



Insight Benefit Administrators LLC
2851 Charlevoix Dr SE, Suite 325
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 | |
| Column Totals | | \$840.00 | \$840.00 | | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | | \$0.00 | |
| 14 Patient's Responsibility: \$0.00 | | | | | | | | | | | Other Credits or Adjustments | \$0.00 |
| | | | | | | | | | | | Total Net Payment | \$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 |
| Other Credits or Adjustments | | | | | | | | \$0.00 |
| Adjusted Payment | | | | | | | | \$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.