EGYPTIAN AREA SCHOOLS EMPLOYEE HEALTH PLAN

INDIVIDUAL HEALTH PLAN SELECTION PROCEDURES
NOTICE TO EMPLOYEES

Following are the rules pertinent to Employees whose Employer has chosen to offer Individual Selection of the three Health Plans offered through the Egyptian Trust. Please review this information carefully and direct any questions you may have to your Employer or to Egyptian Area Schools Coordinated Health/Care.

1. If Individual Selection is allowed by the local district, employees will be able to make that selection during the district's open enrollment period of August 1 through September 30 each year. The change will become effective on September 1 or October 1 depending on the Open Enrollment effective date as chosen by the Employer. A change to a different plan of benefits cannot be made until the open enrollment period the following year.
2. Employees and their dependents must be on the same plan of benefits.
3. Employees may only move from a lower plan of benefits to a higher plan of benefits (Plan C to Plan B or Plan A, or Plan B to Plan A) after giving an advance written notice of one year. **This notice must be given during the open enrollment period.** As an example, someone desiring to move from Plan B to Plan A would have to give notice during the open enrollment period (August 1 – September 30) in 2014 to make the change effective for September 1 or October 1, 2015. This notice is not revocable. However, the employee may change back to a lower plan of benefits following at least one year in the higher benefit plan.
4. Any change in benefit plans by the employee must be provided to the employer in writing, and the employer must keep the written notice on file.

Complete the following statement and return to your Employer as a 12 month notification to change to a higher plan of benefits.

Current Coverage:	**Change To:**
☐ Plan A	☐ Plan A
☐ Plan B	☐ Plan B
☐ Plan C	☐ Plan C
☐ HDHP	

Date of Notice _____

Effective Date of Change _____

Employer & Group # _____

Employee Name _____

Employee ID No. _____

I understand by increasing my health plan coverage level, I am making an irrevocable change that will become effective only with a 12 month notice to my employer. I further understand any dependents I choose to have covered under my health plan will be enrolled in the same health plan I choose.

Employee Signature _____

EMPLOYERS: Retain a original for your records. EMPLOYEES: Retain a copy for your records.