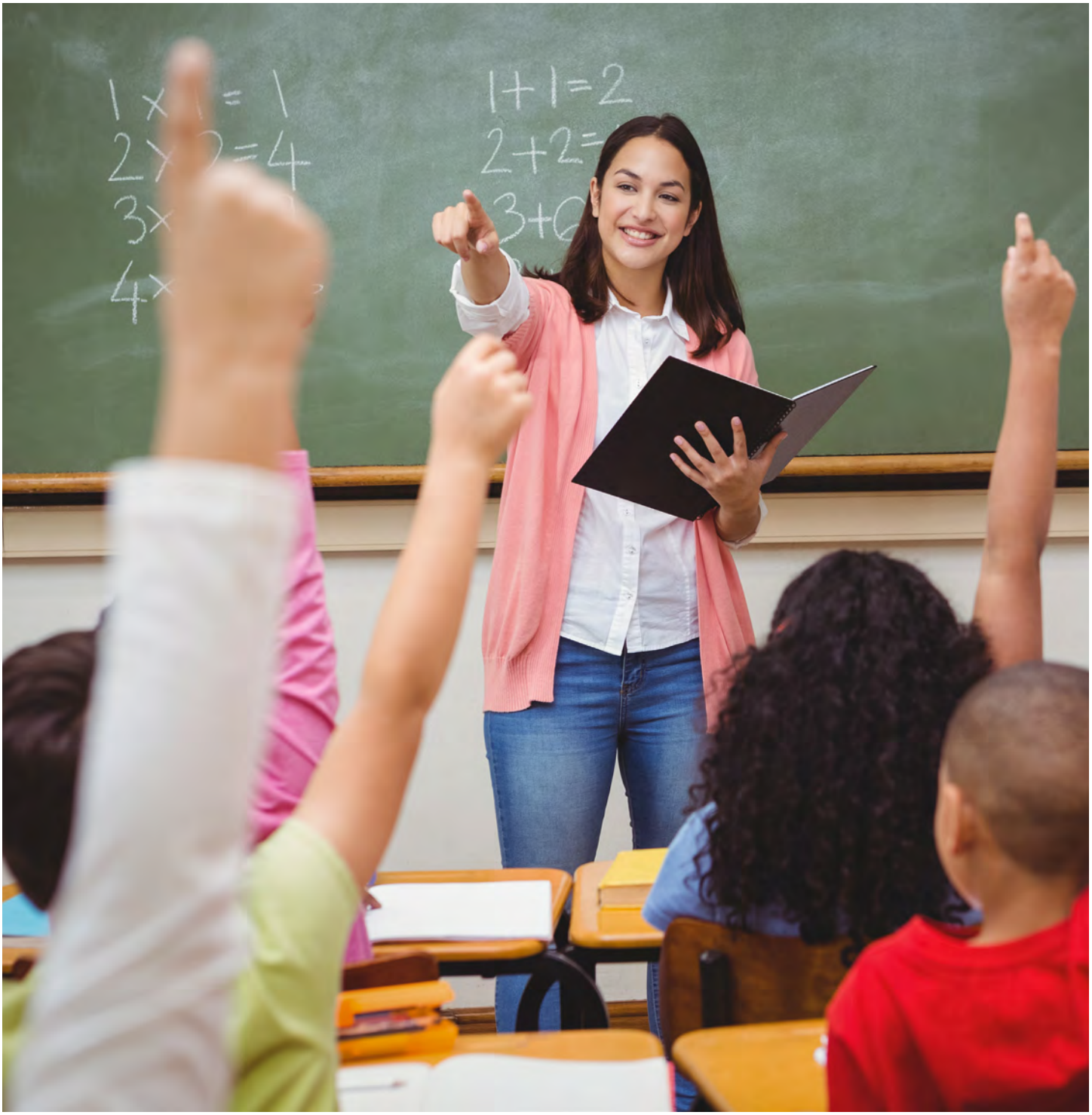

Egyptian Area Schools with Care Coordinators by Quantum Health

2016–2017 Benefits Enrollment Guide

EGYPTIAN AREA SCHOOLS | CARE COORDINATORS BY QUANTUM HEALTH

Dear Member,

Egyptian Area Schools Employee Benefit Trust genuinely cares about your well being. That is why your health benefits plan includes Care Coordinators by Quantum Health, a program to help you manage your health and get the most out of your benefits.

This benefits guide contains an overview of the benefits available to you through Egyptian Area Schools. You'll find information about Care Coordinators by Quantum Health, the Teladoc program, health plan options, and more!

As a reminder:

+ For those enrolled in an Egyptian Area Schools health plan, don't forget to complete your wellness initiatives by September 30, 2016 in order to reduce your 2017 out-of-pocket expenses.
+ Did you complete the requirements in 2015? If so, and you are currently receiving the credit, you will also receive the credit for 2017 and do not need to repeat the requirements this year.

Open Enrollment—What You Need To Do

If you are a new employee and wish to enroll, complete the Enrollment Form (located at the back of this document) and return it to your District Office to complete the enrollment process. You may obtain additional Enrollment Forms from your District Office or at www.egtrust.org.

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 wish to make changes to your current coverage or plan elections, complete the Change Enrollment Form (located at the back of this document) and return it to your District Office to complete the enrollment process. You may obtain additional Change Enrollment Forms from your District Office or at www.egtrust.org.

Please read this benefit guide carefully so you can choose the plans that best meet the needs of you and your family, and be sure to keep it on hand to reference throughout the year.

