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# 2017-18 Benefit Enrollment Guide Egyptian Area Schools





# Table of Contents

Welcome to Open Enrollment .....	2
General Plan Information.....	3
Your Preferred Provider Network .....	4
Precertification Information .....	5
<b>Introducing HealthSCOPE Benefits</b>	
How your medical bills get paid.....	6
Customer Care .....	7
Member Communications .....	8
Member Web Portal .....	9
HealthSCOPE Benefits Mobile App .....	10
Member Mailings.....	11
Sample Claims Processing Notification .....	12
Explanation of Benefits .....	13
Prescription Drug Coverage overview.....	15
Dental Coverage overview .....	15
Vision Coverage overview .....	16
Life Insurance/ AD&D Coverage overview .....	16
Prescription Insurance plan .....	17
Dental Insurance plan .....	18
Vision Insurance plan.....	20
Life, Group Life, and AD&D plans.....	22
Your Teladoc Program.....	24
Enrollment forms .....	25
List of Contacts.....	34



**Egyptian**  
AREA SCHOOLS

**HealthSCOPE**  
BENEFITS

# Welcome to 2017-18 Open Enrollment

**F**or the 2017-18 benefit year, Egyptian Area Schools Employee Benefit Trust is proud to announce two new vendors: HealthSCOPE Benefits and MedWatch.

Beginning September 1, 2017, HealthSCOPE Benefits will be the new claims administrator. HealthSCOPE Benefits is bringing to the Trust health plan many cost savings opportunities through their network and vendor partner relationships. In addition to the claims administration services, HealthSCOPE Benefits will also manage the plan's eligibility, ID cards, and offer the Customer Care Unit. Additional information is available throughout this Guide outlining the various services HealthSCOPE Benefits will be offering to members.

Also effective September 1, 2017, MedWatch will provide Utilization Management (pre-certification) and Case Management services to the members of Egyptian Trust. Your benefit plans require certain medical procedures to be pre-certified. This process helps ensure that you are receiving appropriate, high quality care at the most appropriate time and at the best possible price. Should you be in need of Case Management, the MedWatch team of professional nurse case managers will work with you, your physicians and your family as appropriate to help navigate the multitude of care and treatment options that may be available and help achieve the best possible outcomes.

As a member of the Trust, we are proud to continue offering an attractive, broad range suite of benefits. To prepare for open enrollment, please read this guide carefully to get answers to your questions, and adjust your coverage where necessary for the upcoming plan year. Consider options which best support your current needs, and make sure to include any other individuals who will be affected by your elections in the decision making process.

This year's open enrollment is passive, which means your current coverage elections will automatically renew for 2017 - 2018, but you may need to take action:

- If you need to enroll or make changes to your coverage elections
- If you need to enroll, terminate, or make changes to your current plan options
- If you waive medical coverage, you will need to complete an enrollment form indicating you waive coverage and submit to your employer

This Benefits Enrollment Guide contains information on the medical, dental, vision, life and telemedicine plans available to you and your dependents. You will find information about some of our new vendors, as well as existing product offerings and more!

## 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 can obtain additional Enrollment Forms from your District Office or at [www.egtrust.org](http://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 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 can obtain additional Change Enrollment Forms from your District Office or at [www.egtrust.org](http://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.

# General Plan Information

## When can you 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 life 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 life event.\*

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

## OPEN ENROLLMENT AUGUST 1—SEPTEMBER 30!

The next Open Enrollment takes place **August 1—September 30, 2017**. 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.

### \*QUALIFYING LIFE EVENTS

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

# Your Preferred Provider Network

**W**hen you need to see a physician, a physician network, PHCS, is utilized for all physician services (primary care and specialists). This gives you access to a wide network of providers.

**When you need care from a hospital or outpatient facility, Value-Based Payments come into play to keep your costs down.** Your physician will recommend a hospital or outpatient facility, as usual. They will pre-certify your treatment based on the Plan Guidelines. Based on rates established by Medicare and other resources, a fair price will be identified for your treatment. The facility will then be advised up front of the allowable charge, which is almost always lower than what they would normally charge, and proceed with scheduled services. As customary, you will be responsible for any copays, deductible, and coinsurance up to the annual out-of-pocket maximum.

## How your Primary Doctor can help you save money


### HERE'S HOW

- 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.
- 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 a PHCS/Multiplan Network Provider

For assistance in finding a PHCS provider of your choice, you can contact PHCS direct at 800-922-4362 (7am - 7pm), or HealthSCOPE Benefits Customer Care at 800-397-9598 (8am - 6pm). Assistance is available Monday - Friday (except major holidays). Identify yourself as an Egyptian Trust health plan participant accessing the PHCS Network for practitioners and ancillaries only. This means that your access includes the full network of physicians and ancillary providers, such as labs, durable medical equipment, etc. You may also search online at [www.multiplan.com](http://www.multiplan.com). Follow these directions:

1. Go online to [www.multiplan.com](http://www.multiplan.com) and click on the "Search for a Doctor or Facility" button.
2. Indicate that you have the logo shown here on the front of your ID card:  

3. Follow the prompts to enter your search criteria. When performing searches, keep in mind that your network includes the full network of physicians and ancillary providers, such as labs, durable medical equipment, etc.



4. Click on **Doctor** to search for a physician or other healthcare professional.
5. Click on **Facility** to search for an ancillary provider (such as labs, durable medical equipment, home health, etc.).

### Before your appointment

Please be sure to follow any preauthorization procedures required by your plan. In addition, to ensure proper handling of your claim, always present your current benefits ID card upon arrival at your appointment.

### If you need assistance

If you encounter issues when scheduling appointments with PHCS Network providers, call either PHCS at 800-922-4362, or HealthSCOPE Benefits' Customer Care at 800-397-9598.



# Pre-certification

MedWatch will work closely with your medical providers on any pre-cert requirements. To be covered at the highest level of benefits and to ensure complete care coordination, the Plan requires that certain care, services and procedures be pre-certified before they are provided. Pre-certification requests are submitted on your behalf by a specialty Physician, Primary Doctor, or other healthcare provider. Provider offices have been provided with materials and education regarding this process, and your Plan identification card includes instructions. Approvals of pre-certification requests for specialty visits, procedures, hospitalizations and other services, indicates that the medical condition, services and care settings meet the utilization criteria established by the Plan. The following services require precertification:



- All outpatient surgeries not done in a doctor's office
- 23-hour observation stays
- Biologic Drugs
- Chemotherapy
- Deviated septum/nasal surgery
- Dialysis
- DME over \$1,500
- EBCT (Electron Beam Tomography)
- Endoscopic procedures
- Epidural/facet and trigger point injections
- Extended Nursing Facility
- High-Tech Radiology (CT, MRA, MRI, PET)
- Home Health Care
- Hospice Care
- Infusions (Infusion Therapy) of any type over \$1,500
- Inpatient Admissions
- Long Term Acute Care (LTAC)
- MRI/CT/Pet Scan—excludes bone density studies
- Physical/occupational/speech therapy
- Psychiatric Treatment: Intensive Outpatient, Residential, Partial
- Radiation Treatments
- Rehabilitation facility
- Rehabilitation for Substance Abuse: Outpatient, Residential, Partial
- Skilled Nursing Facility (SNF)
- Varicose vein ligation

## Pre-certification Notice

Prior-Authorization is required for all inpatient hospitalizations and all surgeries (outside of the physician's office) or for other services as specified in your plan document. To avoid a penalty, your provider must contact the Customer Care unit at least 7 days before the hospitalization / treatment or within 48 hours of an emergency admission. Your provider may contact the HealthSCOPE Benefits Customer Care unit at 800-397-9598, Monday through Friday, 8:00 a.m. - 6:00 p.m. Central Standard Time to obtain a pre-certification. **Precertification does not guarantee payment.**



# Your Medical Claims

How your healthcare bills get paid

The Medical Claims Administrator for your health benefits plan is HealthSCOPE Benefits. HealthSCOPE Benefits is a full-service claims administration and health management firm providing administrative and other support services to self-funded employers.

