2021-2022
Benefit Enrollment Guide
Egyptian Area Schools Employee Benefit Trust

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Welcome to 2021-2022 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 details about each benefit program including key points to consider, whether you are making first-time enrollment decisions or changes to your current coverage elections.

Please check with your Employer for the plans and rates offered in your district. Benefit summaries, for plan comparison purposes, are available in each section of this guide and on the Egyptian Trust website (www.egtrust.org).

Review this guide carefully as you make your enrollment decisions and choose the plans that best meet the needs for you and your family. Keep the guide on hand to reference throughout the year. If you have questions about any program, please reach out to the vendor contact as noted in the Member Communications Guide near the back of this guide.

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

Note: Some Employers do not offer all health and voluntary plan options described in this booklet. Please contact your Employer for the specific plans and premiums offered by your district.

BENEFIT PROGRAM CHANGES AS OF SEPTEMBER 1, 2021

New Carrier	
MetLife	**Dental** High and Low plan options will be moving from Blue Cross Blue Shield to MetLife. Deductibles, annual benefit maximums, and benefit coinsurance levels remain the same. MetLife dental rates are lower than current and are guaranteed for two years.
	Vision plan will be moving from EyeMed to MetLife. Benefits will remain the same. MetLife vision rates are guaranteed for three years.

See the Dental and Vision sections of this booklet for more details.

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 Open 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.

Enrollment forms are available:

- At the back of this guide,
- From your employer, and
- On the Trust website at www.egtrust.org

OPEN ENROLLMENT AUGUST 1—SEPTEMBER 30!

Open Enrollment takes place **August 1—September 30, 2021**. That is when you will be able to select or make changes to health, dental, and vision plans for you and your family. Elections made during Open Enrollment are irrevocable until the next Open Enrollment period unless there is a qualifying life event. The effective date of your changes will either be September 1 or October 1 as determined by your Employer.

When you submit 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.

Note: New supplemental life insurance elections or volume increases (except for newly eligible employees who enroll at the guarantee issue amount) are subject to Evidence of Insurability (EOI). Approval must be received before any new life insurance or increased volume will be put into effect. *See the Life Insurance section of this guide for more information.*

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.*

CURRENT ACTIVE EMPLOYEES

All current 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: Supplemental Life Insurance elections or volume increases for current active employees are subject to Evidence of Insurability (EOI). *See the Life Insurance section of this guide for more information.*

SPECIAL ENROLLMENT DUE TO A QUALIFYING EVENT

If you experience a Qualifying Life Event, you may be eligible for Special Enrollment allowing you to change your previous benefit elections. Your requested change must be consistent with the life event which has occurred. You must notify your Employer within **31 days** of your qualifying life event to add, drop, or change your benefit elections. If you do not provide timely notification of the qualifying event, you must wait until the next Open Enrollment period to change your benefit elections.

Exception: *Employees or dependents who gain or lose eligibility for Medicaid or SCHIP coverage must notify their employer within* ***60 days*** *of that event to be eligible for a Special Enrollment opportunity.*

*QUALIFYING LIFE EVENTS

- Marriage
- Divorce or termination of civil union
- Birth or adoption of a child
- Changes in a child's dependent status
- Death of a 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. Blue Cross Blue Shield (BCBSIL) is the health claims administrator. Prime Therapeutics is the pharmacy benefit manager. The plans provide discounted rates when you obtain medical care from participating hospitals, doctors, and other healthcare providers in the BCBSIL PPO network, one of the largest networks in the country. However, you have the flexibility to use any provider you choose. If you use a non-network provider, be aware that deductibles and out-of-pocket amounts are significantly increased, and you will have greater patient responsibility.

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 any questions or need assistance, contact the BVA, now available 24/7, at 855-686-8517.

Please confirm with your Employer which medical plans are offered and carefully review the benefit plan summaries on the next few pages of this guide to compare your plan options.

BLUE ACCESS FOR MEMBERS (BAM)

Once you have your BCBSIL Member ID card, go to bcbsil.com to register for Blue Access for Members (BAM). Current members will use the same ID card. 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
- View or print Explanation of Benefits (EOB) 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 mobile 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)

List of services requiring preauthorization is subject to change.

Plans A, B, and C— Summary Benefit Schedules as of September 1, 2021

Check with your employer for plans offered and monthly premiums.
More plan details are available on the Trust website at www.egtrust.org/schedule-of-benefits/.

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 Family	 $400 $1,200	 $800 $2,400	 $600 $1,800	 $1,200 $3,600	 $1,100 $3,300	 $2,200 $6,600
Out of Pocket Maximum Individual Family	 $1,200 $2,400	 $3,700 $11,100	 $1,300 $3,900	 $4,100 $12,300	 $2,300 $6,900	 $6,900 $20,700
Cost Share Maximum Individual Family	 $6,600 $13,200	 N/A N/A	 $6,600 $13,200	 N/A N/A	 $6,600 $13,200	 N/A 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 Generic Formulary Non-Formulary	Retail 30 days $12 $25 $40	ESN Retail 90 days** $36 $85 $130	Home Delivery 90 days** $30 $55 $100	Retail 30 days $12 $25 $40	ESN Retail 90 days** $36 $85 $130	Home Delivery 90 days** $30 $55 $100	Retail 30 days $12 $25 $40	ESN Retail 90 days** $36 $85 $130	Home Delivery 90 days** $30 $55 $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.

Plans D, E, and AB1— Summary Benefit Schedules as of September 1, 2021

Check with your employer for plans offered and monthly premiums.
More plan details are available on the Trust website at www.egtrust.org/schedule-of-benefits/.

