Egyptian Area Schools Coordinated Health/Care™

2013-2014 Benefits Enrollment Guide

EGYPTIAN AREA SCHOOLS | Coordinated Health/Care®

Dear Member,

Egyptian Area Schools Employee Benefit Trust genuinely cares about your well being. That is why your health benefits plan includes *Coordinated Health/Care*, an exciting program to help you manage your health and get the most out of your benefits.

This benefits guide contains an overview of the benefits available to you through Egyptian Area Schools. You'll find information about *Egyptian Area Schools Coordinated Health/Care*, the Consult a Doctor program, health plan options and premiums, and more!

New this year:

- Beginning September 1, 2013, you may enroll in the Consult a Doctor program, even if you're not enrolled in one of the Egyptian Area Schools health plans.
- If you are enrolled in an Egyptian Area Schools health plan, you will have access to Healthcare Blue Book which provides assistance in finding lower-cost providers to reduce your out-of-pocket expenses.
- Also for those enrolled in the health plan, please don't forget to complete your Wellness Initiative by September 30, 2013.

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

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

If you wish to make changes to your current coverage or plan elections, complete the attached Change Enrollment Form and return it to your District Office to complete the enrollment process. You may obtain additional Change Enrollment Forms from your District Office or at www.egtrust.org.

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

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

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

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Coordinated Health/Care: A Single-Point-of-Contact for All of Your Healthcare Needs

Have you ever wished you had someone to help you find answers when it comes to your health and benefits? Now you do!

The *Egyptian Area Schools Coordinated Health/Care* program works by bringing together all of your healthcare information under one roof so it can be managed by a single team of Care Coordinators who are ready to help you before, during, or after any health event. Anything related to your health, health benefits, or medical care will be directed to them through a single toll-free number and an exclusive program website. It's a single point-of-contact to help you find answers!

The result? *Egyptian Area Schools Coordinated Health/Care* can help you get the most out of your health benefits with the least amount of worries, which goes a long way to helping you actually feel better.

Care Coordinators: Your Trusted Advocates

Care Coordinators are the heart of your *Egyptian Area Schools Coordinated Health/Care* program. They are a highly-responsive team of nurses, social workers, patient services representatives, and benefits experts. Using a uniquely human touch, this warm and caring team guides you through healthcare events and the healthcare system. They collaborate with you and your healthcare providers to ensure a smooth healthcare process.

Turn to Your Care Coordinators to Help With:

- Medical Plan Questions
- Benefits
- Saving Money *(ex. obtaining referrals, using in-network providers)*
- Your Wellness Initiative
- ID Cards
- Claims Questions
- In-Network Provider Assistance
- Patient Advocacy
- Nurse Coaching
- Leading a Healthier Life

Your Wellness Initiative: Be Healthy and Save Money

Saving money on your health plan has never been easier with the Egyptian Area Schools Wellness Initiative. To earn your incentive, go to www.egtrust.org and click the *Egyptian Area Schools Coordinated Health/Care* logo (pictured above, to the right). Then, under Health & Wellness, click "Your Incentive Checklist," log on or register, and follow the instructions to complete the requirements (listed below). All results must be reported to *Coordinated Health/Care* by September 30, 2013.

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

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

Complete the following requirements to earn your incentive in 2014:

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

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

  If you've already visited your Primary Doctor, your biometrics screening results must have been obtained between September 1, 2012 and September 30, 2013.

  There are several ways to obtain your biometrics results:
  - Visit your Primary Doctor.
  - Visit your county health department or other out-of-network provider. Egyptian Trust will pay up to $75 of the cost.
  - Onsite screenings may be an option for some districts. Your administration will communicate if this is available to you.
  - Obtain a prescription or order for blood work from your Primary Doctor and take it to a Lab Card facility. To locate a Lab Card facility, go to www.labcard.com.
- **Complete your online Wellness Assessment (HRA).**

Please note: *Coordinated Health/Care* keeps your health information confidential and does not share it with Egyptian Area Schools and your employer.

In-Network Healthcare Providers

In-network helps keep money in your pocket

Your medical benefits plan works with HealthLink, your Tier 1 and Tier 2 PPO, to offer the broadest medical coverage for you and your family.

