



Insight Benefit Administrators LLC  
3033 Orchard Vista SE Suite 312  
Grand Rapids, MI 49546



# Explanation of Benefits

**RETAIN FOR TAX PURPOSES  
THIS IS NOT A BILL**

## Forwarding Service Requested

JOHN SMITH  
100 MAIN STREET  
LINCOLNTON NC 28092-0665

### 1 Customer Service

If you have questions regarding this claim, please call us at (877) 827-1414

**Group#:** 7126  
**Group:** ABC Group  
**Date:** 5/2/2016  
**EOB #:** 123456789  
**Tax Id:** 123456789

**Claim#:** 201604070608  
**Patient:** JOHN SMITH

**Provider:** NORTH CAROLINA DHH  
**Patient#:** 123456789

2	3	4	5	6	7	8	9	10	11	12	13	
Dates of Service	Procedure Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount	
06/10-06/10/2014	12345	\$840.00	\$840.00	1	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00	
<b>Column Totals</b>		\$840.00	\$840.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	
<b>14 Patient's Responsibility:</b> \$0.00											<b>Other Credits or Adjustments</b>	\$0.00
											<b>Total Net Payment</b>	\$0.00

### 15 Reason Code Description

1 This is a duplicate charge that was previously considered for payment.

### 16 Plan Status

Member Name	Description	Year	Satisfied
Family Totals:	MAJOR MEDICAL DED	2013	\$1,054.65
Family Totals:	MAJOR MEDICAL OOP	2013	\$1,054.65
JOHN	MAJOR MEDICAL DED	2014	\$435.93
JOHN	MAJOR MEDICAL OOP	2014	\$680.30
Family Totals:	MAJOR MEDICAL DED	2014	\$2,500.00
Family Totals:	MAJOR MEDICAL OOP	2014	\$2,980.39

### Statement Totals

17	Number of Claims	Billed Amount	Not Covered	Other Insurance	Provider Discount	Deductible Amount	Co-pay Amount	Payment Amount
	1	\$840.00	\$840.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>Other Credits or Adjustments</b>								\$0.00
<b>Adjusted Payment</b>								\$0.00

### 18 Additional Information

If you believe your claim warrants reconsideration, your Health Plan has an appeal process. Appeals must be filed within one hundred and eighty (180) days from receipt of this notice. Please contact Insight Benefit Administrators for details.

- 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 **Dates of Service:** Represents the date in which the patient was treated and the date in which you are submitting charges.
- 3 **Procedure Code:** This section is to determine what service was performed.
- 4 **Total Charge:** This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amount.
- 5 **Ineligible Amount:** Amount not covered according to your plan.
- 6 **Reason Code:** Please reference the 'Reason Code Description' section of this document to determine why a specific code was ineligible for payment or whether the code represents a savings or negotiated adjustment.
- 7 **Discount Amount:** Amount that has been reduced according to your PPO Network.
- 8 **Covered by Plan:** Represents the total amount to be considered under the plan.
- 9 **Deductible Amount:** This amount reflects the deductible requirement at the time charges were processed. If you see an amount in the deductible column, the patient would be responsible for these amounts and the patient may receive a balance bill from the provider.
- 10 **Co-pay Amount:** This amount represents the patient co-pay responsibility. This would typically be for an office visit, emergency room or in-patient facility. Copays are specific to the benefit plan.
- 11 **Balance Amount:** This section contains total amount that the plan is expected to be responsible for.
- 12 **Paid At:** This is the percentage services are covered at after any deductions are taken from the billed amount. This amount is reflected in the plan benefits.
- 13 **Payment Amount:** This amount represents the plan payment after any ineligible charges, co-pays, deductibles, negotiated adjustments and patient's coinsurance is determined.
- 14 **Patient's Responsibility:** This section contains total amount that the patient is expected to be responsible for.
- 15 **Reason Code Description:** This section includes any additional notes or information as to what was covered or not covered.
- 16 **Plan Status:** Accumulation of individual and family deductibles and out of pocket expenses.
- 17 **Statement totals:** This will be the total of all claims paid on this statement.
- 18 **Your Right to Appeal (Additional Information):** This will be the procedure and information needed to file a formal review for any denied claim.