Headquartered in Little Rock, Arkansas, HealthSCOPE Benefits administers benefits in all 50 states for over 250 companies and more than 500,000 members. HealthSCOPE Benefits' more than 600 employees support clients in the management of greater than \$1.6 billion in annual healthcare expenditures. HealthSCOPE Benefits has eight offices across the country to serve its customers. We are currently the 4th largest TPA in the United States as ranked by *Business Insurance* magazine.

## The 2017-18 Medical Plans

The Medical Plans offered in this benefit plan year are detailed on separate documents, not included in this booklet.



## SERVICES FROM HEALTHSCOPE BENEFITS



HealthSCOPE Benefits will strive to provide you with responsive service and ensure that your experience is very positive.

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 HealthSCOPE Benefits for processing.

HealthSCOPE Benefits will process the claims, send payment to the provider, and send you a monthly member statement listing all claims processed during the statement period.

The next few pages provide information on the services offered to Egyptian Area Schools members from HealthSCOPE Benefits. You will find information regarding:



Customer Care



Member Communications



Using the Member Web Portal



"My HSB" Mobile App



Member Mailings



Sample Claims Processing Notifications



Sample Explanation of Benefits



# Customer Care

## FROM HEALTHSCOPE BENEFITS

**O**utstanding customer service is where we truly feel HealthSCOPE Benefits is head and shoulders above our competition. We are committed to facilitating timely, appropriate, and effective customer care for our members.

HealthSCOPE Benefits offers **toll-free access** to a team of representatives to respond to member calls. Our Customer Care Team is responsible for facilitating effective communication, including maintaining established phone standards, as well as timely response to written and phone inquiries.

Live representatives are available from **8 a.m. to 6 p.m. CST, Monday through Friday at 1-800-397-9598**. During non-business hours, members and their families will be able to access our online and **Interactive Voice Response (IVR)** systems to obtain information about their claims or to address other issues like ordering a replacement ID card. The automated claims inquiry (IVR) feature is available **24 hours a day, 365 days a year**. We encourage members to utilize this feature and take advantage of placing calls at their convenience.



## OUR CUSTOMER CARE STAFF OFFERS THE FOLLOWING

### LANGUAGES

We provide services in English as well as other languages. We employ a bilingual staff and utilize the AT&T language translation line, TDD services, and provide documents in Spanish.

### ELDERLY CALLERS

We take special care to meet the needs of our elderly callers. We will adjust our speed and volume when speaking, repeat ourselves, listen patiently, and not interrupt the caller.

Customer care representatives are able to review your transactions in detail.

### ESCALATION OF INQUIRIES

Questions that cannot be answered by a representative are transferred to a team lead. If a transfer is not possible, a message is taken and return calls are made by the end of that business day.

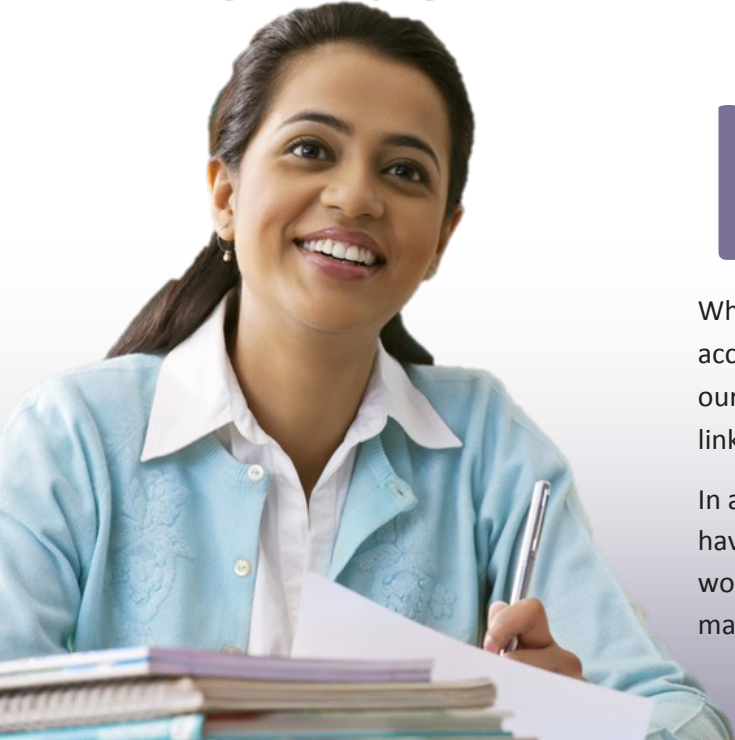
It is our goal to ensure callers are completely satisfied!

 [www.healthscopebenefits.com](http://www.healthscopebenefits.com)





# Member Communications

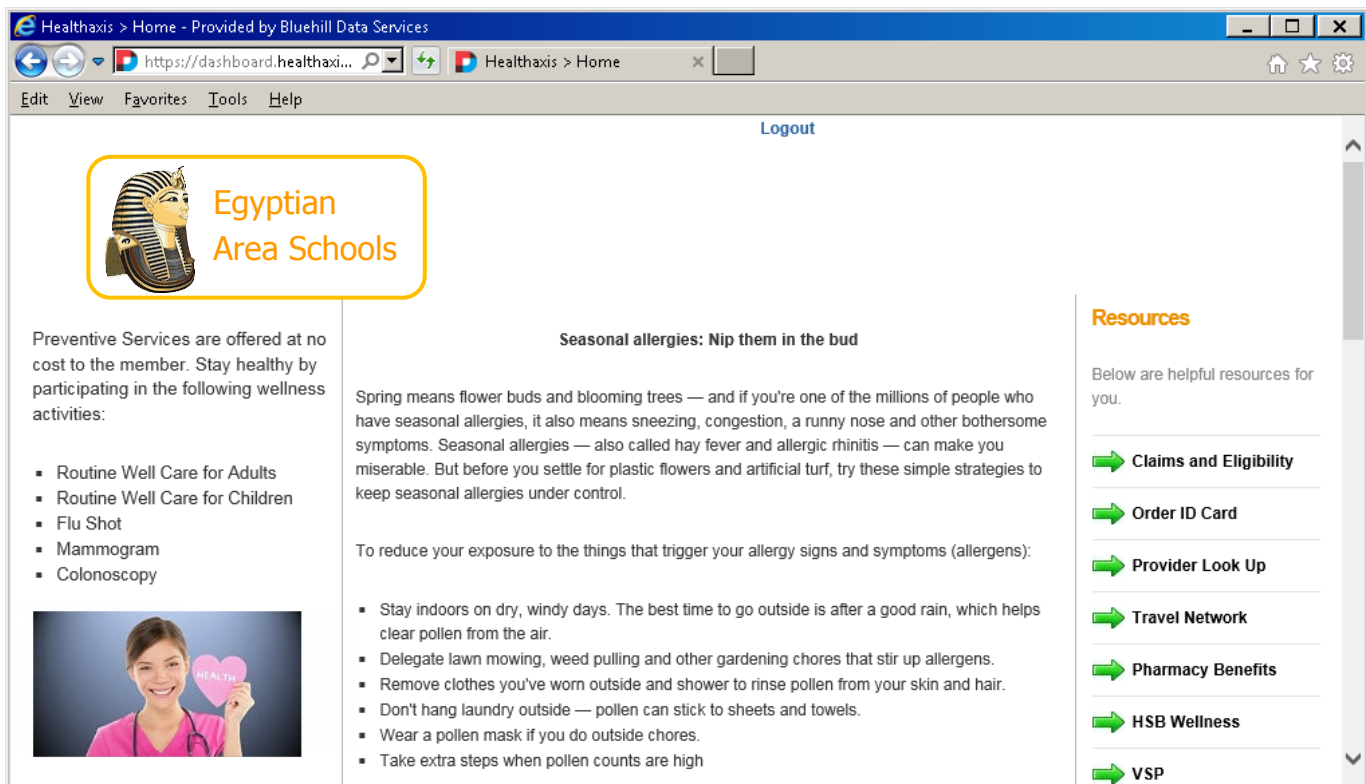


Like shown below, the Member Landing page is customized for each client of HealthSCOPE Benefits. Think of it as your specialized portal to all information regarding your account.

