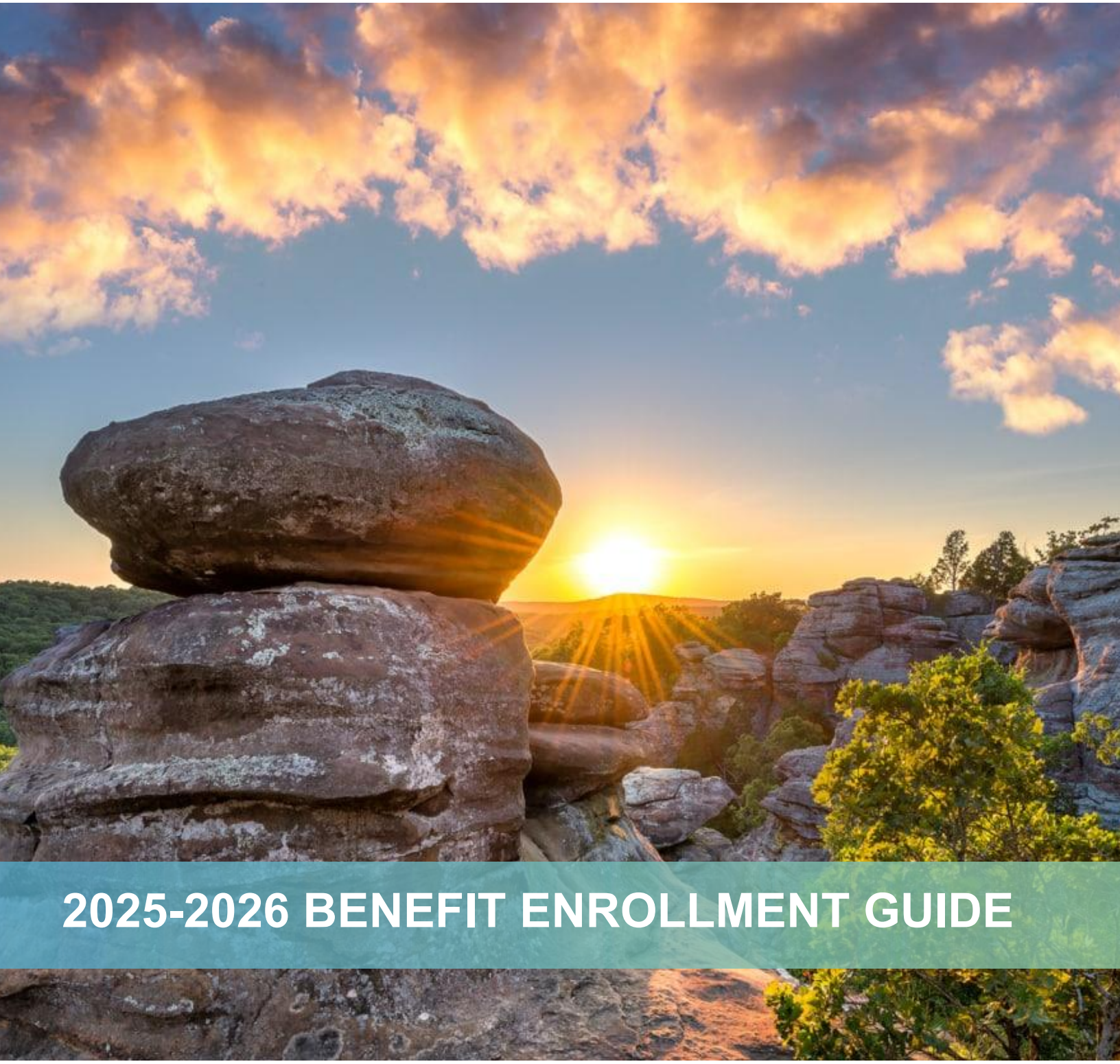
Egyptian Area Schools Employee Benefit Trust



2025-2026 BENEFIT ENROLLMENT GUIDE

Table of Contents

An Enrollment form is included at the back of this Guide and is perforated for easy removal. Complete this form and submit to your employer to enroll or make changes to your benefits.

Welcome to 2025-2026 Open Enrollment

This Benefit Enrollment guide contains information about medical, dental, vision, life and other 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 current coverage elections.

Please check with your Employer for the plans and rates offered at your district. Benefit summaries for all plans offered by the Trust are available in the appropriate sections 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 of 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 proper contact as noted in the Member Communication Guide near the back of this book.

Here's to your health!

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, 2025

Health Plan Updates	Plan deductibles, out of pocket maximums, copayments and coinsurance levels will change. Please review the plan summaries in this guide and schedules of benefits at www.egtrust.org for full details.
	Hearing aid benefits will include one hearing instrument for each ear every 36 months. Benefits are subject to plan deductible, coinsurance and out of pocket maximums.
	Biosimilar preferred drug formulary list will be adopted. This means available biosimilars should be used in place of certain brand name medications, such as Humira and Stelara.
	Preventive screenings and other benefits will be updated to comply with the appropriate Illinois state mandates.
Supplemental Life Insurance Rates	Supplemental life insurance rates for employee, spouse and child life will change. New rates are guaranteed through 8/31/2027. If you have coverage please see the new rate table on page 36.

OPEN ENROLLMENT—WHAT YOU NEED TO DO

If you are a new employee and wish to enroll, complete the Enrollment 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 Enrollment 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 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, 2025**. 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 enroll or 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 benefit 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.*

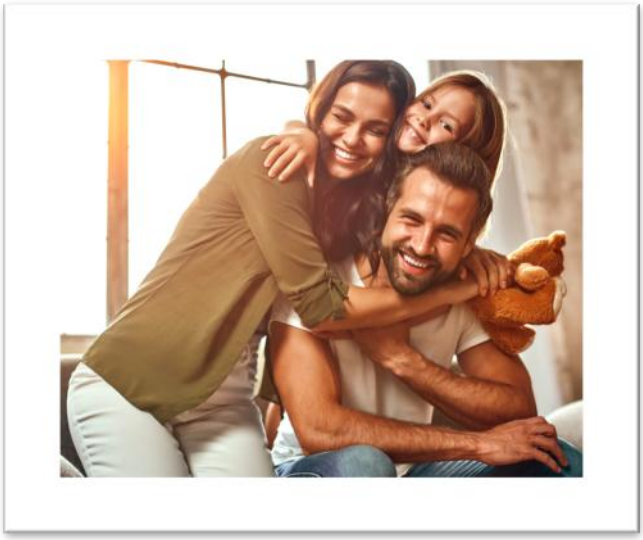
*QUALIFYING LIFE EVENTS

- 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 network participating hospitals, doctors, and other healthcare providers. However, you have the flexibility to use any provider you choose. If you use a non-network provider, deductibles and out of pocket amounts are increased, and there is larger out of pocket responsibility for the patient.



PPO NETWORK

Trust health plan members are enrolled in the **Blue Choice Select (BCS)** PPO Network. Because the BCS Network includes only providers located in the state of Illinois, the larger **Blue PPO** network is used for services received from providers outside Illinois (i.e. Indiana, Missouri, etc.).

Due to BCS network limitations, the following exceptions apply for certain Trust members:

1. Employees whose home residence is not in Illinois will be enrolled in the Blue PPO network.
2. Employees with a home zip code in Sangamon, Wabash, or Lawrence counties will be enrolled in the Blue PPO network.
3. Employees of the following districts will be enrolled in Blue PPO network: A-C Central CUSD 262; Northwestern CUSD 2; Panhandle CUSD 2; Red Hill CUSD 10; Tremont CUSD 702; Triopia CUSD 27; and Wabash CUSD 348.

Benefits Value Advisors (BVA)

BVA customer service representatives are available to assist you with questions about claims, benefit coverage, finding network providers, navigating digital tools and resources, getting cost estimates, and even scheduling appointments.

If you have questions or need assistance, they are available 24/7. Contact the BVA at 855-686-8517.

BLUE ACCESS FOR MEMBERS (BAM)

Once you have your BCBSIL Member ID card, go to https://www.bcbsil.com to register for Blue Access for Members (BAM). All covered individuals age 18 and older can create a BAM account. Use this secure website from your desktop or mobile device to:

- View or print Explanation of Benefits (EOB) statements
- View prescription history
- Request or print your ID card
- Use the Provider Finder tool to search for providers

Current members who make no medical plan changes will continue to use their current BCBS ID card.

MEDICAL PLAN SUMMARIES REFERENCE GUIDE

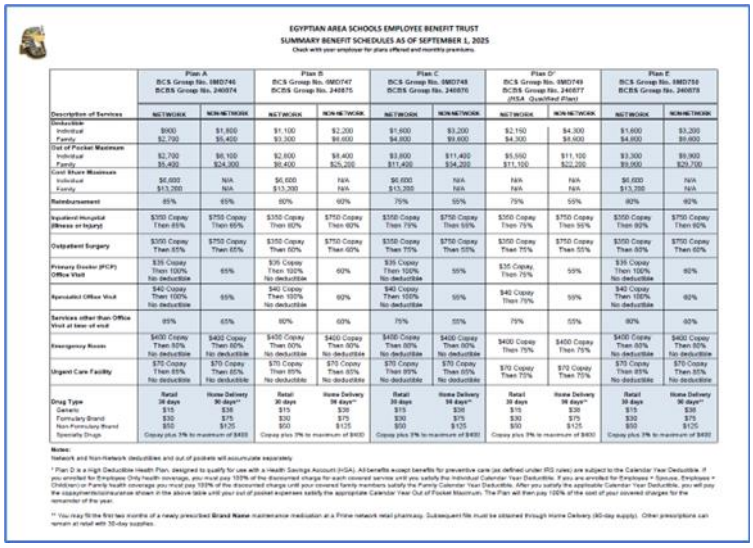
The Trust has a variety of summary documents available that explain each of the medical plans offered. All plan benefit summaries can be found on the Trust website at https://www.egtrust.org/.

Before you begin to review these summaries, **please confirm with your Employer which medical plans are offered at your district** to ensure you are reviewing the appropriate plan information. Your Employer will also provide the premiums associated with the plans offered.

BENEFIT PLAN COMPARISIONS

https://www.egtrust.org/medical-benefits/traditional-plans/

These side-by-side comparisons, found on the next three pages (8-10), include key plan details, such as deductible, out of pocket maximum, ACA cost share maximum (if applicable), office visit and prescription drug copays, etc.



EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2025

Description of Services	Plan A BCS Group No. 9MD746 BCBS Group No. 240074		Plan B BCS Group No. 9MD747 BCBS Group No. 240075		Plan C BCS Group No. 9MD748 BCBS Group No. 240076		Plan D* BCS Group No. 9MD749 BCBS Group No. 240077 (HSA Qualified Plan)		Plan E BCS Group No. 9MD750 BCBS Group No. 240078	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible Individual Family	$900 $2,700	$1,800 $5,400	$1,100 $3,300	$2,200 $6,600	$1,600 $4,800	$3,200 $9,600	$2,150 $4,300	$4,300 $8,600	$1,600 $4,800	$3,200 $9,600
Out of Pocket Maximum Individual Family	$2,700 $5,400	$6,100 $24,300	$2,600 $9,400	$8,400 $25,200	$3,800 $11,400	$11,400 $34,200	$5,550 $11,100	$11,100 $22,200	$3,300 $9,900	$9,900 $29,700
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	N/A N/A	N/A N/A	$6,600 $13,200	N/A N/A
Reimbursement	85%	65%	80%	60%	75%	55%	75%	55%	80%	60%
Inpatient Hospital (Illness or Injury)	$350 Copay Then 85%	$750 Copay Then 65%	$350 Copay Then 80%	$750 Copay Then 60%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 80%	$750 Copay Then 60%
Outpatient Surgery	$350 Copay Then 85%	$750 Copay Then 65%	$350 Copay Then 80%	$750 Copay Then 60%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 80%	$750 Copay Then 60%
Primary Doctor (PCP) Office Visit	$35 Copay Then 100% No deductible	65%	$35 Copay Then 100% No deductible	60%	$35 Copay Then 100% No deductible	55%	$35 Copay Then 75%	55%	$35 Copay Then 100% No deductible	60%
Specialist Office Visit	$40 Copay Then 100% No deductible	65%	$40 Copay Then 100% No deductible	60%	$40 Copay Then 100% No deductible	55%	$40 Copay Then 75%	55%	$40 Copay Then 100% No deductible	60%
Services other than Office Visit at time of visit	85%	65%	80%	60%	75%	55%	75%	55%	80%	60%
Emergency Room	$400 Copay Then 85% No deductible	$400 Copay Then 85% No deductible	$400 Copay Then 85% No deductible	$400 Copay Then 60% No deductible	$400 Copay Then 85% No deductible	$400 Copay Then 60% No deductible	$400 Copay Then 75%	$400 Copay Then 75%	$400 Copay Then 85% No deductible	$400 Copay Then 60% No deductible
Urgent Care Facility	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 75%	$70 Copay Then 75%	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible
Drug Type Generic Formulary Brand Non-Formulary Brand Specialty Drugs	Retail 30 days $15 $30 $50 Copay plus 3% to maximum of $400	Home Delivery 90 days** $38 $75 $125	Retail 30 days $15 $30 $50 Copay plus 3% to maximum of $400	Home Delivery 90 days** $38 $75 $125	Retail 30 days $15 $30 $50 Copay plus 3% to maximum of $400	Home Delivery 90 days** $38 $75 $125	Retail 30 days $15 $30 $50 Copay plus 3% to maximum of $400	Home Delivery 90 days** $38 $75 $125	Retail 30 days $15 $30 $50 Copay plus 3% to maximum of $400	Home Delivery 90 days** $38 $75 $125

Notes:
Network and Non-Network deductibles and out of pockets will accumulate separately.

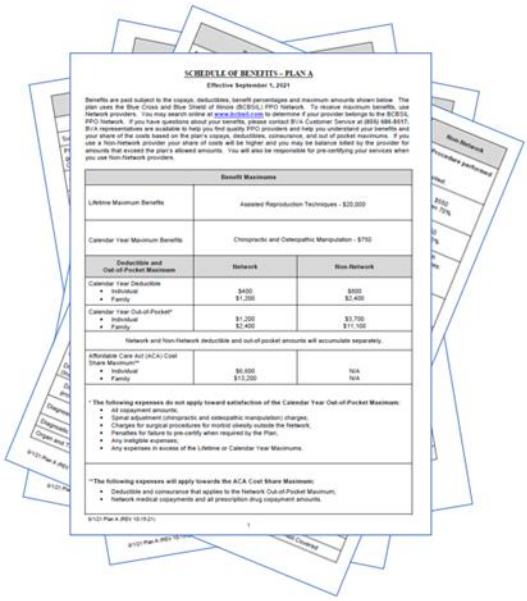
* Plan D is a High Deductible Health Plan, designed to qualify for use with a Health Savings Account (HSA). All benefits except benefits for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. If you enrolled for Employee Only health coverage, you must pay 100% of the discounted charge for each covered service until you satisfy the Individual Calendar Year Deductible. If you are enrolled for Employee + Spouse, Employee + Child(ren) or Family health coverage you must pay 100% of the discounted charge until your covered family members satisfy the Family Calendar Year Deductible. After you satisfy the applicable Calendar Year Deductible, you will pay the copayment/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 Brand Name maintenance medication at a Prime network retail pharmacy. Subsequent fills must be obtained through Home Delivery (90-day supply). Other prescriptions can remain at retail with 30-day supplies.

SCHEDULES OF BENEFITS (SOB)

https://www.egtrust.org/schedule-of-benefits/

Each Schedule of Benefits document is a handy reference guide that outlines a **single** health plan. This schedule includes key plan details, such as deductible, out of pocket maximum, and ACA cost share maximum. In addition, the SOB provides expanded explanations of plan coverage based on common medical procedures, supplies, and services.



SCHEDULE OF BENEFITS – PLAN A
Effective September 1, 2021

Benefits are paid subject to the copays, deductibles, benefit percentages and maximum amounts shown below. The plan uses the Blue Cross and Blue Shield of Illinois (BCBSIL) PPO Network. To receive maximum benefits, use Network providers. You may search online at www.bcbsil.com to determine if your provider belongs to the BCBSIL PPO Network. If you have questions about your benefits, please contact BVA Customer Service at (866) 686-8617. BVA representatives are available to help you find quality PPO providers and help you understand your benefits and your share of the costs based on the plan's copays, deductibles, coinsurance, and out of pocket maximums. If you use a Non-Network provider your share of costs will be higher and you may be balance billed by the provider for amounts that exceed the plan's allowed amounts. You will also be responsible for pre-certifying your services when you use Non-Network providers.

Benefit Maximums		
Lifetime Maximum Benefits	Assisted Reproduction Techniques - $20,000	
Calendar Year Maximum Benefits	Chiropractic and Osteopathic Manipulation - $750	
Deductible and Out-of-Pocket Maximum	Network	Non-Network
Calendar Year Deductible • Individual • Family	$400 $1,200	$800 $2,400
Calendar Year Out-of-Pocket* • Individual • Family	$1,200 $2,400	$3,700 $11,100
Network and Non-Network deductible and out-of-pocket amounts will accumulate separately.		
Affordable Care Act (ACA) Cost Share Maximum** • Individual • Family	$6,600 $13,200	N/A N/A

* The following expenses do not apply toward satisfaction of the Calendar Year Out-of-Pocket Maximum:
- All copayment amounts;
- Spinal adjustment (chiropractic and osteopathic manipulation) charges;
- Charges for surgical procedures for morbid obesity outside the Network;
- Penalties for failure to pre-certify when required by the Plan;
- Any ineligible expenses;
- Any expenses in excess of the Lifetime or Calendar Year Maximums.

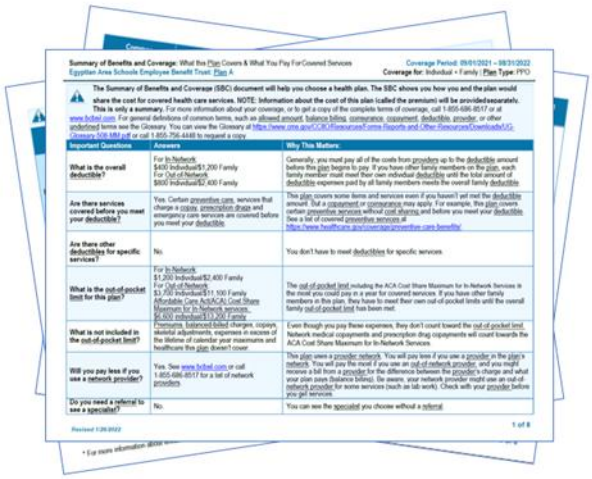
** The following expenses will apply towards the ACA Cost Share Maximum:
- Deductible and coinsurance that applies to the Network Out-of-Pocket Maximum;
- Network medical copayments and all prescription drug copayment amounts.

8121 Plan A (REV 10-19-21)

SUMMARY OF BENEFITS AND COVERAGE (SBC)

https://www.egtrust.org/schedule-of-benefits/

Each 8-page document provides an easy to read summary to compare coverage and expected patient out of pocket expense for a **single** health plan. The SBC explains key plan details like deductible, out of pocket maximum, and limitations or exceptions which may apply. In addition, the SBC provides coverage examples using three common claims.



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Egyptian Area Schools Employee Benefit Trust: Plan A
Coverage Period: 09/01/2021 – 08/31/2022
Coverage for: Individual + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-686-8517 or at www.bcbsil.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	For In-Network: $400 Individual/$1,200 Family. For Out-of-Network: $800 Individual/$2,400 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, services that charge a copay, prescription drugs and emergency care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: $1,200 Individual/$2,400 Family. For Out-of-Network: $3,700 Individual/$11,100 Family. Affordable Care Act(ACA) Cost Share Maximum for In-Network services: $6,600 Individual/$13,200 Family	The out-of-pocket limit including the ACA Cost Share Maximum for In-Network Services is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, copays, skeletal adjustments, expenses in excess of the lifetime of calendar year maximums and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Network medical copayments and prescription drug copayments will count towards the ACA Cost Share Maximum for In-Network Services.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-855-686-8517 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Revised 1/26/2022 — 1 of 8

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com.

Use these resources to select the medical plan which will best suit the needs of you and your family.

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2025

Check with your employer for plans offered and monthly premiums.

