Independent Health

Independent Health Association, Inc.
511 Farber Lakes Drive
Buffalo, NY 14221

SAMPLE

Electronic Service Requested

Mr. Sample
1234 Main Street
Anywhere, NY 14216

If you have any questions, please call Independent Health at (716) 631-2661 or (800) 257-2753 or visit us online at www.independenthealth.com

Statement Date: 03/21/13
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EXPLANATION OF BENEFITS – THIS IS NOT A BILL **Please retain this copy for your records and tax purposes**

Member Name: John Sample
Member ID # 12345678-01
Group Name: ABC Company
Provider: Smith, Robert
Group #: 123456
Claim # 9876543

Dates of Service (1)	Service Description (2)	Rate (3)	Deduct (4)	Copay/Coins (5)	Not Covered (6)	Other Ins Paid (7)	Provider Liability (8)	Remark Code (9)	Plan Pays (10)
1/29/13	Medical Service	65.00	65.00	0.00	0.00	0.00	0.00	R	0.00
Totals (11)	Claim		65.00	0.00	0.00				
							(12)	Interest	0.00
Total Member Responsibility (13)					65.00		Total Plan Payment (14)		0.00

Remark code description:
R Paid at Usual and Customary Rate-UCR-. You are responsible for the Not Covered Amount when the provider balance bills. (18)

Summary information for 01/01/13 – 12/31/13
Your individual annual deductible is $1000.00
Amount applied to your individual annual deductible is 384.87 (15)
Amount remaining until you meet your individual annual deductible is $615.13 (16)
Your annual out-of-pocket maximum is $2000.00 (17)
Amount applied to your individual annual out-of-pocket maximum is $384.87
Amount remaining until you meet your individual annual out-of-pocket is $1615.13

Definition of terms on your Explanation of Benefits (EOB)

1. **Dates of Service** – The actual date and/or timeframe when you received medical services.
2. **Service Description** – The type of service(s) you received.
3. **Rate** – The actual amount charged to you and Independent Health.
4. **Deduct (deductible)** – The initial out-of-pocket amount you are responsible for when receiving covered services. Once you reach your deductible amount, copay and/or coinsurance may apply. (Note: The amount remaining until you meet your plan year annual deductible amount is determined as of the date(s) claims are completed by us, not the date that services were provided.)
5. **Copay/Coins (coinsurance**) – The amount you are responsible for paying the provider once you meet your plan year annual deductible amount.
6. **Not Covered** – Any portion of the submitted charges that are not covered by your benefit plan. Your provider may bill you for these charges.
7. **Other Ins (Insurance) Paid** – Amount paid by another insurance carrier. Only applies if patient has additional health coverage besides Independent Health.
8. **Provider Liability** – The amount of a claim determined to be neither Independent Health responsibility nor member responsibility. Most often this is the difference between the provider's billed charge and the contracted or discounted rate ("Independent Health allowed amount").
9. **Remark Code** – Used to call your attention to a specific message about the service charged. (See #18.)
10. **Plan Pays** – The amount paid by Independent Health to your physician or provider.
11. **Totals** – The total for each respective column.
12. **Interest** – You are not required to pay this amount. On very limited occasions, Independent Health is required to pay interest on a claim when that claim is determined to be paid beyond a specific timeframe. (The criteria to determine late payment are defined by various regulatory agencies.)
13. **Total Member Responsibility** – The amount you owe this provider for services rendered. (Note: This is not a bill; your provider will send you a bill if you owe anything.)
14. **Total Plan Payment** – The total amount paid by Independent Health for all the services incurred for each claim.
15. The amount that you (as determined by plan) have accumulated toward your plan year annual deductible. This amount includes previous claim activity.
16. Amount remaining until your plan year annual deductible is satisfied.
17. **Out-of-Pocket Maximum** – The maximum dollar limit for deductibles, copays and coinsurance amounts that you are responsible for in a given plan year.
18. **Remark Code Description** – Specific message about the service charged.