When Members access our Member Web Portal, they have access to this page. It allows access to information available from our claims administration and adjudicating system, as well as links to other resources such as PPO networks and forms.

In addition, our HealthSCOPE Benefits Customer Care specialists have the ability to log into the Landing Page just as a member would, in order to assist in troubleshooting problems members may encounter while utilizing our web portal.

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Healthaxis > Home - Provided by Bluehill Data Services

https://dashboard.healthaxi... Healthaxis > Home

Edit View Favorites Tools Help

Logout



**Egyptian Area Schools**

Preventive Services are offered at no cost to the member. Stay healthy by participating in the following wellness activities:

- Routine Well Care for Adults
- Routine Well Care for Children
- Flu Shot
- Mammogram
- Colonoscopy

**Seasonal allergies: Nip them in the bud**

Spring means flower buds and blooming trees — and if you're one of the millions of people who have seasonal allergies, it also means sneezing, congestion, a runny nose and other bothersome symptoms. Seasonal allergies — also called hay fever and allergic rhinitis — can make you miserable. But before you settle for plastic flowers and artificial turf, try these simple strategies to keep seasonal allergies under control.

To reduce your exposure to the things that trigger your allergy signs and symptoms (allergens):

- Stay indoors on dry, windy days. The best time to go outside is after a good rain, which helps clear pollen from the air.
- Delegate lawn mowing, weed pulling and other gardening chores that stir up allergens.
- Remove clothes you've worn outside and shower to rinse pollen from your skin and hair.
- Don't hang laundry outside — pollen can stick to sheets and towels.
- Wear a pollen mask if you do outside chores.
- Take extra steps when pollen counts are high

**Resources**

Below are helpful resources for you.

- ➔ Claims and Eligibility
- ➔ Order ID Card
- ➔ Provider Look Up
- ➔ Travel Network
- ➔ Pharmacy Benefits
- ➔ HSB Wellness
- ➔ VSP

# Member Web Portal

Beginning September 1, you have 24/7 access to your personal benefits, claims, and eligibility information. Here's how it works.

**1** Connect to [www.healthscopebenefits.com](http://www.healthscopebenefits.com) and click on **Member**.

**2** Enter your **Company Name (EGYP)** and click **Enter**.

**3** Enter your user name and password and click **Sign In**. If you haven't registered for an account yet, follow the on-screen prompts to do so.

**4** On the next screen, click **Claims and Eligibility**.

**5** The **Member Dashboard** displays several options, including:

**Current coverages** – displays current plans and any changes in history.

**Recent Claims** – displays claims history.

**Benefits Used** – displays dollar amounts paid per category per benefit year and overall lifetime maximum.

**Quick Links** – users can request duplicate ID cards, or review demographic information.

**MEMBER** CUSTOMER PROVIDER

En Español

HealthSCOPE BENEFITS | Healthy People Healthy Business Healthy Futures

HOME ABOUT CONTACT PRODUCTS BROKERS CAREERS

TO VIEW BENEFIT INFORMATION, YOU MUST SPECIFY WHICH TYPE OF VISITOR YOU ARE. SELECT FROM THE OPTIONS ABOVE.

**Welcome Members**

HealthSCOPE Benefits makes it easy to manage your health care!

HealthSCOPE Benefits is pleased to provide our customers with convenient online resources and services.

In this section, you can view your personal account information, find a provider, download forms and member publications, and contact us directly. To view account information about yourself or your family member, you can create a user profile and access online services.

**BENEFIT INFORMATION**

Please Enter Your:

Company Name:  Enter

Friday, April 21, 2017 #DY3K55

**Site Sign In**

Username:  x

Password:

Sign In

New Member Registration  
Forgot Username or Password?

Healthy People Healthy Business Healthy Futures

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Spring means flower buds and blooming trees — and if you're one of the millions of people who have seasonal allergies, it also means sneezing, congestion, a runny nose and other bothersome symptoms. Seasonal allergies — also called hay fever and allergic rhinitis — can make you miserable. But before you settle for plastic flowers and artificial turf, try these simple strategies to keep seasonal allergies under control.

**Resources**

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[Claims and Eligibility](#)

[Order ID Card](#)

HealthSCOPE BENEFITS | Healthy People Healthy Business Healthy Futures

Home My Account Profile Member Services Contact Us / Feedback

Thursday, 01/28/2016 #ANVZES

**HEALTHSCOPE BENEFITS, INC (CEN - CBUSA)**

**Member Dashboard**

**Current Coverages**

Coverage Type	Coverage Name	Effective Date	Termination Date	Premium Payer	Covered Dependents
Health	PRO GUEST	02/01/2015			JOHN (S)
Dental	AETNA DENTAL	02/01/2015			JOHN (S)
Vision	CENTRAL BENEFITS VISION PLAN	02/01/2015			JOHN (S)

**Recent Claims**

Claims ID	Claims Type	Patient	Service Date	Billed	Paid	Provider	Status	EOB
135533	Health	JOHN (S)	01/11/2016	\$6.09	\$0.00	Pharmacy Benefit	Processed	
134117	Health	JOHN (S)	12/22/2015	\$239.10		Pharmacy Benefit	Pending	
177332	Health	JOHN (S)	10/23/2015	\$217.67	\$177.67	Pharmacy Benefit	Processed	
175567	Health	JOHN (S)	10/09/2015	\$157.00	\$41.52	Heritage Medical Associates PC	Processed	
173864	Health	JOHN (S)	10/09/2015	\$17.36	\$7.36	Pharmacy Benefit	Processed	
174265	Health	JOHN (S)	09/15/2015	\$144.00	\$80.85	Heritage Medical Associates PC	Processed	
173517	Health	JOHN (S)	09/16/2015	\$6.80	\$0.00	Pharmacy Benefit	Processed	

Don't see the claim you're looking for? [Search Claims](#)

**Benefits Used**

Plan Year: 2016

	Medical	Dental	Vision		
Out of Pocket Spending					
Member	Ind/Pam \$0.00/\$0.00	Ind/Pam \$0.00/\$0.00	Ind/Pam \$6.06/\$6.09	Individual \$0.00	Individual \$307.40

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**Quick Links**

- [View Wellness Activity](#)
- [Request ID Card](#)
- [Change COB Information](#)
- [Electronic Transactions Setup](#)
- [View Personal Information](#)

**Announcements**

No Announcements

**Documents**

No Documents

**Links**

- [Health Care Cost Estimator](#)



# My HSB Mobile App

**You can also use your smart phone to view eligibility and claim information anywhere, anytime!**

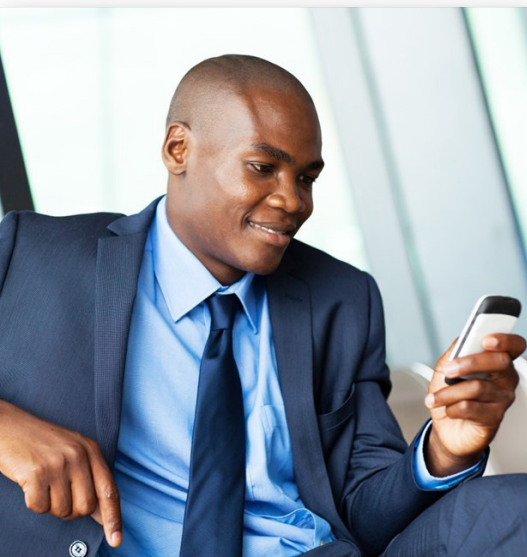
No sensitive account information is stored on your mobile device, and the highest level of secure encryption is used to protect all transmissions. Note that the MyHealthSCOPE Benefits mobile app is separate from your online account set up on our website.