Services received from physicians in the HealthLink network are paid at the in-network benefit level. While you do not have to choose an in-network Primary Doctor, it's highly recommended that you do. The fact is, selecting an in-network Primary Doctor for each member of your family is good for you and your wallet. Here's why:

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

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

Note: You do not have to select an in-network Primary Doctor. However, if you use the services of a doctor who is out-of-network, you will pay higher out-of-pocket expenses. In some cases, out-of-network providers are not covered.

Medical Claims Payer

How your healthcare bills get paid

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

All providers, whether they are a Tier 1 or Tier 2 PPO, must send claims directly to HealthLink at an address listed on your *Egyptian Area Schools Coordinated Health/Care* ID card. HealthLink will apply the appropriate discount, and then send your claim to Meritain for processing. Meritain Health will process the claim, send payment to the provider, and send you a monthly member statement indicating all claims processed during the statement period.

If any of your providers do not send bills directly to HealthLink and you receive a bill, you can pay the provider directly for their services and then submit your own claim form and receipt to HealthLink. You may obtain a claim form at www.egtrust.org. All claims must be sent to HealthLink at the address listed on your ID card. HealthLink will apply the appropriate discount and then will send your claim to Meritain for processing. Meritain Health will then process your claim and promptly reimburse you.

Prescription Drug Coverage

How your prescriptions get filled and billed

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

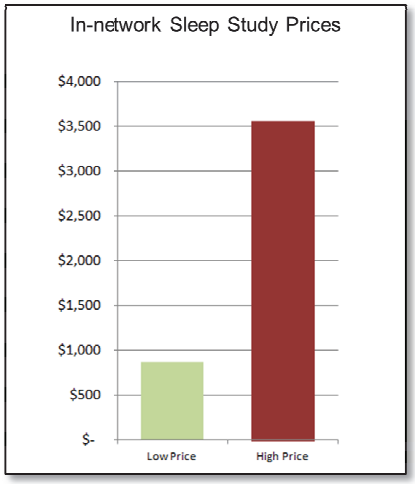
To fill a prescription, visit a pharmacy in the CVS Caremark network and present your prescription. The pharmacist will enter your information into their system, which links to CVS Caremark, and your prescription claim will be processed immediately. At the time you pick up your prescription, you typically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

Introducing Healthcare Blue Book September 1, 2013! Find Fair Prices, Compare Providers, Shop for Care and Save Money

Healthcare Blue Book is an online tool that enables you to find the best prices for healthcare services you may need. With Healthcare Blue Book, you can shop for care so that you get the most affordable care available in your area, from high quality providers.

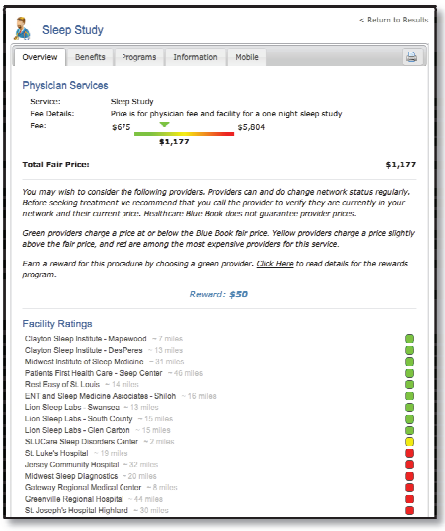
Why use a healthcare pricing tool?

- Healthcare costs have doubled in the past 9 years
- In-network prices for most healthcare services vary by 300% to 500% or more, depending on the provider
  - A sleep study (see example to right) can cost under $1,000 or over $3,500 in the same town
- Your friends may already be saving by using Healthcare Blue Book
- You too can reduce your healthcare costs by becoming a ***true healthcare consumer***



How does Healthcare Blue Book work?

- Search for services by using drop down menus or searching on key terms
- Learn the Fair Price you should pay in your area, and how much you can save by making cost-effective choices
- Prices are based on your local area
- You can then compare specific providers on both cost and quality



What do the colors mean?

