



2020-2021 Benefit Enrollment Guide

Egyptian Area Schools Employee Benefit Trust

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Welcome to 2020-2021 Open Enrollment

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

Please check with your Employer for the plans and rates being offered in your district. Medical plan benefit summaries are available near the back of this guide and on the Egyptian Trust website (www.egtrust.org) for plan comparison purposes.

Review this 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. If you have questions about individual programs, please reach out to the proper contact as noted in the Member Communications Guide on page 29.

Here's to your health!

Egyptian Area Schools Employee Benefit Trust



Note: Some Employers 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 by your Employer.

OPEN ENROLLMENT—WHAT YOU NEED TO DO



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



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



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



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

Additional enrollment forms are available from your employer or at www.egtrust.org.

General Plan Information

When can you make changes?

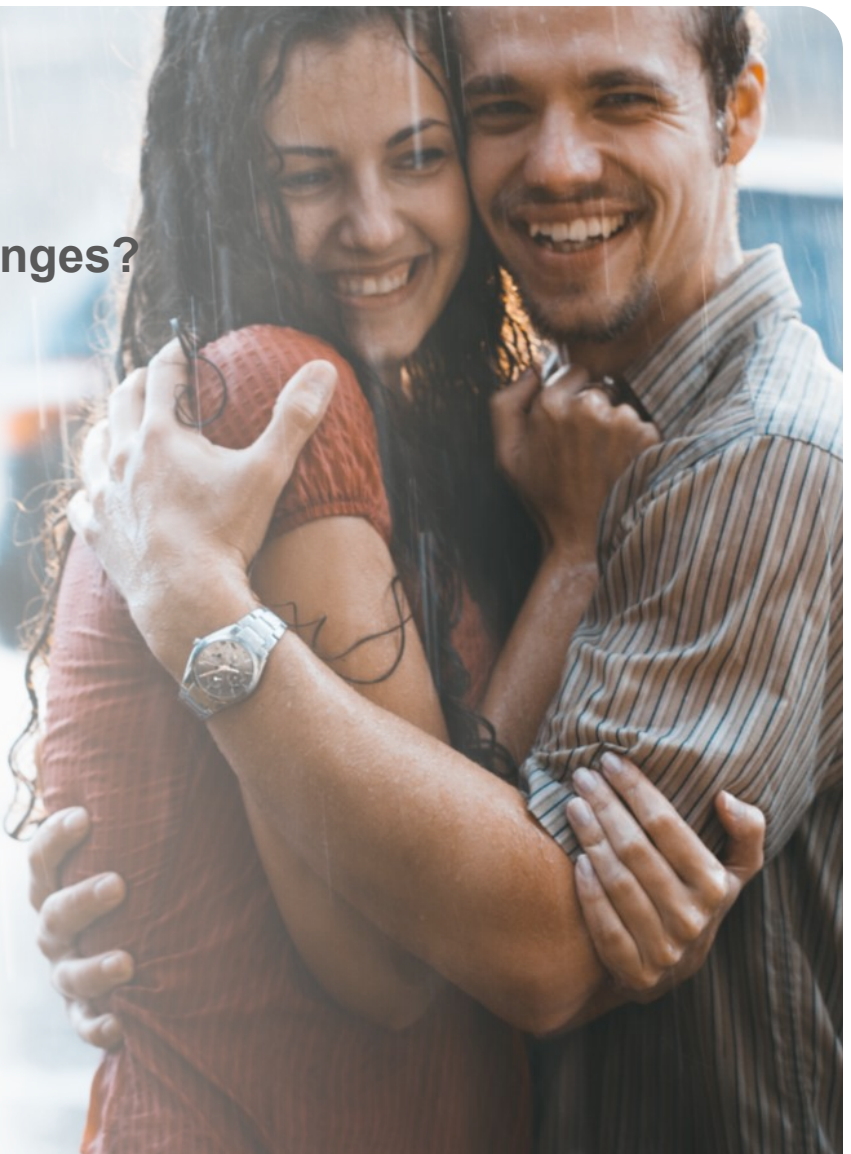
NEW ACTIVE EMPLOYEES

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

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: Life insurance or life volume changes for other than newly eligible employees are subject to medical underwriting.



OPEN ENROLLMENT AUGUST 1—SEPTEMBER 30!

Open Enrollment takes place **August 1—September 30, 2020**. 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 the effective date of your enrollment or change.

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

Important Note for Employees Opting Out

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

*QUALIFYING LIFE EVENTS

- Marriage
- Divorce/Termination of Civil Union
- 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

Medical Benefits



BlueCross BlueShield of Illinois

The Egyptian Trust offers a variety of medical plan options. All plan options cover the same services, including prescription drugs. The plans provide discounted rates when you obtain medical care within the BCBSIL PPO network; however, you have the flexibility to use any provider you choose. If you use a non-network provider, deductibles and out-of-pocket amounts are significantly increased, and you will have a greater patient responsibility. Blue Cross Blue Shield (BCBSIL) is the health claims administrator. Prime Therapeutics is the pharmacy benefit manager.

With BCBSIL PPO-based plans, you can access participating hospitals, doctors, and other healthcare providers in one of the largest PPO networks in the country.

Benefits Value Advisors (BVA)

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

If you have questions or need assistance, contact a Benefits Value Advisor (BVA) Customer Service Representative, Monday through Friday from 8:00 a.m. to 6:00 p.m. CST at 855-686-8517.

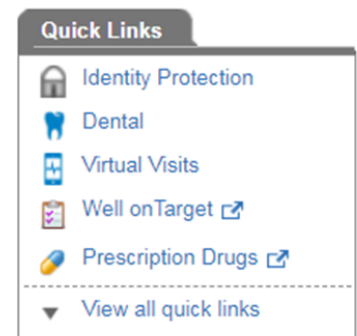


Please confirm with your Employer which medical plans are offered and carefully review the benefit plan summaries near the end of this guide to see the differences between your plan options.

BLUE ACCESS FOR MEMBERS (BAM)

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

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



PREAUTHORIZATION/ PRE-CERTIFICATION

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

PREDETERMINATION

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

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

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

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

Musculoskeletal

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

Pain Management

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

Non-Emergency Fixed-Wing Ambulance Transportation

- Non-emergency fixed-wing ambulance transportation

Behavioral Health

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

Find what you need with Blue Access for Members

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

BlueCross BlueShield of Illinois

8 **CURRENTLY VIEWING MY PLAN**
PPO
View My Plans

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

Welcome **NATHAN SMITH!**

6 **Message Center**
You have no messages
[View all messages](#)

7 **Quick Links**
[Stop receiving paper statements](#)
[Connect](#)
[Member Discount Program](#)
[Manage preferences](#)
[Verification of Coverage](#)

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

MEDICAL BENEFITS
Preferred Network

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

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

10 **11**
[Important Information](#) | [Non-Discrimination Notice](#) | [Help](#) | [Contact Us](#)

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



BlueCross BlueShield of Illinois



Get the most from your benefits

A Benefits Value Advisor* (BVA) is like a tour guide, helping to point you in the right direction.