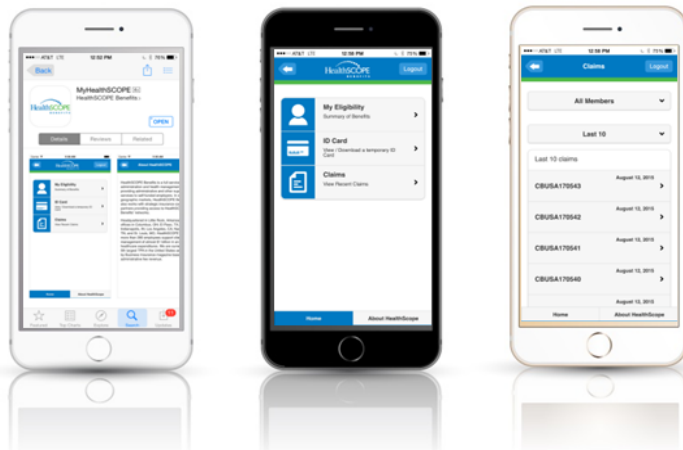
**HealthSCOPE Benefits offers various tools to monitor your benefit plan information.** On our website you can locate providers, order ID cards, view claims status, and check eligibility information.

Now in addition to creating an account on our website, you can also download the **MyHealthSCOPE Benefits app** for your Android or iPhone device. The free app allows you to have your health, dental, and vision plan information at your fingertips 24/7.

**Downloading is easy!** Search for MyHealthSCOPE Benefits. Download the app. Choose “Access Your Account,” then “Create An Account.”



Have questions? Visit our website at [www.healthscopebenefits.com](http://www.healthscopebenefits.com) or call our toll-free number shown on your ID card.



# Member Mailings

We stay in contact with our members to notify them of products and services available. Communication may be in the form of mailings delivered to member's homes or mass emails. The flier shown here explains how members can set up their Web Portal to automatically send electronic EOBs to their email address.

**HealthSCOPE**  
BENEFITS

**Electronic Explanation of Benefits**

RECEIVE YOUR EOBs ONLINE

HealthSCOPE Benefits offers you the ability to receive your Explanation of Benefits (EOBs) electronically. **Enrolling is free and only takes a few minutes.** Once enrolled, you will receive an email letting you know when an EOB is available to review online.

Upon completion of enrollment for electronic EOBs, a traditional paper Explanation of Benefits will no longer be sent to you unless you are receiving a reimbursement check. However, **you can always retrieve a paper copy online for your records.**

**IT'S SIMPLE, QUICK, & EASY TO ENROLL**

**ADVANTAGES TO RECEIVING AN ELECTRONIC EOB**





- ◆ Quicker availability to paid claims.
- ◆ Paper conservation.
- ◆ Email notification of when your claim is processed.

**HOW TO ENROLL**


1. Log on to [www.healthscopebenefits.com](http://www.healthscopebenefits.com).
2. Click on "Claims Status" and enter your personal ID and password.
3. Click "Set up a new web account."
4. Select "Electronic Transactions Setup."
5. Enter your email address in the box indicated where you want your EOBs sent.
6. In the "Add an EFT Bank Account," mark this section "Disabled" and click "Next Page."
7. Review the summary information.
8. If all is correct, click "Submit Change Request."

After you have completed these steps, you will receive a notification when an EOB is available online for your review.

**QUESTIONS?**

[www.healthscopebenefits.com](http://www.healthscopebenefits.com)

 1.800.844.0284

1.800.844.0284 | [www.healthscopebenefits.com](http://www.healthscopebenefits.com)





# Sample Claims Processing Notification

**H**ealthSCOPE Benefits offers EEOB (Electronic Explanation of Benefits) for our members. Members will receive email notifications when a claim is processed or when a monthly statement is available for viewing. The following is a sample email a member would receive.

**Doe, Jane**

---

**From:** Email on behalf of CLAIMS.NOTIFICATION@HEALTHSCOPEBENEFITS.COM  
**Sent:** Thursday, June 29, 2017 8:52 AM  
**To:** Doe, Jane  
**Subject:** HealthSCOPE Benefits Claim Processing Notification

Please be advised that your claim has been processed. An electronic image of the EOB will be available within 24-48 hours. You may check your plan website at [www.healthscopebenefits.com](http://www.healthscopebenefits.com) for complete details regarding your Benefit Plan consideration. Your Monthly Activity will be sent at the end of the current month. We are very pleased to be able to offer this monthly activity service.

Sincerely,

This email message is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender immediately by reply email and destroy all copies of the original message.

# Explanation of Benefits

HealthSCOPE Benefits  
27 Corporate Hill Drive  
Little Rock, AR 72205



Customer Service Hours:  
8AM-5PM CST 888-555-1234  
IVR & Website available 24 hrs  
www.healthscopebenefits.com

015779-0000001-0000002-0197920

JOHN DOE  
123 N. MAPLE STREET  
ANYTOWN, AR 37902

### Customer Service Data

Member: John Doe  
Patient: Jane Doe  
Birthdate: 0212XXXX  
Relationship: Child  
Patient Account Number: J12345678  
Trans#: CHP8066888  
Provider: MEMORIAL HEALTH UNIVERSITY MED  
Date Processed: 04/11/2017  
Check #:   
Group ID: ABC  
Subgroup Name: ABC.1000

## Explanation of Benefits (EOB)

This is not a bill

This is an Explanation of Benefits for a claim received for JANE DOE on 04/07/2017 for services provided by MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER INC.

### Claim Summary

Amount Billed	\$284.00	This is the full amount the provider billed for services.
Discount	\$0.00	You saved \$0.00 by using an in-network provider. HealthSCOPE Benefits has negotiated discounts with in-network providers to help save you money.
What the plan paid	\$75.35	The amount the plan paid on your behalf.
What you owe	\$0.00	This is the amount that you owe after discounts have been applied and the plan has paid. Your liability includes deductible amounts, applicable co-insurance, and services not covered under the plan.

### Claim Detail

Service Date	Type of Service	Comment Codes	Amount Billed	Discounts	Excluded	Adjusted	Copay	Deductible	Balance	Paid At %	Benefit
03-14-17	1-Professional Service		284.00	0.00	208.65	0.00	0.00	0.00	75.35	100	75.35
<b>Claim Totals</b>			284.00	0.00	208.65	0.00	0.00	0.00	75.35		75.35

Comment Codes: P1871

PAID to Provider CHECK # 000000-7878-999 75.35  
Patient Liability 0.00

### Plan Status/Accumulators

INDIVIDUAL Deductible Met \$	\$128.04
INDIVIDUAL Deductible MET \$	\$32.04
INDIVIDUAL Coinsurance MET \$	\$81.01
INDIVIDUAL Coinsurance Met \$	\$81.01
INDIVIDUAL Cumulative Copay MET \$	\$863.04
FAMILY Deductible Met \$	\$318.84
FAMILY Deductible MET \$	\$32.04
FAMILY Coinsurance MET \$	\$385.47
FAMILY Coinsurance Met \$	\$385.47
FAMILY Cumulative Copay MET \$	\$913.04

# Explanation of Benefits

## Comment Code Descriptions

**P1871** The amount exceeds the Plan's Reasonable and Allowed Amount that generally limits the maximum amount payable to 140% of the Medicare Allowable.

Providers are reimbursed in accordance with the governing Plan Document up to the Reasonable and Allowed Amount less any required deductibles/copays/coinsurance and subject to Plan limitations and exclusions as set forth in the Plan Document at the time the charges are incurred.

Under the terms of the Plan Document, an Assignment of Benefits is valid only when a Provider accepts the Reasonable and Allowed Amount as consideration in full for the services rendered. Consideration in full requires that the Provider refrain from seeking any additional payment for Excess Charges directly from the Plan Participant (i.e. balance billing the patient).