- Green = at or below the Fair Price
- Yellow = somewhat above the Fair Price
- Red = among the most expensive providers

How do I access Healthcare Blue Book?

Beginning September 1, 2013, Healthcare Blue Book will be available on the Egyptian Trust/ Coordinated Health/Care Website.

What is the *GreenPlus* Rewards Program?

- Cash rewards for employees who use Healthcare Blue Book to shop for Fair Price™ providers for specific procedures
- No forms to submit or approvals needed – simply visit a green provider for designated procedures!
- Employees will receive the cash reward at their home address

Your Consult A Doctor™ Program

The Consult A Doctor 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 Consult a Doctor program, employees ONLY may enroll for a small monthly fee.

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

Sometimes you need to speak with a doctor when it's not possible to attend an office visit. That's why the Consult A Doctor 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 Consult A Doctor program provides more than just on-demand medical support.

This convenient program 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 log in at **www.mydrconsult.com** to set up your personal account.

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

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

Common conditions treated:

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

**Consult A Doctor 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. Consult A Doctor 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. Consult A Doctor is not a prescription distribution center. Consult A Doctor'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. Consult A Doctor, at its sole discretion, reserves the right to cancel your membership at any time. Services are not available in Oklahoma.*

Contact a Consult A Doctor physician at 1.800.362.2667 or visit www.mydrconsult.com.

MERITAIN HEALTH℠
An Aetna Company

General Plan Information

When can I make changes?

New Active Employees

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

All Active Employees

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

Open Enrollment Coming Soon

The next Open Enrollment takes place **August 1 – September 30, 2013**, and that is when you will be able to select or make changes to health, dental, and vision plans for you and your family. The effective date of your changes will either be September 1 or October 1. Check with your employer for your specific effective date.

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

Important Note for Employees Opting Out

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

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2013

	Plan A (formerly Platinum)				Plan B (formerly Gold)			
DESCRIPTION OF SERVICES	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS
Deductible								
INDIVIDUAL	$400	$600	$600	$600	$600	$900	$900	$900
FAMILY	$1,200	$1,800	$1,800	$1,800	$1,800	$2,700	$2,700	$2,700
Out of Pocket Maximum								
INDIVIDUAL	$1,200	$1,800	$3,300	None	$1,300	$1,900	$3,500	None
FAMILY	$2,400	$3,600	$6,600	None	$3,900	$5,700	$10,500	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Wellness Benefit*	$100	$100	$100	$100	$100	$100	$100	$100
Inpatient Hospital (Illness or Injury)	$250 Copay Then 90%	$250 Copay Then 85%	$550 Copay Then 70%	$550 Copay Then 60%	$250 Copay Then 85%	$250 Copay Then 80%	$550 Copay Then 65%	$550 Copay Then 55%
Outpatient Surgery	$250 Copay Then 90%	$250 Copay Then 85%	$550 Copay Then 70%	$550 Copay Then 60%	$250 Copay Then 85%	$250 Copay Then 80%	$550 Copay Then 65%	$550 Copay Then 55%
Primary Doctor (PCP) Office Visit	$25 Copay Then 100% No deductible	$25 Copay Then 100% No deductible	70%	60%	$25 Copay Then 100% No deductible	$25 Copay Then 100% No deductible	65%	55%
Specialist Office Visit with Primary Doctor (PCP) Referral/Notification	$30 Copay Then 100% No deductible	$30 Copay Then 100% No deductible	70%	60%	$30 Copay Then 100% No deductible	$30 Copay Then 100% No deductible	65%	55%
Specialist Office Visit without Primary Doctor (PCP) Referral/Notification	$40 Copay Then 100% No deductible	$40 Copay Then 100% No deductible	70%	60%	$40 Copay Then 100% No deductible	$40 Copay Then 100% No deductible	65%	55%
Emergency Room	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible
Urgent Care Facility	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible	$40 Copay Then 90% No deductible
Drug Card	**Retail 30 days**	**MDN Retail 90 day Maintenance Drug after first 2 fills**		**Home Delivery up to 90 days**	**Retail 30 days**	**MDN Retail 90 day Maintenance Drug after first 2 fills**		**Home Delivery up to 90 days**
GENERIC	$12	$36		$30	$12	$36		$30
FORMULARY	$25	$85		$55	$25	$85		$55
NON-FORMULARY	$40	$130		$100	$40	$130		$100
RATES (Includes $10,000 Basic Life)								
Employee Only	**$710**				**$642**			
Employee + Spouse	**$1,464**				**$1,322**			
Employee+Child or Children	**$1,414**				**$1,274**			
Family	**$1,576**				**$1,420**			

Notes:

All charges are subject to the calendar year deductible unless otherwise specified.