Description of Services	Plan D* BCBS Group No. 240877		Plan E BCBS Group No. 240878		Plan AB1 BCBS Group No. 240879	
	NETWORK	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible Individual Family	 $1,400 $2,800	 $2,800 $5,600	 $1,100 $3,300	 $2,200 $6,600	 $400 $1,200	 $1,200 $3,600
Out of Pocket Maximum Individual Family	 $4,050 $8,100	 $7,900 $15,800	 $1,800 $5,400	 $5,100 $15,300	 $1,300 $3,900	 $4,100 $12,300
Cost Share Maximum Individual Family	 N/A N/A	 N/A N/A	 $6,600 $13,200	 N/A N/A	 $6,600 $13,200	 N/A 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 Generic Formulary Non-Formulary	Retail 30 days $12 $25 $40	ESN Retail 90 days** / Home Delivery 90 days** $36 / $30 $85 / $55 $130 / $100	Retail 30 days $12 $25 $40	ESN Retail 90 days** / Home Delivery 90 days** $36 / $30 $85 / $55 $130 / $100	Retail 30 days $12 $25 $40	ESN Retail 90 days** / Home Delivery 90 days** $36 / $30 $85 / $55 $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 Deducible, 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.

BlueCross BlueShield of Illinois

Take a step in the right direction

Let our Benefits Value Advisors[1] (BVAs) help you get the most from your health plan.

BVAs make it easier to use your health plan, while helping you save time and money. They are available 24 hours a day, seven days a week[2] to explain your benefits and provide guidance on how to use them. BVAs will also help you:

- Find a doctor or facility
- Get cost estimates for procedures and services
- Schedule appointments
- Set up preauthorizations (if needed)

In addition, you can access Provider Finder® to search for in-network doctors, hospitals and more. You can estimate the cost and your out-of-pocket expenses for hundreds of procedures, treatments and tests. You can also see side-by-side provider quality ratings and patient reviews.[3]

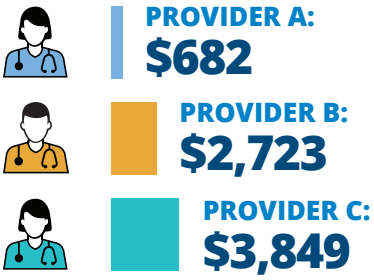
Visit **bcbsil.com**, register or log in to Blue Access for Members℠ and click on the "Doctors & Hospitals" tab – then on the "Find a Doctor or Hospital" link.

Get Informed on Cost Estimates

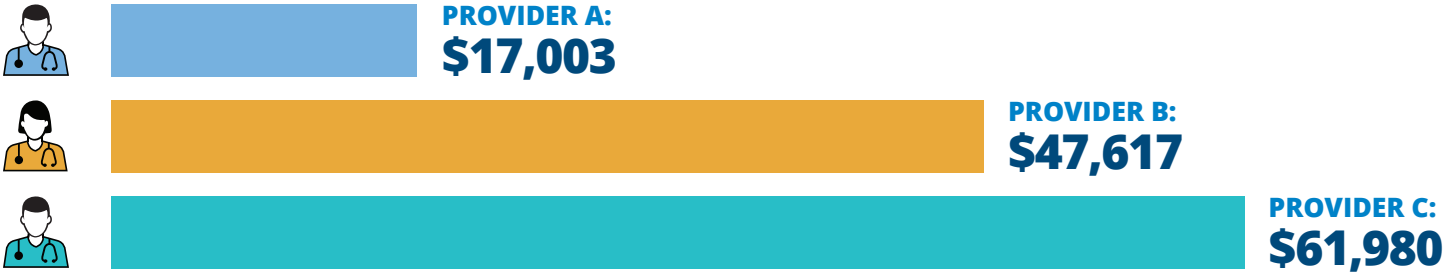
The same procedure performed in the same area by different providers can vary greatly in cost.

Here are examples[4].

Estimated cost comparison for brain MRI



Estimated cost comparison for a knee replacement



Want to know more?

Text* keyword **BVAIL** to **33633** on your mobile phone to watch a video.

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

Remember, BVAs are ready to help you 24/7.
Call the number on the back of your member ID card and ask for a BVA.

1. 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.
2. Excludes major U.S. holidays.
3. Available for most networks and plans.
4. Examples shown are for specific locations and time periods and are not intended to represent costs for procedures in your area.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, 9100093.0920

BlueCross BlueShield of Illinois

Understanding Your Explanation of Benefits

Your **Explanation of Benefits (EOB)** lets you know when and how we process your claims. It isn't a bill. It gives you a detailed look at the covered services and shows how much you may owe your provider after we apply your benefits.

BlueCross BlueShield of Illinois

PO Box 7344
Chicago, IL 60680-7344

EXPLANATION OF BENEFITS

John Smith
1234 Cedar Road
APT #2
Any Town, IL 76065

Sample

B

Log into **Blue Access for Members℠** at **bcbsil.com**
- View plan and claim details
- Contact us through our secure Message Center
- Sign up for digital health plan info
- Search for health care providers

Text* **GOBCBSIL** to **33633** to download the mobile app.

Have questions about this EOB? Customer Advocates are here to help! **XXX-XXX-XXXX**

C

A

SUBSCRIBER INFORMATION
GROUP NAME
Member ID#: XXXXXXXXX**777V** Group #: **000012345**

Dear John Smith,

An Explanation of Benefits (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.**

C

HELPFUL INFORMATION
Want Your Health Care Info Digitally?
To get this EOB and other health care info on our mobile app, text* GOBCBSIL to 33633 to download the app. You can also go digital by logging in at **bcbsil.com/member**. Once logged in, navigate to Settings, click Preferences, then select Go Paperless.

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 (BCBSIL), 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.**

GLOSSARY OF TERMS - We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.

Amount Billed: The amount your provider billed for the service(s) rendered.

Amount Covered (Allowed): Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

Coinsurance: The percentage of the allowed amount you pay as your share of the bill. For example, if your plan pays 80% of the allowed amount, 20% would be your coinsurance.

