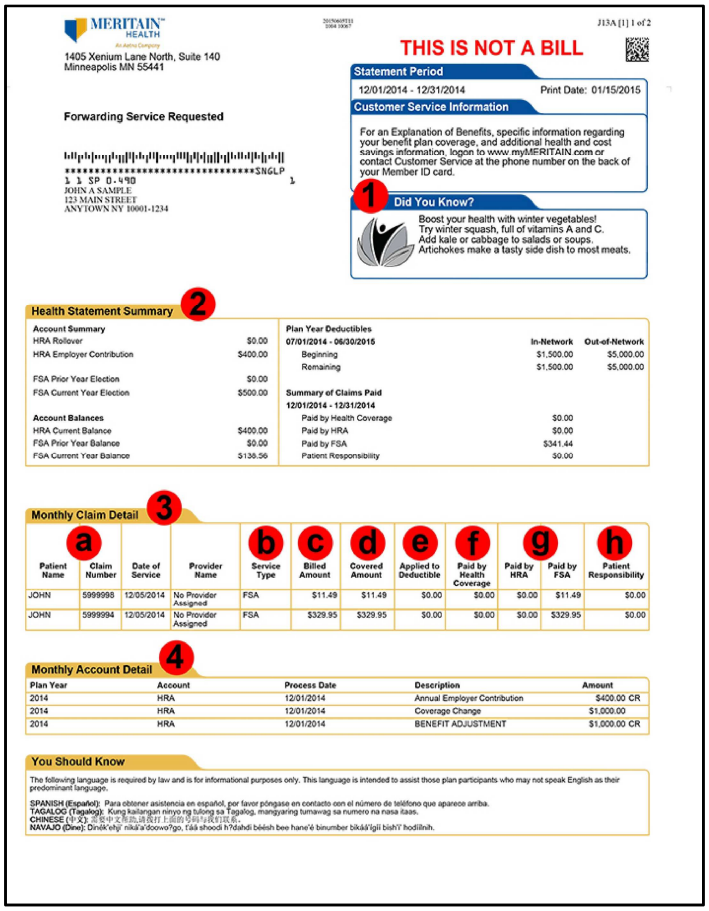
EGYPTIAN AREA SCHOOLS | CARE COORDINATORS BY QUANTUM HEALTH

How to Read Your Member Statement
Mark to Market Plan H5

Your member statement is not a bill or invoice. For additional information or question about this statement go to www.egtrust.org and click on the Care Coordinators logo from the home page to email or chat with a Care Coordinator. You may also reach them at 855-452-9997.

Descriptions of the content of the member statement follow.



1. Statement period and health tips
   The statement period is in the upper right-hand corner followed by monthly health tips under the heading "Did You Know?"

2. Health Statement Summary

   Account Summary. The HRA Employer Contribution is not actually an employer contribution. It is the starting balance of the family in-network claims dollars to be paid by the fully insured carrier (APL). The starting balance will always be $19,500 ($6,500 per covered individual).

   Account Balances. The HRA Current Balance is the remaining balance (as of the date of the statement) of the family in- network claims dollars to be paid by the fully insured carrier (APL).

   Summary of Claims Paid. This includes all claims processed during the statement period broken down by Health Coverage, HRA (amounts paid by fully insured carrier), and Patient Responsibility.

   Plan Year Deductibles. Your deductibles for the plan year are broken down into in-network and out-of-network amounts. The individual in-network deductible for Plan H5 is $6,550 per individual up to a family maximum of $13,100. The beginning in-network deductible will always show as $13,050 In order to properly allocate payments from the fully insured carrier we must artificially inflate the in-network deductible by $6,500.

Below is an illustration of the calculation of the in-network claims.

First	$6,550.00	Applied to deductible	$6,550.00	*Member Responsibility
Next	$6,500.00	Paid at 100%	$6,500.00	Paid by Fully Insured Carrier (APL)
Then		Remaining eligible In-Network expenses paid at 100%		Paid by Egyptian Trust

***Member Responsibility is a total of $6,550.00.**

3. Monthly Claim Detail
   The monthly claim detail shows how your claims were processed. Negative amounts reflect adjusted claims. The details include:

   (a) The patient's name, claim number, date the service was provided, and the name of the provider.

   (b) The type of service provided (such as "Medical," "Rx" or "Protected"). If the type of service and provider say "Protected," this means that the patient is a dependent 18 years or older. In such cases, government regulations stipulate that the information may not be shown in order to protect the dependent patient's privacy. Prescription claims will appear on the member statement if paid under the medical plan as opposed to those paid using your prescription drug card at the pharmacy.

   (c) The amount billed for services provided.

   (d) The amount covered under your plan. If there is an asterisk (*) after the amount, this indicates the claim was from an out-of-network provider. Generally, you may increase your benefit amount by using in-network providers.

   (e) The amount applied to your annual deductible.

   (f) The amount paid by your plan. This amount equals the (d) covered amount, minus (e) the amount applied to your deductible, minus any applicable copay, and coinsurance.

   (g) This is the amount paid by the fully insured carrier (APL).

   (h) The amount of patient responsibility. This reflects the total amount the patient is responsible for paying. This amount does not reflect any copay or other payments made at time of service. You should not make payment to your provider based on the amounts shown on the member statement, but should wait for the provider to send you a bill for the remaining balance.