	Plan A BCS Group No. 0MD746 BCBS Group No. 240874		Plan B BCS Group No. 0MD747 BCBS Group No. 240875		Plan C BCS Group No. 0MD748 BCBS Group No. 240876		Plan D* BCS Group No. 0MD749 BCBS Group No. 240877 *(HSA Qualified Plan)*		Plan E BCS Group No. 0MD750 BCBS Group No. 240878	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible										
Individual	$900	$1,800	$1,100	$2,200	$1,600	$3,200	$2,150	$4,300	$1,600	$3,200
Family	$2,700	$5,400	$3,300	$6,600	$4,800	$9,600	$4,300	$8,600	$4,800	$9,600
Out of Pocket Maximum										
Individual	$2,700	$8,100	$2,800	$8,400	$3,800	$11,400	$5,550	$11,100	$3,300	$9,900
Family	$5,400	$24,300	$8,400	$25,200	$11,400	$34,200	$11,100	$22,200	$9,900	$29,700
Cost Share Maximum										
Individual	$6,600	N/A	$6,600	N/A	$6,600	N/A	N/A	N/A	$6,600	N/A
Family	$13,200	N/A	$13,200	N/A	$13,200	N/A	N/A	N/A	$13,200	N/A
Reimbursement	85%	65%	80%	60%	75%	55%	75%	55%	80%	60%
Inpatient Hospital (Illness or Injury)	$350 Copay Then 85%	$750 Copay Then 65%	$350 Copay Then 80%	$750 Copay Then 60%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 80%	$750 Copay Then 60%
Outpatient Surgery	$350 Copay Then 85%	$750 Copay Then 65%	$350 Copay Then 80%	$750 Copay Then 60%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 75%	$750 Copay Then 55%	$350 Copay Then 80%	$750 Copay Then 60%
Primary Doctor (PCP) Office Visit	$35 Copay Then 100% No deductible	65%	$35 Copay Then 100% No deductible	60%	$35 Copay Then 100% No deductible	55%	$35 Copay, Then 75%	55%	$35 Copay Then 100% No deductible	60%
Specialist Office Visit	$40 Copay Then 100% No deductible	65%	$40 Copay Then 100% No deductible	60%	$40 Copay Then 100% No deductible	55%	$40 Copay Then 75%	55%	$40 Copay Then 100% No deductible	60%
Services other than Office Visit at time of visit	85%	65%	80%	60%	75%	55%	75%	55%	80%	60%
Emergency Room	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible	$400 Copay Then 75%	$400 Copay Then 75%	$400 Copay Then 80% No deductible	$400 Copay Then 80% No deductible
Urgent Care Facility	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible	$70 Copay Then 75%	$70 Copay Then 75%	$70 Copay Then 85% No deductible	$70 Copay Then 85% No deductible
Drug Type	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****
Generic	$15	$38	$15	$38	$15	$38	$15	$38	$15	$38
Formulary Brand	$30	$75	$30	$75	$30	$75	$30	$75	$30	$75
Non-Formulary Brand	$50	$125	$50	$125	$50	$125	$50	$125	$50	$125
Specialty Drugs	Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400	

Notes:

Network and Non-Network deductibles and out of pockets will accumulate separately

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

** You may fill the first two months of a newly prescribed **Brand Name** maintenance medication at a Prime network retail pharmacy. Subsequent fills must be obtained through Home Delivery (90-day supply). Other prescriptions can remain at retail with 30-day supplies.

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2025

Check with your employer for plans offered and monthly premiums.

2025-2026 Medical Plans M3, M5, M6, M7, M8

	Plan M3 BCS Group No. 0MD752 BCBS Group No. M240880		Plan M5 (HRA) BCS Group No. 0ME538 BCBS Group No. 398348		Plan M6 BCS Group No. 0MD753 BCBS Group No. M240881		Plan M7 BCS Group No. 0MD754 BCBS Group No. M240882		Plan M8 BCS Group No. 0MD755 BCBS Group No. M240883	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible*										
Individual	$3,000	$6,000	$5,000	$10,000	$900	$1,800	$1,100	$2,200	$1,600	$3,200
Family	$6,000	$12,000	$10,000	$20,000	$2,700	$5,400	$3,300	$6,600	$4,800	$9,600
Out of Pocket Maximum*										
Individual	$5,000	$15,000	$10,000	$25,000	$2,700	$8,100	$2,800	$8,400	$3,800	$11,400
Family	$10,000	$30,000	$20,000	$50,000	$5,400	$16,200	$8,400	$25,200	$11,400	$34,200
Cost Share Maximum										
Individual	N/A	N/A	N/A	N/A	$4,000	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	$8,000	N/A	N/A	N/A	N/A	N/A
Reimbursement	80%	60%	100%	50%	85%	65%	80%	60%	75%	55%
Inpatient Hospital (Illness or Injury)	80%	60%	$350 then 100%	$750 then 50%	$350 then 85%	$750 then 65%	$350 then 80%	$750 then 60%	$350 then 75%	$750 then 55%
Outpatient Surgery	80%	60%	$350 then 100%	$750 then 50%	$350 then 85%	$750 then 65%	$350 then 80%	$750 then 60%	$350 then 75%	$750 then 55%
Primary Doctor (PCP) Office Visit	$35 copay then 100% no deductible	60%	$35 copay then 100% no deductible	50%	$35 copay then 100% no deductible	65%	$35 copay then 100% no deductible	60%	$35 copay then 100% no deductible	55%
Specialist Office Visit	$40 copay then 100% no deductible	60%	$40 copay then 100% no deductible	50%	$40 copay then 100% no deductible	65%	$40 copay then 100% no deductible	60%	$40 copay then 100% no deductible	55%
Emergency Room	$400 Copay then 80%, no deductible	$400 Copay then 80% no deductible	$400 Copay then 80%, no deductible	$400 Copay then 80% no deductible	$400 Copay then 80%, no deductible	$400 Copay then 80% no deductible	$400 Copay then 80%, no deductible	$400 Copay then 80% no deductible	$400 Copay then 80%, no deductible	$400 Copay then 80% no deductible
Urgent Care Facility	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible	$70 Copay then 85% no deductible
Facility Charges										
Physician Charges	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Drug Type	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****	**Retail 30 days**	**Home Delivery 90 days****
Generic	$15	$38	$15	$38	$15	$38	$15	$38	$15	$38
Formulary Brand	$30	$75	$30	$75	$30	$75	$30	$75	$30	$75
Non-Formulary Brand	$50	$125	$50	$125	$50	$125	$50	$125	$50	$125
Specialty Drugs	Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400		Copay plus 3% to maximum of $400	

The M-series plans on this sheet are not NOT HSA-compatible.

Notes:

* Network and Non-Network deductibles and out of pockets will accumulate separately

** You may fill the first two months of a newly prescribed **Brand Name** maintenance medication at a Prime network retail pharmacy. Subsequent fills must be obtained through Home Delivery (90-day supply). Other prescriptions can remain at retail with 30-day supplies.

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
SUMMARY BENEFIT SCHEDULES AS OF SEPTEMBER 1, 2025

Check with your employer for plans offered and monthly premiums.

2025-2026 Medical Plans H1, H4, and H5						
	Plan H1 BCS Group No. 0MD756 BCBS Group No. PI3198 (HSA Qualified Plan) **		Plan H4 BCS Group No. 0MD757 BCBS Group No. PI3199 (HSA Qualified Plan) ***		Plan H5 BCS Group No. 0MD758 BCBS Group PI3200 (HSA Qualified Plan) ***	
Description of Services	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**	**NETWORK**	**NON-NETWORK**
Deductible*						
Individual	$2,600	$5,200	$4,100	$8,200	$6,000	$12,000
Family	$5,200	$10,400	$8,200	$16,400	$12,000	$24,000
Out of Pocket Maximum*						
Individual	$2,600	$7,800	$4,100	$12,300	$6,000	$18,000
Family	$5,200	$15,600	$8,200	$24,600	$12,000	$36,000
All charges are subject to the Calendar Year Deductible unless otherwise specified.						
Reimbursement	100%	70%	100%	70%	100%	70%
Inpatient Hospital (Illness or Injury)	100%	70%	100%	70%	100%	70%
Outpatient Surgery	100%	70%	100%	70%	100%	70%
Primary Doctor (PCP) Office Visit	100%	70%	100%	70%	100%	70%
Specialist Office Visit	100%	70%	100%	70%	100%	70%
Emergency Room	100%	100%	100%	100%	100%	100%
Urgent Care Facility	100%	70%	100%	70%	100%	70%
Drug Type[1]	**Participating**	**Non-Participating (Non-Network)**	**Participating**	**Non-Participating (Non-Network)**	**Participating**	**Non-Participating (Non-Network)**
Generic	100%	70%	100%	70%	100%	70%
Formulary	100%	70%	100%	70%	100%	70%
Non-Formulary	100%	70%	100%	70%	100%	70%
Specialty	100%	n/a	100%	n/a	100%	n/a
Preventive Drugs (HHS classification)	100%, No Deductible	100%	100%, No Deductible	100%	100%, No Deductible	100%

Notes:

* Network and Non-Network deductibles and out of pockets will accumulate separately

** H1 is a High Deductible Health Plan, designed to qualify for use with a Health Savings Account (HSA). All benefits except benefits for preventive care (as defined under IRS rules) are subject to the Calendar Year Deductible. If you enrolled for Employee Only health coverage, you must pay 100% of the discounted charge for each covered service until you satisfy the Individual Calendar Year Deductible. If you are enrolled for Employee + Spouse, Employee + Child(ren) or Family health coverage you must pay 100% of the discounted charge until your covered family members satisfy the Family Calendar Year Deductible. After you satisfy the applicable Calendar Year Deductible, you will pay the copayments/coinsurance shown in the above table until your out of pocket expenses satisfy the appropriate Calendar Year Out of Pocket Maximum. The Plan will then pay 100% of the cost of your covered charges for the remainder of the year.

*** H4 and H5 are High Deductible Health Plans, 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 each individual in a family is not required to contribute more than the single Deductible/Out of Pocket Maximum before the Plan will pay 100% of covered expenses for that individual.

[1] You may fill the first two months of a newly prescribed **Brand Name** maintenance medication at a Prime network retail pharmacy. Subsequent fills must be obtained through Home Delivery (90-day supply). Other prescriptions can remain at retail for 30-day supplies.

PREAUTHORIZATION/ PRECERTIFICATION

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.

BlueCross BlueShield of Illinois

Blue Access for Members℠

Health care at your fingertips.

Blue Cross and Blue Shield of Illinois helps you get the most from your health care benefits with Blue Access for Members. You and all covered dependents age 18 and up can create a BAM℠ account.

With BAM you can:

- Find care – search for in-network doctors, hospitals, pharmacies and other health care providers
- Get your digital member ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Sign up for text or email alerts

It's easy to get started.

Use your member ID card to create a BAM account at **bcbsil.com**, or text **BCBSILAPP** to **33633** to download our mobile app.*

SCAN ME

Scan this QR code to visit bcbsil.com.

*Message and data rates may apply.

How to Navigate Provider Finder

The Provider Finder tool available on the BlueCross BlueShield of Illinois (BCBSIL) website helps you find in-network physicians, providers. Below is a step-by-step guide to aid you in navigating Provider Finder.