Copay Amount (Also known as Copayment): The set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit (Maximum): Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this

*Message and data rates may apply. Terms & Conditions and Privacy Policy **bcbsil.com/text-messaging**
Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

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Page One Covers the Basics

A. Confirm your policy ID.

B. Learn how to download the mobile app and access your claims online.

C. Find helpful contacts and a glossary.

BlueCross BlueShield of Illinois

F SUBSCRIBER INFORMATION
GROUP NAME
Member ID#: XXXXXXXXX**777V** Group #: **000012345**
Customer Advocates are here to help! **XXX-XXX-XXXX**

CLAIM DETAIL (1 OF X)
PATIENT: John Smith D
PROVIDER: Ralph Johnston M.D. E

Sample

CLAIM # XXXXXXXXXXXXX **DATE PROCESSED:** 06/20/2020

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 of Illinois (BCBSIL) has negotiated discounts with this provider. The following shows how this claim was adjusted.

O²	
Amount Billed	$7,850.00
Discounts and Reductions	- $3,930.00
Health Plan Responsibility	- $2,219.00
You may owe your health care provider for these services	**$1,701.00**

		YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				
Service Description	Service Dates	Amount Billed G	Discounts and Reductions H	Amount Covered (Allowed) I	Health Plan Responsibility J	Deductible Amount K	Copay Amount L	Coinsurance M	Amount Not Covered N	Your Total Costs O
Surgical Charges	04/04/2020	4,000.00	(1) 1,800.00	2,200.00	960.00	1,000.00		240.00		1,240.00
Recovery Room	04/04/2020	900.00	(1) 410.00	490.00	392.00			98.00		98.00
Med/Surg Supplies	04/04/2020	300.00	(1) 140.00	160.00	128.00			32.00		32.00
Med/Surg Supplies	04/04/2020	100.00							(2) 100.00	100.00
Laboratory Services	04/04/2020	1,200.00	(1) 820.00	380.00	304.00			76.00		76.00
Laboratory Services	04/04/2020	400.00	(1) 270.00	130.00	72.00		50.00	8.00		58.00
MRI Outpatient	04/04/2020	950.00	(1) 490.00	460.00	363.00		15.00	82.00		97.00
CLAIM TOTALS		**$7,850.00**	**$3,930.00**	**$3,820.00**	**$2,219.00**	**$1,000.00**	**$65.00**	**$536.00**	**$100.00**	**$1,701.00**

Total covered benefits approved for this claim: $2,219.00 to Ralph Johnston M.D. on 06-20-20. J²

Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"

(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. P

Your health care plan has a calendar year maximum for x-rays and laboratory services performed in the outpatient department of a hospital, a clinic or a doctor's office. When this maximum has been reached, the balance is eligible under your major medical benefits, subject to a yearly deductible and a coinsurance share.

For your up-to-date Medical Spending summary, visit Blue Access for Members℠ on our website, the BCBSIL Mobile App or call the phone number on the back of your ID card. Q

JOHN SMITH - For benefit period 01-01-20 through 12-31-20 to date this patient has met $4,515.02 of her/his $7,350.00 Out-of-Pocket Expense Limit.

242384.0421 2

On Page Two You Can:

At a glance, confirm the:

D. Patient **E.** Provider **F.** Policy Information

Get the Details

YOUR BENEFITS APPLIED–This section shows your list of services and how they're covered.

G. Amount Billed is the total amount your provider billed for the services.

I. Amount Covered (Allowed) is the amount billed (G) minus any discounts or reductions (H).

J. Health Plan Responsibility is the portion we paid to your provider.

See Your Cost Share

YOUR RESPONSIBILITY–This section shows your member cost-share amounts, including:

K. Deductible **L.** Copays **M.** Coinsurance

O. Your Total Costs is the sum of your copay, deductible and coinsurance. You may owe less if your provider collected any of these payments before beginning services. It also includes any amounts not covered by your health plan. The total cost in this column details the amount shown in the claim summary (O²). It does not include any amounts that a non-participating provider may bill you.

Get More Information

Your EOB may include a little more information about:

J². Total covered benefits approved – This is the amount and the date we paid your provider. The total matches the total in the Health Plan Responsibility column (J).

P. Numbered notes give more details about discounts and reductions (H) and any amounts that aren't covered (N).

Q. Health care plan maximums help you track your yearly out-of-pocket totals so you'll know when your patient cost-shares are met.

Sign up to get your EOBs online on **Blue Access for Members℠** or Text* **GOBCBSIL to 33633** to download the mobile app.

* Message and data rates may apply. See terms and conditions and our privacy policy at bcbsil.com/text-messaging.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, 20154.0121

Find what you need with Blue Access for Members

NATHAN SMITH Settings ▼ 9 Language Assistance En Español Log Out

BlueCross BlueShield of Illinois

CURRENTLY VIEWING MY PLAN
8 PPO
View My Plans

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

blueaccess for Members

Welcome NATHAN SMITH!

Message Center 6
You have no messages
View all messages

Quick Links 7
- 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
Coinsurance	N/A

My Care Profile

Blue Button
Learn how to get your health care profile electronically

Get Started »

10 Important Information | Non-Discrimination Notice | Help | 11 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.

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

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PRESCRIPTION DRUG BENEFITS

Prime Therapeutics, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit. Prime Therapeutics maintains the Balanced Drug List (also known as a preferred 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 prescription 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-2021.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 prescription benefits. These can include drugs that must be administered 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 home delivery option.*

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 prescription 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) at **855-686-8517.**

EXTENDED SUPPLY NETWORK (ESN) RETAIL PHARMACIES

If you need medication on long-term 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 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) at **855-686-8517**.

***Note:** Home delivery service provider is changing as of October 1, 2021. Watch for more details.

HOME DELIVERY SERVICE

Home Delivery service is a convenient way to have your maintenance medications delivered to you and can save you money.

- Medications are shipped in discreet packaging via standard delivery at no additional cost.
- First-time orders are usually delivered within 10 days after receipt and confirmation of 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 request refills online or over the phone. You can also choose to receive refill reminder notices by phone or email.
- Copayments for the home delivery option are less than 90-day retail.