BVAs can help you save money on health procedures and tests. They can also help you understand and use your benefits more wisely.

You'll get guidance for all your health plan benefits so you only need one call to get support. BVAs can help you:

- Maximize your benefits to get better value
- Get cost estimates for various providers and procedures
- Schedule appointments
- Find a doctor or facility
- Set up preauthorization

In addition, you can access Provider Finder® to search for in-network physicians, specialists or hospitals. You can estimate the cost and your out-of-pocket expenses for hundreds of procedures, treatments and tests. Log in to your Blue Access for MembersSM (BAMSM) account and click on "Doctors and Hospitals." If you haven't registered, go to bcbsil.com, click the "Log In" tab and then click the "Register Now" link.

Get Informed on Cost Estimates

The same procedure performed in the same area by different providers can vary greatly in cost.

Here are a few examples.

Estimated cost comparison for brain MRI



PROVIDER A:
\$977**



PROVIDER B:
\$3,821**

Estimated cost comparison for a knee replacement



PROVIDER A:
\$15,837**



PROVIDER B:
\$58,758**

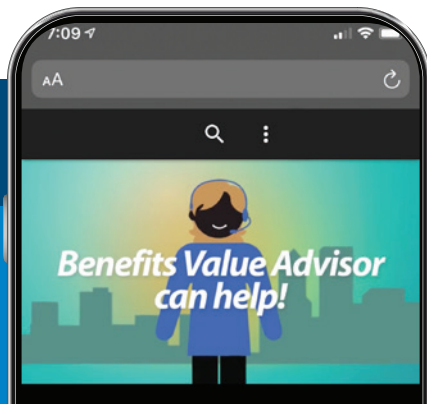
Estimated cost comparison for a C-section



PROVIDER A:
\$11,156**



PROVIDER B:
\$33,751**



Want to know more? Watch a video.

You may text¹ keyword **MYBVA** to **33633** on your mobile phone to get more information and watch a video.

1 Message and data rates may apply. Terms, conditions and privacy policy at bcbsil.com/mobile/text-messaging.

One call can help you get the most from your benefits.

Call the number on the back of your member ID card before your next procedure.

* Benefits Value Advisors offer cost estimates for various providers, facilities and procedures. Lower pricing and cost savings are dependent on the provider or facility of your choosing. Member communications and information from Benefits Value Advisors are not meant to replace the advice of health care professionals. Members are encouraged to seek the advice of their doctors to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers. Cost estimates are just an estimate. In addition to your usual deductibles, copayments and/or coinsurance, the actual cost of the services may vary based on a number of factors including the date of service, the actual procedure performed and what services were billed by the provider and your particular benefit plan. Coverage is subject to the limitations, exclusions and terms of your plan.

** Allowable in-network cost data from Cook County, IL. Costs are examples and may not be the same for every member's situation.



BlueCross BlueShield of Illinois



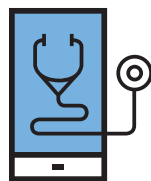
Your Doctor Is In...Provider Finder[®]

**Spend less time
looking for a doctor
and more time
enjoying your life.**

Provider Finder from
Blue Cross and Blue Shield
of Illinois (BCBSIL) is a fast,
easy-to-use tool to find your
next health care provider.
Plus, it can help you
manage health care costs.

Go to **bcbsil.com** and log in or create a Blue Access for MembersSM (BAMSM) account and click on the Doctors and Hospitals tab in Provider Finder to:

- Find in-network providers, hospitals, laboratories and more.
- Search by specialty, ZIP code, language spoken, gender and more.
- See clinical certifications and recognitions.
- Estimate the out-of-pocket costs of more than 1,600 health care procedures, treatments and tests.*
- Use quality awards such as Blue Distinction[®] Center (BDC), BDG+ or Total Care to inform your choices.
- See side-by-side provider or facility quality ratings and patient reviews.*



Go Mobile with BCBSIL

At bcbsil.com, log into or create your BAM account. You can stay linked to your claims activity, member ID card and coverage details. It's also where to see prescription refill reminders and health tips by text messages at 33633.

*Available for most networks and plans.



Understanding Your Explanation of Benefits

An Explanation of Benefits (EOB) is a notification provided to members when a health care benefits claim is processed by Blue Cross and Blue Shield of Illinois (BCBSIL). The EOB shows how the claim was processed. The EOB is not a bill. Your provider may bill you separately.



THE EOB HAS THREE MAJOR SECTIONS:

- **Subscriber Information and Total of Claim(s)** includes the member's name, address, member ID number and group name and number. The Total of Claims table shows you the amount billed, any applied discounts, reductions and payments and the amount you may owe the provider.
- **Service Detail** for each claim includes:
 - Patient and provider information
 - Claim number and when it was processed
 - Service dates and descriptions
 - The amount billed
 - The discounts or other reductions subtracted from amount billed
 - Total amount covered
 - The amount you may owe (your responsibility)
- **Summary** - Shows you what the plan covers for each claim and your responsibility including:
 - Plan Provisions**
 - The amount covered
 - Less any amounts you may owe, like deductible, copay and coinsurance
 - Your Responsibility**
 - Deductible and copay amount
 - Your share of coinsurance
 - Amount not covered, if any
 - Amount you may owe the provider. You may have paid some of this amount, like your copay, at the time you received the service.

THE EOB MAY INCLUDE ADDITIONAL INFORMATION:

- **Amounts Not Covered** will show what benefit limitations or exclusions apply.
- **Out-of-Pocket Expenses** will show an amount when a claim applies toward your deductible or counts toward your out-of-pocket expenses.
- **Fraud Hotline** is a toll-free number to call if you think you are being charged for services you did not receive or if you suspect any fraudulent activity.
- **An explanation** of your right to appeal if your health plan doesn't cover a health care claim.

Available in English and Spanish

Your EOBs Are Available Online!

Sign up for Blue Access for MembersSM (BAMSM) at bcbsil.com for convenient and confidential access to your claim information and history. Choose to opt out of receiving EOBs by mail to save time and resources. Go to BAM and click on **Settings/Preferences** to change your preferences.

bcbsil.com

Sample EOB



BlueCross BlueShield of Illinois

P.O. Box 660044
Dallas, TX 75266-0044

1 Jon Smith
1234 Cedar Road
APT #2
Chicago, IL 60601

Sample

EXPLANATION OF BENEFITS

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



Log in to Blue Access for MembersSM at bcbsil.com to see plan and claim details or to contact us through our secure Message Center.



