Dear <First Name><Last Name>,

As of January 1, 2021, you will no longer receive an Explanation of Benefits (EOB) for each claim submitted to AmeriBen. Instead, you will receive one consolidated EOB per quarter. A sample consolidated EOB is included below, including descriptions of relevant terms.

If you have any questions, please contact AmeriBen's Customer Care Center at 1-833-951-1371

AmeriBen
PO Box 7186
Boise ID 83707-1186

Explanation of Benefits

[DR-]

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

J232 1

JOHN SMITH
123 MAIN ST
JACKSONVILLE IL 62650

Customer Service

Group # ABCCOMP
Date: 04/19/16
Group Name: ABC Company
Provider JANE DOE, MD
Division: D61 JBS OTTUMWA ACTIVE UNION
EOB: 20160415-7809
Check #:

Contact AmeriBen
Si usted necisita asistencia, por favor llame.
(208)344-7910 or (833)-951-1371
www.MyAmeriBen.com

Document #: B608703982
Patient: JOHN SAMPLE **Relationship** SELF
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 99999999

1 Dates of Service	2 Description Of Service	3 Billed Amount	4 Provider Discount	5 Ineligible Amount	6 Message Code	7 Covered By Plan	8 Deductible Amount	9 Co-pay Amount	10 Coinsurance Amount	11 Balance Amount	Paid At	Payment Amount
12/30-12/30/2015	INJECTIONS	$1,344.00	$0.00	$1,344.00	015	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
12/30-12/30/2015	SURGERY	$266.00	$0.00	$266.00	015	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
12/30-12/30/2015	OFF.VISIT SPEC.	$150.00	$0.00	$150.00	015	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
Column Totals		$1,760.00	$0.00	$1,760.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
											Adjustments	$0.00
											Total Net Payment	$0.00

You May Owe: **$1,760.00**

Document #: B609113149
Patient: JOHN SAMPLE **Relationship** SELF
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 999999999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
01/19-01/19/2016	LAB	$5.00	$0.00	$0.00	ANT	$5.00	$5.00	$0.00	$0.00	$0.00	0%	$0.00
Column Totals		$5.00	$0.00	$0.00		$5.00	$5.00	$0.00	$0.00	$0.00		$0.00
											Adjustments	$0.00
											Total Net Payment	$0.00

You May Owe: **$5.00**

Document #: B609113147
Patient: JOHN SAMPLE **Relationship** SELF
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 999999999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
02/02-02/02/2016	OFFICE VISIT	$145.00	$22.22	$0.00	ANT	$122.78	$122.78	$0.00	$0.00	$0.00	0%	$0.00
Column Totals		$145.00	$22.22	$0.00		$122.78	$122.78	$0.00	$0.00	$0.00		$0.00
											Adjustments	$0.00
											Total Net Payment	$0.00

You May Owe: **$122.78**

Document #: B608400472
Patient: JOHN SAMPLE **Relationship** SELF
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 99999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
02/06-02/06/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$113.68	$568.40	80%	$454.72
		$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$4,147.41	100%	$4,147.41
02/09-02/09/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/11-02/11/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/12-02/12/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/13-02/13/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/16-02/16/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/18-02/18/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81

02/20-02/20/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/23-02/23/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
02/25-02/25/2016	DIALYSIS	$4,715.81	$0.00	$0.00	MCR	$4,715.81	$0.00	$0.00	$0.00	$4,715.81	100%	$4,715.81
Column Totals		$47,158.10	$0.00	$0.00		$47,158.10	$0.00	$0.00	$113.68	$47,158.10		$47,044.42
											Adjustments	-$46,541.92
											Total Net Payment	$502.50

You May Owe: **$0.00**

Document #: **B609113673**
Patient: **JOHN SAMPLE** **Relationship** **SELF**
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 999999999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
02/25-02/25/2016	LAB	$38.30	$34.80	$0.00	ANT	$3.50	$0.00	$0.00	$0.70	$3.50	80%	$2.80
Column Totals		$38.30	$34.80	$0.00		$3.50	$0.00	$0.00	$0.70	$3.50		$2.80
											Adjustments	$0.00
											Total Net Payment	$2.80

You May Owe: **$0.70**

Document #: **B608307656**
Patient: **JOHN SAMPLE** **Relationship** **SELF**
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 999999999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
03/09-03/09/2016	WELLCHILD CA	$174.00	$32.54	$0.00	ANT	$141.46	$0.00	$0.00	$0.00	$141.46	100%	$141.46
03/09-03/09/2016	SCREENING SE	$50.00	$28.59	$0.00	ANT	$21.41	$0.00	$0.00	$0.00	$21.41	100%	$21.41
Column Totals		$224.00	$61.13	$0.00		$162.87	$0.00	$0.00	$0.00	$162.87		$162.87
											Adjustments	$0.00
											Total Net Payment	$162.87

You May Owe: **$0.00**

Document #: **B609007809**
Patient: **JOHN SAMPLE** **Relationship** **SELF**
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 999999999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
03/16-03/16/2016	OFFICE VISIT	$102.00	$54.40	$0.00	ANT	$47.60	$47.60	$0.00	$0.00	$0.00	0%	$0.00
Column Totals		$102.00	$54.40	$0.00		$47.60	$47.60	$0.00	$0.00	$0.00		$0.00
											Adjustments	$0.00
											Total Net Payment	$0.00

You May Owe: **$47.60**

Document #: **B609113682**
Patient: **JOHN SAMPLE** **Relationship** **SELF**
Employee:JOHN SAMPLE
Provider: JANE DOE, MD
Patient Account: 999999999999999

Dates of Service	Description Of Service	Billed Amount	Provider Discount	Ineligible Amount	Message Code	Covered By Plan	Deductible Amount	Co-pay Amount	Coinsurance Amount	Balance Amount	Paid At	Payment Amount
03/19-03/19/2016	NON EMG PHYS	$467.00	$294.92	$0.00	ANT	$172.08	$0.00	$0.00	$34.42	$172.08	80%	$137.66
Column Totals		$467.00	$294.92	$0.00		$172.08	$0.00	$0.00	$34.42	$172.08		$137.66
											Adjustments	$0.00
											Total Net Payment	$137.66

12

You May Owe: **$34.42**

Message Code/Description

015	DUPLICATE CHARGES.THESE CHARGES WERE PREVIOUSLY PROCESSED/CONSIDERED.
ANT	IN-NETWORK PROVIDER; MEMBER HELD HARMLESS FOR DISCOUNT
MCR	THIS CLAIM HAS BEEN COORDINATED WITH MEDICARE. THE PATIENT IS NOT RESPONSIBLE FOR THE MEDICARE INELIGIBLE AMOUNTS.

Comments

Claim Number	Comments	
B608400472	COB Adjustments	-46541.92

14

Payment Details

Paid To	Amount
BIO MEDICAL APPLICATIO	$502.50
CLINICAL PATHOLOGISTS	$2.80
SIU PHYSICIANS & SURGE	$162.87

AmeriBen
PO Box 7186
Boise ID 83707-1186

Reference Info

Group Name: ABC Company
Check #:

[DR-]

MIDWEST EMERGENCY DEPA	$137.66
JANE DOE, MD	$54.26
JANE DOE, MD	$118.12

Appeal Rights

The Plan relies on internal rules, guidelines, and protocols to make its determinations. A copy of the relevant information used to make the determination will be provided free of charge upon request. If applicable, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances will be provided free of charge upon request. You may appeal this determination to the plan administrator within 180 days after receiving this notice. Appeals will be decided no later than 30 days after they are received and the decision will be provided to you in writing. There are two levels of review. If you remain dissatisfied after completing both levels, you may pursue civil action under Section 502(a) of ERISA. A complete description of the Plan's appeals process is in the participant's summary plan description.

To find out if the Affordable Care Act (ACA) entitles you to receive future notices of adverse benefit determinations in a non-English language (for example, Spanish, Tagalog, Navajo or Chinese) please call the number on the back of your ID card.
SPANISH (Español): Para descubrir si el Acto de Cuidado Economico (Affordable Care Act) le da derecho a recibir el aviso de una determinación adversa de la ventaja o el otro aviso en Español, llame por favor el número siguiente: 1-800-786-7930.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-786-7930.
CHINESE (中文): 要找出如果支付得起的医疗法(Affordable Care Act)有权接收不良受益决心在中国的未来通知,请致电以下号码: 1-800-786-7930.。
NAVAJO (Dine): Dinék'ehji' niká'a'doowo?go, t'áá shoodi h?dahdi béésh bee hane'é binumber bikáá'ígíí bish'i' hodíílnih.1-800-786-7930

You can now access your claims on-line 24 hours a day. Go to www.MyAmeriBen.com.

1. DATES OF SERVICE - The date the patient received services from the provider.

2. DESCRIPTION OF SERVICE - A brief description of the service provided.

3. BILLED AMOUNT - The amount the provider billed for the service.

4. PROVIDER DISCOUNT - The discount amount negotiated by the plan.

5. INELIGIBLE AMOUNT - Charges for which there are no insurance benefits.

6. MESSAGE CODE - This code will have the description or note listed in the message section.

7. COVERED BY PLAN - Charges that are covered under the plan.

8, 9 and 10. DEDUCTIBLE, COPAY AND COINSURANCE - These are the amounts for which the patient is responsible.

11. BALANCE AMOUNT - This is the amount remaining after any deductions. This amount is what is considered under the plan.

12. MESSAGE CODE/DESCRIPTION - These codes refer to the message code. The explanations are in the description listed by the code.

13. PLAN DETAILS - Total amount of deductible, out of pocket, etc. you have paid out for the year listed.

14. PAYMENT DETAILS - If a check has been issued on this Explanation of Benefits, this section will note who the check was made to and for what amount.