To start using home delivery pharmacy services, visit myprime.com for more information on how to register. Once you have registered, your doctor can send new 90-day prescriptions electronically to the pharmacy, or via fax, or call them.

SPECIALTY PHARMACY

Specialty medications that are self-administered generally must be filled through an in-network specialty pharmacy. You may have coverage for a first fill at some other pharmacy prior to being required to use an in-network option. 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 experience.
- You have access to around-the-clock customer service and educational materials about your particular diagnosis.
- 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.

To start using a specialty pharmacy, visit myprime.com for a list of locations, or call your Benefits Value Advisor (BVA) at **855-686-8517.**

ATTENTION MEMBERS USING HOME DELIVERY OR SPECIALTY PHARMACY

As of **October 1, 2021**, Prime Therapeutics will begin using **Express Scripts (ESI)** for home delivery service and **Accredo** for specialty pharmacy. Members currently utilizing either of these options will receive direct communication 30-60 days prior to this change which will include direction on next steps for transition of these maintenance or specialty drugs. The Trust will provide additional details as more information becomes available.

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 2021 drug list can be found at https://www.bcbsil.com/PDF/rx/rx-list-bal-il-2021.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 BCBSIL (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 use 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.

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.teladoc.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.teladoc.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.*

VOLUNTARY DENTAL PROGRAM

Beginning September 1, 2021, MetLife will become the administrator of the fully insured voluntary dental program. If you are currently enrolled in one of the BCBSIL voluntary dental plans, your enrollment will be transferred to MetLife.

Dental services provided by your dentist that are billed with a date of service on or after September 1, 2021 are eligible for consideration under the new MetLife plan. *Services received prior to September 1, 2021 should be submitted to BCBSIL.*

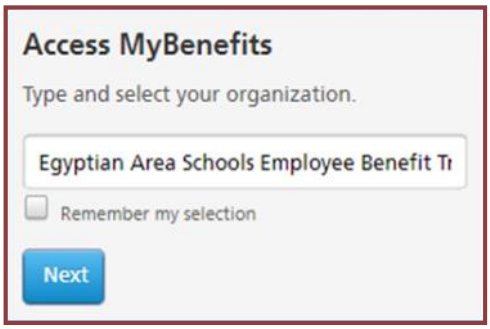
Below are important details regarding the transition of your 2021 dental deductible and annual benefit maximum:

- MetLife will provide covered members credit for any 2021 dental deductible satisfied and/or dental benefits paid and applied toward the annual benefit maximum under the BCBSIL plans.
- Covered members will be eligible to receive their remaining annual benefit maximum which is the difference between what BCBSIL previously paid in 2021 and the applicable maximum under the MetLife dental plan in which you are enrolled.
- As usual, the deductible and annual benefit maximum will reset as of January 1, 2022.

Below are important details on how orthodontia benefits will be administered under the MetLife High Plan, if orthodontia treatment started prior to September 1, 2021:

- Members enrolled in the High Plan who are currently receiving orthodontia treatment will be eligible to receive any remaining portion of their orthodontia lifetime maximum.
- For the remaining active treatment period and services received on or after September 1, 2021, MetLife will prorate benefits up to the orthodontia lifetime maximum.
- MetLife will need the complete treatment plan including total case fee, down payment amount, number of months in treatment, and initial banding date.
- You and/or your orthodontist will need to submit a claim to MetLife to be reimbursed for the ongoing orthodontic treatments.

Please advise your dental provider of your new dental plan with MetLife. Dental ID cards can be requested at metlife.com/mybenefits. In the Access MyBenefits box (see example) enter ***Egyptian Area Schools Employee Benefit Trust*** to begin the registration process.



If you have any questions about the MetLife dental benefits, call Customer Service at
1-800-ASK-4MET
(1-800-275-4638)
Monday through Friday
7:00 AM to 10:00 PM (CT)

MetLife

Dental - High Plan Summary*

Metropolitan Life Insurance Company

Plan Design for: Egyptian Area Schools Employee Benefit Trust
Coverage Effective: September 1, 2021

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	**In-Network**[1] % of PDP Fee[2]	**Out-of-Network**[1] % of R&C Fee[4]
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible[3]		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit:		
Per Individual	$1500	$1500
Orthodontia Lifetime Maximum - Ortho applies to Child Only	Up to dependent age limit	
	$1000 per Person	$1000 per Person

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

We're here to help

Find a Dental provider at
www.metlife.com/dental

For general questions go to
www.metlife.com/mybenefits or
call 1-800-275-4638

Monthly Premium Payment	
Employee	$35.56
Employee + 1 Dependent	$67.12
Employee + 2 or more Dependents	$98.46

Note: The monthly rates above have been adjusted by the Egyptian Trust as approved by the Board of Managers. These rates will remain in effect for dental participants through August 31, 2023.

*This information provides highlights of this dental program only. Full benefit details are available at:
http://www.egtrust.org/voluntary-benefits/dental/

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MetLife

Dental - Low Plan Summary*

Metropolitan Life Insurance Company

Plan Design for: Egyptian Area Schools Employee Benefit Trust
Coverage Effective: September 1, 2021

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	**In-Network**[1] % of PDP Fee[2]	**Out-of-Network**[1] % of R&C Fee[4]
Type A - Preventive	80%	80%
Type B - Basic Restorative	70%	70%
Type C - Major Restorative	Not Covered	Not Covered
Deductible[3]		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit:		
Per Individual	$750	$750

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

We're here to help

Find a Dental provider at
www.metlife.com/dental

For general questions go to
www.metlife.com/mybenefits or
call 1-800-275-4638

Monthly Premium Payment	
Employee	$14.60
Employee + 1 Dependent	$28.50
Employee + 2 or more Dependents	$54.88

Note: The monthly rates above have been adjusted by the Egyptian Trust as approved by the Board of Managers. These rates will remain in effect for dental participants through August 31, 2023.