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

Note: Some districts do not offer all health plan options and all voluntary plans described in this booklet. Please contact your employer for the specific plans and premiums offered in your District.

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MEET YOUR CARE COORDINATORS

Your health benefits experts

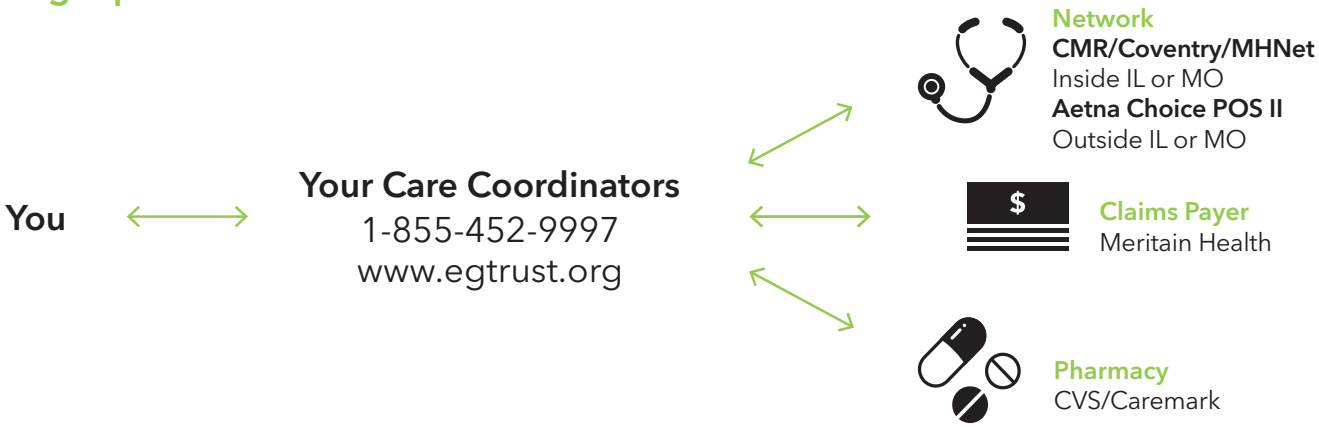


With Care Coordinators by Quantum Health, you have an expert team of nurses, patient services representatives and benefits specialists who are ready to help you before, during and after any health event. Think of Care Coordinators as your personal healthcare team—they fight hard to help you save money and make sure you get the best possible care for you and your family.

Turn to your Care Coordinators for help with:

+ ID cards
+ Claims, billing and benefit questions
+ Finding in-network providers
+ Nurse support to help you stay or get healthy
+ Reducing out-of-pocket costs
+ Anything that can make the healthcare process easier for you

A single point of contact for healthcare



Egyptian Area Schools partners with Care Coordinators by Quantum Health to help you and your family get the most out of your benefits while simplifying the healthcare process.

Your Wellness Initiative: Be Healthy and Save Money

EGYPTIAN AREA SCHOOLS | CARE COORDINATORS BY QUANTUM HEALTH

Saving money on your health plan has never been easier with the Egyptian Area Schools Wellness Initiative. To earn your incentive, go to www.egtrust.org and click the Care Coordinators by Quantum Health logo (pictured above, to the right). Then, under Health & Wellness, click "Your Incentive Checklist," log on or register, and follow the instructions to complete the requirements (listed below). All results must be reported to Care Coordinators by September 30, 2016.

Once completed, if you are in a non-HDHP plan, the employee deductible will decrease by $100. If you have a family plan, each family member's deductible will be reduced by $100 (but with a limit of up to $300). If you're in the HDHP, the employee and all other family members will pay 10% less after you meet the deductible (the co-insurance level paid by the plan will increase by 10% for everyone on the plan).

In order to be eligible for the incentive, participation is required by Egyptian Area Schools employees only. (This includes retired employees and individuals covered by COBRA.) Dependents do not need to complete the requirements.

Complete the following requirements to earn your incentive in 2017:

If you completed the wellness requirements in 2015 and earned the 2016 incentive, no action is required to complete the program this year. Your 2017 incentive will be applied automatically.

+ **Designate a Primary Doctor.**
+ **Enter your biometrics results online.**

  Your biometrics screening results include height, weight, blood pressure, total cholesterol, LDL, HDL, triglycerides and glucose.

  If you've already visited your Primary Doctor, your biometrics screening results must have been obtained between October 1, 2014 and September 30, 2016.

  There are several ways to obtain your biometrics results:

  - Visit your Primary Doctor. The screening must occur between October 1, 2014 and September 30, 2016. Please be sure to enter biometric results on the incentive checklist by the September 30, 2016 deadline.
  - Contact your school to see if they are hosting an onsite screening. If so, please be sure to enter biometric results on the incentive checklist by the September 30, 2016 deadline.
  - Visit your local county health department for a biometric screening. Though your local county health department is likely out of network, Egyptian Area Schools provides a benefit up to $75 at 100% for this screening.

+ **Complete your Wellness Assessment (HRA) online.**

Note: Care Coordinators by Quantum Health keeps your health information confidential and does not share it with Egyptian Area Schools or your employer.

Your Preferred Provider Network

In-network helps keep money in your pocket

Your preferred provider network arrangement offers you broad access in all states. Access to a broader network means you and your family will have more network providers to choose from. You have access to the CMR/Coventry/MHNet network for services in Illinois or Missouri. You have access to Aetna Choice POS II for services outside of Illinois or Missouri.

