

How to Read Your Member Statement Mark to Market Plan D1 – Plan HDHP Equivalent

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 HDHP (D) is \$1,300 per individual up to a family maximum of \$2,600. The beginning in-network deductible will always show as \$9,425.00. In order to properly allocate payments from the fully insured carrier we must artificially inflate the in-network deductible by \$8,125.00.

Health Statement Summary

Account Summary	Plan Year Deductibles	In-Network	Out-of-Network
HRA Rollover \$0.00	07/01/2014 - 06/30/2015		
HRA Employer Contribution \$400.00	Beginning \$1,500.00	\$5,000.00	\$5,000.00
FSA Prior Year Election \$0.00	Remaining \$1,500.00		
FSA Current Year Election \$500.00	Summary of Claims Paid		
Account Balances	12/01/2014 - 12/31/2014		
HRA Current Balance \$400.00	Paid by Health Coverage \$0.00		
FSA Prior Year Balance \$0.00	Paid by HRA \$0.00		
FSA Current Year Balance \$138.56	Paid by FSA \$341.44		
	Patient Responsibility \$0.00		

Monthly Claim Detail

a	b	c	d	e	f	g	h				
Patient Name	Claim Number	Date of Service	Provider Name	Service Type	Billed Amount	Covered Amount	Applied to Deductible	Paid by Health Coverage	Paid by HRA	Paid by FSA	Patient Responsibility
JOHN	5999998	12/05/2014	No Provider Assigned	FSA	\$11.49	\$11.49	\$0.00	\$0.00	\$0.00	\$11.49	\$0.00
JOHN	5999994	12/05/2014	No Provider Assigned	FSA	\$329.95	\$329.95	\$0.00	\$0.00	\$0.00	\$329.95	\$0.00

Monthly Account Detail

Plan Year	Account	Process Date	Description	Amount
2014	HRA	12/01/2014	Annual Employer Contribution	\$400.00 CR
2014	HRA	12/01/2014	Coverage Change	\$1,000.00
2014	HRA	12/01/2014	BENEFIT ADJUSTMENT	\$1,000.00 CR

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

First	\$1,300.00	Applied to deductible	\$1,300.00	*Member Responsibility
Next	\$8,125.00	Paid at 80%	\$6,500.00	Paid by Fully Insured Carrier (APL)
	\$8,125.00	Member Pays 20%	\$1,625.00	*Member Responsibility
Next	\$4,875.00	Paid at 80%	\$3,900.00	Paid by Egyptian Trust
	\$4,875.00	Member Pays 20%	\$975.00	*Member Responsibility
Then		Remaining eligible In-Network expenses paid at 100%		Paid by Egyptian Trust

***Member Responsibility is a total of \$3,900. This is equivalent to the Traditional Plan HDHP in-network Out of Pocket.**

3. Monthly Claim Detail

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

- The patient's name, claim number, date the service was provided, and the name of the provider.
- 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.
- The amount billed for services provided.
- 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.
- The amount applied to your annual deductible.
- 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.
- This is the amount paid by the fully insured carrier (APL).
- 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.