*This information provides highlights of this dental program only. Full benefit details are available at:
http://www.egtrust.org/voluntary-benefits/dental/

DN-GCERT-GOLD GCERT Voluntary Dental Benefit Summary

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Selected Covered Services and Frequency Limitations*

Type A - Preventive (HIGH & LOW PLAN)	How Many/How Often:
Oral Examinations	2 in a year
Full Mouth X-rays	1 in 36 months
Bitewing X-rays (Adult/Child)	2 in a year
Prophylaxis - Cleanings	2 in a year
Topical Fluoride Applications	1 in a year - Children to age 19

Type B - Basic Restorative (HIGH & LOW PLAN)	How Many/How Often:
Sealants	1 in 60 months - Children to age 19
Space Maintainers	1 per lifetime per tooth area - Children up to age 19
Amalgam and Composite Fillings	1 in 12 months
Prefabricated Crowns	1 per tooth in 60 months
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 12 months per quadrant
Periodontal Scaling & Root Planing	1 in 12 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery (Simple Extractions)	
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	
Emergency Palliative Treatment	
General Anesthesia	
Consultations	1 in 12 months

Type C - Major Restorative (HIGH PLAN ONLY)	How Many/How Often:
Crowns/Inlays/Onlays	1 per tooth in 60 months
Repairs	1 in 12 months
Bridges	1 in 60 months
Dentures	1 in 60 months
Implant Services	1 service per tooth in 60 months - 1 repair per 12 months

Type D – Orthodontia (HIGH PLAN ONLY)

- Dependent children up to age 26. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

***Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

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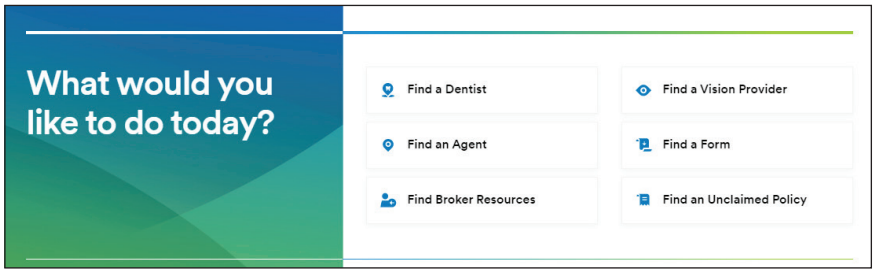
Find a Dental Provider

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

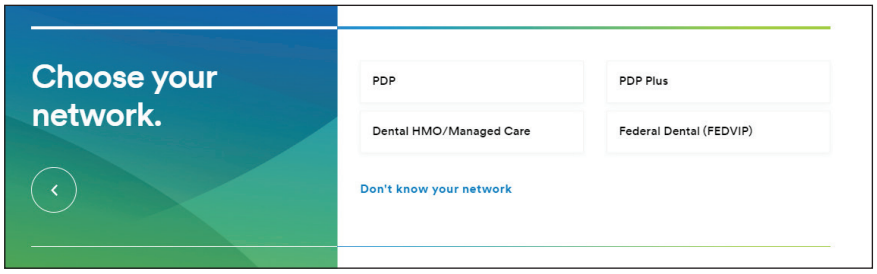
Step 1:
Go to metlife.com

Step 2:
Select "Find a Dentist" next to "What would you like to do today?"



Step 3:
Select "PDP/ PDP Plus" next to "Choose your network."

Enter your Zip, City or State and select the "Find a Dentist" button.



NOTE: Egyptian Trust Members select PDP Plus

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

Navigating life together

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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VOLUNTARY VISION PROGRAM

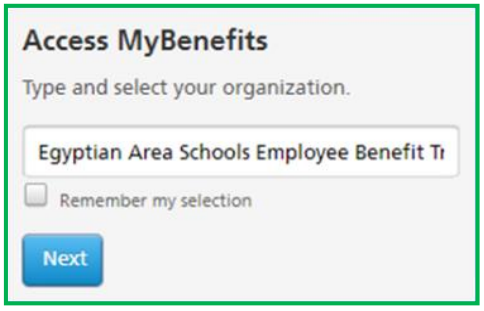
Effective September 1, 2021, MetLife will become the administrator of the fully insured voluntary vision program. The MetLife PPO Vision Network includes certified optometrists, ophthalmologists, and opticians in private practice, as well as retailers such as Costco Optical, Walmart, Sam's Club and Visionworks. You have the freedom to choose from both in-network and out–of-network providers, while out-of-network provider costs may be higher.

Vision services provided with a date of service on or after September 1, 2021 are eligible for consideration under the new MetLife plan. *Services received prior to September 1, 2021 should be submitted to EyeMed.*

All vision benefits will reset as of September 1st with the transition to MetLife. Below is an explanation of how vision benefit frequencies will be administered by MetLife:

- Members are allowed a vision exam and/or lenses every 12 months. If you have an exam on 10/1/2021, you will be eligible for your next eye exam and/or lenses as of 10/1/2022.
- Members are allowed new frames every 24 months. If you receive new frames on 12/15/2021, you will be eligible for your next set of frames under the plan as of 12/15/2023.

Please let your vision provider know about your new benefit plan with MetLife. While vision ID cards are not required to be presented at time of service, you can request a card at metlife.com/mybenefits. In the Access MyBenefits box (see example) enter ***Egyptian Area Schools Employee Benefit Trust*** to begin the registration process.



If you have any questions about the MetLife vision benefits,
call Customer Service at
1-855-MET-EYE1 (1-855-638-3931)
Monday-Friday
7:00 AM - 4:00 PM (CT)
and Saturday-Sunday
9:00 AM - 3:00 PM (CT)

MetLife

Vision Plan Summary effective September 1, 2021*

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.[1]

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.[1]

Laser vision correction:[2] Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

Frequency

Eye exam

Once every **12** months

- Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a **$15** copay.
- Retinal imaging: Up to a **$39** copay on routine retinal screening when performed by a private practice provider.