Have questions about this EOB? Customer Advocates are here to help! **800-409-9462**

SUBSCRIBER INFORMATION

GROUP NAME HERE

2 Member ID#: BCS888999777V Group #: 000012345

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

4 SERVICE DETAIL - CLAIM (1)

5 PATIENT: JON SMITH
SERVICE DATE: 04/04/2016

6 PROVIDER: Ralph Johnston M.D.

7 CLAIM # 012345687
Processed: 06/20/2016

8 Service Description	9 Amount billed	10 PLAN PROVISIONS		11 YOUR RESPONSIBILITY		
		Discounts and reductions	Amount covered (allowed)	Deductible and copay amount	Coinsurance	Amount not covered
Surgical Charges	4,000.00	(1) 1,800.00	2,200.00	1,000.00	240.00	
Recovery Room	900.00	(1) 410.00	490.00		98.00	
Med/Surg Supplies	300.00	(1) 140.00	160.00		32.00	
Med/Surg Supplies	100.00					(2) 100.00
Laboratory Services	1,200.00	(1) 820.00	380.00		76.00	
Laboratory Services	200.00	(1) 160.00	40.00		8.00	
MRI Outpatient	850.00	(1) 440.00	410.00		82.00	
Drugs	200.00	(1) 110.00	90.00	50.00		
Muscle Manipulation	100.00	(1) 50.00	50.00	15.00		
CLAIM TOTALS	\$7,850.00	\$3,930.00	\$3,820.00	\$1,065.00	\$536.00	\$100.00

* Amount covered (allowed) reflects the savings we've negotiated with your provider for this service. Your deductible, coinsurance and copay are based on the allowed amount. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

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

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

Total covered benefits approved for this claim: \$2,219.00 to Ralph Johnston M.D. on 06-20-16.

12 SUMMARY - CLAIM (1)

PLAN PROVISIONS		YOUR RESPONSIBILITY	
Amount covered (allowed)*	\$3,820.00	Deductible and copay amount	+ \$1,065.00
Deductible and copay amount	- \$1,065.00	Coinsurance	+ \$536.00
Coinsurance	- \$536.00	Amount not covered	+ \$100.00
Total	\$2,219.00	You may have to pay your provider	\$1,701.00

14 Health Care Fraud Hotline: 800-543-0867

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

13 Benefit Period: 01-01-16 Through 12-31-16 To date this patient has met \$1,000.00 of her/his \$1,000.00 Health Care Plan Deductible.

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

- Member's name and mailing address
- Member ID and group number
- Summary box for all claims including total billed by the provider, and discounts, reductions or payments made, and the amount you may owe
- Detailed claim information for each claim
- Patient name and service date
- Provider information
- Claim number and date the claim was processed
- Service description
- Amount billed for each service
- The amount covered (allowed) for each service and the discounts or reductions subtracted from the amount your provider billed
- Your share of the costs
- Claim summary with amount covered less your responsibility
- Deductible and/or out-of-pocket expense information
- Health Care Fraud Hotline

* Please provide this information when contacting us about a claim.

Not all EOBs are the same. The format and content of your EOB depends on your benefit plan and the services provided. Deductible and copayment amounts vary.

Your Teladoc[®] Program

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

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

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

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

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

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

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

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

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

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

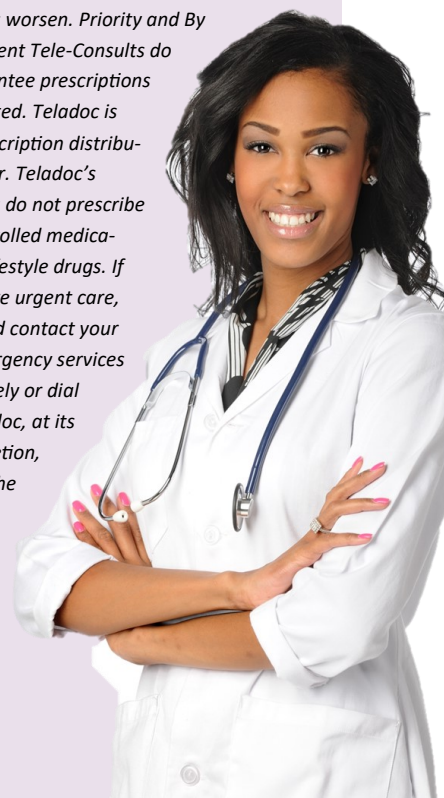
- **Health Library.** Research the latest health articles, then click to consult with a doctor.
- **Personal Health Record.** Store your consultation and medical history within a single, secure location. Share it with your primary care physician.
- **Symptom Checker.** User interactive tools, designed 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**

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.*





Prescription Drug Program



BlueCross BlueShield
of Illinois

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

The Balanced Drug List is a list of drugs available to Blue Cross and Blue Shield of Illinois (BCBSIL) members. How much you pay out-of-pocket for prescription drugs is determined by whether your medication is on the list and the tier designation of the drug. Generally, if you choose a drug that is generic or preferred, your out-of-pocket costs will be less. Your doctor should consult the Balanced Drug List when prescribing drugs for you. This may help lower your out-of-pocket costs. This list can be found at <https://www.bcbsil.com/PDF/rx/rx-list-bal-il-2020.pdf> and is regularly updated as generic drugs become available and changes take place in the pharmaceuticals market.

Some drugs are covered under your medical plan instead of your pharmacy benefits. These can include drugs that must be given to you by a health care provider. These drugs are often given to you in a hospital, doctor's office or health care setting. Examples of these drugs are contraceptive implants and chemo infusion. If you are taking or prescribed a drug that is not on the Balanced Drug List, call a Benefits Value Advisor (BVA) Customer Service Representative at **855-686-8517** to see if the drug may be covered by your medical plan.

Certain medications are subject to limitations and may require prior authorization for continued use.

Covered members may use either network retail pharmacies or the AllianceRx Walgreens Prime home delivery pharmacy service.

RETAIL PHARMACIES

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

EXTENDED SUPPLY NETWORK (ESN) RETAIL PHARMACIES

If you need medication on an ongoing basis you can ask your 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. You may buy your maintenance drugs at any Prime ESN retail pharmacy or through the AllianceRx Walgreens Prime home delivery service. Copays are higher if you choose to use an ESN retail pharmacy instead of home delivery for maintenance drugs. To find Prime ESN pharmacies, visit **www.myprime.com** or call a Benefits Value Advisor (BVA) Customer Service Representative at **855-686-8517**.

AllianceRx WALGREENS PRIME HOME DELIVERY SERVICE

The AllianceRx Walgreens Prime home delivery service is a convenient way to have your maintenance medications delivered to you and can save you money.