You have benefits whether you decide to use a network or non-network provider. But, the best way to lower your healthcare costs is to use a provider who participates in your network. Services received from providers participating in the network are paid at the network benefit level. While you do not have to choose a network Primary Doctor, it's highly recommended that you do. The fact is, selecting a network Primary Doctor is good for you and your wallet.

Here's why:

+ They are specially-trained to work with you to coordinate your overall healthcare.
+ They get to know you and your health issues over time, which ensures you have the best doctor to direct you to a specialist when you need one. A visit to a specialist without a referral from your Primary Doctor results in a higher copay.
+ Using a Primary Doctor can reduce your out-of-pocket expenses, including copays.

Keep in mind your Primary Doctor can be a family physician, a general practitioner, an internal medicine doctor, a pediatrician (for children), or an OB/GYN.

How To Find An In-Network Provider

1. For all Egyptian Area Schools health plans, visit egtrust.org
2. Select the Medical Benefits tab at the top of the page
3. Select "Finding a Network Provider" in the drop-down menu
   a. For providers located WITHIN Illinois or Missouri:
      Select the appropriate link under **CMR/Coventry/MHNet**

      CMR
      A Division of Coventry Health Care of Missouri, Inc.

   b. For providers located OUTSIDE Illinois or Missouri:
      Select the link under **Aetna Choice POS II**

      aetna®

4. Instructions on the screen will guide you through the rest of the process.
   If you would like further assistance finding a provider, call your Care Coordinators—we're here to help!

Medical Claims Payer

How your healthcare bills get paid

The Medical Claims Administrator for your health benefits plan is Meritain Health.

All provider claims are to be sent to the appropriate address as indicated on your ID card. The appropriate discount will be applied and sent to Meritain for processing. Meritain Health will process the claims, send payment to the provider, and send you a monthly member statement listing all claims process during the statement period.

If any of your providers do not send bills to the address on the ID card and you receive a bill, you can pay the provider directly and then submit your own claim form and receipt to the address on the ID card. You may obtain a claim form at www.egtrust.org, under the **Administrative Forms** tab at the top of the page. All claims must go through the network as indicated on the ID card in order for you to receive the appropriate discount. Meritain will then process your claim and promptly reimburse you.

Prescription Drug Coverage

How your prescriptions get filled and billed

CVS Caremark is part of a prescription processing system that is linked to most pharmacies nationwide, allowing you to enjoy easy access to a pharmacy near you.

To fill a prescription, visit a pharmacy in the CVS Caremark network and present your prescription. The pharmacist will enter your information into their system, which links to CVS Caremark, and your prescription claim will be processed immediately. At the time you pick up your prescription, you typically will be charged only the patient responsibility amount and the balance will be billed to your health benefits program. CVS Caremark also offers convenient mail service.

General Plan Information

When can I make changes?

New Active Employees

Egyptian Area Schools requires *new active employees* 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 event.

All Active Employees

All 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 event.

Note: Any life insurance changes for other than newly eligible employees are subject to medical underwriting.

Open Enrollment Coming Soon

The next Open Enrollment takes place **August 1 – September 30, 2016**, and that is when you will be able to select or make changes to health, dental, and vision plans for you and your family. The effective date of your changes will either be September 1 or October 1. Check with your employer for your specific effective date.

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

Important Note for Employees Opting Out

If you are opting out of medical coverage, you must complete the waiver portion of the Enrollment Form and return it to your employer.

Notes:

Save on Healthcare Costs

And Earn Valuable Incentives

How Healthcare Bluebook TM can help

Healthcare Bluebook is an added healthcare benefit to help you shop for care, compare facilities, save money on healthcare services, and earn rewards. Did you know that in-network prices for the same procedures can vary by *over 500%* depending on the facility you choose? Our web and mobile applications make it easy to save money on hundreds of the most common medical services and procedures by showing you the cost ranges in your area, and providing you with a selection of FAIR PRICE facilities.

What do the colors mean?

You can use your Healthcare Bluebook online tool to search for providers based on prices charged for these services. Within Healthcare Bluebook, providers are listed as red, yellow and green; "green" providers charge at or below the Fair Price TM. When you choose a "green" provider, you'll maximize your benefits coverage and save money on the cost of the procedure. You may choose to visit any provider you like; but, if you choose not to visit a "green" provider, you'll owe more out of pocket.

"Go Green to Get Green" and earn cash incentives

The Egyptian Trust offers an additional incentive for certain healthcare services when you visit a "green" provider. That's because "green" providers offer services at the most reasonable rates, providing you the most value for your healthcare dollar.

How do I earn Go Green to Get Green Rewards?

You earn rewards by visiting green providers for rewards-eligible procedures. Bluebook does all of the processing, there are no additional forms to submit.

Service Type	Procedure Name	Incentive
Cardiac	Doppler exam of the heart	$25
Cardiac	Heart echo imaging	$25
Cardiac	Heart perfusion imaging	$50
Outpatient	Remove tonsils and adenoids	$50
Outpatient	Ear tubes	$50
Outpatient	Cataract surgery	$50
Outpatient	Laparoscopic cholecystectomy	$50
Outpatient	Lithotripsy	$50
Outpatient	Knee arthroscopy	$100
Outpatient	Shoulder arthroscopy	$100
Outpatient	Rotator cuff repair	$100
Outpatient	Carpal tunnel surgery	$50
Diagnostic	Colonoscopy (with and without biopsy)	$100
Diagnostic	Upper GI endoscopy (with and without biopsy)	$100
Imaging	All CTs	$25
Imaging	All MRIs	$25
Women's Health	Breast Biopsy (with device)	$50
Women's Health	Hysteroscopy with biopsy	$50

How to access Healthcare Bluebook:

Healthcare Bluebook is available on the Egyptian Trust/Coordinated Healthcare website at www.egtrust.org. You can also download the Bluebook Mobile app and use it when you're in your doctor's office to request a referral to a Fair Price facility. You'll be shocked at how much you can save.