The Plan Participant has the right to appeal a denial (in whole or part) and a Provider by virtue of a valid Authorized Representative Designation (as set forth in the Plan Document), may also exercise the Plan Participant's right to appeal. The initial appeal must be submitted to HealthSCOPE Benefits within (180) days following the receipt of an Adverse Benefit Determination. Notice of an appeal decision will be provided within 30 days of the receipt of the request.

For questions regarding this claim and/or the denied charges please feel free to call the number identified on the header of this document, or make an appeal to HealthSCOPE Benefits, Inc., Attn: Appeals, P.O. Box 2860, Little Rock, AR 72203.

## You Should Know...

It is Stress Awareness Month. If you are feeling stressed, look for ways to relieve it. Have you tried meditation, yoga, or even a simple walk? Find stress relievers that work for you!

## Important Information

If you have any questions about this explanation of benefits, please call Customer Service at the toll free number on your ID Card or send a written request to My Health Plan c/o HealthSCOPE Benefits, Attn: Claims Inquiry, P. O. Box 99005, Lubbock, TX 79490-9005. You may also contact us to request free of charge a copy of any rules, guidelines, protocols, or the scientific or clinical basis used in making the decision on processing of your claim.

If you are not satisfied with this decision, either you or your authorized representative can start the appeals process by sending a written request to My Health Plan c/o HealthSCOPE Benefits, Inc., Attn: Appeals, P. O. Box 2860, Little Rock, AR 72203, or as otherwise set out in your benefit plan book within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.

Please follow the steps below to make sure your appeal is processed in a timely manner:

- Send a copy of this explanation of benefits, along with any relevant additional information (e.g., benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your Name, 2) Account Number from the front of this form, 3) ID Number from the front of this form, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge. You have the right to billing and diagnosis codes as well.
- If your situation is urgent, you may request an expedited appeal which will generally be conducted within 72 hours. If you believe your situation is urgent, follow the instructions above from filing an internal appeal and also call Customer Service to request a simultaneous external review if permitted by your plan.

You will be notified of the final decision in a timely manner, as described in your plan materials. If we continue to deny payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party. Contact us at the appeal address about to find out how to start an external review. If your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision. In addition, you may have a separate time limitation for legal action regarding the recovery of benefits under the plan. Refer to your plan documents for the time limitation.

SPANISH (Español) Si usted tiene dificultades para leer inglés, ofrecemos asistencia en su idioma. Para obtener ayuda por favor llame al servicio al número en su tarjeta de identificación.

# Prescription Drug coverage by



**EXPRESS SCRIPTS®**



Your Prescription Drug plan is administered by Express Scripts. At Express Scripts we believe in practicing pharmacy smarter. We put medicine within reach of tens of millions of people by aligning with our customers, taking bold action, and delivering patient-centered care to make better health more affordable and accessible.

You and your covered dependents who enroll in the Express Scripts pharmacy benefit will enjoy options to shop either by retail or the Express Scripts Mail Service Pharmacy.

**For plan details, refer to page 17.**

## Ameritas Dental

For 2017-18, the administrator for your dental insurance is Ameritas. At Ameritas, we have the benefit plans that keep organizations like yours in the game by helping keep plan members and their loved ones happy. It all begins by fulfilling life. And that's what we do best.

### **Customer Service**

Get answers to your claims questions from award-winning claims representatives Monday through Thursday from 7 a.m. to Midnight and Friday from 7 a.m. to 6:30 p.m. Central Time. Languages spoken include English and Spanish in addition to multilingual interpretation through our language service.

- We are accredited by URAC, the Utilization Review Accreditation Commission, an organization that accredits health plans and preferred provider organizations.
- Our claims contact center associates have earned BenchmarkPortal's Center of Excellence award since 2007, an achievement held only by two other companies.
- They also won third place in BenchmarkPortal's 2016 and 2017 Top 100 competition for medium-sized call centers.

**For plan details and rates, refer to pages 18 and 19.**



# Vision Coverage



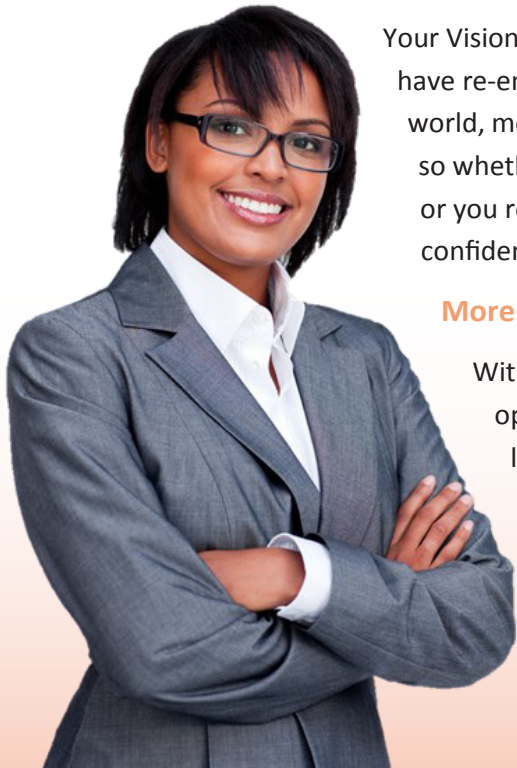
Your Vision Insurance provider is EyeMed. At EyeMed, we have re-envisioned the world of vision benefits. In our world, members are at the heart of everything we do, so whether you have an existing vision correction need or you rely on annual eye exams to keep your vision healthy and sharp, you can feel confident knowing you get more to love with EyeMed.

## More Choice

With EyeMed, you get the right mix of thousands of independent providers, top optical retailers and online options, like Glasses.com or ContactsDirect or lenscrafterscontacts.com. You can see the doctors you want and pick from top brands like Ray-Ban®, Oakley®, and Coach®. The who, what, where, and when are all up to you.

With nearly 30 years of experience, EyeMed is America's fastest growing vision benefits company.

**For plan details and rates, refer to pages 20 and 21.**



# Life and AD&D Coverage

Life Insurance, Supplemental Life Insurance, and Accidental Death and Dismemberment plans and policies are available from Dearborn National®.

Fort Dearborn Life is there for those who want to provide for their dear ones. Fort Dearborn Life Insurance offers employee benefits including group life and disability insurance products throughout the US. Its products include annuities, dental plans, discount prescription drug programs, and critical illness benefit plans. Fort Dearborn Life also offers individual life insurance and annuity products. Along with sister company Dental Network of America, the company is part of Health Care Service Corporation and their products are marketed under the Dearborn National brand. The firm is selling its Colorado Bankers Life Insurance unit to Southland National Insurance. Fort Dearborn Life Insurance was founded in 1969.

**For plan details and rates, refer to pages 22 and 23.**



# Prescription Drug Benefit

**E**xpress Scripts, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit. Express Scripts maintains the Preferred Drug list (also known as a Formulary), manages a network of retail pharmacies and operates Mail Service and Specialty Drug pharmacies. Express Scripts, in consultation with the Plan, also provides services to promote the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions and other safety measures.



Your benefit covers most prescription drugs. Certain medications are subject to limitations and may require prior authorization for continued use.

Employees and dependents covered by the prescription drug benefit can use either retail or the Express Scripts Mail Service Pharmacy.



## Retail Pharmacies

Retail pharmacy service is most convenient for short-term prescription needs. For example, if you need an antibiotic to treat an infection, you can go to one of the many pharmacies that participate in the Express Scripts network. At retail, you can get up to a 30-day supply or a 90-day supply for maintenance drugs. All major chain pharmacies participate in the network. If you are using an independent drugstore, you should confirm whether it participates, too. To find out, visit [www.express-scripts.com](http://www.express-scripts.com) or call Member Services at **800-706-1754**.