Frame

Once every **24** months

- Allowance: **$130** after **$15** eyewear copay.
- Costco, Walmart and Sam's Club: **$70** allowance after **$15** eyewear copay. You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.

Standard corrective lenses

Once every **12** months

- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **$15** eyewear copay.

Standard lens enhancements*

Once every **12** months

- Polycarbonate (child up to age 18), Ultraviolet (UV) coating, Progressive Standard and Scratch-resistant coatings: Covered in full after **$15** eyewear copay.
- Progressive Premium/Custom, Polycarbonate (adult), Photochromic, Anti-reflective and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits.

Contact lenses instead of eye glasses

Once every **12** months

- Contact fitting and evaluation: Covered in full with a maximum copay of **$40**.
- Elective lenses: **$130** allowance.
- Necessary lenses: Covered in full after eyewear copay.

Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefits for detailed out-of-network benefits information.

- Eye exam: up to **$45**
- Frames: up to **$70**
- Contact lenses:
  - Elective up to **$105**
  - Necessary up to **$210**
- Single vision lenses: up to **$30**
- Lined bifocal lenses: up to **$50**
- Lined trifocal lenses: up to **$65**
- Lenticular lenses: up to **$100**
- Progressive lenses: up to **$50**

Monthly Premium Payment	
Employee	$ 8.02
Employee + 1 Dependent	$11.54
Employee + 2 or more Dependents	$20.84

We're here to help

Find a Vision provider at www.metlife.com/vision

Download a claim form at www.metlife.com/mybenefits

For general questions go to www.metlife.com/mybenefits or call 1-855-MET-EYE1 (1-855-638-3931)

*This information provides highlights of this vision program only. Full benefit details are available at: http://www.egtrust.org/voluntary-benefits/vision/

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L0720006150[exp1221][All States]

Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments:

Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses, furnished under this Plan which are lost, stolen, or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90 day) fitting period.
- Contact lens modification, polishing, and cleaning.

Treatments

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

Medications

- Prescription and non-prescription medication

[1] All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart and Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

[2] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

Important: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

M130D-15/15-C/E
MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

200 Park Ave., New York, NY 10166
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Find a vision provider

With MetLife Vision, you can choose from thousands of ophthalmologists, optometrists and opticians at private practices or at popular retail locations like Costco® Optical, Visionworks and more. You can find the names, addresses, and phone numbers of providers by searching our online **Find a Vision Provider** directory.

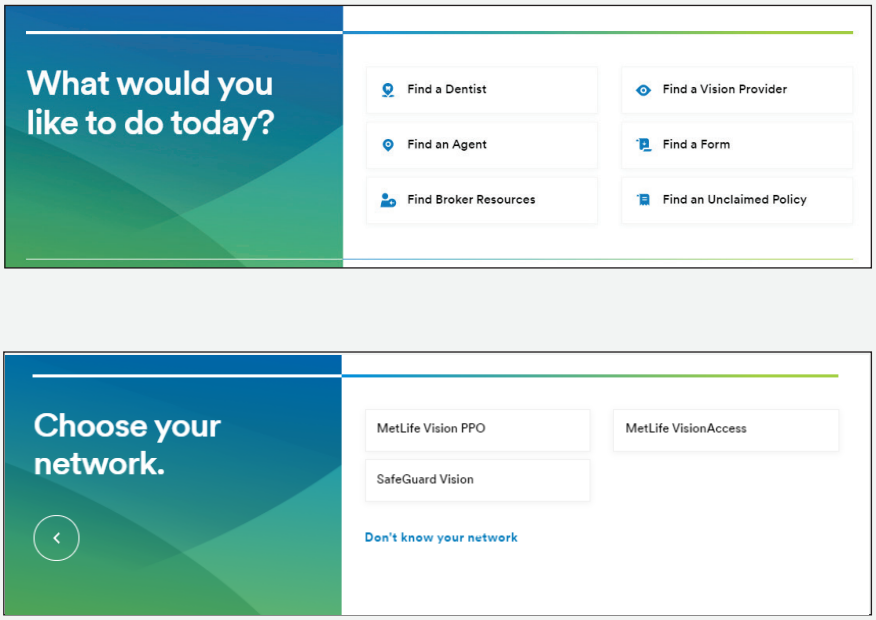
Step 1:
Go to metlife.com

Step 2:
Select "Find a Vision Provider" next to "What would you like to do today?"

Step 3:
Select your vision plan next to "Choose your network."

Enter your Zip, City or State and select the "Find a Vision Provider" button.

NOTE: Egyptian Trust Members select MetLife Vision PPO



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Navigating life together

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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LIFE INSURANCE AND AD&D COVERAGE

Life insurance is the tool most people use to financially protect their families in the event of 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 life insurance options offered through the Egyptian Trust provide that financial security for your family.

Life Insurance, Supplemental Life Insurance, and Accidental Death and Dismemberment (AD&D) plans are available from Blue Cross Blue Shield of Illinois (BCBSIL), previously Dearborn National. You may see either of these companies listed on various life insurance forms and documentation.

BlueCross BlueShield of Illinois

Helpful Tips For Your Life Insurance

Life insurance is one of those things that we purchase, file away, and often forget 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 the certificate for actual terms and conditions. Your life insurance certificate is available at www.egtrust.org.

GUARANTEE ISSUE AMOUNT

For new entrants enrolled within 31 days of being eligible, the following guarantee issue amounts are available without Evidence of Insurability (EOI):

Employee:	$100,000 (under age 60); or $25,000 (age 60-69)
Spouse:	$37,500 (under age 60)

EVIDENCE OF INSURABILITY (EOI)

EOI is an application process to provide information on the condition of your health or your dependent's health in order to be considered for life insurance coverage. The completed EOI application needs to be reviewed and approved by BCBSIL before coverage becomes effective. EOI is required if:

1) you apply for an amount of coverage higher than the guarantee issue amount,
2) you are currently enrolled and want to increase your insurance amount, or
3) you declined coverage previously.