Getting Started

Click on this link: ***Provider Finder***

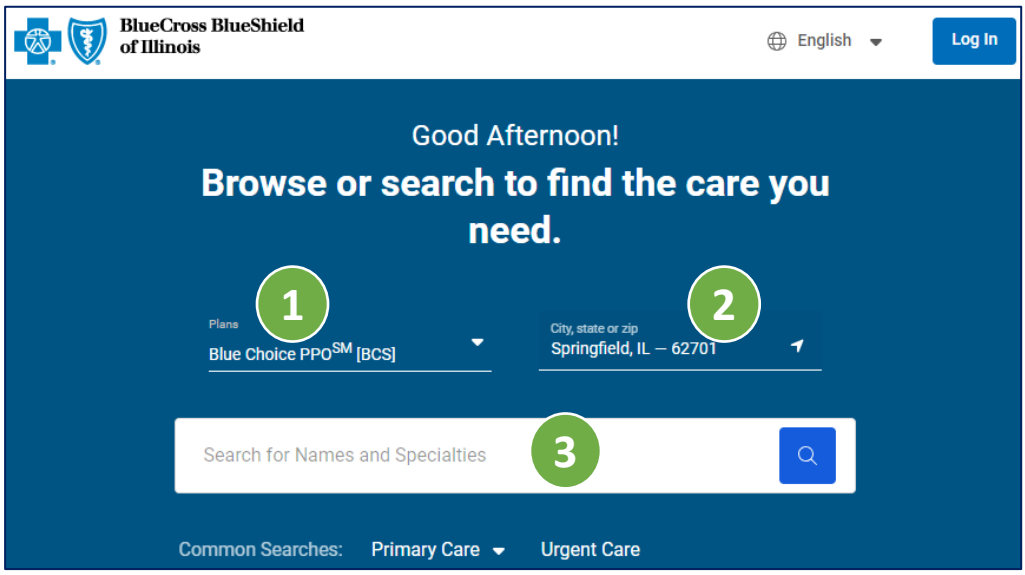
If your computer is logged in to Blue Access for Members (BAM), you may need to logout to change the Plan (i.e. Network) for your search.

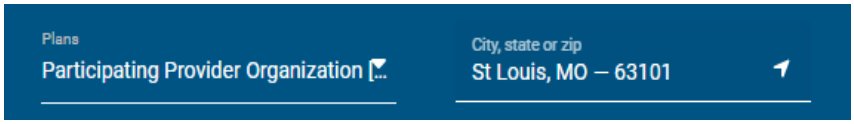
Enter your Plan and Location into Provider Finder

1. Select **PLAN** -
   a. If in the **BCS network**, choose **Blue Choice PPO (BCS)**

   b. If in the **BCS network** and ***needing services from a provider outside the state of Illinois***, choose **Participating Provider Organization (PPO)**

   c. If in the **Blue PPO network**, choose **Participating Provider Organization (PPO)**





2. Enter your **City**, **State** or **Zip**

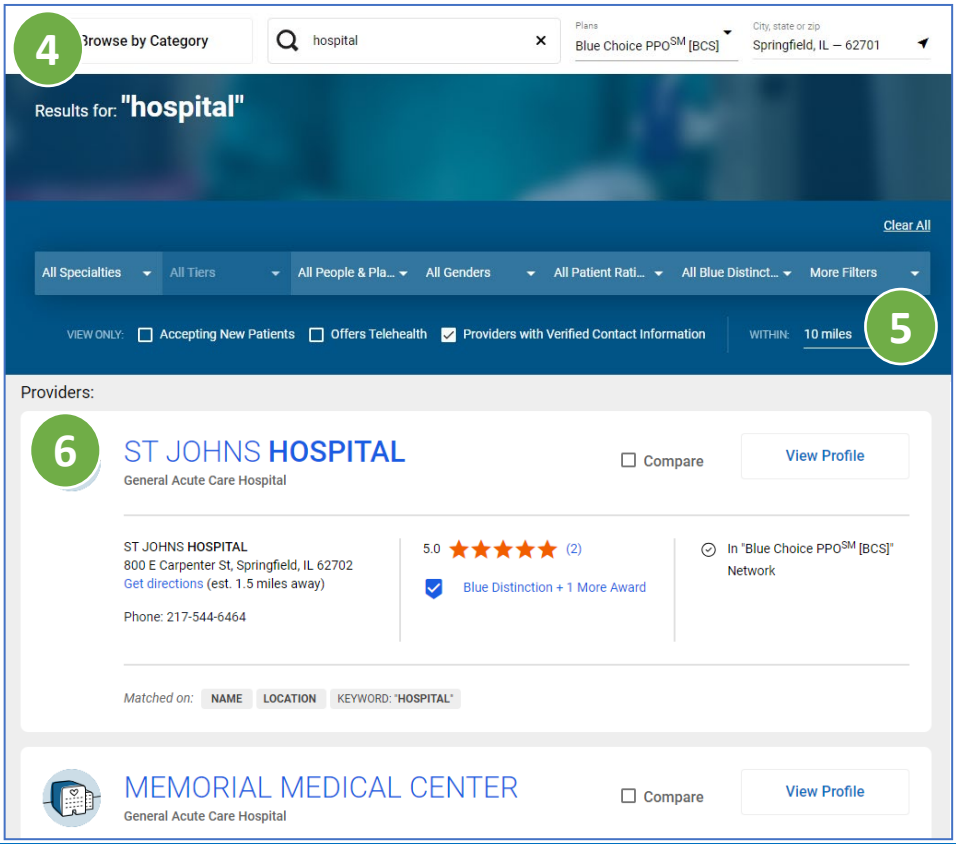
3. Enter a **Provider Name** or **Specialty** to begin the search

Refine your Search or Results

4. Revise **Browse by Category** to search for other provider types

5. Enter the **distance** you are willing to travel

6. View your **Provider results**



BlueCross BlueShield of Illinois

Understanding Your Explanation of Benefits

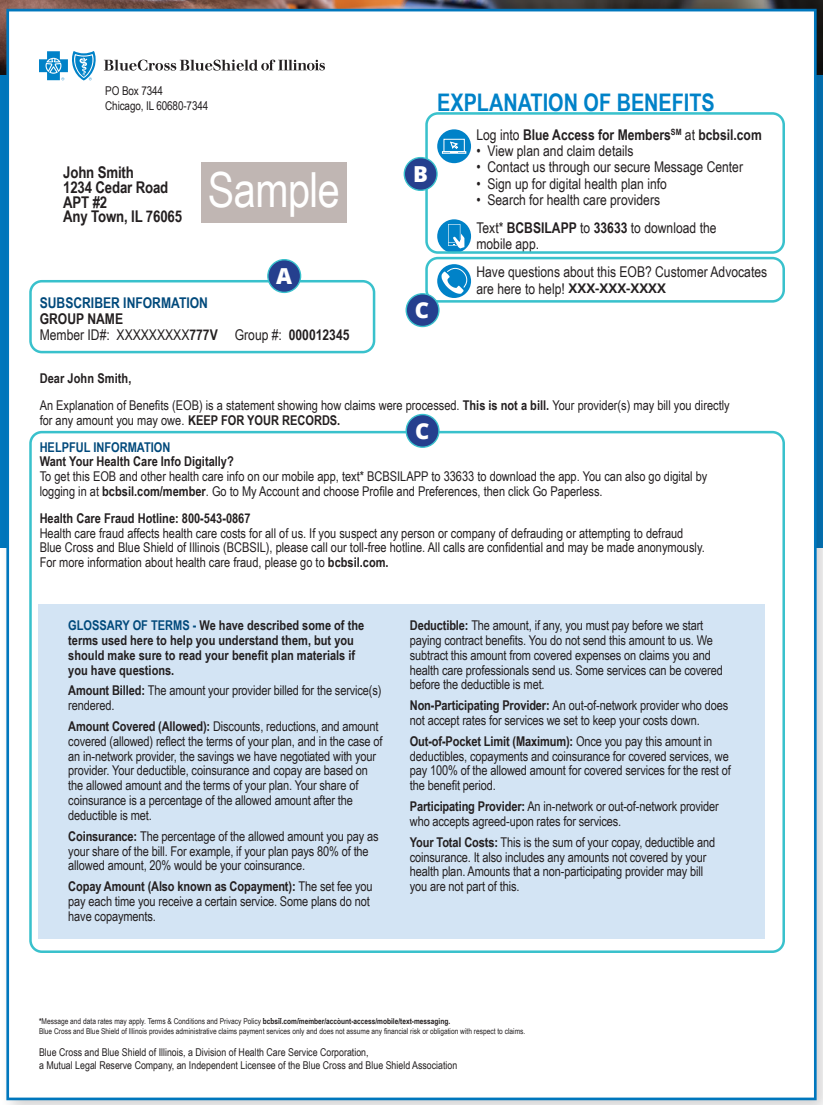
Your **Explanation of Benefits (EOB)** lets you know when and how we process your claims. It isn't a bill. It gives you a detailed look at the covered services and shows how much you may owe your provider after we apply your benefits.

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
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* **BCBSILAPP** 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* BCBSILAPP to 33633 to download the app. You can also go digital by logging in at **bcbsil.com/member**. Go to My Account and choose Profile and Preferences, then click 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/member/account-access/mobile/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.

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

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 1)
PATIENT: JOHN SMITH **D**
PROVIDER: RALPH JOHNSTON M **E**
CLAIM # XXXXXXXXXXXX

Sample

DATE PROCESSED: 06/20/2022

O² Amount Billed	$7,850.00
Discounts and Reductions	- $3,930.00
Health Plan Responsibility	- $2,219.00
O³ Paid from your HCA Account	- $0.00
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	04/04/2022	4,000.00	(1) 1,800.00	2,200.00	960.00	1,000.00		240.00		1,240.00
Recovery Room	04/04/2022	900.00	(1) 410.00	490.00	392.00			98.00		98.00
Med/Surg Supplies	04/04/2022	300.00	(1) 140.00	160.00	128.00			32.00		32.00
Med/Surg Supplies	04/04/2022	100.00							(2) 100.00	100.00
Laboratory Services	04/04/2022	1,200.00	(1) 820.00	380.00	304.00			76.00		76.00
Laboratory Services	04/04/2022	400.00	(1) 270.00	130.00	72.00		50.00	8.00		58.00
MRI Outpatient	04/04/2022	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 06-20-22. **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. **P**

(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.

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 - Benefit Period: 01-01-22 Through 12-31-22 To date this patient has met $2,900.00 of her/his $2,900.00 Out-of-pocket Expense.

Benefit Period: 01-01-22 Through 12-31-22 To date $3,870.78 of the Family $5,800.00 Out-of-pocket Expense has been met.

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 details the amount shown in O^2, and is the sum of your copay, deductible and coinsurance. You may owe less if your provider collected any of these payments up front. It also includes amounts not covered by your health plan (N). It does not include charges that a non-participating provider may bill you. If your benefits feature a Health Care Account (HCA), or other Health Savings Account (HSA), any payments from those accounts will be reflected in this line (O^3). HCAs and HSAs do not apply to all benefit plans.

