

1206 West Campus Drive Temple, TX 76502

**Forwarding Service Requested** 

# Explanation of Benefits This is NOT a bill

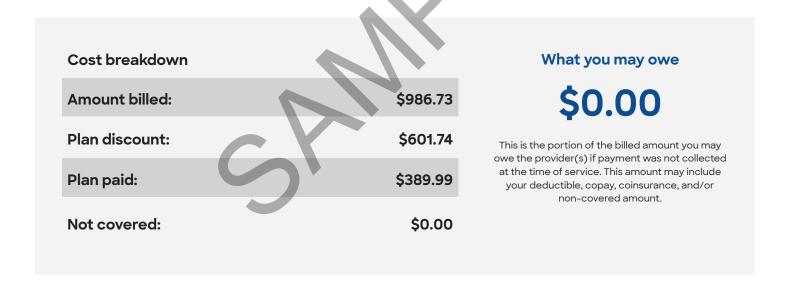
#### **QUESTIONS?**

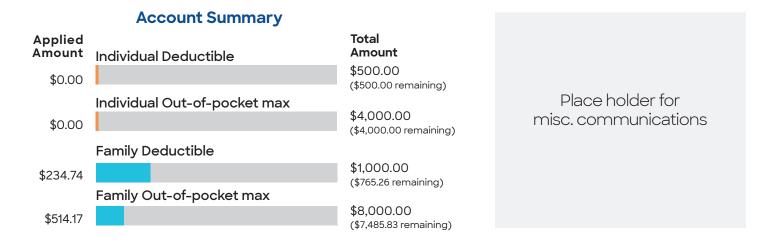
Customer service: (844) 843-3229 Hours: 7 a.m. to 7 p.m. CT Website: bswh.swhp.org

John Smith 789 TEST STREET REDCARD, MO 63141 Member ID: 12345678 Group Number: 050054 Group Name: BSWH SEQA Print date: 02/18/2020

#### Hi John,

This document summarizes recent claims the Plan has processed for healthcare services. It confirms the amount charged by your provider(s) and the amount the Plan paid for those charges.





### **Now...the Detailed Version**

Here's a detailed breakdown or Explanation of Benefits for this service. In case there's any doubt - this is NOT a bill! Subscriber: John Smith

Member ID: 12345678

Group Name: BSWH SEQA

Group Number: 050054

Patient: Ann Smith Claim Number: 123x456x789 Provider: Test Provider 2									In-Netw	ork	
Date of Service	Description	Amount Billed	Allowed Amount	Non-Covered Amount	Other Coverage Payment	Plan Paid	Copay	Deductible	Coinsurance	What You May Owe	Notes
2/04/20	REMOVAL INTRAUTERINE	\$911.73	\$309.99	\$0.00	\$0.00	\$309.99	\$0.00	\$0.00	\$0.00	\$0.00	
Total		\$911.73	\$309.99	\$0.00	\$0.00	\$309.99	\$0.00	\$0.00	\$0.00	\$0.00	

Patient: Ann Smith Claim Number: 123x456x788 Provider: Test Provider 1									In-Network		
Date of Service	Description	Amount Billed	Allowed Amount	Non-Covered Amount	Other Coverage Payment	Plan Paid	Copay	Deductible	Coinsurance	What You May Owe	Notes
2/04/20	OUTPATIENT OFFICE VI	\$75.00	\$75.00	\$0.00	\$0.00	\$75.00	\$0.00	\$0.00	\$0.00	\$0.00	
Total		\$75.00	\$75.00	\$0.00	\$0.00	\$75.00	\$0.00	\$0.00	\$0.00	\$0.00	

### **Notes:**



## **Helpful Definitions**

**Allowed Amount** -The amount considered for payment based on our provider contracts and your benefits.

**Amount Billed** -The amount your provider billed for the services. Note: This amount does not reflect discounts that the plan has negotiated with the provider or facility.

Amount Paid - The amount we paid to you or your provider.

Copay -The amount you are responsible to pay for certain services, typically paid at the time of service.

**Coinsurance** - A percentage of the "allowed amount" you are responsible for paying for services after your deductible is met. Providers may require payment when you receive services.

**Deductible** - The amount you pay before the Plan begins to pay for covered services. Note: "Non-Covered" amounts don't count toward meeting the yearly deductible. Your provider may bill you for these charges.

**Discount Amount** -The amount you saved by using the plan's preferred providers.

**Non-Covered Amount** - The amount that is not coverd by your benefit Plan and you are responsible for paying. Also, if you've used an out-of-network provider, "non-covered amount" includes any amount the out-of-network provider bills in excess of the plan-negotiated network rates.

Other Coverage Payment - The amount paid by your other insurance carrier.

**Out-of-Pocket Maximum** -The most you have to pay for in-network health services every year. Once you have paid this amount, the Health Plan typically pays 100% of your allowed health care charges, subject to any policy limitations.

# Report Fraud

If you suspect fraud, contact the Scott and White Health Plan Compliance HelpLine at (888) 484-6977.

# Language Assistance/ Nondiscrimination Notice

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call (844) 843-3229 (TTY: 711).

Scott and White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**ATENCIÓN**: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 843-3229 (TTY: 711).

Scott and White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (844) 843-3229 (TTY: 711).

Scott and White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