WAIVER OF PREMIUM

The Life Insurance policy has a Waiver of Premium provision. If an employee is younger than age 60, becomes totally disabled and is unable to work for at least six months, the employee is no longer required to submit life insurance premium for the duration of the disability. *A Waiver or Premium claim form must be submitted to BCBSIL for review to determine if the employee meets the definition of total disability.* 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 terminates at the employee's Social Security Normal Retirement Age or when the employee is no longer considered totally disabled.

PORTABILITY

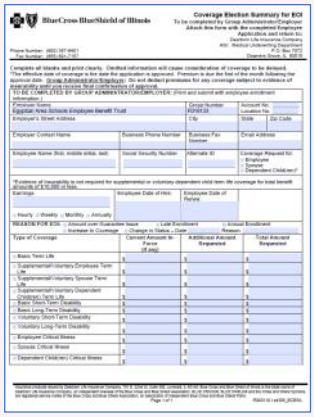
At termination of employment, an employee has the option to retain life insurance coverage through this Portability provision. Portability premiums must be submitted timely and rates increase as the employee's age increases. If the employee ports his or her coverage, a covered spouse and any covered children may also port their coverage. Portability coverage ends at age 65. Portability application form must be completed and submitted to the carrier within 31 days of coverage termination. Rates are found on the Portability application.

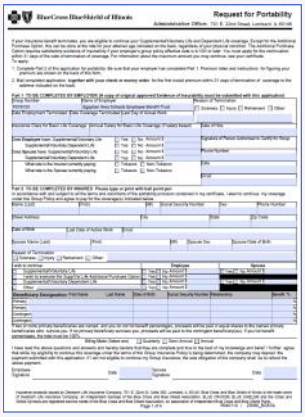
CONVERSION

If an employee is terminating employment or if the Waiver of Premium benefit is ending, the employee can convert life insurance 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. Conversion application form must be completed and submitted to the carrier within 31 days of coverage termination. Rates are found on the Conversion application.

Where do I find Life Insurance forms?

All necessary life insurance forms and applications are available on the Egyptian Trust website at http://egtrurst.org/voluntary-benefits/life-insurance/.





Many of these forms have portions to be completed by both the employer and the employee. Forms should be submitted to BCBSIL at the address or fax number indicated on the

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.

SUPPLEMENTAL GROUP LIFE AND AD&D
PREMIUM RATE GRID

BlueCross BlueShield of Illinois

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 timess 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)**

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

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

EMPLOYEE Benefit Amount	EMPLOYEE ATTAINED AGE <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

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.

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. Policy Provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations.

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	Vendor	Phone	Website
Health Plans	For any Health plan questions including: • Benefits • Precertification/Predetermination • Request Health Plan ID cards • Find a network provider	**BCBS of IL**	1-855-686-8517	www.bcbsil.com
Prescription Drugs	For any Prescription questions including: • Benefits • Eligibility • Prescription Drug Plan • Claim questions • Find a network provider	**Prime Therapeutics**	1-800-423-1973	www.myprime.com
Teladoc	Health plan and voluntary Teladoc participants have 24/7 access to medical consults for common conditions	**Teladoc**	1-800-DOC-CONSULT 1-800-362-2667	www.teladoc.com
Voluntary Dental	For any Dental plan questions including: • Benefits • Eligibility • Claim questions • Find a network provider	For services on or after September 1, 2021		
		MetLife	1-800-ASK-4MET 1-800-275-4638	www.metlife.com
Voluntary Vision	For any Vision plan questions including: • Benefits • Eligibility • Claim questions • Find a network provider	For services on or after September 1, 2021		
		MetLife	1-855-MET-EYE1 1-855-638-3931	www.metlife.com
Basic or Supplemental Life Insurance	Member questions concerning: • Portability or Conversion • Claim issues • Travel or Beneficiary Resources	**BCBS of IL**	1-877-442-4207 Option 4	www.egtrust.org
Voluntary Dental	For Services between September 1, 2019 through August 31, 2021	**BCBS of IL**	1-800-367-6401	www.bcbsil.com
Voluntary Vision	For Services prior to September 1, 2021	**EyeMed**	1-866-804-0982	www.eyemed.com

If you need contact information for vendors who are no longer listed, please contact us via email at egtrust@healthscopebenefits.com

IMPORTANT LEGAL NOTICES

COBRA

Under certain circumstances, you and your enrolled dependents have the right to continue coverage under the medical, dental and vision plans, beyond the time coverage would have ordinarily ended. You may elect continuation coverage for yourself and your dependents if you lose coverage under the Trust plan(s) because of one of the following qualifying events:

- Termination (for reasons other than gross misconduct)
- Reduction in employment hours
- Retirement
- You become entitled to Medicare

Upon a qualifying event, a COBRA election packet will be mailed to your home address by our COBRA administrator.

In addition, continuation coverage may be available to your eligible dependents if:

- You die
- You and your spouse divorce or legally separate
- A covered child ceases to be an eligible dependent
- You become entitled to Medicare

To initiate a COBRA continuation coverage offer, you or a dependent must notify your Employer within 60 days of a qualifying life event. You and/or your dependents must pay the full cost of COBRA coverage. Under the law, COBRA must be offered to eligible individuals at group rates. These rates are subject to change annually.