Inpatient Hospital and Outpatient Surgery copays are limited to 3 copays in any calendar year and do not count toward deductible or out of pocket maximum.

*WELLNESS BENEFIT refers to routine diagnostic lab and x-ray wellness charges. For a complete list of Wellness Benefits, refer to the Schedule of Benefits.

SUMMARY PLAN DESCRIPTIONS AS OF SEPTEMBER 1, 2013

	Plan C (formerly Silver)				HDHP (formerly Bronze) All charges except charges for preventive care are subject to the Calendar Year Deductible. Calendar Year Deductible must be satisfied before Copays apply.			
DESCRIPTION OF SERVICES	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS	TIER 1 HMO	TIER 2 PPO	TIER 3 NON NETWORK	TIER 4 NON NETWORK METRO ST LOUIS
Deductible								
INDIVIDUAL	$1,100	$1,600	$1,600	$1,600	$1,250	$1,650	$1,650	$1,650
FAMILY	$3,300	$4,800	$4,800	$4,800	$2,500	$3,300	$3,300	$3,300
Out of Pocket Maximum								
INDIVIDUAL	$2,300	$3,300	$5,800	None	$3,750	$4,950	$6,250	Unlimited
FAMILY	$6,900	$9,900	$17,400	None	$7,500	$9,900	$12,500	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Wellness Benefit*	$100	$100	$100	$100	$100	$100	$100	$100
Inpatient Hospital (Illness or Injury)	$250 Copay Then 80%	$250 Copay Then 75%	$550 Copay Then 60%	$550 Copay Then 50%	$250 Copay, Then 80%	$250 Copay, Then 75%	$550 Copay, Then 60%	$550 copay, Then 50%
Outpatient Surgery	$250 Copay Then 80%	$250 Copay Then 75%	$550 Copay Then 60%	$550 Copay Then 50%	$250 Copay, Then 80%	$250 Copay, Then 75%	$550 Copay, Then 60%	$550 copay, Then 50%
Primary Doctor (PCP) Office Visit	$25 Copay Then 100% No deductible	$25 Copay Then 100% No deductible	60%	50%	$25 Copay, Then 80%	$25 Copay, Then 75%	60%	50%
Specialist Office Visit with Primary Doctor (PCP) Referral/Notification	$30 Copay Then 100% No deductible	$30 Copay Then 100% No deductible	60%	50%	$30 Copay Then 80%	$30 Copay Then 75%	60%	50%
Specialist Office Visit without Primary Doctor (PCP) Referral/Notification	$40 Copay Then 100% No deductible	$40 Copay Then 100% No deductible	60%	50%	$40 Copay Then 80%	$40 Copay Then 75%	60%	50%
Emergency Room	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 85% No deductible	$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 80%	$300 Copay Then 80%
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 80%	$40 Copay Then 80%	$40 Copay Then 80%	$40 Copay Then 80%
Drug Card	**Retail 30 days**	**MDN Retail 90 day Maintenance Drug after first 2 fills**		**Home Delivery up to 90 days**	**Retail 30 days**	**MDN Retail 90 day Maintenance Drug after first 2 fills**		**Home Delivery up to 90 days**
GENERIC	$12	$36		$30	$12	$36		$30
FORMULARY	$25	$85		$55	$25	$85		$55
NON-FORMULARY	$40	$130		$100	$40	$130		$100
RATES (Includes $10,000 Basic Life)								
Employee Only	**$554**				**$472**			
Employee + Spouse	**$1,146**				**$970**			
Employee+Child or Children	**$1,106**				**$952**			
Family	**$1,234**				**$1,046**			

High Deductible Health Plan (HDHP):

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

Please Note:

Deductibles and Out-of-Pocket amounts are established by the IRS and are subject to change every January 1. This Plan will follow the rules established by the IRS.