## The Express Scripts Pharmacy, Mail Service

Members that need medication on an ongoing basis can ask their doctor to prescribe up to a 90 day supply, plus refills if appropriate. Examples are ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. Just a single co-payment is required for each 90 day prescription.

- Medications are shipped standard delivery at no additional cost.
- First-time orders are usually delivered within 8-11 days after we receive your order.
- Refills usually arrive in less time – refills ordered online are usually delivered within 3-5 days and refill orders mailed in are usually delivered within 6-9 days.
- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines and other important details.
- You can track your prescriptions and order refills at [www.express-scripts.com](http://www.express-scripts.com) or by calling customer service.
- Registered pharmacists are available around the clock for consultation.

**Plan 1: Dental Plan Summary**

**Effective Date: 9/1/2017**

Plan Benefit	High Plan	Low Plan
Type 1	100%	80%
Type 2	80%	70%
Type 3	50%	N/A
<b>Deductible</b>	\$50/Calendar Year Type 2 & 3 \$10/visit Type 1 3 Family Maximum	\$50/Calendar Year Type 2 \$10/visit Type 1 3 Family Maximum
<b>Maximum (per person)</b>	\$1500 per calendar year	\$750 per calendar year
<b>Allowance Type 1</b>	90th U&C	90th U&C
<b>Allowance Type 2</b>	Maximum Procedure Allowance	Maximum Procedure Allowance
<b>Allowance Type 3</b>	Maximum Procedure Allowance	None
<b>Dental Rewards®</b>	Included	Included
<b>Ameritas Rewards<sup>SM</sup></b>	Included	N/A
<b>Annual Eye Exam</b>	None	None

**Orthodontia Summary - Child Only Coverage**

<b>Allowance</b>	U&C	No Ortho
<b>Plan Benefit</b>	50%	
<b>Lifetime Maximum (per person)</b>	\$1,000	
<b>Ameritas Rewards<sup>SM</sup></b>	\$100	
<b>Lifetime (per person)</b>		
<b>Waiting Period</b>	n/a	

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

Type 1	Type 2	Type 3 (High Plan Only)
<ul style="list-style-type: none"> <li>Routine Exam (2 per benefit period)</li> <li>Bitewing X-rays (2 per benefit period)</li> <li>Full Mouth/Panoramic X-rays (1 in 3 years)</li> <li>Periapical X-rays</li> <li>Cleaning (2 per benefit period)</li> <li>Fluoride for Children 18 and under (1 per benefit period)</li> </ul>	<ul style="list-style-type: none"> <li>Sealants (age 16 and under)</li> <li>Space Maintainers</li> <li>Restorative Amalgams</li> <li>Restorative Composites</li> <li>Endodontics (nonsurgical)</li> <li>Endodontics (surgical)</li> <li>Periodontics (nonsurgical)</li> <li>Periodontics (surgical)</li> <li>Denture Repair</li> <li>Simple Extractions</li> <li>Complex Extractions</li> <li>Anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>Onlays</li> <li>Crowns (1 in 5 years per tooth)</li> <li>Crown Repair</li> <li>Implants</li> <li>Prosthetics (fixed bridge; removable complete/partial dentures) (1 in 5 years)</li> </ul>

**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..

Monthly Rates	High Plan	Low Plan
Employee Only (EE)	\$35.96	\$14.76
EE + 1 Dependent	\$67.84	\$28.84
EE + 2 or more Dependents	\$99.48	\$55.44

**Ameritas Rewards<sup>SM</sup> (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<sup>®</sup> (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.

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](http://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](http://www.ameritas.com/group/olbc/egyptianschooltrust) for plan information and online presentations. If already enrolled you may also use the [www.ameritas.com](http://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

## SUMMARY OF BENEFITS

### Additional discounts

**40% OFF**

Complete pair of prescription eyeglasses

**20% OFF**

Non-prescription sunglasses

**20% OFF**

Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

### Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on [eyemed.com](http://eyemed.com) or call 1.866.804.0982.
- For LASIK providers, call 1.877.5LASER6.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
<b>Exam With Dilation as Necessary</b>	\$15 Co-pay	Up to \$45
<b>Retinal Imaging</b>	Up to \$39	N/A
<b>Frames</b>	\$0 Co-pay, \$130 Allowance, 20% off balance over \$130	Up to \$91
<b>Standard Plastic Lenses</b>		
Single Vision	\$15 Co-pay	Up to \$30
Bifocal	\$15 Co-pay	Up to \$50
Trifocal	\$15 Co-pay	Up to \$65
Lenticular	\$15 Co-pay	Up to \$100
Standard Progressive Lens	\$70 Co-pay	Up to \$50
Premium Progressive Lens <sup>A</sup>	\$90 Co-pay - \$115 Co-pay	
Tier 1	\$90 Co-pay	Up to \$50
Tier 2	\$100 Co-pay	Up to \$50
Tier 3	\$115 Co-pay	Up to \$50
Tier 4	\$70 Co-pay, 20% off retail less \$120 Allowance	Up to \$50
<b>Lens Options</b>		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate—Adults	\$40	N/A
Standard Polycarbonate—Kids under 19	\$0	Up to \$5
Standard Anti-Reflective Coating	\$45	N/A
Premium Anti-Reflective Coating <sup>A</sup>	\$57 - \$68	N/A
Tier 1	\$57	N/A
Tier 2	\$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	\$75	N/A
Polarized	20% off retail	N/A
Other Add-Ons and Services	20% off retail	N/A
<b>Contact Lens Fit and Follow-Up</b> (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to \$40	N/A
Premium Contact Lens Fit & Follow-Up	10% off Retail Price	N/A
<b>Contact Lenses</b> (Contact lens allowance includes materials only.)		
Conventional	\$0 Co-pay, \$130 Allowance, 15% off balance over \$130	Up to \$105
Disposable	\$0 Co-pay, \$130 Allowance; plus balance over \$130	Up to \$105
Medically Necessary	\$0 Co-pay, paid-in-full	Up to \$210
<b>Laser Vision Correction</b>		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
<b>Hearing Care</b>		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
<b>Frequency</b>		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
<b>Premiums—Monthly</b>		
Subscriber	\$7.76	
Subscriber + 1	\$11.12	
Subscriber + Family	\$20.12	

Benefits are not provided from services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/ Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use with the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. <sup>A</sup>Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

# What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.



Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every 12 months)	\$15 Co-pay	Up to \$45
Frames (once every 24 months)	\$0 Co-pay, \$130 Allowance; 20% off balance over \$130	Up to \$91
Single Vision Lenses (once every 12 months) or	\$15 Co-pay	Up to \$30
Contacts (once every 12 months)	\$0 Co-pay, \$130 Allowance; plus balance over \$130	Up to \$105

## And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs \$163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

**78%**  
SAVINGS  
with us\*

With EyeMed		Without Insurance**	
Exam	\$15 Co-pay	Exam	\$106
Frame	\$163 <u>-\$130 Allowance</u> \$33 <u>-\$6.60 (20% discount off balance)</u> \$26.40	Frame	\$163
Lens	\$15 Co-pay \$15 UV treatment add-on <u>+\$15 scratch coating add-on</u> \$45	Lens	\$78 \$23 UV treatment add-on <u>+\$25 scratch coating add-on</u> \$126
<b>Total</b>	<b>\$86.40</b>	<b>Total</b>	<b>\$395</b>



## Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.



\*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. \*\*Based on industry averages.



# Life Insurance

## Group Life Benefit Program Summary — 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: Employee Options	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 increases 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 FDL 1-504-707-IL.)