- Medications are shipped standard delivery at no additional cost.
- First-time orders are usually delivered within 10 days after we receive and confirm your order.
- You can receive notification by phone or email when your orders are shipped. You will be contacted, if needed, to complete your order.
- Medication packages will include instructions for ordering refills, if applicable, and may also include information about the purpose of the medication, appropriate dosage guidelines and other important details.
- You can ask for refills online or over the phone. You can also choose to receive refill reminder notices by phone or email.
- You can set all of your notification preferences when you register online at **www.alliancerxwp.com/home-delivery** or by calling them at **877-357-7463**.
- Registered pharmacists are available around the clock for consultation.

To start using the home delivery pharmacy service, visit **www.alliancerxwp.com/home-delivery**. Click “register now” to create an account and follow the steps. Or, you can call **877-357-7463** for assistance. Your doctor can send a new prescription electronically to AllianceRx Walgreens Prime (AllianceRx Walgreens Prime-MAIL AZ) or fax the prescription to **800-332-9581** after you have created an account.

Note: If you have an existing account at **www.walgreens.com**, you can use the same log in information.



AllianceRx WALGREENS PRIME SPECIALTY PHARMACY

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

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

To start using the AllianceRx Walgreens Prime specialty pharmacy, call **877-627-6337**, weekdays from 8 a.m. to 8 p.m. ET.



Prescription Drug Program Questions & Answers

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

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

Q: What are my prescription copays?

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

Prescription Drug Copayments	Retail 30 day supply	ESN Retail 90 day supply after first 2 fills	Home Delivery up to 90 day supply
Generic	\$12	\$36	\$30
Preferred Brand	\$25	\$85	\$55
Non-Preferred	\$40	\$130	\$100
Oral & Injectable Specialty Drugs	Copay plus 3%*	Copay plus 3%*	Copay plus 3%*
*Most specialty drugs (oral and injectable) will have a maximum copay of \$150 per month.			

Q: Where can I view the Balanced Drug List?

A: The 2020 drug list can be found at <https://www.bcbsil.com/PDF/rx/rx-list-bal-il-2020.pdf>.

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

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

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

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

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

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

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

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

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



Do You Need Specialty Medications?



Blue Cross and Blue Shield of Illinois (BCBSIL) has arranged for AllianceRx Walgreens Prime* to support members who need self-administered specialty medication and help them manage their therapy.

Specialty drugs are often prescribed to treat chronic, complex or rare conditions, such as multiple sclerosis, hepatitis C and rheumatoid arthritis. These drugs may be given by infusion (intravenously), injection, taken by mouth or some other way.

Specialty drugs often call for carefully following a treatment plan (or taking them on a strict schedule). These medications have special handling or storage needs and may not be stocked by retail pharmacies. They often cost more than non-specialty prescriptions.

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

Your plan may require you to get your self-administered specialty drugs through AllianceRx Walgreens Prime or another in-network specialty pharmacy. If you do not use these pharmacies, you may pay higher out-of-pocket costs.**

Examples of Self-administered Specialty Medications

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

Condition	Sample Medications***
Osteoporosis	Forteo, Tymlos
Cancer (oral)	Gleevec, Nexavar, Sprycel, Sutent, Tarceva
Growth Hormones	Increlex, Omnitrope
Hepatitis C	Epclusa, Harvoni, Mavyret and Vosevi
Multiple Sclerosis	Betaseron, Copaxone, Rebif
Rheumatoid Arthritis/Psoriasis	Enbrel, Humira, Stelara

Support in Managing Your Condition: AllianceRx Walgreens Prime

Through AllianceRx Walgreens Prime, you can have your covered, self-administered specialty drugs delivered straight to you. When you get your specialty drugs through AllianceRx Walgreens Prime, you get one-on-one support in managing your therapy – at no additional charge – including:

- Convenient delivery of drugs to you or your doctor's office
- Information to help you stay on track with your therapy and help you manage any side effects you may feel
- Syringes, sharps containers and other supplies with each shipment for self-injectable drugs
- 24/7/365 specialty pharmacy access

Ordering Through AllianceRx Walgreens Prime

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to AllianceRx Walgreens Prime. **To start using AllianceRx Walgreens Prime, call 877-627-6337, Monday-Friday, 8 a.m. - 8 p.m. ET.**

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

When switching pharmacies, have your ID card and be ready with your:

- Name, address, phone number
- Name of medication
- Current pharmacy's name and phone number (for existing prescriptions), and the prescription number
- Doctor's name, phone and fax numbers

Your doctor may also order select specialty drugs that must be given to you by a health professional through AllianceRx Walgreens Prime.

Receiving Specialty Medications

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

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

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

You can reach AllianceRx Walgreens Prime at 877-627-6337.



bcbsil.com

*Blue Cross and Blue Shield of Illinois (BCBSIL) contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics. Prime Therapeutics has an ownership interest in AllianceRx Walgreens Prime, a central specialty pharmacy and home delivery company.

**The BCBSIL specialty pharmacy network includes AllianceRx Walgreens Prime as well as other in-network specialty pharmacies for select specialty drugs. BCBSIL HMO members have a separate specialty pharmacy network. Based on the benefit plan, members may be responsible for the full cost of the specialty drug for not using an in-network specialty pharmacy. You can log in to your Blue Access for Members (BAM) account to find an in-network specialty pharmacy near you.

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

****Treatment decisions are between you and your doctor.



BlueCross BlueShield
of Illinois



BlueCare Dental PPOSM

BlueCare Dental PPO offers you and your family access to one of the largest national dental PPO networks¹. This network includes general and specialty dentists in Illinois as well as across the country. As a BlueCare Dental PPO plan member, you can go to any dentist. However, you'll save money and get more from your benefits when you use an in-network dentist. These in-network dentists have agreed to:

- Accept set fees for covered services
- Not bill you for costs over the negotiated fees (except copayments, coinsurance and deductibles)

You can choose an out-of-network dentist, but he or she may have higher fees and charge you for amounts not covered by your insurance.

Finding an In-Network Dentist is Easy

For a list of in-network general and specialty dentists, go to bcbsil.com and use the Provider Finder[®] tool. You can search for a dentist near your home, school or office and easily download a map with driving directions.

BlueCare Dental ConnectionSM

As an enhanced service, Blue Cross and Blue Shield of Illinois (BCBSIL) offers BlueCare Dental Connection. This service provides educational information and other resources to help you make choices about your dental care — at no extra cost.

To help you learn about good oral health, BlueCare Dental Connection offers:

- Educational mailings
- 24-hour online access to the Dental Wellness Center,^{*} which offers educational articles and special tools

The Dental Wellness Center allows you to:

- Ask dental-related questions through [Ask a Dentist^{*}](#)
- Find an in-network dentist using [Provider Finder](#)
- Research dental fees in your area with the [Dental Cost Advisor^{*}](#)
- Search the [Dental Dictionary^{*}](#) of common clinical terms
- View animations on different dental topics in the [Treatment and Procedure^{*}](#) tool

To access the Dental Wellness Center, log in to Blue Access for MembersSM at bcbsil.com and click on the [My Health](#) tab.