EGYPTIAN AREA SCHOOLS
VOLUNTARY DELTA DENTAL PLAN SUMMARY

As of September 1, 2013

Following is a brief overview of your voluntary dental benefits. You may visit any dentist and receive the same reimbursement percentage. However, you can realize significant savings by choosing a Delta Dental Network Provider. Please visit www.deltadentalil.com, or call **1-800-323-1743** if you have specific questions regarding benefit coverage, limitations or exclusions.

Dental Coverage	Low Plan	High Plan
Calendar Year Deductible Per Individual Per Family Waived for Preventive Services?	 $50 $150 Yes	 $50 $150 No
Percentage Payable (of covered charges)		
Preventive Services *(such as oral exams, routine teeth cleaning, fluoride treatments, x-rays)*	80%	100%
Basic Services *(such as simple extractions, basic fillings, repair of bridges & dentures, recementing crowns & bridges, surgical extractions, general anesthesia & intravenous sedation, endodontics, periodontics)*	70%	80%
Major Services *(such as crowns, implants, bridges, dentures)*	Not Covered	50%
Calendar Year Maximum	$750	$1500
Dependent Child Orthodontia	**Not Covered**	**Children Only Covered**
Calendar Year Deductible Percentage Payable (of covered charges) Lifetime Maximum		$0/$0 50% $1000

Rates Effective September 1, 2013

COVERAGE TYPE	LOW PLAN	HIGH PLAN
Employee Only	$13.68	$30.74
Employee + 1 Dependent	$25.12	$56.44
Employee + 2 or more Dependents	$47.60	$82.00

Updated 6/13

Egyptian Area Schools Vision Plan

UniCare. A Healthy Dose of Innovation™

THE BENEFITS ARE CLEAR

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

WHEN USING A PARTICIPATING PROVIDER, YOU RECEIVE:

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

Locating a Provider

1. Go to **www.unicare.com**
2. Click Find a Doctor
3. Click UniView Vision

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

YOU CAN SEE THE SAVINGS

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

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

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

EASY-TO-USE-BENEFITS

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

1. Choose a UniView network eye care provider
2. Make an appointment
3. Pay your copayment at the time of your office visit

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

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

COVERAGE	RATE
Employee	$7.24
Employee + One	$10.36
Employee + Family	$18.76

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

SC11468 8/07

Lincoln Financial Group®

EduBenefit

Group Life Insurance — Life and AD&D

SUMMARY OF BENEFITS

Sponsored by: Egyptian Area Schools Employee Benefit Trust

All Classes as defined by your school district.

Life/AD&D Benefit	Employee
Amount	Benefit amount as defined by your school district.
Benefit Reduction Basic Life and Optional Life	**Employee and Spouse**
	50% at age 70. Benefits will terminate when the Insured Person retires, except if a Person retires at the end of the scheduled school year (June), coverage will not terminate until October 31st of that same year.
Optional Life/AD&D Benefit	
Employee Amount	Options of $10,000 - $25,000 - $50,000 - $75,000 - $100,000 or $10,000 increments to a max of $500,000 Not to exceed 5 times your annual salary.
Spouse Amount	Minimum of $5,000. Not to exceed 50% of employee elected amount. Employee must elect coverage for spouse to be eligible.
Dependent	Option 1: $5,000 Child: 14 days to age 19 (to age 25 if full-time student). Option 2: $10,000 Child: 14 days to age 19 (to age 25 if full-time student). Newborn children to age 14 days are not eligible for a benefit. Employee must elect coverage for dependents to be eligible.
Guarantee Issue	Employee - $100,000 (Under age 60) Spouse - $37,500 (Under age 60) Valid as long as a timely entrant.
Eligibility & Definitions	**Employee**
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.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming 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.
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To quality, you satisfied the Active Work rule and have been covered under this policy for at least 12 months.
Limited Activity	A period when a spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 2 years after coverage is effective. May apply if employee contributes toward the premium.
BeneficiaryConnect℠	Support services for beneficiaries who have experienced a loss.
TravelConnect℠	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