Products and services marketed under the Dearborn National<sup>®</sup> brand and the star logo are underwritten and/or provided by Dearborn National<sup>®</sup> Life Insurance Company (Downer's Grove, IL) (formerly known as Fort Dearborn Life Insurance Company<sup>®</sup>) and certain of its affiliates. Dearborn National<sup>®</sup> 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



www.dearbornnational.com

### 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 your annual salary
- Spouse Benefit: \$5,000 to \$250,000, in increments of \$25,000, 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 \$5,000 or \$10,000

### Employee Supplemental Life/AD&D Insurance

Monthly premium cost (based on 12 payroll deductions per year)

Employee & Spouse Supplemental Life/AD&D Monthly rates per \$1,000	
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

Benefit	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
<b>\$10,000</b>	\$0.85	\$0.85	\$0.95	\$1.05	\$1.35	\$1.95	\$3.05	\$4.95	\$7.95	\$9.85	\$16.85	\$16.85
<b>\$25,000</b>	\$2.13	\$2.13	\$2.38	\$2.63	\$3.38	\$4.88	\$7.63	\$12.38	\$19.88	\$24.63	\$42.13	\$42.13
<b>\$50,000</b>	\$4.25	\$4.25	\$4.75	\$5.25	\$6.75	\$9.75	\$15.25	\$24.75	\$39.75	\$49.25	\$84.25	\$84.25
<b>\$75,000</b>	\$6.38	\$6.38	\$7.13	\$7.88	\$10.13	\$14.63	\$22.88	\$37.13	\$59.63	\$73.88	\$126.38	\$126.38
<b>\$100,000</b>	\$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	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
<b>\$5,000</b>	\$0.43	\$0.43	\$0.48	\$0.53	\$0.68	\$0.98	\$1.53	\$2.48	\$3.98	\$4.93	\$8.43	\$8.43
<b>\$10,000</b>	\$0.85	\$0.85	\$0.95	\$1.05	\$1.35	\$1.95	\$3.05	\$4.95	\$7.95	\$9.85	\$16.85	\$16.85
<b>\$25,000</b>	\$2.13	\$2.13	\$2.38	\$2.63	\$3.38	\$4.88	\$7.63	\$12.38	\$19.88	\$24.63	\$42.13	\$42.13
<b>\$30,000</b>	\$2.55	\$2.55	\$2.85	\$3.15	\$4.05	\$5.85	\$9.15	\$14.85	\$23.85	\$29.55	\$50.55	\$50.55
<b>\$35,000</b>	\$2.98	\$2.98	\$3.33	\$3.68	\$4.73	\$6.83	\$10.68	\$17.33	\$27.83	\$34.48	\$58.98	\$58.98
<b>\$37,500</b>	\$3.19	\$3.19	\$3.56	\$3.94	\$5.06	\$7.31	\$11.44	\$18.56	\$29.81	\$36.94	\$63.19	\$63.19

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downer's Grove, IL) (formerly known as Fort Dearborn Life Insurance Company®) 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.

# Your Teladoc<sup>+</sup> Program

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

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

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

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

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

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

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

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

Doctors can be reached by phone at 1-800-362-2667. If you prefer, you can also email a doctor or request a video consultation through the online health portal, My Personal Health Manager. Simply login at [www.mydrconsult.com](http://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.** User interactive tools, designed to help you get well.
- **Health Centers.** Comprehensive resource guides for every medical condition, with medical tests, drug reference libraries, and corresponding links to community reference forums.

Contact a Teladoc physician at 1-800-362-2667, or by visiting [www.mydrconsult.com](http://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.*





# Egyptian Area Schools Employee Benefit Trust

## UNIVERSAL CHANGE ENROLLMENT FORM

All Changes Effective 9/1/17 or Later Must Be Entered By Employer In HealthSCOPE Benefits Website

<b>EMPLOYER / PLAN SPONSOR AUTHORIZATION SECTION – EMPLOYER MUST COMPLETE</b> (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
Special Instructions					
<b>ENROLLMENT CHANGE SECTION</b> Effective Date of Change _____ / _____ / _____ (indicate changes below)					
<b>EMPLOYEE INFORMATION – EMPLOYEE MUST COMPLETE THIS SECTION</b> (Incomplete forms will be returned and may delay enrollment)					
Employee Name		Last	First	MI	Sex
					<input type="checkbox"/> M <input type="checkbox"/> F
		Date of Birth		Social Security Number	
<input type="checkbox"/> <b>Employee Name</b> From: _____ To: _____ <input type="checkbox"/> <b>Employee Address</b> From: _____ To: _____ <input type="checkbox"/> <b>Employee Phone</b> From: _____ To: _____ <input type="checkbox"/> <b>Employee Email</b> From: _____ To: _____ <input type="checkbox"/> <b>Marital Status</b> From: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced To: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Divorced					
<input type="checkbox"/> <b>Termination</b> Choose Reason			<input type="checkbox"/> <b>Dependent Status</b> (When adding or terminating a dependent you must complete Dependent Section on the reverse side.)		
<input type="checkbox"/> Active <input type="checkbox"/> Lay Off <input type="checkbox"/> Death <input type="checkbox"/> Retired <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other			<input type="checkbox"/> <b>Add Dependent(s)</b> Reason for Addition: <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible Full-time Student <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Reduction In Hours <input type="checkbox"/> Medicare Entitlement <input type="checkbox"/> Marriage <input type="checkbox"/> Civil Union			<input type="checkbox"/> <b>Terminate Dependent(s)</b> Reason for Termination: <input type="checkbox"/> Ineligible Child <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Civil Union <input type="checkbox"/> Civil Union Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Death <input type="checkbox"/> Other _____		
<input type="checkbox"/> Leave of Absence <input type="checkbox"/> Terminate Employment <input type="checkbox"/> Divorce <input type="checkbox"/> 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.		
<b>EMPLOYEE COVERAGE CHANGE: You must check one box in each column below</b>					
<b>Medical</b>		<b>Voluntary Teladoc</b>	<b>Voluntary Dental</b>		<b>Voluntary Vision</b>
Changes to health plan coverage or Voluntary Teladoc may only be made during annual open enrollment period or within 31 days of a qualifying event.  Instruction: Enter the Plan Name/Coverage Type in which you are selecting to enroll or change. Only populate if you are changing your medical plan option or coverage type. Check "No Change Medical" if no medical changes are being made.  Enter Plan Name Here: _____		Add <input type="checkbox"/> Cancel <input type="checkbox"/>	Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.  TO: <input type="checkbox"/> High <input type="checkbox"/> Low		Changes to voluntary vision plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.  TO: Add <input type="checkbox"/> Cancel <input type="checkbox"/>
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Terminate Medical <input type="checkbox"/> No Change Medical		<input type="checkbox"/> Employee Only <input type="checkbox"/> Terminate <input type="checkbox"/> No Change	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Dental <input type="checkbox"/> No Change Dental		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more Dependents <input type="checkbox"/> Terminate Vision <input type="checkbox"/> No Change Vision
<b>Basic Life</b> – All life insurance terminates upon employment termination or retirement.			<b>Optional Life</b> – 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 <a href="http://www.egtrust.org">www.egtrust.org</a> .		
<input type="checkbox"/> Add Basic Life (Only available when employee is newly eligible.) <input type="checkbox"/> Term Basic Life <input type="checkbox"/> No Change			EMPLOYEES: Check all boxes that apply: <input type="checkbox"/> Add Optional Employee (Evidence of Insurability REQUIRED) <input type="checkbox"/> Terminate Optional Employee <input type="checkbox"/> Add Optional Spouse (Evidence of Insurability REQUIRED) <input type="checkbox"/> Terminate Optional Spouse <input type="checkbox"/> Add Optional Dependent( Evidence of Insurability REQUIRED) <input type="checkbox"/> Terminate Optional Dependent <input type="checkbox"/> 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.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
2.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
3.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
4.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline
5.				- -	<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline

**BASIC LIFE – CHANGE Beneficiary Information**

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

**OPTIONAL LIFE – CHANGE Beneficiary**

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

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

**OTHER INSURANCE COVERAGE**

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

Names of individuals with other coverage: \_\_\_\_\_  
 Name of insurance carrier or TPA: \_\_\_\_\_ Group No. \_\_\_\_\_

Name of employer providing coverage: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Effective Date of other coverage : \_\_\_\_\_ Is other coverage Medicare or Medicaid?  Yes  No

**ADDITIONAL CHANGES – Please add any comments concerning your changes.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

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

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



**IF YOU ARE A NEW ENROLLEE, COMPLETE AND RETURN TO YOUR EMPLOYER**



## Egyptian Area Schools Employee Benefit Trust

### UNIVERSAL NEW ENROLLEE (Not Currently Covered)

**All Changes Effective 9/1/17 or Later Must Be Entered By Employer In HealthSCOPE Benefits Website**

<b>EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER MUST COMPLETE THIS SECTION</b> (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 <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"/> Annual Enrollment- Applies to dental plan only <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Change in Family Status Reason					Employee Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Other		Date of Hire _____	
Certified by (Authorized Representative) _____				Date _____		Employer Telephone _____		
Special Instructions: _____								
<b>EMPLOYEE INFORMATION: EMPLOYEE MUST COMPLETE THIS SECTION (Incomplete forms will be returned and may delay enrollment)</b>								
Employee Name Last _____		First _____		MI _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union	Social Security Number _____
Employee Home Address _____		Street/Apt. _____		City _____		State _____	Zip _____	
Home Phone _____		Email Address _____			Occupation: _____		Earnings \$ _____	
Business Phone _____					Average Hours Worked per Week: _____		<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	
<b>EMPLOYEES: You must check one box in each section below.</b>						<b>EMPLOYEES: Check all boxes that apply:</b>		
<b>Medical Plan Options</b> Instruction: Ask your Employer which Plans are being offered. Enter Plan Name of the Plan in which you are enrolling: _____		<b>Voluntary Teladoc</b>  <input type="checkbox"/> Teladoc Only		<b>Voluntary Dental</b>  <input type="checkbox"/> High  <input type="checkbox"/> Low		<b>Voluntary Vision</b>		<b>Basic Life –</b> Basic Life is automatic when enrolling in Health Plan
								Basic Life Amount _____ Decline coverage
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child or Children <input type="checkbox"/> Family <input type="checkbox"/> Decline Coverage NOTE: Includes Teladoc, Basic Life Insurance and Prescription Coverage		<input type="checkbox"/> Employee Only <input type="checkbox"/> Decline Coverage  NOTE: Teladoc is included in Medical Plan.		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more depts <input type="checkbox"/> Decline Coverage		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more depts <input type="checkbox"/> Decline Coverage		<b>Optional Life –</b> When applying for more than guaranteed issue amounts an Evidence of Insurability form must be completed.
								<input type="checkbox"/> Optional Employee Life Amount _____ Note: Evidence of Insurability Form required for amounts over \$100,000 <input type="checkbox"/> Optional Spouse Life Amount _____ Note: Limited to 50% of Employee Life – Evidence of Insurability required for amounts over \$37,500 <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> \$5,000 or <input type="checkbox"/> \$10,000 Note: Covers all eligible children <input type="checkbox"/> Decline Coverage
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. _____				/ /	- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline	
2. _____				/ /	- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline	
3. _____				/ /	- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline	
4. _____				/ /	- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline	
5. _____				/ /	- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Decline	
<b>OTHER INSURANCE COVERAGE</b>								
Are you or any of your dependents covered by another group, medical, dental, or vision plan?				<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, type(s) of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare/Medicaid Effective Date of coverage _____		



<b>BASIC LIFE – Beneficiary Information</b>						
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	
<b>OPTIONAL LIFE – Beneficiary Information</b>						
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	
<b>Note:</b> 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.						
<b>REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE)</b>				<b>Dearborn National</b>		
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> <b>"I APPLY FOR THE BASIC GROUP LIFE BENEFITS</b> indicated above and, if my application is approved by Dearborn National, I authorize deductions from my pay for any required contributions."				<input type="checkbox"/> <b>"I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS</b> indicated above and, if my application is approved by Dearborn National, I authorize deductions from my pay for any required contributions."		
<input type="checkbox"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program.</b> 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"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program.</b> 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"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program.</b> 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.						
<b>REQUEST FOR COVERAGE (MEDICAL)</b>						
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> <b>"I APPLY FOR THE GROUP BENEFITS</b> 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."						
<input type="checkbox"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program.</b> I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply."						
<b>REQUEST FOR COVERAGE (VOLUNTARY TELADOC)</b>						
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> <b>"I APPLY FOR THE GROUP BENEFITS</b> indicated above and, I authorize deductions from my pay for any required contributions.						
<input type="checkbox"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll myself in the Teladoc Program.</b>						
<b>REQUEST FOR COVERAGE (VOLUNTARY DENTAL)</b> <span style="float: right;"><b>Ameritas</b></span>						
<b>Select Coverage.</b> 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"/> <b>"I APPLY FOR THE GROUP BENEFITS</b> indicated above and, if my application is approved by Ameritas, I authorize deductions from my pay for any required contributions."						
<input type="checkbox"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program.</b> I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply."						
<b>REQUEST FOR COVERAGE (VOLUNTARY VISION)</b> <span style="float: right;"><b>EyeMed</b></span>						
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:						
<input type="checkbox"/> <b>"I APPLY FOR THE GROUP BENEFITS</b> indicated above and I authorize deductions from my pay for any required contributions.						
<input type="checkbox"/> <b>"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program."</b>						
<b>Please read, sign, and date the following Authorization &amp; Acknowledgement</b>						
<ul style="list-style-type: none"> <li>• I have read and understand the information provided in the summary of benefits and other enrollment materials.</li> <li>• 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.</li> <li>• 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) _____</li> </ul>						
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.						
<b>Employee's Signature</b>						<b>Date:</b>

**EMPLOYER RETAIN ORIGINAL FOR YOUR FILE**







# Contact List for covered members



**Please read:** The following is a contact list for **covered members**. All of the following information is also contained on the ID card issued by HealthSCOPE Benefits. We request members use this reference to contact the appropriate vendor or provider of service. HealthSCOPE Benefits only submits enrollment information to the other carriers and cannot respond to inquiries concerning those program benefits. Failure to contact the appropriate vendor or carrier will result in a delay of services to the member.

PROGRAM	SUBJECT MATTER	VENDOR	TELEPHONE	WEBSITE
Health Plans	Any medical/benefit questions, including: <ul style="list-style-type: none"> <li>• Health plan benefits</li> <li>• Claims questions/status</li> <li>• Request health, dental, &amp; vision ID cards</li> <li>• Find a network provider</li> </ul>	HealthSCOPE Benefits	800-397-9598	www.egtrust.org or www.healthscopebenefits.com
Teladoc	Request an appointment with a healthcare provider by: <ul style="list-style-type: none"> <li>• Telephonic</li> <li>• Video</li> </ul>	Teladoc	800-362-2667	www.mydrconsult.com
Pharmacy Plans	Any pharmacy questions, including: <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Eligibility</li> <li>• Claims questions</li> <li>• Find a network provider</li> </ul>	Express Scripts  Accredo (specialty pharmacy)	800-706-1754  877-222-7336	www.egtrust.org or www.express-scripts.com
Voluntary Dental	Any dental questions, including: <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Eligibility</li> <li>• Claims questions</li> <li>• Find a network provider</li> </ul>	Ameritas	800-487-5553	www.egtrust.org or www.amiertas.com/group/olbc/egyptianschooltrust
Voluntary Vision	Any vision questions, including: <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Eligibility</li> <li>• Claims questions</li> <li>• Find a network provider</li> </ul>	EyeMed	866-804-0982	www.egtrust.org or www.eyemed.com
Basic or Voluntary Life Insurance	Any life questions, including: <ul style="list-style-type: none"> <li>• Portability or conversion</li> <li>• Claims</li> <li>• Travel or Beneficiary Resources</li> </ul>	Dearborn National Life	800-348-4512	www.egtrust.org