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. See discounts and reductions (H), and any amounts that aren't covered (N).

Q. 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* **BCBSILAPP to 33633** to download the mobile app.

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

EOB samples are for illustrative purposes only. Not all EOBs are the same. The format and content of an EOB depends on your benefit plan and the services provided.

20154.0523

PRESCRIPTION DRUG BENEFITS

Prime Therapeutics, the Pharmacy Benefit Manager (PBM), manages your prescription drug benefit and their network of retail pharmacies. Prime Therapeutics, in consultation with the Plan, provides services that promote the appropriate use of prescription benefits, such as review for possible excessive use, drug interactions and other safety measures.

BALANCED DRUG LIST

The Balanced Drug List (also known as a preferred drug list) is available to Blue Cross and Blue Shield of Illinois (BCBSIL) members. How much you pay for prescription drugs is based on 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 list can be found at https://www.bcbsil.com/docs/rx-drugs/drug-lists/il/rx-list-bal-il-2025.pdf and is regularly updated as generic drugs become available and changes take place in the pharmaceuticals market. Note that certain medications are subject to limitations and may require **prior authorization** as noted on the drug list.

FLEXACCESS

Members taking certain high-cost medications may be eligible for a cost assistance program called **FlexAccess** which is designed to help you lower your out-of-pocket expense for these medications. Members taking drugs that qualify for this program may get a letter or, in some cases, a phone call from the Flex Access team to help you get started. Participation in the program is voluntary. Call FlexAccess at 888-302-3618 to ask questions or find out if your prescription drug is part of this program. More information regarding this program is available at https://www.egtrust.org/medical-benefits/prescription-drug-program/.

What are biosimilars? They are medications that are designed to be interchangeable with certain biological medications but are priced significantly lower. They have the same clinical effects and are approved to treat the same conditions. Individuals taking certain biologics (i.e. Humira or Stelara) will be required to switch to the preferred biosimilar.

RETAIL PHARMACIES (30-DAY SUPPLY)

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 Advantage network. At retail, you can receive up to a 30-day supply of 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.**

If you need medication on a long-term basis, you should ask your physician to prescribe a 90-day supply, plus refills if appropriate. Examples include ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. **90-Day supplies are available only through the Home Delivery (or Mail Order) service and are required for Brand name maintenance medications.**

EXPRESS SCRIPTS (ESI)[1] HOME DELIVERY/MAIL ORDER

The Trust requires that all 90-day maintenance **Brand** name drugs be filled through Home Delivery, also known as Mail Order. To determine if your prescription is subject to the mandatory mail order requirement, please check the Rx90 Maintenance Drug List (also linked on the Trust website). Brand name drugs listed in all CAPITAL letters on the list must be filled using mail order.[2]

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

- Copayments for 90-day home delivery are less than three 30-day retail fills.
- 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.
- Shipments will include instructions for ordering refills.
- You can request refills online or over the phone. You can also choose to receive refill reminder notices by phone or email.

To start using ESI home delivery pharmacy services, visit https://www.express-scripts.com/rx and follow the instructions to register and create a profile. Once you have registered, your doctor can send new 90-day prescriptions electronically to the pharmacy.

You may fill the first two months of a newly prescribed **Brand** name maintenance medication at a Prime network retail pharmacy. Subsequent fills **MUST** be obtained through Home Delivery/Mail Order (90-day supply).

ACCREDO SPECIALTY PHARMACY

Specialty medications that are self-administered generally must be filled through the 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 the Accredo Specialty Pharmacy, call **833-721-1619**. An Accredo representative will work with your doctor on the rest. Once registered, you can manage your prescriptions on accredo.com or through their mobile app.

[1] Evernorth **EnGuide Pharmacy** is a new home delivery pharmacy dedicated to filling GLP-1 medications.
[2] **Generic maintenance medications** are available for ongoing 30-day retail fill or 90-day fill through mail order. There is no 90-day retail option.

Prescription Drug Q&A

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) and M plans. In Plan D (HDHP), you must meet the calendar year deductible before these copayments apply, except for IRS-approved maintenance and pre-ventive 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	Home Delivery up to 90 day supply
Generic	$15	$38
Preferred Brand	$30	$75
Non-Preferred	$50	$125
Oral & Injectable Specialty Drugs	Copay plus 3%*	Copay plus 3%*
*Most specialty drugs (oral and injectable) will have a maximum copay of $400 per month.		

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 Drug Tier column and shown in all CAPITAL letters. Non-preferred brands are marked with a "NP" in the Drug Tier 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 as "SP" in the Requirements 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.*

***Note:** Some drugs are covered under the medical plan instead of the prescription plan. This can include drugs administered in a hospital or physician office setting. If your prescribed drug in not on the Balanced Drug List, call a Blue Value Advisor (BVA) at 855-686-8517 to see if the drug may be covered by the medical plan.*

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 an Advantage network pharmacy near you.

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

BlueCross BlueShield of Illinois

A home delivery (mail order) pharmacy service you can trust.

Express Scripts® Pharmacy delivers your long-term (or maintenance) medicines right where you want them. No driving to the pharmacy. No waiting in line for your prescriptions to be filled.

Savings and Convenience

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines.[1]
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.
- You can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy.
- Tamper-evident, unmarked packaging protects your privacy.

Support and Service

- You can receive notices by phone, email or text — your choice — when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at **express-scripts.com/rx** or call **833-715-0942**.
- 24/7 access to a team of knowledgeable pharmacists and support staff.
- Choose to receive refill reminder notices by phone or email.
- Multiple pharmacy locations are located across the U.S., for fast processing and dispensing.

Medicines may take up to 5 business days to deliver after Express Scripts® Pharmacy receives and verifies your order.

Getting Started with Express Scripts® Pharmacy Mail Order

Online and Mobile

You have more than one option to fill or refill a prescription online or from a mobile device:

- Visit **express-scripts.com/rx.** Follow the instructions to register and create a profile. See your active prescriptions and/or send your refill order.
- Log in to **myprime.com** and follow the links to Express Scripts® Pharmacy.

Over the Phone

Call **833-715-0942**, 24/7, to refill, transfer a current prescription or get started with mail order. Please have your member ID card, prescription information and your doctor's contact information ready.

Through the Mail

To send a prescription order through the mail, visit **bcbsil.com** and log in to Blue Access for Members℠ (BAM℠). Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

Talk to Your Doctor

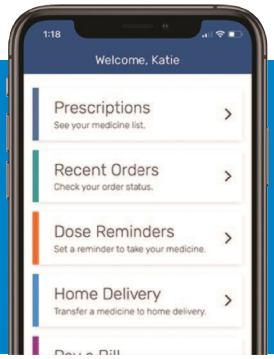
Ask your doctor for a prescription for up to a 90-day supply of each of your long-term medicines.[1] You can ask your doctor to send your prescription electronically to Express Scripts® Pharmacy, call **888-327-9791** for faxing instructions or call the pharmacy at **833-715-0942**. If you need to start your medicine right away, request a prescription for up to a one-month supply you can fill at a local retail pharmacy.

Refills Are Easy

Refill dates are shown on each prescription label. You can choose to have Express Scripts® Pharmacy remind you by phone or email when a refill is due. Choose the reminder option that best suits you.

Questions?

Visit **bcbsil.com**. Or call the phone number listed on your member ID card.



Use the mobile app to manage your prescriptions

- Refill prescriptions
- Track your order
- Make payments
- Set reminders to take medicines and more

1. Prescriptions of up to a 90-day supply, or the most amount allowed by the benefit plan.

BlueCross BlueShield of Illinois

Do You Need Specialty Medications?

Blue Cross and Blue Shield of Illinois (BCBSIL) supports members who need self-administered specialty medication and helps them manage their therapy. Accredo® is the specialty pharmacy chosen to do just that.[1]

Specialty drugs are often prescribed to treat complex and/or chronic conditions, such as multiple sclerosis, hepatitis C and rheumatoid arthritis.

Specialty drugs often call for carefully following a treatment plan (or taking them on a strict schedule). These medications have special handling or storage needs and may only be stocked by select pharmacies.

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

Your plan may require you to get your self-administered specialty drugs through Accredo or another in-network pharmacy. If you do not use these pharmacies, you may pay higher out-of-pocket costs.[2] Your doctor may also order select specialty drugs that must be given to you by a health professional through a contracted specialty pharmacy.

Blue Cross and Blue Shield of Illinois, 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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Do You Need Specialty Medications?

Examples of Self-administered Specialty Medications

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

Condition	Sample Medications[3]
Autoimmune Disorders	Cosentyx, Enbrel, Humira, Xeljanz
Osteoporosis	Forteo, Tymlos
Cancer (oral)	Sprycel, Imbruvica, Kisqali, Ibrance, Xtandi
Growth Hormones	Norditropin Flexpro, Genotropin
Hepatitis C	Epclusa, Harvoni, Mavyret, Sovaldi, Vosevi
Multiple Sclerosis	Betaseron, Rebif, Aubagio

Support in Managing Your Condition: Accredo

Through Accredo, you can have your covered, self-administered specialty drugs delivered straight to you. When you get your specialty drugs through Accredo, you get:

- One-on-one counseling from 500+ condition-specific pharmacists and 600+ nurses
- Simple communication, including refill reminders, by your choice of phone, email, text or web[4]
- An online member website to order refills, check order status and track shipments, view order and medication history, set profile preferences and learn more about your condition
- A mobile app that lets you refill and track prescriptions, make payments and set reminders to take your medicine[4]
- Free standard shipping
- 24/7 support

Ordering Through Accredo

You can order a new prescription or transfer your existing prescription for a self-administered specialty drug to Accredo. **To start using Accredo, call 833-721-1619.** An Accredo representative will work with your doctor on the rest.

Once registered, you can manage your prescriptions on **accredo.com** or through the Accredo mobile app.

Receiving Specialty Medications

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

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

- Confirm your drugs, dose and the delivery location
- Check any prescription changes your doctor may have ordered[5]
- Discuss any changes in your condition or answer any questions about your health[5]

One-on-One Support

Accredo has 15 Therapeutic Resource Centers® (TRCs), each focused on a specific specialty condition. Through your one-on-one counseling sessions, they'll discuss how to reduce your disease progression and achieve your treatment goals, manage any side effects from your drugs, help you stick to your regimen and monitor your progress. They can also offer support with any financial or insurance concerns you may have.

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

1. Blue Cross and Blue Shield of Illinois (BCBSIL) contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.
2. The BCBSIL specialty pharmacy network includes Accredo as well as other in-network specialty pharmacies for select specialty drugs. Based on the benefit plan, members may be responsible for the full cost of the specialty drug for not using an in-network specialty pharmacy. You can log in to your Blue Access for Members℠ (BAM℠) account to find an in-network specialty pharmacy near you.
3. Third-party brand names are the property of their respective owners.
4. Not all medicines can be refilled on the app, by text or email.
5. Treatment decisions are between you and your doctor.