Lincoln Financial Group®

EduBenefit

Egyptian Area Schools Employee Benefit Trust

Employee & Spouse Monthly Premium
Optional Life and AD&D Insurance
Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse rates are based on employee's age
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

AGE	Monthly Rate per $1,000	$10,000	$25,000	$50,000	$75,000	$100,000	Spouse Rates	Rate per $1,000	$5,000	$12,500	$25,000	$37,500
<25	0.085	$0.85	$2.13	$4.25	$6.38	$8.50		0.085	$0.43	$1.07	$2.13	$3.19
25-29	0.095	$0.95	$2.38	$4.75	$7.13	$9.50		0.095	$0.48	$1.19	$2.38	$3.57
30-34	0.105	$1.05	$2.63	$5.25	$7.88	$10.50		0.105	$0.53	$1.32	$2.63	$3.94
35-39	0.135	$1.35	$3.38	$6.75	$10.13	$13.50		0.135	$0.68	$1.69	$3.38	$5.07
40-44	0.195	$1.95	$4.88	$9.75	$14.63	$19.50		0.195	$0.98	$2.44	$4.88	$7.32
45-49	0.305	$3.05	$7.63	$15.25	$22.88	$30.50		0.305	$1.53	$3.82	$7.63	$11.44
50-54	0.495	$4.95	$12.38	$24.75	$37.13	$49.50		0.495	$2.48	$6.19	$12.38	$18.57
55-59	0.795	$7.95	$19.88	$39.75	$59.63	$79.50		0.795	$3.98	$9.94	$19.88	$29.82
60-64	0.985	$9.85	$24.63	$49.25	$73.88	$98.50		0.985	$4.93	$12.32	$24.63	$36.94
65-69	1.685	$16.85	$42.13	$84.25	$126.38	$168.50		1.685	$8.43	$21.06	$42.13	$63.19
70-74	2.275	**$5,000**	**$12,500**	**$25,000**	**$37,500**	**$50,000**		2.275	**$2,500**	**$6,250**	**$12,500**	**$18,750**
		$11.38	$28.44	$56.88	$85.31	$113.75			$5.69	$14.22	$28.44	$42.66
75-79	4.185	**$5,000**	**$12,500**	**$25,000**	**$37,500**	**$50,000**		**75+**	**For benefit and premium amounts, please see your Plan Administrator.**			
		$20.93	$52.31	$104.63	$156.94	$209.25						
80+		**For benefit and premium amounts, please see your Plan Administrator.**										

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Dependent Children Monthly Rate =

$5,000 = $0.47
$10,000 = $0.94
Premium covers all dependent children regardless of the number of children.

Please note that if coverage is not elected within 31 days of your hire date then medical underwriting will be required for ANY amounts of coverage elected.

For assistance or additional information - Contact Lincoln Financial Group at (800) 423-2765

Enrollment and Change Enrollment Forms

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

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

Have questions?
Contact your Care Coordinators!

1-855-452-9997

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

www.egtrust.org

EGYPTIAN AREA SCHOOLS | Coordinated Health/Care

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

MERITAIN℠ HEALTH

Egyptian Area Schools Employee Benefit Trust

ENROLLMENT FORM

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

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

Employer Name	Group Number	Certified Staff ☐ Yes ☐ No	Effective Date / /

Enrollment Event: ☐ Open Enrollment-Applies to medical plan only ☐ Annual Enrollment-Applies to dental plan only ☐ New Hire ☐ Late Enrollment ☐ Qualifying Change in Family Status Reason _____

Employee Status: ☐ Active ☐ COBRA ☐ Retiree ☐ Other

Date of Hire / /

Will Employee be Medicare Eligible at Age 65? ☐ Yes ☐ No

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

Employers please indicate which Health Plan options your district offers:

☐ **Plan A (formerly Platinum)** ☐ **Plan B (formerly Gold)** ☐ **Plan C (formerly Silver)** ☐ **HDHP (formerly Bronze)** ☐ **All Plans**