Dedicated to Customer Service

After signing up, you will get more detailed information about your dental plan. Look at your plan materials for complete details. Customer Service can answer questions about eligibility, claims, benefits and providers. Just call **800-367-6401** between 8 a.m. and 6 p.m. (CT), Monday through Friday. In addition, you can find general benefit information at bcbsil.com.

¹ Dental Network of America, LLC. (DNoA), a separate company and the network manager providing access to the national network. Source: Netminder, February 2015

^{*} The Dental Wellness Center, Dental Cost Advisor, Ask a Dentist, Dental Dictionary and Treatment and Procedure are provided by DNoA, a separate company that acts as the administrator of Blue Cross and Blue Shield of Illinois dental programs. DNoA is solely responsible for the products or services it offers. BCBSIL assumes no liability or responsibility for damage or injury to persons or property arising from the use of any product, information, idea or instruction mentioned in DNoA's content.

The following is a listing of common services available through your BlueCare Dental PPO Plan.
The member's share of the cost is determined by whether care is received from a contracting or non-contracting provider.
This information only provides highlights of this program. Please refer to the BlueCare Dental Freedom Certificate for additional benefit information.

BENEFIT HIGHLIGHTS

Program Basics

Contracting Provider*

Non-Contracting Provider* ^{90th} U & C

Benefit Period Maximum

\$1,500 per benefit period

Deductible

\$50 per person per benefit period
\$150 maximum per family

Dependent Coverage

Spouse and unmarried dependent
children up to age 26

Services

Diagnostic & Preventive Services

Dental exams and Cleanings (limited to 2 per benefit period)
Bitewing X-rays (limited to 2 sets per benefit period)
Full mouth & Panoramic X-rays (limited to 1 every 36 months)
Fluoride treatment (to age 19, 1 per benefit period)

100% of Maximum
Allowance

100% of Usual and
Customary

Miscellaneous Services

Sealants (covered to age 19)
Space maintainers (covered to age 19)
Labs & tests
Emergency Care (treatment for the relief of pain)

80% of Maximum
Allowance

80% of Usual and
Customary

Restorative Services

Routine fillings (amalgams and resins)
Pin retention
Simple extractions

80% of Maximum
Allowance

80% of Usual and
Customary

General Services

Intravenous sedation
General anesthesia
Stainless steel crowns

80% of Maximum
Allowance

80% of Usual and
Customary

Endodontic Services

Root canals
Pulp caps
Apicoectomy / apexification

80% of Maximum
Allowance

80% of Usual and
Customary

Periodontic Services

Scaling & root planning (limited to one time per quadrant per benefit period)
Gingivectomy / gingivoplasty
Osseous surgery
Periodontal Maintenance (limited to 2 per benefit period)

80% of Maximum
Allowance

80% of Usual and
Customary

Oral Surgery Services

Surgical extractions
Alveoloplasty
Vestibuloplasty

80% of Maximum
Allowance

80% of Usual and
Customary

Crowns, Inlays / Onlays Services

Crowns, Inlays / onlays (limited to one per tooth every 60 months)
Prefabricated posts and cores
Repair and recementation of crown, inlays / onlays

50% of Maximum
Allowance

50% of Usual and
Customary

Prosthodontic Services

Bridges and dentures and implants (limited to one every 60 months)
Reline / rebase of dentures (limited to once every 6 months)
Addition of tooth or clasp
Repair of bridges and dentures

50% of Maximum
Allowance

50% of Usual and
Customary

Orthodontics

Coverage for eligible dependent children to age 26

50%

50%

Lifetime Maximum

\$1,000

\$1,000

* Schedule of Maximum Allowances

Contracting providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services. Non-contracting providers do not accept the Schedule of Maximum Allowances as payment in full. For services received from a non-contracting provider, member will be liable for the difference between the dentist's charge and covered benefits.

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

The following is a listing of common services available through your BlueCare Dental PPO Plan.
The member's share of the cost is determined by whether care is received from a contracting or non-contracting provider.
This information only provides highlights of this program. Please refer to the BlueCare Dental Freedom Certificate for additional benefit information.

BENEFIT HIGHLIGHTS

Program Basics

Contracting Provider*

Non-Contracting Provider* ^{90th} U & C

Benefit Period Maximum

\$750 per benefit period

Deductible

\$50 per person per benefit period
\$150 maximum per family

Dependent Coverage

Spouse and unmarried dependent
children up to age 26

Services

Diagnostic & Preventive Services

Dental exams and Cleanings (limited to 2 per benefit period)
Bitewing X-rays (limited to 2 sets per benefit period)
Full mouth & Panoramic X-rays (limited to 1 every 36 months)
Fluoride treatment (to age 19, 1 per benefit period)

80% of Maximum
Allowance

80% of Usual and
Customary

Miscellaneous Services

Sealants (covered to age 19)
Space maintainers (covered to age 19)
Labs & tests
Emergency Care (treatment for the relief of pain)

70% of Maximum
Allowance

70% of Usual and
Customary

Restorative Services

Routine fillings (amalgams and resins)
Pin retention
Simple extractions

70% of Maximum
Allowance

70% of Usual and
Customary

General Services

Intravenous sedation
General anesthesia
Stainless steel crowns

70% of Maximum
Allowance

70% of Usual and
Customary

Endodontic Services

Root canals
Pulp caps
Apicoectomy / apexification

70% of Maximum
Allowance

70% of Usual and
Customary

Periodontic Services

Scaling & root planning (limited to one time per quadrant per benefit period)
Gingivectomy / gingivoplasty
Osseous surgery
Periodontal Maintenance (limited to 2 per benefit period)

70% of Maximum
Allowance

70% of Usual and
Customary

Oral Surgery Services

Surgical extractions
Alveoloplasty
Vestibuloplasty

70% of Maximum
Allowance

70% of Usual and
Customary

Crowns, Inlays / Onlays Services

Crowns, Inlays / onlays (limited to one per tooth every 60 months)
Prefabricated posts and cores
Repair and recementation of crown, inlays / onlays

Not Covered

Not Covered

Prosthodontic Services

Bridges and dentures and implants (limited to one every 60 months)
Reline / rebase of dentures (limited to once every 6 months)
Addition of tooth or clasp
Repair of bridges and dentures

Not Covered

Not Covered

Orthodontics

Not Covered

Not Covered

Not Covered

* Schedule of Maximum Allowances

Contracting providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services. Non-contracting providers do not accept the Schedule of Maximum Allowances as payment in full. For services received from a non-contracting provider, member will be liable for the difference between the dentist's charge and covered benefits.

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

Vision Coverage

Your Vision Insurance provider is EyeMed. EyeMed provides members with flexibility and choice, extra savings and services, plus it is easy and transparent to use. Whether you need vision correction or not, feel confident knowing your EyeMed benefit provides an annual comprehensive eye exam. Positive impacts start with a routine eye exam so feel confident because EyeMed provides you freedom to choose the doctor, hours and location that work for you.