Accredo is contracted to provide services for BCBSIL. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Your partner for pain relief

With Hinge Health, you can get virtual physical therapy and more from real people who are dedicated to helping you feel your best.

Specialized care, personalized for you

Reduce everyday joint and muscle aches. Recover from an injury.

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals
- Access to Hinge Health Enso® a non-addictive, FDA-cleared wearable device to calm and soothe pain flare-ups in minutes

Scan the QR code or visit:
hinge.health/egtrust-join

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

A HINGE HEALTH EXCLUSIVE

Meet Enso

The small device for pain relief on-the-go.

*Eligibility to receive Hinge Health Enso is based on the program in which you are placed, fulfillment of clinical eligibility criteria, and completion of a qualifying number of exercise sessions.

Employees and their eligible dependents 18+ enrolled in a Blue Cross Blue Shield of Illinois medical plan through Egyptian Trust are eligible.

Teladoc HEALTH

Egyptian Trust health plan members receive Teladoc services at **NO COST**. Be certain to indicate your coverage is through **Egyptian Trust** when registering for your Teladoc account.

AVAILABLE NOW

You've got Teladoc Health

Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to get care for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account

Use your phone, the app, or the website to create an account and complete your medical history

Get Care

Request a time and a Teladoc Health provider will contact you

Feel better

The provider will diagnose symptoms and send a prescription if necessary

Get care now

Visit TeladocHealth.com
Call 1-800-835-2362 | Download the app

If you are not enrolled in one of the Egyptian Trust health plans, but wish to participate in the Teladoc program, employees may enroll for a small monthly fee.

*Teladoc Health is not available internationally.

Dental Benefit Highlight Sheets

Egyptian Area Schools Eb Trust, Group #11695

Delta Dental of Illinois is pleased to be your dental benefits carrier. Your group plan offers you the dental benefits program: Delta Dental PPO Plus Delta Dental Premier.

Delta Dental PPO Plus Premier

This information includes a summary of your plan options*. Please also see the sheet, "How You Can Save with a Delta Dental Network Dentist," which provides an example of your out-of-pockets costs with network dentists and a non-network dentist. With Delta Dental PPO Plus Premier:

- You can go to any licensed general or specialty dentist.
- **You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist.**
- Delta Dental's network dentists have agreed to reduced fees as payment in full, which means you will likely save money by going to a Delta Dental PPO or Delta Dental Premier network dentist. Non-network dentists have not agreed to accept our reduced fees as payment in full, which means they may bill you for any charges over our allowed fees.
- You are charged only the patient's share** at the time of treatment. Delta Dental pays its portion directly to network dentists.

Finding a Dentist

Visit our web site at www.deltadentalil.com and click on Provider Search. Please see the "How to Find a Network Dentist" sheet for more details.

Example of Your Copayment with Delta Dental Network Dentists and Non-Network Dentists

- Delta Dental PPO: Lowest out-of-pocket costs and network protection.
- Delta Dental Premier: Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection.
- Non-network: You may have the highest out-of-pocket costs.

Delta Dental PPO Plus Premier Plan Features

Your Delta Dental PPO Plus Premier plan includes the following features (please see pieces for more information):

- **Enhanced Benefit Program** offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, suppressed immune systems, and special needs) that can be positively affected by additional oral health care.

Customer Service

The Member Connection sheet explains how to register on Delta Dental of Illinois' website, www.deltadentalil.com. Once registered, you can **get real time benefit information, check claim status, sign up for electronic Explanation of Benefits and print a temporary ID card.**

Call 1-800-323-1743 to access our automated phone system or speak to a customer service representative from 7 am to 7 pm Monday through Thursday and 7 am to 6 pm Friday, Central Time. Our automated phone system is available 24 hours a day, seven days a week, and offers dentist listings and claim information.

You can also connect with us through our mobile app, Facebook, Twitter, our blog and more. See the enclosed sheets on connecting with us.

Learn More

You can learn more about your Delta Dental of Illinois dental plan by reading the information included in this benefit guide and on the Trust website.

***The information following this sheet is a brief summary of our dental plans and the services covered. There are some limitations on the expenses for which your dental plan pays If you have specific questions regarding benefit coverage, limitations, exclusions, or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact Delta Dental of Illinois.

**Patient's share is the coinsurance/copayment, any remaining deductible any amount over the annual maximum and any services your plan does not cover.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

PPOPREF

Egyptian Area Schools Employee Benefit Trust Plan Design Summary
High Dental Plan

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$1500/ person
To Go℠ Carryover Feature	Not Included
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.
Lifetime Orthodontic Maximum **Dependent Children to Age 19** **Adults are not eligible for coverage**	$1000/ person

	Delta Dental PPO Network Dentist*	Delta Dental Premier Network Dentist**	Non-Network Dentist***
PREVENTIVE/DIAGNOSTIC SERVICES (no waiting period) • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years) • Fluoride treatments (twice per benefit year to age 19)	100%	100%	100%
BASIC SERVICES (no waiting period) • Space maintainers (to age 19) • Sealants (to age 19) • Emergency exams and palliative (pain relief) treatment • Fillings (silver (amalgam) and tooth colored (composite) on front teeth) • Posterior composites (tooth colored fillings on back teeth) • Oral surgery (simple extractions) • Oral surgery (surgical extractions including general anesthesia) • Oral surgery (all other) • Prefabricated stainless steel or resin crowns	80%	80%	80%
MAJOR RESTORATIVE SERVICES (no waiting period) • Non-surgical Periodontic (gum) maintenance • Surgical Periodontic (gum) maintenance • Endodontics (root canals and pulpal therapy) • Repairs and recements to crowns, bridges, inlays and onlays • Crowns, onlays, and other ceramic restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges • Implants	50%	50%	50%
ORTHODONTICS (no waiting period) Dependent Children to Age 26; Adults are not eligible for coverage	50%	50%	50%

v. 7/q. 10241

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15 – 40% discount off of average billed charges nationally.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance (MPA), which is established at a level that typically delivers discounts of 25% - 30% off of average billed charges nationally.

***Non-network (non-Delta Dental PPO/non-Delta Dental Premier) dentists are reimbursed at the 90th percentile of "reasonable and customary" charges.

Delta Dental PPO and Premier dentists cannot balance bill the enrollee for the difference between Delta Dental's allowed fee and the dentist's submitted charge.

Monthly Premium Payment	
Employee	$40.46
Employee + 1 Dependent	$84.08
Employee + 2 or more Dependents	$118.70

Rates through August 31, 2026

Delta Dental of Illinois

DELTA DENTAL®

Egyptian Area Schools Employee Benefit Trust Plan Design Summary
Low Dental Plan

Annual Deductible Deductible applies to Basic and Major services	$50/ person; $150/ family
Annual Maximum	$750/ person
To Go℠ Carryover Feature	Not Included
Enhanced Benefits Program	Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.

	Delta Dental PPO Network Dentist*	Delta Dental Premier Network Dentist**	Non-Network Dentist***
PREVENTIVE/DIAGNOSTIC SERVICES (no waiting period) • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings -2 per benefit year; full mouth-1 per 3 years) • Fluoride treatments (twice per benefit year to age 19)	80%	80%	80%
BASIC SERVICES (no waiting period) • Space maintainers (to age 19) • Sealants (to age 19) • Emergency exams and palliative (pain relief) treatment • Fillings (silver (amalgam) and tooth colored (composite) on front teeth) • Posterior composites (tooth colored fillings on back teeth) • Non-surgical Periodontic (gum) maintenance • Oral surgery (simple extractions) • Oral surgery (surgical extractions including general anesthesia) • Oral surgery (all other) • Prefabricated stainless steel or resin crowns • Endodontics (root canals and pulpal therapy)	70%	70%	70%
MAJOR RESTORATIVE SERVICES (no waiting period) • Crowns, onlays, and other ceramic restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges • Implants	0%	0%	0%
ORTHODONTICS (no waiting period)	Not Included	Not Included	Not Included

v. 5/q. 10145

*Delta Dental PPO dentists accept payment based on the lesser of the submitted fee or the PPO fee schedule, which is established at a level that typically delivers a 15 – 40% discount off of average billed charges nationally.

**Delta Dental Premier dentists accept payment based on the lesser of the submitted fee or Delta Dental's maximum plan allowance (MPA), which is established at a level that typically delivers discounts of 25% - 30% off of average billed charges nationally.

***Non-network (non-Delta Dental PPO/non-Delta Dental Premier) dentists are reimbursed at the 90th percentile of "reasonable and customary" charges.

Delta Dental PPO and Premier dentists cannot balance bill the enrollee for the difference between Delta Dental's allowed fee and the dentist's submitted charge.

Monthly Premium Payment	
Employee	$17.60
Employee + 1 Dependent	$35.06
Employee + 2 or more Dependents	$66.68

Rates through August 31, 2026

Delta Dental of Illinois

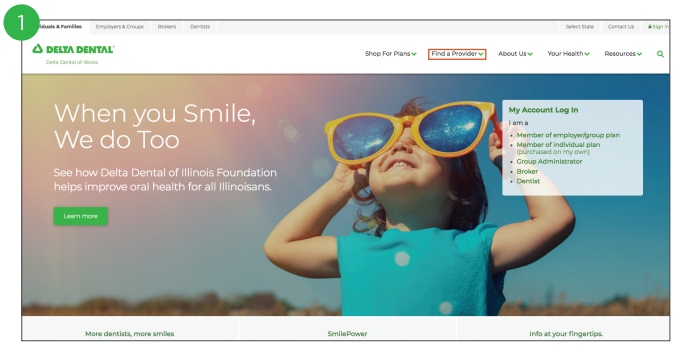
DELTA DENTAL®

Finding a Delta Dental PPO™ or Delta Dental Premier® Dentist

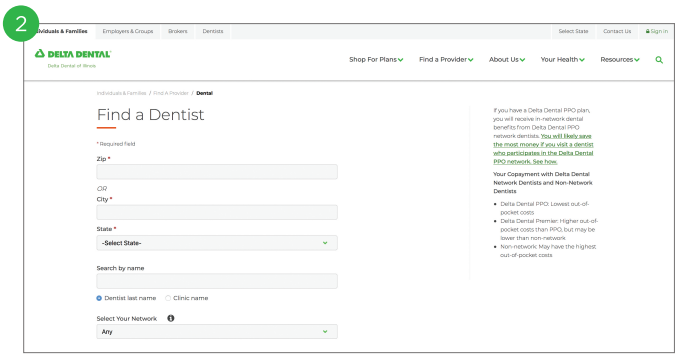
Finding a Delta Dental network dentist is easy. More than 3 out of every 4 dentists nationwide participate in a Delta Dental network. In Illinois, more than 75 percent of dentists participate in a Delta Dental network. You can find a network dentist today by using the Dentist Search on our website or calling our automated phone system.