EGYPTIAN AREA SCHOOLS | CARE COORDINATORS BY QUANTUM HEALTH

If you have questions or need help finding a provider, just call your Care Coordinators at Quantum Health at 1.855.452.9997.

MERITAIN HEALTH An Aetna Company

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 ONLY 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.mydrconsult.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.** Use 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.mydrconsult.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.*

Teladoc®

MERITAIN℠ HEALTH

An Aetna Company

TRADITIONAL PLANS
SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2016

Description of Services	Plan A		Plan B	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible				
Individual	$300/$400**	$800	$500/$600**	$1,200
Family	$900/$1,200**	$2,400	$1,500/$1,800**	$3,600
Out of Pocket Maximum				
Individual	$1,100/$1,200**	$3,700	$1,200/$1,300**	$4,100
Family	$2,200/$2,400**	$11,100	$3,600/$3,900**	$12,300
Cost Share Maximum				
Individual	$6,600	N/A	$6,600	N/A
Family	$13,200	N/A	$13,200	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Reimbursement	90%	70%	85%	65%
Inpatient Hospital (Illness or Injury)	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%
Outpatient Surgery	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%
Primary Doctor (PCP) Office Visit	$25 Copay Then 100% No deductible	70%	$25 Copay Then 100% No deductible	65%
Specialist Office Visit with PCP Referral	$30 Copay Then 100% No deductible	70%	$30 Copay Then 100% No deductible	65%
Specialist Office Visit without PCP Referral	$40 Copay Then 100% No deductible	70%	$40 Copay Then 100% No deductible	65%
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
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
Drug Card	**Retail 30 days** / **Retail 90 day Maintenance Drug after first 2 fills**	**Home Delivery up to 90 days**	**Retail 30 days** / **Retail 90 day Maintenance Drug after first 2 fills**	**Home Delivery up to 90 days**
Generic	$12 / $36	$30	$12 / $36	$30
Formulary	$25 / $85	$55	$25 / $85	$55
Non-Formulary	$40 / $130	$100	$40 / $130	$100

Notes:
Network and Non-Network deductibles and out of pockets will accumulate separately

** Members may achieve a reduced individual and family deductible and out of pocket when completing the wellness requirements Members who are enrolled in Plan HDHP may achieve a 10% increased benefit level when completing the wellness requirements.

TRADITIONAL PLANS
SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2016

Plan C		HDHP (HSA Qualified Plan) ***		Plan E1	
NETWORK	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
$1,000/$1,100** $3,000/$3,300**	$2,200 $6,600	$1,300 $2,600	$2,600 $5,200	$1,000/$1,100** $3,000/$3,300**	$2,200 $6,600
$2,200/$2,300** $6,600/$6,900**	$6,900 $20,700	$3,900 $7,800	$7,750 $15,500	$1,700/$1,800** $5,100/$5,400**	$5,100 $15,300
$6,600 $13,200	N/A N/A	$6,550 $13,100	N/A N/A	$6,600 $13,200	N/A N/A
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
80%	60%	90% / 80%**	60%	85%	65%
$250 Copay Then 80%	$550 Copay Then 60%	$250 Copay, Then 80%	$550 Copay Then 60%	$250 Copay Then 85%	$550 Copay Then 65%
$250 Copay Then 80%	$550 Copay Then 60%	$250 Copay, Then 80%	$550 Copay, Then 60%	$250 Copay Then 85%	$550 Copay Then 65%
$25 Copay Then 100% No deductible	60%	$25 Copay, Then 80%	60%	$25 Copay Then 100%	65%
$30 Copay Then 100% No deductible	60%	$30 Copay Then 80%	60%	$30 Copay Then 100%	65%
$40 Copay Then 100% No deductible	60%	$40 Copay Then 80%	60%	$40 Copay Then 100%	65%
$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible
$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 80%	$40 Copay Then 80%	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible
Retail 30 days	**Retail 90 day Maintenance Drug after first 2 fills**	**Home Delivery up to 90 days**	**Retail 30 days**	**Retail 90 day Maintenance Drug after first 2 fills**	**Home Delivery up to 90 days**	**Retail 30 days**	**Retail 90 day Maintenance Drug after first 2 fills**	**Home Delivery up to 90 days**
$12	$36	$30	$12	$36	$30	$12	$36	$30
$25	$85	$55	$25	$85	$55	$25	$85	$55
$40	$130	$100	$40	$130	$100	$40	$130	$100

*** **High Deductible Health Plan (HDHP):**

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

Traditional Plan Equivalents (Mark to Market Plans)

You must check with your employer to see if these plans are offered to you.
Only those individual participating groups who have gone through the individual underwriting process may qualify for these plans. The individual rates by plan and by employer group will vary dependent on your groups participation levels, average age, employee count and geographic location.

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2016

	Plan A1		Plan B1		Plan C1	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible						
Individual	$400**	$800	$600**	$1,200	$1,100**	$2,200
Family	$1,200**	$2,400	$1,800**	$3,600	$3,300**	$6,600
Out of Pocket Maximum						
Individual	$1,200**	$3,700	$1,300**	$4,100	$2,300**	$6,900
Family	$2,400**	$11,100	$3,900**	$12,300	$6,900**	$20,700
Cost Share Maximum						
Individual	$6,600	N/A	$6,600	N/A	$6,600	N/A
Family	$13,200	N/A	$13,200	N/A	$13,200	N/A
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Reimbursement	90%	70%	85%	65%	80%	60%
Inpatient Hospital (Illness or Injury)	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 80%	$550 Copay Then 60%
Outpatient Surgery	$250 Copay Then 90%	$550 Copay Then 70%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 80%	$550 Copay Then 60%
Primary Doctor (PCP) Office Visit	$25 Copay Then 100% No deductible	70%	$25 Copay Then 100% No deductible	65%	$25 Copay Then 100% No deductible	60%
Specialist Office Visit with PCP Referral	$30 Copay Then 100% No deductible	70%	$30 Copay Then 100% No deductible	65%	$30 Copay Then 100% No deductible	60%
Specialist Office Visit without PCP Referral	$40 Copay Then 100% No deductible	70%	$40 Copay Then 100% No deductible	65%	$40 Copay Then 100% No deductible	60%
Emergency Room	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible
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
Drug Card	**Retail 30 days** / **Retail 90 day Maintenance Drug after first 2 fills** / **Home Delivery up to 90 days**					
Generic	$12 / $36 / $30		$12 / $36 / $30		$12 / $36 / $30	
Formulary	$25 / $85 / $55		$25 / $85 / $55		$25 / $85 / $55	
Non-Formulary	$40 / $130 / $100		$40 / $130 / $100		$40 / $130 / $100	

Notes:
Network and Non-Network deductibles and out of pockets will accumulate separately

** Members may achieve a reduced individual and family deductible and out of pocket when completing the wellness requirements. Members who are enrolled in Plan D1 may achieve a 10% increased benefit level when completing the wellness requirements.

Traditional Plan Equivalents (Mark to Market Plans)

You must check with your employer to see if these plans are offered to you.
Only those individual participating groups who have gone through the individual underwriting process may qualify for these plans. The individual rates by plan and by employer group will vary dependent on your groups participation levels, average age, employee count and geographic location.

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2016

Plan D1 (HSA Qualified Plan) ***		Plan E1M		Plan AB1	
NETWORK	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
$1,300 $2,600	$2,600 $5,200	$1,100** $3,300**	$2,200 $6,600	$400** $1,200**	$1,200 $3,600
$3,900 $7,800	$7,750 $15,500	$1,800** $5,400**	$5,100 $15,300	$1,300** $3,900**	$4,100 $12,300
$6,550 $13,100	N/A N/A	$6,600 $13,200	N/A N/A	$6,600 $13,200	N/A N/A
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
90% / 80%**	60%	85%	65%	85%	65%
$250 Copay, Then 80%	$550 Copay Then 60%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 85%	$550 Copay Then 65%
$250 Copay, Then 80%	$550 Copay, Then 60%	$250 Copay Then 85%	$550 Copay Then 65%	$250 Copay Then 85%	$550 Copay Then 65%
$25 Copay, Then 80%	60%	$25 Copay Then 100%	65%	$25 Copay Then 100%	65%
$30 Copay Then 80%	60%	$30 Copay Then 100%	65%	$30 Copay Then 100%	65%
$40 Copay Then 80%	60%	$40 Copay Then 100%	65%	$40 Copay Then 100%	65%
$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible
$40 Copay Then 80%	$40 Copay Then 80%	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible

Retail 30 days	Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Retail 30 days	Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days	Retail 30 days	Retail 90 day Maintenance Drug after first 2 fills	Home Delivery up to 90 days
$12	$36	$30	$12	$36	$30	$12	$36	$30
$25	$85	$55	$25	$85	$55	$25	$85	$55
$40	$130	$100	$40	$130	$100	$40	$130	$100

*** Plan D1 is a High Deductible Health Plan, designed to qualify for use with a Health Savings Account (HSA). All benefits except benefits for preventive care (as defined under IRS rules)are subject to the Calendar Year Deductible. If you enrolled for Employee Only health coverage, you must pay 100% of the discounted charge for each covered service until you satisfy the Individual Calendar Year Deductible. If you are enrolled for Employee + Spouse, Employee + Child(ren) or Family health coverage you must pay 100% of the discounted charge until your covered family members satisfy the Family Calendar Year Deductible. After you satisfy the applicable Calendar Year Deductible, you will pay the copayments/coinsurance shown in the above table until your out of pocket expenses satisfy the appropriate Calendar Year Out of Pocket Maximum. The Plan will then pay 100% of the cost of your covered charges for the remainder of the year.

Egyptian Area Schools Employee Benefit Trust

Dental Highlight Sheet

Ameritas

Plan 1: Dental Plan Summary **Effective Date: 9/1/2016**

Plan Benefit	High Plan	Low Plan
Type 1	100%	80%
Type 2	80%	70%
Type 3	50%	N/A
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 3 Family Maximum	$50/Calendar Year Type 2 Waived Type 1 3 Family Maximum
Maximum ***(per person)***	$1500 per calendar year	$750 per calendar year
Allowance Type 1	90th U&C	90th U&C
Allowance Type 2	Maximum Procedure Allowance	Maximum Procedure Allowance
Allowance Type 3	Maximum Procedure Allowance	None
Dental Rewards®	Included	Included
Ameritas Rewards SM	Included	N/A
Annual Eye Exam	None	None

Orthodontia Summary - Child Only Coverage

Allowance	U&C	No Ortho
Plan Benefit	50%	
Lifetime Maximum *(per person)*	$1,000	
Ameritas RewardsSM **Lifetime** *(per person)*	$100	
Waiting Period	n/a	

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3 (High Plan Only)
• Routine Exam (2 per benefit period)	• Sealants (age 16 and under)	• Onlays
• Bitewing X-rays (2 per benefit period)	• Space Maintainers	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Restorative Amalgams	• Crown Repair
• Periapical X-rays	• Restorative Composites	• Implants
• Cleaning (2 per benefit period)	• Endodontics (nonsurgical)	• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
• Fluoride for Children 18 and under (1 per benefit period)	• Endodontics (surgical)	
	• Periodontics (nonsurgical)	
	• Periodontics (surgical)	
	• Denture Repair	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

U&C Disclosure

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. U&C levels are based on experience from the Company and an independent outside source of claim charge information.

Maximum Procedure Allowance (WPA)

* With MPA, the plan allowance for each covered procedure is established according to the median dentist charges in the ZIP Code area where the services are provided.
* Keeps cost-conscious plan members from subsidizing those who use more expensive dentists.
* Reimbursement allowances automatically adjust if there's an increase or decrease in the overall charges in the area..

Egyptian Area Schools Employee Benefit Trust

Dental Highlight Sheet

Ameritas

Monthly Rates	High Plan	Low Plan
Employee Only (EE)	$32.08	$14.26
EE + 1 Dependent	$58.96	$26.18
EE + 2 or more Dependents	$85.70	$49.70

Ameritas Rewards℠ (Feature with High Plan)

Ameritas Rewards is an enhanced product that offers an increased maximum for hearing, LASIK, orthodontia and vision as well as dental. It allows members to utilize unused dental maximum carryover amounts from previous years towards dental benefits or other lines of coverage included in a plan. Employees and their covered dependents may accumulate dental rewards with an unlimited maximum carryover amount. These rewards can be used to increase the maximum for the other lines of coverage which can then be used for certain covered services or materials subject to applicable deductible, coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. A member is eligible to earn rewards again the next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Ameritas Rewards amount is added to the following year's maximum
Annual PPO Bonus	$150	Additional bonus is earned if the member sees a network provider
Maximum Carryover	Unlimited	Maximum possible accumulation for Dental Rewards and PPO Bonus combined

Dental Rewards® (Feature with Low Plan)

This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

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Benefit Threshold	$250	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$125	Dental Rewards amount is added to the following year's maximum
Annual PPO Bonus	$ 50	Additional bonus is earned if the member sees a network provider
Maximum Carryover	$500	Maximum possible accumulation for Dental Rewards and PPO Bonus combined

Dental Network Information

Both the High and Low Plan have the freedom to use any licensed dental provider. However, both plans include access to the Ameritas PPO Network. To find a provider, visit ameritas.com and select **FIND A PROVIDER,** then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. Members utilizing a PPO provider may experience lower out of pocket costs due to negotiated fees with in-network providers

Questions?

Members can call 800-487-5553 or visit www.ameritas.com/group/olbc/egyptianschooltrust for plan information and online presentations. If already enrolled you may also use the www.ameritas.com website, members can select Account Access in the upper right hand corner to set up a user ID and password to check claim status, view detailed plan information, search for PPO providers and more

Egyptian Area Schools Employee Benefit Trust

Eye Care Highlight Sheet

Ameritas

Plan 1: Focus® Plan Summary **Effective Date: 9/1/2016**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$15 Exam	$15 Exam
	$15 Eye Glass Lenses or Frames*	$15 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Member cost up to $60	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frames	$130**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco allowance will be the wholesale equivalent.*

Lasik Advantage®

Benefits	**Year 1--$700 ($350 per eye)** **Year 2--$700 ($350 per eye)** **Year 3--$1,400 ($700 per eye)**

Lens Options (member cost)*

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Monthly Vision Rates

Employee Only (EE)	$7.96
EE + 1 Dependent	$11.40
EE + 2 or more Dependents	$20.64

Egyptian Area Schools Employee Benefit Trust

Eye Care Highlight Sheet

Ameritas

Additional Focus® Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Retail Chain Affiliate Providers Available With Focus Plans

Effective January 1, 2012, retail chain affiliate providers, which include Costco® Optical and Visionworks, give members added convenience and additional retail choices. Costco Optical has 400 locations across the country, while Visionworks manages nearly 400 optical stores in 37 states and DC, including well-known stores such as EyeMasters, Visionworks, Dr. Bizer's VisionWorld, Eye DRx, and Hour Eyes, to name a few. Members enjoy a covered-in-full benefit experience with equivalent frame benefit at any of these retail chain locations.

Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com
View plan benefit information at: vsp.com

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

GROUP LIFE BENEFIT PROGRAM SUMMARY
For Egyptian Area Schools Employee Benefit Trust

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.	Birth to 14 days: $0 Age 15 days to 19 years (25 if full-time student): $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)
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 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 information is only a product highlight. Life benefits may be subject to medical underwriting. Coverage for a medically underwritten benefit is not effective until the date the insurer has approved the employee's application. The policy has exclusions, 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. (For Internal Use Only: FDL Policy number FDL1-504-707-IL)

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) (formerly known as Fort Dearborn Life Insurance Company®) and certain of its affiliates. Dearborn National® Life Insurance Company offers insurance products in all states (excluding New York, where it is not licensed and does not solicit business), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. Product features and availability vary by state and company, and are solely the responsibility of each affiliate.

