P9971021001

National Claims Administrative Services
P.O. Box 10136
Fairfax, VA 22038-8022

Electronic Service Requested

EXPLANATION OF BENEFITS

*** This is NOT a Bill ***

ENV 8768

200912230101

Questions?

PHONE INQUIRIES: (800)888-6227

3-DIGIT 208

8768 0.3584 AT 0.357

JANE DOE
2705 HAPPY DRIVE
NEWARK, DE 12345-1212

35

(1)

Date: 12/22/09
EOB #: 0806260020
Employee: JANE DOE
Emp ID.: 8839XXXXX
Patient: JANE DOE
Group #: ABC
Group: ABC COMPANY
Patient Acct: 149393

This is an explanation of benefits for claim we received for services rendered to: **Claim #** 200909300001

JANE DOE

(2)

Provider	(3) Dates of Service	(4) Procedure	(5) Charge	(6) PPO Disc	(7) Ineligible	(8) Ref	(9) Deductible	(10) Paid %	(11) Payment	(12) Paid To
GLASGOW MEDICAL CE	09/22/2009-09/22/2009	MEDICINE	115.00	.00	101.24	1,2,3	.00	80	.00	N/A

Benefit Summary

(13)

Charges	(14) Ineligible	(15) Deductible	(16) Co-Payment	(17) PPO Disc	(18) Other Ins	(19) Plan Pays	(20) Co-Insurance	(21) Patient Responsibility
115.00	101.24	.00	.00	.00	55.04	.00	13.76	13.76

(22)

Ref #	Explanation
1	Benefits were coordinated with your primary health care plan.
2	This amount is not allowed according to the Medicare contract currently in effect.
3	Routine preventive exams and screenings with your healthcare provider help you in Adopting a Positive Lifestyle by maintaining your health and detecting problems early when they are most treatable. By completing a preventive exam/screening, you may be eligible for 15 Wellness Points in the APL In The Zone Health Improvement Program. Don't forget to log your points at www.APLInTheZone.com by September 30. The program is only offered to all ACTIVE APL staff and their spouses/same sex domestic partners. Retirees and their spouses/same sex domestic partners are NOT ELIGIBLE for the Health Improvement Program.
*	The Plan has established and maintained a procedure by which a member or their authorized representative has a reasonable opportunity to appeal our decision to deny a claim. An adverse benefit determination may be based upon an internal rule or protocol. Upon request you will be provided, free of charge, that rule or an explanation of the scientific or clinical judgement used in making the decision. You may also review documents pertinent to your claim. This Plan offers 2 levels of appeal. You have the right to file an appeal to the Plan within 180 days from the date of the initial notice and within 30 days of a second adverse benefit determination notice. Your appeal request should include your name, the enrollee's identification number, and any additional documentation to be reviewed. Both levels of appeal will receive a full and fair review and the claimant will be notified of the Plan's benefit determination not later than 30 days after receipt of the request. If you are enrolled through an employer-sponsored or other group health benefit plan that is subject to Employee Retirement Income Security Act (ERISA), and receive an adverse benefit determination on your appeal(s), you may bring a civil action under Section 502(a) of ERISA.

(23)

Member Name	Description	Year	Satisfied
JANE DOE	PPO/NOPPO DEDUCTIBLE	2009	300.00
	PPO/NOPPO OOP	2009	789.80

**See explanation key on page 2.

How to Read Your Explanation of Benefits

1. **Member Information** – includes specific information about the EOB including date and EOB number, employee name, employee ID, patient name, group number, group name, and patient account number.
2. **Provider** – provider of service.
3. **Dates of Service** – the date the service was provided.
4. **Procedure** – description of type of procedure provided.
5. **Charge** – amount billed by the service provider.
6. **PPO Disc** – PPO Discount is the difference between the provider's billed amount and the Preferred Provider Organization's (PPO) allowed amount. This is the amount the health plan member saves by using a network provider. This amount may be $0 (zero) if your plan does not use a PPO network.
7. **Ineligible** – When Medicare is the Primary Carrier this amount represents the Medicare Paid Amount (if Medicare made payment), the Medicare Dis-Allowed Amount, and any other services excluded by this health plan.
8. **Ref Number** – this Reference Number refers the recipient to the appropriate explanation (see number 22 below).
9. **Deductible** – patient's liability.
10. **Paid %** – plan paid coinsurance.
11. **Payment** – plan paid amount.
12. **Paid To** – description of payee.
13. **Charges** – amount billed by the service provider.
14. **Ineligible** – When Medicare is the Primary Carrier this amount represents the Medicare Paid Amount (if Medicare made payment), the Medicare Dis-Allowed Amount, and any other services excluded by this health plan.
15. **Deductible** – patient's liability.
16. **Co-Payment** – the amount the health plan member may be charged by the provider at the time of service.
17. **PPO Disc** – PPO Discount is the difference between the provider's billed amount and the Preferred Provider Organization's (PPO) allowed amount. This is the amount the health plan member saves by using a network provider. This amount may be $0 (zero) if your plan does not use a PPO network.
18. **Other Ins** – the amount paid by another insurance plan such as Medicare.
19. **Plan Pays** – the amount paid by NCAS to the provider of service or to the health plan member.
20. **Co-Insurance** – the amount of eligible charges that the health plan member is responsible for paying to the provider of service.
21. **Patient Responsibility** – the total amount the patient is responsible to pay.
22. **Ref # and Explanation** – the specific comment related to this service or claim.
23. **Payment History** – this field is not applicable to all EOBs; this field may include deductible or coinsurance amounts met to date.