Provider Search

1. Go to deltadentalil.com, and select "Find a Provider." On the following page, select "Dental."



2. To start your search, you can either enter the location where you want to locate network dentists (search by city/state or ZIP code), or search for a particular dentist or practice by name and ZIP code.



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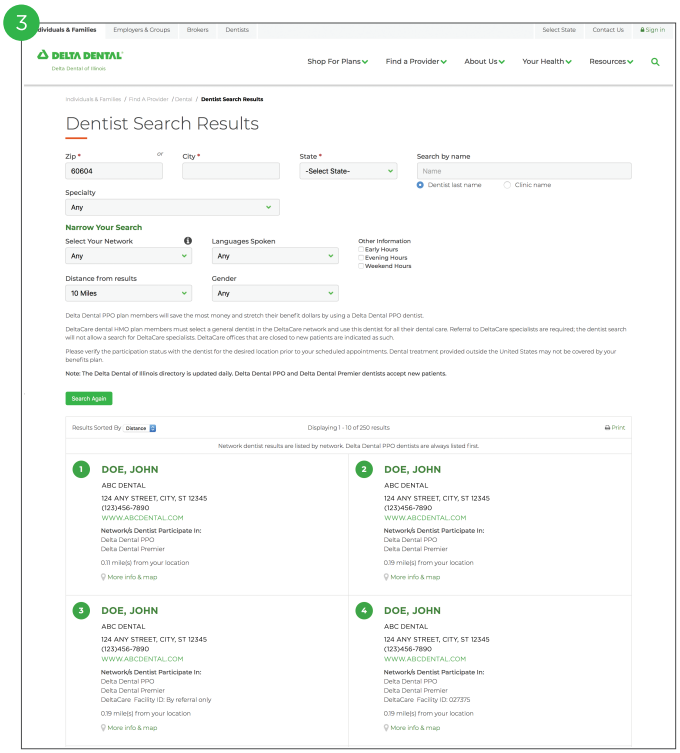
3 Results will automatically display by proximity (within 10 miles from city or ZIP code) and all Delta Dental networks the dentist participates in will be listed. You can change the distance by selecting a new option under the “Distance from results” dropdown menu and clicking “Search Again.”

4 You have the option to narrow your search based on the Delta Dental network a dentist participates in. You will save the most if you use a Delta Dental PPO network dentist.

Any field marked with a red asterisk is a required field.

5 You can further narrow your search by selecting a specialty (such as orthodontist), languages spoken and gender.



Automated Phone System

You can also find a dentist through our automated phone system. Delta Dental PPO and Delta Dental Premier members can call 800-323-1743, say “Dentist Directory” and follow the automated instructions.

Attention Egyptian Trust Members

Find additional Delta Dental literature titled "Member Connections" and "How You Can Save with a Delta Network Dentist" on the Trust website at: https://www.egtrust.org/voluntary-benefits/dental/

DELTA DENTAL®

Delta Dental of Illinois | deltadentalil.com | **Smart plans for smart mouths.**

VOLUNTARY VISION PROGRAM

See premiums on next page

Egyptian Area Schools EB Trust

DeltaVision Benefit Highlight Insight Network

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks. DeltaVision offers members vision care benefits that combine choice, value and wellness. Your DeltaVision program provides vision care insurance to you (and your family, if applicable) according to the following information.

Vision Care Services	Insight Network Member Cost (Complete)	Out-of-Network Allowance
Exam with Dilation as Necessary:	$10 Copay	$35
Contact Lens Fit & Follow-up: (Available once a comprehensive eye exam has been completed)		
Standard*	Member pays up to $40 for fit and two follow-up visits	$0
Premium**	10% off retail price	$0
Frames: (Any available frame at provider location)	$130 allowance, 20% off balance over allowance	$65
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Progressive (in addition to to Bifocal copay)	$65	$40
Premium Progressive – (in addition to Bifocal copay)	Tier 1 - $95, Tier 2 - $105, Tier 3- $120, Tier 4 - $75, 80% of retail, less $120 allowance	$40
Standard Anti-Reflective Coating	$45	N/A
Premium Anti –Reflective Coating	Tier 1 - $57, Tier 2 - $68, Tier 3 – 80% of charge	N/A
Photocromatic/Transition Plastic	$75	N/A
Polarized	80% of charge	N/A
Other Add-Ons and Services	20% discount off retail price	N/A
Contact Lenses: (Contact lens allowance covers materials only)		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Visually Required	$0 Copay, Paid-in-Full	$200
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include, but are not limited to, disposable and frequent replacement)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings, other than Standard Contact Lenses (Examples include toric and multifocal)

Additional Discounts

Member will receive a 20% discount at in-network providers on items not covered by the program. This discount may not be combined with any other discounts or promotional offers and the discount does not apply to contact lenses or an in-network provider's professional services. Retail prices may vary by location.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses at in-network providers once the funded benefit has been used.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www deltadentalil.com/deltavision. The contact lens benefit allowance is not applicable to this service.

LASIK or PRK: DeltaVision enrollees can receive a discount of 15% off retail price or 5% off promotional price from select providers. Please contact us at www.deltadentalil.com/deltavision or 866-723-0513 for a current list of LASIK/PRK providers.

Network Information

You may choose to go to any licensed optometrist, ophthalmologist and/or dispensing optician whenever you need vision care. However, there may be significant cost advantages when you receive treatment from an in-network provider.

We offer two easy ways to locate an in-network provider 7 days a week, 24 hours a day. You can either:

- search our online Provider directory at www.deltadentalil.com/deltavision; or
- use the automated phone system by calling 1-866-723-0513

Using Your Vision Program

1. Have your DeltaVision information card available when scheduling and visiting an in-network provider. An in-network provider is one who participates in the EyeMed Vision Care Provider network. **It's very important that you know which network your benefit plan utilizes (your plan uses the Insight network).** You will only receive in-network benefits from Insight network providers. Please note: the network provider will need the primary enrollee's name and date of birth to verify eligibility.

2. Pay your copayment and any other charges not covered at the time of service. No paperwork is required. You continue to save on additional eyewear purchases any time you present your card to an in-network provider.

3.If you select a provider who is not in the network, you do not receive preferred pricing and you may be asked to provide full payment to your out-of-network provider at the time of service. To receive benefit reimbursement, submit a completed claim form (available on our website), along with itemized receipts from your provider and your prescription to:

DeltaVision Claims Processing
c/o EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111

DeltaVision® is provided by ProTec Insurance Company, a wholly-owned subsidiary of Delta Dental of Illinois, in association with EyeMed Vision Care networks.

Exclusions

In no event will coverage exceed the lesser of:
1. the actual cost of Covered Services or Materials or
2. the limits of the Policy, shown in the Schedule.

Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period.

Benefits may not be combined with any discount, promotional offering or other group benefit programs.

Benefit allowances provide no remaining balance for future use within the same benefit period.

There is no coverage for professional services or materials connected with:

1. Orthoptic or vision training, sub-normal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes or supporting structures;
4. Corrective eyewear required by an employer as a condition of employment and safety eyewear unless specifically covered under this program;
5. Services provided as a result of any Workers' Compensation law;
6. Plano lenses (lenses that have no refractive power), non-prescription lenses and non-prescription sunglasses (except for 20% discount);
7. Two pair of glasses in lieu of bifocals.

The preceding information is a brief summary of ***Egyptian Area Schools Eb Trust*** *Complete Vision Program and the services it covers.*

If you have specific questions regarding benefit coverage, limitations or exclusions, contact our customer service department at 1-866-723-0513.

DELTA DENTAL®

Delta Dental of Illinois
111 Shuman Blvd
Naperville, IL 60563
800-335-8215
www.deltadentalil.com/deltavision

Monthly Premium Payment	
Employee	$ 5.38
Employee + 1 Dependent	$10.52
Employee + 2 or more Dependents	$15.74

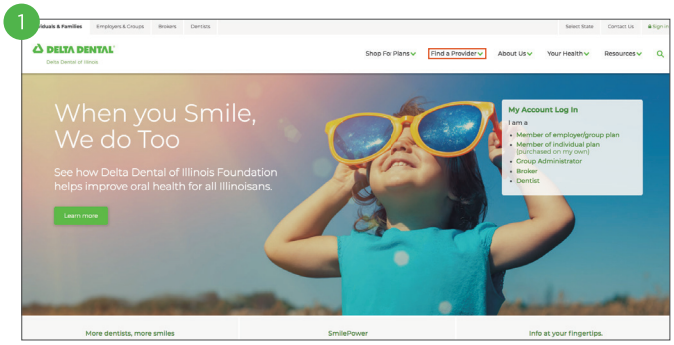
Rates through August 31, 2027

DELTA DENTAL®

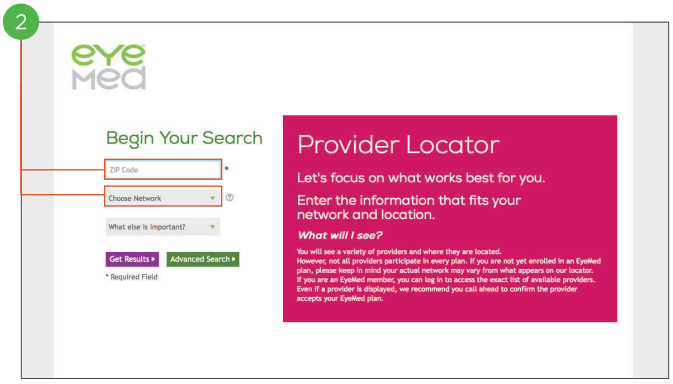
Finding a Network Vision Provider

Finding a network vision provider is easy with DeltaVision®. The DeltaVision program uses the EyeMed network, so you will receive in-network benefits by visiting an EyeMed network provider. Visit deltadentalil.com to locate a vision provider.

