



How To Read Explanation of Benefits

Forwarding Service Requested

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

*****SNGLP
1 1 SP 0.490
JOE SAMPLE
123 MAIN ST
ANYTOWN, USA 12345

1 Customer Service

8:00 am to 6:00 pm MST Monday through Friday
Customer Service and Benefit Inquires call
(Local)(801)262-7475(Toll Free)(800)662-5851
(Fax)(801)269-9734

Employer Group: GROUP ABC
Date Processed: 05/09/2015

This is an explanation of how your claim was processed by EMI Health. If you have questions about payments, contact your provider.

2 Service Dates	3 Description of Service	4 Billed	5 Allowed	6 Provider Discount	7 Not Covered	8 Reason Code	9 Deductible	10 Coinsurance	11 Co-pay	12 Payment
04/03-04/03/2015	Minor diagnostic testing (outpatient)	\$677.79	\$474.45	\$203.34	\$0.00	05	\$474.45	\$0.00	\$0.00	\$0.00
Column Totals		\$677.79	\$474.45	\$203.34	\$0.00		\$474.45	\$0.00	\$0.00	\$0.00
13 Other Insurance Credits or Adjustments										\$142.56
14 Total Payment Amount										\$0.00
15 Member Responsibility										\$474.45

This is an explanation of how your claim was processed by EMI Health. If you have questions about payments, contact your provider.

2 Service Dates	3 Description of Service	4 Billed	5 Allowed	6 Provider Discount	7 Not Covered	8 Reason Code	9 Deductible	10 Coinsurance	11 Co-pay	12 Payment
04/07-04/07/2015	Major diagnostic testing (outpatient)	\$907.50	\$385.84	\$521.66	\$0.00	05 49	\$25.55	\$0.00	\$100.00	\$0.00
Column Totals		\$907.50	\$385.84	\$521.66	\$0.00		\$25.55	\$0.00	\$100.00	\$0.00
13 Other Insurance Credits or Adjustments										\$69.18
14 Total Payment Amount										\$0.00
15 Member Responsibility										\$125.55

Plan Year Accruals

Description	Claim Year	Amount Met
JOE SAMPLE Medical Individual Network Deductible - Participating	2015	\$500.00
JOE SAMPLE Medical Individual Network Out-of-Pocket - Participating	2015	\$100.00
Medical Family Network Deductible - Participating	2015	\$500.00

The Amounts listed above are subject to change due to claim adjustments and/or the order in which claims are received.

Explanation of Codes

05	Negotiated discount has been applied.
49	Service copayment applied.

Benefits Determination**18****Read this carefully - this is your notice of payment or nonpayment of claims.**

In accordance with the provisions of your plan, you may appeal for reconsideration of any denied portion of this claim by writing to the Administration Office (address above). You should state the reason you believe your claim should be paid, attaching any documentation to support your appeal. The Administrator will consider and respond to your appeal within the time required by your plan. You should review your Plan Summary for specific directions on how and when an appeal must be filed.

Any request for a review of this claim must be received by EMI Health within 180 days of the date of this Explanation of Benefits. You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to this claim. If agreement is not reached after exhaustion of the claims review process outlined in your member handbook, you may have the right to submit the matter to voluntary binding arbitration or independent review or to pursue civil action. If you are covered by more than one health plan, you should file all your claims with each plan.

EMI Health now offers a full selection of Medigap & Medicare Prescription Drug Plans. Call us or visit www.emihealth.com and click on the Medicare Products tab for more information.

Claim Summary**19**

Claim #	Patient	Billed	Allowed	Provider Discount	Not Covered	Deductible	Coinsurance	Copay	Payment
215-000111111-00	JOE SAMPLE	\$677.79	\$677.79	\$203.34	\$0.00	\$474.45	\$0.00	\$0.00	\$0.00
215-000222222-00	JOE SAMPLE	\$907.50	\$907.50	\$521.66	\$0.00	\$25.55	\$0.00	\$100.00	\$0.00
Totals:		\$1,585.29	\$1,585.29	\$725.00	\$0.00	\$500.00	\$0.00	\$100.00	\$0.00

How To Read EOB

1. Customer Service: If you have questions, please call us at the toll free number listed at the top of your Explanation of Benefits. Our friendly and knowledgeable representatives are here to assist you.
2. Service Dates: Represents the date(s) the patient received services..
3. Description of Service: Lists the procedure performed.
4. Billed: This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amount.
5. Allowed: The amount allowed by the provider contact.
6. Provider Discount: The amount discounted.
7. Not Covered: Any specific amount that was determined to be ineligible for payment by the plan.
8. Reason Code: This code is used to explain the reason for an adjustment or benefit limitation.
9. Deductible: This amount reflects the deductible requirement at the time charges were processed.
10. Coinsurance: Percentage of allowed amount for which the patient is responsible.
11. Co-Pay: Represents amounts responsible to the patient.
12. Payment: Total amount less any adjustments.
13. Other Insurance Credit or Adjustments: The amount paid by another health plan or insurance company toward services the member received.
14. Total Payment Amount: Total amount less any adjustments.
15. Member Responsibility: This is the total amount that you owe the provider. This includes any co-payments, deductibles, co-insurance and/or excluded charges.
16. Plan Year Accruals: The amount of money you have paid to date for health care services
17. Explanation of Codes: This code is used to explain the reason something is not covered or is discounted from the billed amount.
18. Benefits Determination: This will be the procedure and information needed to file a formal review for any denied claim.
19. Claim Summary: Provides a summary of claims processed during an extended timeframe.