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

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

Employee Name Last First MI	Sex ☐ M ☐ F	Date of Birth / /	Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Social Security Number - -

Employee Home Address Street/Apt. City State Zip

Home Phone ( ) - Business Phone ( ) -	Email Address	Occupation:_____ Average Hours Worked per Week:_____	Earnings $_____ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Annually

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

Medical - Includes Rx Coverage & Consult a Doctor	**Voluntary Consult a Doctor**	**Voluntary Dental**	**Voluntary Vision**
☐ **Plan A** ☐ **Plan B** ☐ **Plan C** ☐ **HDHP**		☐ **High** ☐ **Low**	
☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family ☐ Decline Coverage	☐ Employee Only ☐ Decline Coverage **NOTE:** Consult a Doctor is automatic when enrolling in Health Plan.	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage

EMPLOYEES: Check all boxes that apply:

Basic Life –
Basic Life is automatic when enrolling in Health Plan
☐ Basic Life - Amount _____ ☐ Decline coverage

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

☐ Optional Employee Life Amount _____
* Amounts over $100,000 require completion of Evidence of Insurability Form

☐ Optional Spouse Life Amount _____
* Limited to 50% of Emp Life – Amounts over $37,500 require completion of Evidence of Insurability Form

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

☐ Decline Coverage

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number (Required when enrolling dependents for coverage.)	You must mark the coverage chosen or decline coverage for each dependent listed.
1.			/ /	- -	☐ Health ☐ Dental ☐ Vision ☐ Decline
2.			/ /	- -	☐ Health ☐ Dental ☐ Vision ☐ Decline
3.			/ /	- -	☐ Health ☐ Dental ☐ Vision ☐ Decline
4.			/ /	- -	☐ Health ☐ Dental ☐ Vision ☐ Decline
5.			/ /	- -	☐ Health ☐ Dental ☐ Vision ☐ Decline
6.			/ /	- -	☐ Health ☐ Dental ☐ Vision ☐ Decline

OTHER INSURANCE COVERAGE

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

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

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

Address: _____ Phone: _____

Name of employer providing coverage: _____

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

BASIC LIFE – Beneficiary Information

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

OPTIONAL LIFE – Beneficiary Information

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

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

REQUEST FOR COVERAGE (BASIC AND OPTIONAL LIFE)

Lincoln Financial Group
P.O. Box 2616, Omaha NE 68103-2616
(800) 423-2765 fax: (877) 573-6177

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

☐ **"I APPLY FOR THE BASIC GROUP LIFE BENEFITS** indicated above and, if my application is approved by Lincoln Financial Group, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll myself in the BASIC GROUP LIFE Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."

☐ **"I APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS** indicated above and, if my application is approved by Lincoln Financial Group, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll myself in the OPTIONAL GROUP LIFE Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll my dependents in the OPTIONAL GROUP LIFE Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense."

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

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

REQUEST FOR COVERAGE (MEDICAL)

Administered by Meritain Health

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

☐ **"I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by Egyptian Area Schools Employee Benefit Trust, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Health Program.** I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply."

REQUEST FOR COVERAGE (VOLUNTARY CONSULT A DOCTOR)

Administered by Meritain Health

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

☐ **"I APPLY FOR THE GROUP BENEFITS** indicated above and, I authorize deductions from my pay for any required contributions.

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll myself in the Consult a Doctor Program.**

REQUEST FOR COVERAGE (VOLUNTARY DENTAL)

Delta Dental of Illinois Group Number 20204

Select Coverage. Confirm the options available to you by reviewing your benefit plan description or checking with your employer. Note: Except for COBRA continuance, dependent coverage may be elected only if employee coverage is elected.

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

☐ **"I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by Delta Dental of Illinois, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Dental Program.** I understand that if I apply for coverage at a later date, all the rules of late enrollment will apply."

REQUEST FOR COVERAGE (VOLUNTARY VISION)

Administered by UniView

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

☐ **"I APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by UniView, I authorize deductions from my pay for any required contributions.

☐ **"WAIVER OF COVERAGE: I do NOT want to enroll myself or my dependents in the Vision Program."**

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

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

  If yes, is the other coverage COBRA? ☐ Yes ☐ No

  ☐ Other (Please Explain)_____

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

Employee's Signature	Date:

RETURN THIS COMPLETED FORM TO YOUR EMPLOYER

MERITAIN HEALTH

Egyptian Area Schools Employee Benefit Trust

CHANGE ENROLLMENT FORM

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

(For Employer Use Only) – Retain a copy for your records.
Confirmation No._____

Employer Name	Group Number	Date of Hire	Effective Date of Change

Certified by (Authorized Representative)	Date	Employer Telephone

Employers please indicate which Health Plan options your district offers:

☐ **Plan A** (formerly Platinum) ☐ **Plan B** (formerly Gold) ☐ **Plan C** (formerly Silver) ☐ **HDHP** (formerly Bronze) ☐ **All Plans**

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

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
			☐ M ☐ F		- -

Will Employee be Medicare Eligible at age 65? ☐ Yes ☐ No

	From:	To:
☐ **Employee Name**		
☐ **Employee Address**		
☐ **Employee Phone**		
☐ **Employee Email**		
☐ **Marital Status**	☐ Single ☐ Married ☐ Divorced	☐ Single ☐ Married ☐ Divorced

☐ Termination
Choose Reason

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

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

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

☐ Add Dependent(s)
Reason for Addition:
☐ Newborn
☐ Adoption
☐ Newly Eligible Full-time Student
☐ Marriage
☐ Open Enrollment Period
☐ Other _____

☐ Terminate Dependent(s)
Reason for Termination:
☐ Ineligible Child
☐ Marriage
☐ Divorce
☐ Open Enrollment Period
☐ Death
☐ Other _____

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

Medical
Changes to health plan coverage may only be made during annual open enrollment period or within 31 days of a qualifying event. You may only change to a higher level of benefits with a 12 month notice to your employer.
EMPLOYERS: ATTACH A COPY OF 12 MONTH NOTICE TO CHANGE FORM.

TO: ☐ **Plan A (formerly Platinum)** ☐ **Plan B (formerly Gold)** ☐ **Plan C (formerly Silver)** ☐ **HDHP (formerly Bronze)**

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

Voluntary Consult a Doctor (CaDr)

☐ Employee Only
☐ Terminate CaDr
☐ No Change CaDr

Voluntary Dental
Changes to voluntary dental plan coverage may only be made during the annual enrollment period or within 31 days of a qualifying event.

TO: ☐ **High** ☐ **Low**

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

Voluntary Vision

TO:

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

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

☐ Add Basic Life (Evidence of Insurability REQUIRED)
☐ Term Basic Life
☐ No Change

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

EMPLOYEES: Check all boxes that apply:

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

DEPENDENT – ENTER ONLY THE DEPENDENTS YOU ARE ADDING OR TERMINATING.

List Full Name of Your Eligible Dependents	Relation To Employee 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number	You must check one box in each line below for each dependent listed.
1.				- -	**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
2.				- -	**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
3.				- -	**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline
4.				- -	**Health** ☐ Add ☐ Term ☐ No Change ☐ Decline **Dental** ☐ Add ☐ Term ☐ No Change ☐ Decline **Vision** ☐ Add ☐ Term ☐ No Change ☐ Decline

BASIC LIFE – CHANGE Beneficiary Information

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

OPTIONAL LIFE – CHANGE Beneficiary Information

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

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

OTHER INSURANCE COVERAGE

Are you or any of your dependents covered by another group, medical, vision, or dental plan? ☐ Yes ☐ No

If yes, type(s) of coverage: ☐ Medical ☐ Vision ☐ Dental

Name of individual with other coverage:

Name of insurance carrier or TPA:_____Group No._____

Address:_____

Name of employer providing coverage:

Is other coverage Medicare or Medicaid? ☐ Yes ☐ No

Phone:_____Effective Date of other coverage:_____

Effective Date _____

ADDITIONAL CHANGES – Please add any comments concerning your changes.

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

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

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

Employee's Signature	Date:

EMPLOYER – RETAIN ORIGINAL FOR YOUR FILE