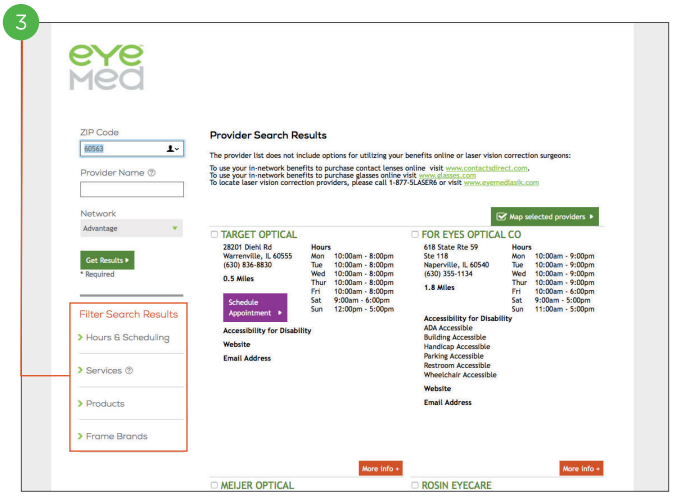
1. Go to deltadentalil.com and select "Find a Provider". On the following page, select "Vision".



2. To begin your search, enter the ZIP code where you want to locate in-network vision providers and select your specific DeltaVision network (Access, Insight or Select) from the drop-down menu. Refer to your enrollment materials to determine which network applies to your vision care program. It is important that you select the correct network – Access, Insight or Select – as providers may not participate in each of these networks.



3. Results will automatically display by proximity to the ZIP code entered and your selected DeltaVision network. **You also have the option to narrow your search based on a provider's name and hours as well as scheduling, services, products and frame brands.**



You can map up to five different vision providers locations, as well as print your search results.

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 https:\\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

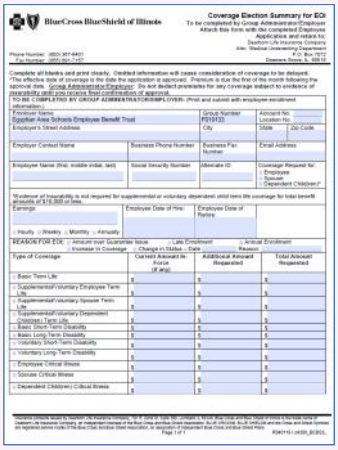
At termination of employment, an employee has the option to retain life insurance coverage through this Portability provision. Portability premiums must be submitted timely and rates increase as the employee's age increases. If the employee ports his or her coverage, a covered spouse and any covered 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.

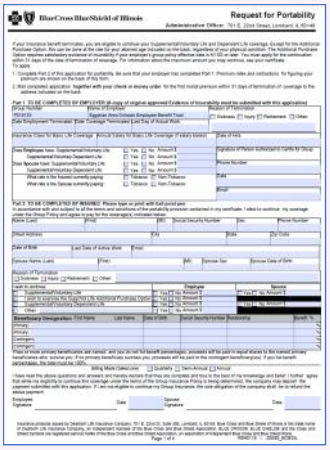
CONVERSION

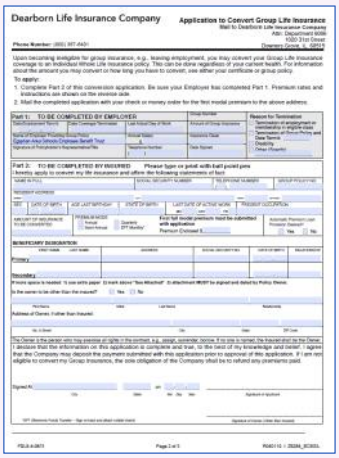
If an employee is terminating employment or if the Waiver of Premium benefit is ending, the employee can convert life insurance coverage to a whole life policy. The rates are age-based, and as long as premiums are paid on time, coverage can stay in effect until age 100. Conversion application form must 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 https://www.egtrust.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 form.

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.

Supplemental 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: **Option 1: Choice of $10,000, $25,000, $50,000, $75,000, $100,000 or**
Option 2: You may choose an amount in $10,000 increments to a max of $500,000
(not to exceed 5 times Annual Earnings)

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

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

Guarantee Issue*

Employee **Under age 60: $100,000; Age 60-69: $25,000; Age 70+: $0**
Spouse **Under Employee age 60: $37,500; Employee age 60+: $0**
* APPLIES TO NEW HIRES

Child Coverage (Life Only)

Birth to 14 days: **$0**
15 days age 26: **$5,000 or $10,000**

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

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

Age	Rates
Under 20	$0.080
20-24	$0.080
25-29	$0.080
30-34	$0.100
35-39	$0.120
40-44	$0.180
45-49	$0.300
50-54	$0.480
55-59	$0.780
60-64	$0.980
65+	$1.680

Dependent Life (Children)
Monthly Premium per Family

Life	
$5,000	$0.40
$10,000	$0.80

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

EMPLOYEE	EMPLOYEE ATTAINED AGE										
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$10,000	$0.80	$0.80	$0.80	$1.00	$1.20	$1.80	$3.00	$4.80	$7.80	$9.80	$16.80
$25,000	$2.00	$2.00	$2.00	$2.50	$3.00	$4.50	$7.50	$12.00	$19.50	$24.50	$42.00
$50,000	$4.00	$4.00	$4.00	$5.00	$6.00	$9.00	$15.00	$24.00	$39.00	$49.00	$84.00
$75,000	$6.00	$6.00	$6.00	$7.50	$9.00	$13.50	$22.50	$36.00	$58.50	$73.50	$126.00
$100,000	$8.00	$8.00	$8.00	$10.00	$12.00	$18.00	$30.00	$48.00	$78.00	$98.00	$168.00

SPOUSE

$5,000	$0.40	$0.40	$0.40	$0.50	$0.60	$0.90	$1.50	$2.40	$3.90	$4.90	$8.40
$10,000	$0.80	$0.80	$0.80	$1.00	$1.20	$1.80	$3.00	$4.80	$7.80	$9.80	$16.80
$15,000	$1.20	$1.20	$1.20	$1.50	$1.80	$2.70	$4.50	$7.20	$11.70	$14.70	$25.20
$20,000	$1.60	$1.60	$1.60	$2.00	$2.40	$3.60	$6.00	$9.60	$15.60	$19.60	$33.60
$25,000	$2.00	$2.00	$2.00	$2.50	$3.00	$4.50	$7.50	$12.00	$19.50	$24.50	$42.00
$30,000	$2.40	$2.40	$2.40	$3.00	$3.60	$5.40	$9.00	$14.40	$23.40	$29.40	$50.40
$35,000	$2.80	$2.80	$2.80	$3.50	$4.20	$6.30	$10.50	$16.80	$27.30	$34.30	$58.80
$37,500	$3.00	$3.00	$3.00	$3.75	$4.50	$6.75	$11.25	$18.00	$29.25	$36.75	$63.00

COVERED MEMBERS COMMUNICATION GUIDE

Important – Please read: Below 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.

Note: Members **must** work with their district contacts to request enrollment or eligibility changes.

Program	Subject Matter	Vendor	Phone	Website
Health Plans	• Health Plan Benefits • Precertification/ Predetermination • Request Health Plan ID cards • Find a network provider	**BCBS of IL**	1-855-686-8517	www.bcbsil.com
Prescription Drugs	• Prescription Drug Plan Benefits • Balanced Drug List • Claim or network questions	**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-TELADOC 1-800-835-2362	www.teladoc.com
Voluntary Dental	• Dental Plan Benefits • Eligibility • Claim questions • Find a network provider	**Delta Dental**	1-800-323-1743	www.deltadentalil.com
Voluntary Vision	• Vision Plan Benefits • Eligibility • Claim questions • Find a network provider	**Delta Dental**	1-866-723-0513	www.deltadentalil.com/ deltavision
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

If you need contact information for vendors who are not listed, please email us 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 2034
Loves Park, IL 61130
Email: egtrust@healthscopebenefits.com

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
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: https://www.egtrust.org/medical-benefits/hipaa-authorization-notice-form/.

Egyptian Trust Privacy Officer
P.O. Box 2034
Loves Park, IL 61130
Email: egtrust@healthscopebenefits.com

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.

Essential Health Benefits Disclosure

Illinois employers, including school districts, are required to provide annual disclosure identifying Essential Health Benefits (EHB) covered by the health plan(s). This document, which applies to all Trust health plans, is available on the Trust website at: https://www.egtrust.org/medical-benefits/essential-health-benefits-disclosure/.

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

ENROLLMENT FORM

EMPLOYER (OR PLAN SPONSOR) SECTION – EMPLOYER COMPLETES THIS SECTION

Unsigned or incomplete forms will be returned and may delay enrollment.

Employer/District Name	Trust Group Number	Coverage Effective Date

Enrollment Events: ☐ **New Hire** ☐ **Open Enrollment-Applies to medical, dental, vision only** ☐ **Special Enrollment**

Qualifying Life Events: ☐ Marriage (incl Civil Union) ☐ Divorce ☐ Newborn / Adoption ☐ Death of Dependent

Event date: _____ ☐ Spouse OE ☐ Change in Other Coverage ☐ Other – Explain below

Employee Status: ☐ Active ☐ COBRA ☐ Retiree ☐ Other

Date of Hire

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

Special Instructions:

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

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

Employee Home Address (Street/Apt. / City / State / Zip)

Home/Cell Phone _____ Work 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	(If you declined Medical coverage)	**Voluntary Dental**	**Voluntary Vision**
Instruction: Ask Employer for your Health Plan options	**Voluntary Teladoc ONLY** ☐	☐ **High** ☐ **Low**	
Enter Plan Name Here: _____			
EMPLOYER complete network: ☐ BCS ☐ PPO			
☐ Employee Only	☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee + Spouse	☐ Decline or Drop Coverage	☐ Employee + 1 Dependent	☐ Employee + 1 Dependent
☐ Employee + Child or Children		☐ Employee + 2 or more deps	☐ Employee + 2 or more deps
☐ Family	**NOTE:** Teladoc is included in Medical Plan.	☐ Decline or Drop Coverage	☐ Decline or Drop Coverage
☐ Decline or Drop Coverage			
NOTE: Includes Teladoc, Basic Life Insurance and Prescription Coverage			

EMPLOYEES: Check all boxes that apply:

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

☐ Basic Life Amount _____

☐ Decline or Drop Coverage

Optional Life –
If applying for more than guarantee issue amounts an Evidence of Insurability (EOI) form must be completed.

☐ Optional Employee Life Amount _____
Note: EOI required for amounts over $100,000

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

☐ Optional Dependent Life ☐ $5,000 or ☐ $10,000
Note: Covers all eligible children. No EOI req'd.

☐ Decline or Drop Coverage

List Full Name of Your Eligible Dependents (Attach sheet if additional lines are needed)	Relation: 1-Spouse 2-Child 3-Stepchild 4-Other	Sex M or F	Date of Birth	Dependent Social Security Number (Required information)	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 _____

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)

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 the carrier, 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 the carrier, 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 carrier's Home Office, and the initial premium is paid. 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)

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)

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)

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.** I understand that if I apply for coverage at a later date all the rules of late enrollment will apply.

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 (required)	**Date:**
X	

NOTES: