

How to Read and Understand Your Integra BMS Explanation of Benefits

You will receive an Explanation of Benefits (EOB) Statement for each claim submitted by you or your provider. The EOB explains how your claim was handled. This information is provided to help you understand your Explanation of Benefits.

1. This box provides information about your claim. This includes group information, member information, patient information, and provider information.
2. The member and address.
3. The "Claim Summary" box displays the amount that the member is responsible for paying.
4. The "Type of Service" column gives a brief description of the type of service rendered.
5. The "Dates of Service" column details the dates that each service was rendered.
6. The "Total Charge" column lists the total charge(s) billed by the provider of the service.
7. The "Not Covered" column shows the amount(s) that are not covered for benefits under your plan.
8. A "Discount or Penalty" amount is displayed in this column if a preferred provider is used. The amount shown is the negotiated discount for the service.
9. PPO information is displayed in this column if applicable.
10. The "Eligible Expense" column displays the amount that will be covered by your plan.
11. If a deductible is applied to the service, the amount applied is displayed here. The amounts are subtracted from your adjusted charges for final benefit calculation.
12. This column represents the amounts applied towards your calendar year coinsurance or applicable co-payments.
13. The percentage the plan paid for these charges is displayed here.
14. If a coinsurance amount has been applied to the service, the amount applied will be displayed here.
15. The "Plan Payment" column displays the actual amount being paid by the plan.
16. If a Remark Code has been assigned it will be displayed in this column. A description of the Remark Code can be found in the Remarks table, #19.
17. The "Accumulators" box displays any deductible and lifetime maximum amounts remaining.
18. The "Payment To" section displays to whom the benefits are payable along with the corresponding check information.
19. The "Remarks" section lists Remark Code descriptions and your rights.
20. Sample of the Check.



Address Service Requested



INSURED NAME
 P O BOX 54321
 CITY, NC 12345-6789

Group #: 9999 Employee #: 0
 Group: COMPANY
 Insured: INSURED NAME
 SSN: ***-**-7890
 Claimant: INSURED NAME
 Processor #: 00
 Patient Acct: 0000000ABC
 Provider Name: PROVIDER NAME
 Provider TIN: 00-0000000
 Claim #: 2011-123456789-0000

Claim Summary

Total Amount Covered:	83.98
Paid by Other Insurance Co:	0.00
Total Paid by Plan:	67.18
Employee's Responsibility:	16.80

Explanation of Benefits - This is NOT a Bill

Type of Service	Dates of Service	Total Charge	Not Covered	Disc. or Penalty	PPO ID	Elig. Exp.	Deduct. Applied	Co-Pay Amount	Balance Paid At	Coins. Applied	Plan Payment	Rem. Code
PRIMARY CARE PHYS VISIT	02/01/2011-02/01/2011	109.00	0.00	25.02	MEDCOST	83.98	0.00	0.00	80%	16.80	16.18	2
TOTALS		109.00	0.00	25.02		83.98	0.00	0.00		16.80	16.18	

Accumulators

DEDUCTIBLE REMAINING - PLAN	0.00
OUT OF POCKET REMAINING - PLAN	1562.82

Payment To

PAYEE NAME	Amount	Check #	Date
	67.18	01234567	04/13/2011

Remarks

- 2 This amount is your co-insurance percentage.
- ** You have a right to appeal this determination. If you disagree with this determination, you must submit proof that the claim for benefits is covered and payable under the Plan's provisions, including (a) all facts and theories supporting your claim, (b) a statement of the reason(s) for disagreement with the handling of the claim, and (c) any material/information that indicates that the claim does not fall within the referenced Plan provision. If you do so, it may be that some or all of this claim will be payable under the Plan.
- ** This Plan allows for (2) two appeals of an adverse benefit determination. Each appeal provides full and fair review of an adverse determination in compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and the regulations issued thereunder. Claimant will be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits by calling the Integra BMS Customer Service Department 1-800-228-1803.
- ** Briefly, claimant may file an appeal within 180 days following receipt of this notice, which must be in writing and addressed as follows: Integra BMS, Attention: Claims Manager, P.O. Box 1178, Matthews, NC 28106. If claimant provides the Plan with all information needed to address the appeal, if this is a claim requiring pre-service authorization, the Plan will respond to the appeal not later than 15 days after receipt of the appeal OR if this is a post-service claim, the Plan will respond to the appeal not later than 30 days after receipt of the appeal.
- ** An internal rule, guideline, protocol or similar criterion was relied upon in making this determination, a copy of which will be provided free of charge upon request. If you receive an adverse benefit determination following the final appeal, you have the right to bring a civil action under section 502(a) of ERISA. You are entitled to receive, free of charge upon request, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- ** Please contact Integra BMS if you are unable to find these provisions in the summary plan description.



00-00/000

CHECK NO. 01234567

ISSUE DATE 04/13/2011

PAY *****SIXTY SEVEN DOLLARS AND 18 CENTS

AMOUNT
****67.18

TO THE PAYEE NAME
 ORDER OF

BANK NAME

VOID 90 DAYS FROM DATE OF ISSUE

William E. Brown
 Authorized Signature