MORE CHOICE

With EyeMed, you have the choice to see independent and top retail providers such as Lenscrafters, Target Optical, EyeMart Express and America's Best. In-network online options are also available to members to use such as Lencrafters.com, TargetOptical.com, Ray-Ban.com, Glasses.com and ContactsDirect.com. Enjoy freedom to choose your glasses and contacts and pick from top brands like Oakley, Ray-Ban and Coach.

With 34 years of experience, EyeMed continues to be America's fastest growing vision benefits company.

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



Life and AD&D Coverage



Life Insurance, Supplemental Life Insurance, and Accidental Death and Dismemberment plans and policies are available from Blue Cross Blue Shield (BCBS), previously Dearborn National. Existing and new policies will be serviced by BCBS. However, you will continue to see either one, or both, of these entities listed on the life insurance forms and documentation.

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



**BlueCross BlueShield
of Illinois**

For plan details and rates, refer to pages 24-26.

Egyptian Schools Employee Trust



40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor (Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads up

You may have additional benefits.

Log into eyemed.com/member to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	\$15 copay	Up to \$45
Retinal Imaging	Up to \$39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to \$40	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	\$0 copay; 20% off balance over \$130 allowance	Up to \$91
STANDARD PLASTIC LENSES		
Single Vision	\$15 copay	Up to \$30
Bifocal	\$15 copay	Up to \$50
Trifocal	\$15 copay	Up to \$65
Lenticular	\$15 copay	Up to \$100
Progressive - Standard	\$70 copay	Up to \$50
Progressive - Premium Tier 1	\$90 copay	Up to \$50
Progressive - Premium Tier 2	\$100 copay	Up to \$50
Progressive - Premium Tier 3	\$115 copay	Up to \$50
Progressive - Premium Tier 4	\$70 copay; 20% off retail price less \$120 allowance	Up to \$50
LENS OPTIONS		
Anti Reflective Coating - Standard	\$45	Not covered
Anti Reflective Coating - Premium Tier 1	\$57	Not covered
Anti Reflective Coating - Premium Tier 2	\$68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	\$75	Not covered
Polycarbonate - Standard	\$40	Not covered
Polycarbonate - Standard - Dependent Children	\$0 copay	Up to \$5
Scratch Coating - Standard Plastic	\$15	Not covered
Tint - Solid or Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	\$0 copay; 15% off balance over \$130 allowance	Up to \$105
Contacts - Disposable	\$0 copay; 100% of balance over \$130 allowance	Up to \$105
Contacts - Medically Necessary	\$0 copay; paid in full	Up to \$210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY		
Exam	Once every 12 months	
Frame	Once every 24 months	
Lenses	Once every 12 months	
Contact Lenses	Once every 12 months	
(Plan allows member to receive either contacts and frame, or frames and lens services)		
MONTHLY PREMIUMS		
Subscriber	\$7.76	
Subscriber + 1	\$11.12	
Subscriber + Family	\$20.12	

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. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) 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; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) 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. 10) 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. Underwritten by Combined Insurance Company of America, 111 East Wacker Drive, Chicago, IL 60601, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. Benefit allowance provides no remaining balance for future use within the same benefit year.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

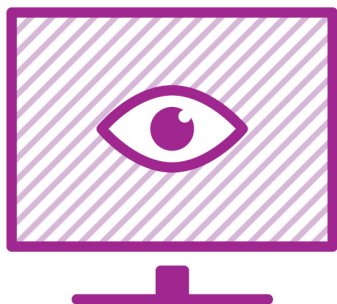
Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,¹ but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

¹Based on weighted average of sample transactions; EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance.



Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS™

PEARLE
VISION
EST. 1961

OPTICAL™

Helpful tips for your Life Insurance

Life insurance is one of those things that we purchase, file away, and often forget about. We don't really think about it until we need it.

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

WAIVER OF PREMIUM

If an employee is out on total disability, the life insurance policy has a Waiver of Premium provision. Waiver of Premium means that if an employee is younger than age 60 when he or she becomes totally disabled and is off work due to a total disability for at least 6 months, the employee is no longer required to submit life insurance premium for the duration of the disability. A Waiver of Premium application needs to be submitted. The application will be reviewed to determine if the employee meets the definition of total disability for Waiver of Premium. If the Waiver of Premium benefit is approved, the employee's life insurance will continue while he or she is not at work. Waiver of Premium would terminate at the employee's Social Security Normal Retirement Age or when the employee is no longer considered totally disabled.

PORTABILITY

If an employee terminates his or her employment, he or she has the option to port his or her life insurance. This means he or she can continue the group term life if the premiums are submitted. Portability rates increase as the employee's age increases. If the employee ports his or her coverage, a covered spouse and any covered children may also port their coverage. Portability coverage ends at age 65.

CONVERSION

If an employee is terminating employment or if the Waiver of Premium benefit is ending, the employee can convert his or her coverage to a whole life policy. The rates are age-based, and as long as premiums are paid on time, coverage can stay in effect until age 100.

Portability and Conversion both require a form to be completed by the employee and your employer. These forms are available on the Egyptian Trust website at www.egtrust.org.



**BlueCross BlueShield
of Illinois**



BlueCross BlueShield
of Illinois

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

All Classes as Defined by your School District

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

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

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



Egyptian Area Schools Employee Benefit Trust - #F019133

Eligibility

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

Supplemental Life/AD&D Insurance

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

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

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

Child Coverage (Life Only)

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

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

Guarantee Issue: New Hires Only

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

Supplemental Life/AD&D Insurance

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

EMPLOYEE		EMPLOYEE ATTAINED AGE									
Benefit Amount		<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
\$10,000		\$0.85	\$0.95	\$1.05	\$1.35	\$1.95	\$3.05	\$4.95	\$7.95	\$9.85	\$16.85
\$25,000		\$2.13	\$2.38	\$2.63	\$3.38	\$4.88	\$7.63	\$12.38	\$19.88	\$24.63	\$42.13
\$50,000		\$4.25	\$4.75	\$5.25	\$6.75	\$9.75	\$15.25	\$24.75	\$39.75	\$49.25	\$84.25
\$75,000		\$6.38	\$7.13	\$7.88	\$10.13	\$14.63	\$22.88	\$37.13	\$59.63	\$73.88	\$126.38
\$100,000		\$8.50	\$9.50	\$10.50	\$13.50	\$19.50	\$30.50	\$49.50	\$79.50	\$98.50	\$168.50
SPOUSE (Employee Attained Age)											
Monthly Premium Cost (Based on 12 payroll deductions per year)											
\$5,000		\$0.43	\$0.48	\$0.53	\$0.68	\$0.98	\$1.53	\$2.48	\$3.98	\$4.93	\$8.43
\$10,000		\$0.85	\$0.95	\$1.05	\$1.35	\$1.95	\$3.05	\$4.95	\$7.95	\$9.85	\$16.85
\$25,000		\$2.13	\$2.38	\$2.63	\$3.38	\$4.88	\$7.63	\$12.38	\$19.88	\$24.63	\$42.13
\$30,000		\$2.55	\$2.85	\$3.15	\$4.05	\$5.85	\$9.15	\$14.85	\$23.85	\$29.55	\$50.55
\$35,000		\$2.98	\$3.33	\$3.68	\$4.73	\$6.83	\$10.68	\$17.33	\$27.83	\$34.48	\$58.98
\$37,500		\$3.19	\$3.56	\$3.94	\$5.06	\$7.31	\$11.44	\$18.56	\$29.81	\$36.94	\$63.19

**EMPLOYEE & SPOUSE
 Supplemental Life/AD&D**

Monthly rates per \$1,000

Age	Rates
Under 25	\$0.085
25-29	\$0.095
30-34	\$0.105
35-39	\$0.135
40-44	\$0.195
45-49	\$0.305
50-54	\$0.495
55-59	\$0.795
60-64	\$0.985
65+	\$1.685

Dependent Life (Children)

Monthly Premium per Family

Life	
\$5,000	\$0.47
\$10,000	\$0.94

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

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Egyptian Area Schools Employee Benefit Trust Plans A, B, and C

Summary Benefit Schedules as of September 1, 2020

Check with your employer for plans offered and monthly premiums.

Description of Services	Plan A BCBS Group No. 240874			Plan B BCBS Group No. 240875			Plan C BCBS Group No. 240876		
	NETWORK	NON-NETWORK		NETWORK	NON-NETWORK		NETWORK	NON-NETWORK	
Deductible									
Individual	\$400	\$800		\$600	\$1,200		\$1,100	\$2,200	
Family	\$1,200	\$4,400		\$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	\$30 Copay Then 100% No deductible	70%		\$30 Copay Then 100% No deductible	65%		\$30 Copay Then 100% No deductible	60%	
Services other than Office Visit at time of visit	90%	70%		85%	65%		80%	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	ESN Retail 90 days**	Home Delivery 90 days**	Retail 30 days	ESN Retail 90 days**	Home Delivery 90 days**	Retail 30 days	ESN Retail 90 days**	Home Delivery 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.

**You may fill the first two months of a newly prescribed maintenance medication at a Prime network retail pharmacy. Subsequent fills must be for 90 days at either an Extended Supply Network (ESN) pharmacy or through Home Delivery.

Egyptian Area Schools Employee Benefit Trust Plans D, E, and AB1

Summary Benefit Schedules as of September 1, 2020

Check with your employer for plans offered and monthly premiums.

Description of Services	Plan D*			Plan E			Plan AB1		
	BCBS Group No. 240877			BCBS Group No. 240878			BCBS Group No. 240879		
	NETWORK	NON-NETWORK		NETWORK	NON-NETWORK		NETWORK	NON-NETWORK	
Deductible									
Individual	\$1,400	\$2,800		\$1,100	\$2,200		\$400	\$1,200	
Family	\$2,800	\$5,600		\$3,300	\$6,600		\$1,200	\$3,600	
Out of Pocket Maximum									
Individual	\$4,050	\$7,900		\$1,800	\$5,100		\$1,300	\$4,100	
Family	\$8,100	\$15,800		\$5,400	\$15,300		\$3,900	\$12,300	
Cost Share Maximum									
Individual	N/A	N/A		\$6,600	N/A		\$6,600	N/A	
Family	N/A	N/A		\$13,200	N/A		\$13,200	N/A	
Lifetime Maximum	Unlimited	Unlimited		Unlimited	Unlimited		Unlimited	Unlimited	
Reimbursement	80%	60%		85%	65%		85%	65%	
Inpatient Hospital (Illness or Injury)	\$250 Copay Then 80%	\$550 Copay Then 60%		\$250 Copay Then 85%	\$550 Copay Then 65%		\$250 Copay Then 85%	\$550 Copay Then 65%	
Outpatient Surgery	\$250 Copay Then 80%	\$550 Copay Then 60%		\$250 Copay Then 85%	\$550 Copay Then 65%		\$250 Copay Then 85%	\$550 Copay Then 65%	
Primary Doctor (PCP) Office Visit	\$25 Copay Then 80%	60%		\$25 Copay Then 100% No deductible	65%		\$25 Copay Then 100% No deductible	65%	
Specialist Office Visit	\$30 Copay Then 80%	60%		\$30 Copay Then 100% No deductible	65%		\$30 Copay Then 100% No deductible	65%	
Services other than Office Visit at time of visit	80%	60%		85%	65%		85%	65%	
Emergency Room	\$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	
Urgent Care Facility	\$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	
Drug Card	Retail 30 days	ESN Retail 90 days**	Home Delivery 90 days**	Retail 30 days	ESN Retail 90 days**	Home Delivery 90 days**	Retail 30 days	ESN Retail 90 days**	Home Delivery 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.

*Plan D 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.

**You may fill the first two months of a newly prescribed maintenance medication at a Prime network retail pharmacy. Subsequent fills must be for 90 days at either an Extended Supply Network (ESN) pharmacy or through Home Delivery.

Covered Members Communication Guide



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

Program	Subject Matter	Contact/ Partner Name	Phone	Website
Health Plans	Member questions concerning: <ul style="list-style-type: none"> • Any Health plan questions including: • Benefits • Pre-certifying services • Request Health Plan ID cards • Find a network provider 	<div>For Services on or after March 1, 2019</div> BCBS of IL	855-686-8517	www.bcbsil.com
Pharmacy	Member questions concerning: <ul style="list-style-type: none"> • Any Pharmacy questions including: • Benefits • Eligibility • Prescription Drug Plan • Claim questions • Find a network provider 	<div>For Services on or after March 1, 2019</div> Prime Therapeutics	800-423-1973	www.myprime.com
Voluntary Dental	Member questions concerning: <ul style="list-style-type: none"> • Any Dental plan questions including: • Benefits • Eligibility • Claim questions • Find a network provider 	<div>For Services on or after September 1, 2019</div> BCBS of IL	800-367-6401	www.bcbsil.com
Voluntary Vision	Member questions concerning: <ul style="list-style-type: none"> • Any Vision plan questions including: • Benefits • Eligibility • Claim questions • Find a network provider 	EyeMed	866-804-0982	www.eyemed.com
Basic or Voluntary Life Insurance	Member questions concerning: <ul style="list-style-type: none"> • Portability or Conversion • Claim issues • Travel or Beneficiary Resources 	BCBS	800-348-4512	www.egtrust.org
Health Plans	For Services prior to March 1, 2019	HealthSCOPE Benefits	800-397-9598	www.healthscopebenefits.com
Voluntary Dental	For Services prior to September 1, 2019	Ameritas	800-487-5553	www.ameritas.com/group/olbc/egyptianschooltrust



RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

Egyptian Area Schools Employee Benefit Trust

NEW ENROLLEE (Not Currently Covered)

EMPLOYER (OR PLAN SPONSOR) SECTION

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

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

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

Employee Name	Last	First	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <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 or Cell Phone				Average Hours Worked per Week:		<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	

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

EMPLOYEES: Check all boxes that apply:

Medical Plan Options Instruction: Ask your Employer which Plans you are eligible for. Enter Plan Name Here: <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	Voluntary Teladoc <input type="checkbox"/> Teladoc Only NOTE: Teladoc is included in Medical Plan.	Voluntary Dental <input type="checkbox"/> High <input type="checkbox"/> Low	Voluntary Vision <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Dependent <input type="checkbox"/> Employee + 2 or more depts <input type="checkbox"/> Decline Coverage	Basic Life – Basic Life is automatic when enrolling in Health Plan <input type="checkbox"/> Basic Life Amount _____ <input type="checkbox"/> Decline coverage Optional Life – When applying for more than 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
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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

OTHER INSURANCE COVERAGE

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	

EMPLOYER: RETAIN ORIGINAL FOR YOUR FILE

BASIC LIFE – Beneficiary Information					
Primary Beneficiary's Last Name		First	MI	Relationship of Beneficiary	DOB
Street Address		City		State	
Contingent Beneficiary's Last Name		First	MI	Relationship of Beneficiary	DOB
Street Address		City		State	
OPTIONAL LIFE – Beneficiary Information					
Primary Beneficiary's Last Name		First	MI	Relationship of Beneficiary	DOB
Street Address		City		State	
Contingent Beneficiary's Last Name		First	MI	Relationship of Beneficiary	DOB
Street Address		City		State	
<p>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.</p>					
REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE)			Blue Cross Blue Shield of Illinois		
<p>This coverage has been offered to me and after careful consideration of the benefits, I have decided to:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p><input type="checkbox"/> "I APPLY FOR THE BASIC GROUP LIFE BENEFITS indicated above and, if my application is approved by BCBS of IL, 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."</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."</p> </div> <div style="width: 48%;"> <p><input type="checkbox"/> "I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS indicated above and, if my application is approved by BCBS of IL 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."</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program. I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense."</p> </div> </div>					
<p>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.</p> <p>The insurance requested on this enrollment form will not be effective until approved by the Home Office of BCBS of IL, and the initial premium is paid to BCBS of IL. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.</p>					
REQUEST FOR COVERAGE (MEDICAL)			Administered By: Blue Cross Blue Shield of Illinois		
<p>This coverage has been offered to me and after careful consideration of the benefits, I have decided to:</p> <p><input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by my employer, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program. I understand that if I apply for coverage at a later date all the rules of late enrollment will apply."</p>					
REQUEST FOR COVERAGE (VOLUNTARY TELADOC)					
<p>This coverage has been offered to me and after careful consideration of the benefits, I have decided to:</p> <p><input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, I authorize deductions from my pay for any required contributions.</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself in the Teladoc Program.</p>					
REQUEST FOR COVERAGE (VOLUNTARY DENTAL)			Blue Cross Blue Shield of Illinois		
<p>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.</p> <p>This coverage has been offered to me and after careful consideration of the benefits, I have decided to:</p> <p><input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by my employer, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program. I understand that if I apply for coverage at a later date all the rules of late enrollment will apply."</p>					
REQUEST FOR COVERAGE (VOLUNTARY VISION)			EyeMed		
<p>This coverage has been offered to me and after careful consideration of the benefits, I have decided to:</p> <p><input type="checkbox"/> "I APPLY FOR THE GROUP BENEFITS indicated above and, if my application is approved by EyeMed I authorize deductions from my pay for any required contributions.</p> <p><input type="checkbox"/> "WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program."</p>					
Please read, sign, and date the following Authorization & Acknowledgement					
<ul style="list-style-type: none"> I have read and understand the information provided in the summary of benefits and other enrollment materials. On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law. Are you declining any coverage due to coverage in another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <div style="margin-left: 20px;"> If yes, is the other coverage COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Please Explain) _____ </div> <p>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.</p>					
Employee's Signature					Date:

EMPLOYER: RETAIN ORIGINAL FOR YOUR FILE



RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

Egyptian Area Schools Employee Benefit Trust

CHANGE ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION –

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

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

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

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

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

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

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

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

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

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

<input type="checkbox"/> Add Basic Life (Only available when employee is newly eligible.) <input type="checkbox"/> Term Basic Life <input type="checkbox"/> No Change	Optional Life – Changes in Optional Life coverage must be submitted using the BCBS Evidence of Insurability form unless you are terminating coverage. Form can be found at www.egtrust.org. EMPLOYEES: Check all boxes that apply: <input type="checkbox"/> Add Optional Employee (Evidence of Insurability REQUIRED) <input type="checkbox"/> Add Optional Spouse (Evidence of Insurability REQUIRED) <input type="checkbox"/> Add Optional Dependent (Evidence of Insurability REQUIRED) <input type="checkbox"/> No Change Optional Life	<input type="checkbox"/> Terminate Optional Employee <input type="checkbox"/> Terminate Optional Spouse <input type="checkbox"/> Terminate Optional Dependent
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DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.						
List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number	You must check one box in each line below for each dependent listed.	
1.					Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Vision <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
2.				- -	Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Vision <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
3.				- -	Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Vision <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
4.				- -	Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Vision <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
5.					Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> No Change <input type="checkbox"/> Decline	
					Vision <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? <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:				Name of insurance carrier or TPA: _____ Group No. _____		
Name of employer providing coverage:				Address: _____		
Is other coverage Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____ Phone: _____ Effective Date of other coverage: _____						
ADDITIONAL CHANGES – Please add any comments concerning your changes.						
Please read, sign, and date the following Authorization & Acknowledgement ♦ I have read and understand the information provided in the summary of benefits and other enrollment materials. ♦ On behalf of myself and enrolling family members, I AUTHORIZE the release to or by Egyptian Area Schools, its administrators, or other insurance companies of information regarding school enrollment, medical history, employment, or other benefits as necessary to verify eligibility, adjudicate claims, or coordinate benefits, to the extent permitted by law. ♦ Are you declining any coverage due to coverage in another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the other coverage COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Please Explain) _____						
To the best of my belief and knowledge, the information I have provided on this form is complete and correct, and that no material information has been withheld or omitted. It is illegal and may be a felony for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information.						
Employee's Signature					Date:	

EMPLOYER – RETAIN ORIGINAL FOR YOUR FILE

Notes

[illegible]