The full General Notice of Continuation Coverage Rights under COBRA is available on the Egyptian Trust website at www.egtrust.org. You may also request a printed copy of this full notice by contacting:

Egyptian Trust
P.O. Box 270237
St. Louis, MO 63127
Email: egtrust@healthscopebenefits.com
Phone: 1-800-397-9598

HIPAA Privacy Notice

This summary notice is a reminder of how medical information about you may be used and disclosed and how you can get access to this information. You are receiving this Notice summary because you are eligible for benefit plans ("Health Plan") offered through the Egyptian Area Schools Employee Benefit Trust. The "Health Plan" includes medical, dental and vision programs. The Health Plan is committed to protecting the confidentiality of any health information it receives, maintains, uses or discloses. This notice describes how the Health Plan may use and disclose your "protected health information" (PHI). PHI is any health information that identifies the individual or may reasonably be used to identify the individual; that is created or received by a health care provider, health plan, employer or health care clearing house; and that relates to your past, present or future physical or mental health conditions, or provision of or payment for health care.

The Trust administers and manages this Health Plan and may use your PHI only for appropriate plan purposes (such as for payment of claims or health care plan operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes. The Trust and all business associates must comply with the same requirements that apply to the Health Plan to safeguard your PHI and protect the confidentiality of your PHI.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide a notice explaining how the Health Plan may use your PHI. Copies of BCBSIL's Notice of Privacy Practices and the Trust's Notice of Privacy Practices are on the Trust website at HIPAA Authorization Notice & Form | EG Trust.

Should you have questions about the Privacy Notices, if you want more information about the privacy practices of the Health Plan, or to request a printed copy of the Privacy Notice, please contact the Trust's Privacy Officer at:

Egyptian Trust Privacy Officer
P.O. Box 270237
St. Louis, MO 63127
Email: egtrust@healthscopebenefits.com
Phone: 1-800-397-9598

HIPAA Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan in the following circumstances:

- If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage);
- If you or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP'') coverage as a result of a loss of eligibility for such coverage. However, you must request enrollment within 60 days after the loss of such coverage; or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP. However, you must request enrollment within 60 days after you or your dependents become eligible for such assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Employer.

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of the above periods.

Women's Health & Cancer Rights Act

Group health plans that cover mastectomies must cover postmastectomy reconstructive breast surgery. Specifically, health plans must cover:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy including lymphedemas.

Benefits required by law will be provided in consultation between the patient and attending physician. These benefits are subject to the health plan's regular plan provisions and benefits.

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

Employee Status: ☐ Active ☐ COBRA ☐ Retiree ☐ Other

Date of Hire

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

Special Instructions:

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

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

Employee Home Address Street/Apt. City State Zip

Home Phone _____

Business or Cell Phone _____

Email Address

Occupation: _____

Average Hours Worked per Week: _____

Earnings $_____ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Annually

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

Medical Plan Options	Voluntary Teladoc	Voluntary Dental	Voluntary Vision
Instruction: Ask your Employer which Plans you are eligible for. **Enter Plan Name Here:** _____	☐ **Teladoc Only**	☐ **High** ☐ **Low**	
☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family ☐ Decline Coverage **NOTE:** Includes Teladoc, Basic Life Insurance and Prescription Coverage	☐ Employee Only ☐ Decline Coverage **NOTE:** Teladoc is included in Medical Plan.	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more deps ☐ Decline Coverage

EMPLOYEES: Check all boxes that apply:

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

☐ Basic Life Amount _____

☐ Decline coverage

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

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

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

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

☐ Decline Coverage

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

OTHER INSURANCE COVERAGE

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

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

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

Address: _____ Phone: _____

Name of employer providing coverage: _____

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

EMPLOYER: RETAIN ORIGINAL FOR YOUR FILE

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) **Blue Cross Blue Shield of Illinois**

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

☐ **APPLY FOR THE BASIC GROUP LIFE BENEFITS** indicated above and, if my application is approved by BCBSIL, 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.

☐ **WAIVE 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.

☐ **APPLY FOR THE OPTIONAL GROUP LIFE BENEFITS** indicated above and, if my application is approved by BCBSIL 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.

☐ **WAIVE 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.

☐ **WAIVE 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 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.

REQUEST FOR COVERAGE (MEDICAL) **Administered By: Blue Cross Blue Shield of Illinois**

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 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.

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

REQUEST FOR COVERAGE (VOLUNTARY TELADOC)

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 Voluntary Teladoc Program.**

REQUEST FOR COVERAGE (VOLUNTARY DENTAL) **Met Life**

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 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.

☐ **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) **Met Life**

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 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:**

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 ☐ M ☐ F	Date of Birth	Social Security Number

☐ **Employee Name** From: _____ To: _____

☐ **Employee Address** From: _____ To: _____

☐ **Employee Phone** From: _____ To: _____

☐ **Employee Email** From: _____ To: _____

☐ **Marital Status** From: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced. To: ☐ Single ☐ Married ☐ Civil Union Termination ☐ Divorced

☐ Termination Choose Reason

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

☐ Terminate Dependent(s)

Reason for Termination:

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

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: ☐ High ☐ 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:**
☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child or Children ☐ Family ☐ Terminate Medical ☐ No Change Medical	☐ Employee Only ☐ Terminate ☐ No Change	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more Dependents ☐ Terminate Dental ☐ No Change Dental	☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or more Dependents ☐ Terminate Vision ☐ No Change Vision

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

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

Optional Life – Changes in Optional Life coverage must be submitted using the BCBS 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) ☐ Terminate Optional Employee
☐ Add Optional Spouse (Evidence of Insurability REQUIRED) ☐ Terminate Optional Spouse
☐ Add Optional Dependent (Evidence of Insurability REQUIRED) ☐ Terminate Optional Dependent
☐ No Change Optional Life

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

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

BASIC LIFE – CHANGE Beneficiary Information

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

OPTIONAL LIFE – CHANGE Beneficiary

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

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

OTHER INSURANCE COVERAGE

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

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

Name of individual with other coverage: _____

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

Name of employer providing coverage: _____

Address: _____

_____

Is other coverage Medicare or Medicaid? ☐ Yes ☐ 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? ☐ 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

NOTES: