P9971021001

ncas
The Team Approach to Benefit Administration

WHITE STOCK

200806270154

EXPLANATION OF BENEFITS

*** This is NOT a Bill ***

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

Questions?
PHONE INQUIRIES (800) 888-6277
E-MAIL INQUIRIES SERVICE@NCAS.COM

1 OF 1

ENV 133

Forwarding Service Requested

SINGLE PIECE

133 0.3516 SP 0.420

JANE DOE 1
2705 HAPPY DRIVE
NEWARK, DE 12345-1212

1

Date: 06/26/08
EOB #: 0806260020
Employee: JAN DOE
Emp ID.: 8839XXXXX
Patient: BABY DOE
Group #: ABC
Group: ABC COMPANY
Patient Acct: 149393

This is an explanation of benefits for claim we received for services rendered to: **Claim #:** 200806180049
BABY 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	04/04/2008 – 04/04/2008	MEDICINE	75.00	15.00	0.00	1		100	30.00	HOSPITAL

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
75.00	0.00	0.00	30.00	15.00	0.00	30.00	0.00	30.00

22 Ref #	Explanation
1	This represents the ABC PPO Discount.
*	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
BABY DOE	PPO/NOPPO DEDUCTIBLE	2008	124.00
Family Totals:	PPO/NOPPO DEDUCTIBLE	2008	124.00

How to Read Your Explanation of Benefit

1. Member Information- includes specific information about the EOB including date and EOB number, employee ID, patient name, group number, group name, and patient account number.
2. Provider of Service
3. Dates of Services- The date the service was provided.
4. Procedure- Description of type of procedure provided.
5. Charge- Billed Amount
6. PPO Disc- The difference between the billed amount and the Medicare allowed amount or the Preferred Provider Organization allowed amount. This is the amount written off by Medicare or by a participating provider within the Preferred Provider Organization (PPO).
7. Ineligible- Any services excluded by this health plan.
8. Reference Number- This number will refer the recipient to the appropriate explanation (see 22).
9. Deductible- Patient's Liability
10. Paid %- Plan paid Coinsurance
11. Payment-Plan paid amount
12. Paid To- Description of Payee
13. Charges-Billed amount
14. Ineligible- Any services excluded by this health plan.
15. Deductible- - Patient's Liability
16. Co-Payment- The amount the member paid to the provider.
17. PPO Disc- The difference between the billed amount and the Medicare allowed amount or the Preferred Provider Organization allowed amount. This is the amount written off by Medicare or by a participating provider within the Preferred Provider Organization (PPO).
18. Other Ins-The amount paid by the other insurance plan.
19. Plan Pays-The amount paid to the provider of services or to the health plan member by NCAS.
20. Co- Insurance- The co-pay amount paid to the provider (patient responsibility).
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 EOB's. Displays may include deductible or coinsurance amounts met to date.