SUPPLEMENTAL GROUP LIFE AND AD&D
PREMIUM RATE GRID

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

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 annual salary**

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

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

Guarantee Issue

Employee	**$ 100,000** (Under age 60)
Spouse	**$ 37,500** (Under age 60)

Child Coverage (Life coverage only)

Live birth to 14 days:	**$0**
15 days to age 19 (25 if full-time student)	**$5,000 or $10,000**

Life/AD&D benefits reduce by 50% of the original amount at employee's attained age of 70.

EMPLOYEE & SPOUSE
Supplemental Life/AD&D
Monthly rates per $1,000

Age	Rates
Under 20	$0.085
20-24	$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
65-69	$1.685
70-74	$1.685
75+	$1.685

Dependent Life (Children)
Monthly Premium per Family

$5,000	$0.47
$10,000	$0.94

EMPLOYEE - Supplemental Life/AD&D Insurance
Monthly Premium Cost (Based on 12 payroll deductions per year)

Benefit Amount		ATTAINED AGE											
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$10,000		$0.85	$0.85	$0.95	$1.05	$1.35	$1.95	$3.05	$4.95	$7.95	$9.85	$16.85	$16.85
$25,000		$2.13	$2.13	$2.38	$2.63	$3.38	$4.88	$7.63	$12.38	$19.88	$24.63	$42.13	$42.13
$50,000		$4.25	$4.25	$4.75	$5.25	$6.75	$9.75	$15.25	$24.75	$39.75	$49.25	$84.25	$84.25
$75,000		$6.38	$6.38	$7.13	$7.88	$10.13	$14.63	$22.88	$37.13	$59.63	$73.88	$126.38	$126.38
$100,000		$8.50	$8.50	$9.50	$10.50	$13.50	$19.50	$30.50	$49.50	$79.50	$98.50	$168.50	$168.50

SPOUSE - Supplemental Life/AD&D Insurance

Benefit Amount		EMPLOYEE'S ATTAINED AGE											
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
$5,000		$0.43	$0.43	$0.48	$0.53	$0.68	$0.98	$1.53	$2.48	$3.98	$4.93	$8.43	$8.43
$10,000		$0.85	$0.85	$0.95	$1.05	$1.35	$1.95	$3.05	$4.95	$7.95	$9.85	$16.85	$16.85
$25,000		$2.13	$2.13	$2.38	$2.63	$3.38	$4.88	$7.63	$12.38	$19.88	$24.63	$42.13	$42.13
$30,000		$2.55	$2.55	$2.85	$3.15	$4.05	$5.85	$9.15	$14.85	$23.85	$29.55	$50.55	$50.55
$35,000		$2.98	$2.98	$3.33	$3.68	$4.73	$6.83	$10.68	$17.33	$27.83	$34.48	$58.98	$58.98
$37,500		$3.19	$3.19	$3.56	$3.94	$5.06	$7.31	$11.44	$18.56	$29.81	$36.94	$63.19	$63.19

For internal use only: Policy number FDL1-504-707 Slife/blend-w/add/12

Enrollment and Change Enrollment Forms

The following pages contain the necessary forms for enrollment and changes in your enrollment. Please fill out the appropriate form, remove it from the brochure, and return it to your employer to complete the enrollment process.

If you need additional forms, you may obtain them from your employer or at www.egtrust.org.

Please note: It is very important that the attached forms are completed legibly, in order for us to properly enroll you in the programs you choose. Please pay special attention to the date-of-birth and social security number fields.

Have questions about your health plan?
Contact your Care Coordinators!

1-855-452-9997

Monday – Friday, 7:30 a.m. – 9:00 p.m. CST

www.egtrust.org

EGYPTIAN AREA SCHOOLS | CARE COORDINATORS BY QUANTUM HEALTH

MERITAIN HEALTH
An Aetna Company

Egyptian Area Schools Employee Benefit Trust

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	Certified Staff ☐ Yes ☐ No	Effective Date
Enrollment Event: ☐ Open Enrollment-Applies to medical plan only ☐ Annual Enrollment-Applies to dental plan only ☐ New Hire ☐ Late Enrollment ☐ Qualifying Change in Family Status Reason		Employee Status ☐ Active ☐ COBRA ☐ Retiree ☐ Other	Date of Hire
Certified by (Authorized Representative)	Date	Employer Telephone ( ) -	

Select only One Health Plan Type you offer: ☐ Traditional OR ☐ Mark to Market

Select all Health Plans you offer: ☐ Plan A/A1 ☐ Plan B/B1 ☐ Plan C/C1 ☐ HDHP/D1 ☐ Plan E1/E1M ☐ Plan AB1 ☐ All Plans

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

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

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

Medical Plan Options	Voluntary Teladoc	Voluntary Dental	Voluntary Vision
☐ **Plan A/A1** ☐ **Plan B/B1** ☐ **Plan C/C1** ☐ **HDHP/D1** ☐ **Plan E1/E1M** ☐ **Plan AB1**		☐ High ☐ Low	
☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family ☐ Decline Coverage NOTE: Includes Teladoc, Basic Life Insurance and Prescription Coverage	☐ Employee Only ☐ Decline Coverage NOTE: Teladoc is included in Medical Plan.	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage

EMPLOYEES: Check all boxes that apply:

Basic Life –
Basic Life is automatic when enrolling in Health Plan

☐ Basic Life Amount _____
☐ Decline coverage

Optional Life –
When applying for more than guaranteed issue amounts an Evidence of Insurability form must be completed.

☐ Optional Employee Life Amount _____ Note: Evidence of Insurability Form required for amounts over $100,000

☐ Optional Spouse Life Amount_____ Note: Limited to 50% of Employee Life – Evidence of Insurability required for amounts over $37,500

☐ Optional Dependent Life ☐ $5,000 or ☐ $10,000 Note: Covers all eligible children

☐ 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.)	You must mark the coverage chosen or decline coverage for each dependent listed.
1.					☐ Medical ☐ Dental ☐ Vision ☐ Decline
2.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
3.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
4.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ Decline
5.			/ /	- -	☐ Medical ☐ Dental ☐ Vision ☐ 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) — Dearborn National

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

☐ "I APPLY FOR THE BASIC GROUP LIFE BENEFITS indicated above and, if my application is approved by Dearborn National, 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 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."

☐ "I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS indicated above and, if my application is approved by Dearborn National, 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 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."

☐ "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 Dearborn National, and the initial premium is paid to Dearborn National. 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 Meritain Health

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 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."

☐ "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) — Administered by Meritain Health

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 Teladoc Program.

REQUEST FOR COVERAGE (VOLUNTARY DENTAL) — Ameritas

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 Ameritas, 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) — VSP, Administered by Ameritas

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 Ameritas, 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:

MERITAIN HEALTH
An Aetna Company

Egyptian Area Schools Employee Benefit Trust

CHANGE 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) – Retain a copy for your records
Confirmation No._____

Employer Name	Group Number	Date of Hire	Effective Date of Change

Certified by (Authorized Representative)	Date	Employer Telephone

Select only One Health Plan Type you offer: ☐ **Traditional** **OR** ☐ **Mark to Market**

Select All Health Plans you offer: ☐ **Plan A/A1** ☐ **Plan B/B1** ☐ **Plan C/C1** ☐ **HDHP/D1** ☐ **Plan E1/E1M** ☐ **Plan AB1** ☐ **All Plans**

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 ☐ M ☐ F	Date of Birth	Social Security Number

	From:	To:
☐ Employee Name		
☐ Employee Address		
☐ Employee Phone		
☐ Employee Email		
☐ Marital Status	☐ Single ☐ Married ☐ Civil Union ☐ Divorced	☐ Single ☐ Married ☐ Civil Union Termination ☐ Divorced

☐ Termination Choose Reason

☐ Active
☐ Lay Off
☐ Death
☐ Retired
☐ Open Enrollment
☐ Other
☐ Reduction In Hours
☐ Medicare Entitlement
☐ Marriage
☐ Civil Union
☐ Leave of Absence
☐ Terminate Employment
☐ Divorce
☐ Civil Union Termination

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

☐ Dependent Status

(When adding or terminating a dependent you must complete Dependent Section on the reverse side.)

☐ Add Dependent(s)

Reason for Addition:

☐ Newborn
☐ Marriage
☐ Civil Union
☐ Open Enrollment
☐ Newly Eligible Full-time Student
☐ Adoption
☐ Divorce
☐ Civil Union Termination
☐ Other _____

☐ Terminate Dependent(s)

Reason for Termination:

☐ Ineligible Child
☐ Marriage
☐ Civil Union
☐ Open Enrollment
☐ Death
☐ Divorce
☐ Civil Union Termination
☐ Other _____

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.

TO: ☐ Plan A/A1 ☐ Plan B/B1 ☐ Plan C/C1 ☐ HDHP/D1 ☐ Plan E1/E1M ☐ Plan AB1

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child or Children
☐ Family
☐ Terminate Medical
☐ No Change Medical

Voluntary Teladoc

☐ Employee Only
☐ Terminate
☐ 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: ☐ High ☐ Low

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Dental
☐ No Change Dental

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:

☐ Employee Only
☐ Employee + 1 Dependent
☐ Employee + 2 or more Dependents
☐ Terminate Vision
☐ No Change Vision

Basic Life – All life insurance terminates upon employment termination or retirement.

☐ Add Basic Life (Only available when employee is newly eligible.)
☐ Term Basic Life
☐ No Change

Optional Life – Changes in Optional Life coverage must be submitted using the Dearborn National Evidence of Insurability form unless you are terminating coverage. Form can be found at www.egtrust.org.

EMPLOYEES: Check all boxes that apply:

☐ Add Optional Employee (Evidence of Insurability REQUIRED)
☐ Add Optional Spouse (Evidence of Insurability REQUIRED)
☐ Add Optional Dependent(Evidence of Insurability REQUIRED)
☐ Terminate Optional Employee
☐ Terminate Optional Spouse
☐ Terminate Optional Dependent
☐ No Change Optional Life

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.
1.					Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
2.				- -	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
3.				- -	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
4.				- -	Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline Vision ☐ Add ☐ Term ☐ No Change ☐ Decline
5.					Medical ☐ Add ☐ Term ☐ No Change ☐ Decline Dental ☐ Add ☐ Term ☐ No Change ☐ Decline vision ☐ Add ☐ Term ☐ No Change ☐ 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 employer providing coverage:

_____

Is other coverage Medicare or Medicaid? ☐ Yes ☐ No

Effective Date_____

Name of insurance carrier or TPA:_____Group No._____

Address:_____

_____

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:

EMPLOYER – RETAIN ORIGINAL FOR YOUR FILE