIT	COPAY/In Network	Out of Network	FREQUENCY
Vision Examination	\$15	\$35	Once every 12 months
Eyeglass Lenses (Standard)			
Single	\$15	\$25	Once every 12 months
Bifocal	\$15	\$40	
Trifocal	\$15	\$55	
Progressive	\$80	\$40	
Frames	No copay; up to \$130 retail value	\$45	Once every 24 months
Contact Lenses			
Elective conventional or disposable contact lenses (in lieu of frame & lens benefit)	No copay; up to \$130 retail value	\$105	Once every 12 months
Non-Elective – contact lenses prescribed for reasons that are not cosmetic in nature.	No copay	\$210	

YOU CAN SEE THE SAVINGS

While you're using – and even after you've exhausted – your in-network vision benefits, UniView Vision offers you additional savings. You'll save 15-40% on extra pairs of eyewear, a number of non-prescription sunglasses and other popular accessories. And there is no limit to the number of purchases you can make using this great savings opportunity.

Extra Pair of Eyeglasses	40% off retail
Conventional Contact Lenses	15% off retail (applied to materials only)
Eyewear Accessories	20% off retail

(The additional savings program may change at any time.)

EASY-TO-USE-BENEFITS

Simply present your vision I.D. card every time you go to an eye care provider. Just follow these steps:

- Choose a UniView network eye care provider
- Make an appointment
- Pay your copayment at the time of your office visit

Your network eye care provider will verify eligibility and handle all of the necessary paperwork.

Out-of-Network Claims Address:

UniView Vision, Attn: OON Claims, P.O. Box 8504, Mason, OH, 45070-7111

COVERAGE	RATE
Employee	\$6.64
Employee + One	\$9.50
Employee + Family	\$17.20

Please call UniView® Vision at (888) 884-8428 if you have any questions about your vision benefits or need to locate a network provider.

* NAHU Health Insurance Underwriters UniCare Life & Health Insurance Company, Tel. (877) UNICARE www.unicare.com © Registered Mark and SM Service Mark of We llPoint, Inc. © 2006 WellPoint, Inc. Insurance provided or benefits administered by UniCare Life & Health Insurance Company, which is a separately formed and capitalized subsidiary of WellPoint, Inc., an Indiana corporation, and is a part of the WellPoint, Inc. family of companies