HealthSmart BENEFIT SOLUTIONS

HealthSmart Benefit Solutions, Inc.

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

		COMPANY/PLAN:	1234-02-M
		CLAIM:	0000044
EMPLOYEE:	ADAM A CORNWELL	SSN:	XXX-XX-1234
PATIENT:	ADAM	LOC:	DEPT:
PATIENT DOB:	05/14/1975	CHECK DATE:	07/31/2001
PATIENT ACCT:	5555555	CHECK NUMBER:	10769

Provider/Date of Service Type of Service	Charges	*Provider Discount	Your Co-Pay	Not Covered	REMARK	Covered	Applied to Deductible	%	Plan Benefit	Paid by Other Insurance	Paid
GRACE HOSPITAL											
DOS: 06/01/01-06/01/01											
240-DIAGNOSTIC SVC	150.00	24.75		10.00	K3	115.25		90	103.73		103.73
240-EMERGENCY ROOM	350.00	57.75	250.00		R9	42.25	42.25				

BEV1 04J02 REV 01/12

Date of service reflecting services below date

Co-pay is now displayed in this column

Advises recipient no payment is due HealthSmart Benefit Solutions, Inc.

Explanation of remark codes is displayed on the back

Description of services Rendered

Provider discount is now displayed in this column

Payment Calculation:	Total Charges	- Provider Discount	- Your Co-Pay	- Total Not Covered	= Total Covered	- Total Deductible	%	Total Plan Benefit	Total Paid by Other Insurance	Total Paid
GRAND TOTALS	500.00	82.50	250.00	10.00	157.50	42.25		103.73		103.73

PAY PROVIDER AMOUNT DUE---> **PATIENT RESPONSIBILITY: 313.77**

	BENEFIT YEAR $ TO DATE	BENEFIT YEAR $ REMAINING		BENEFIT YEAR $ TO DATE	BENEFIT YEAR $ REMAINING
INDIVIDUAL DEDUCTIBLE	129.25	20.75	FAMILY DEDUCTIBLE	213.57	186.43
INDIVIDUAL OUT OF POCKET	282.54	2,217.46	FAMILY OUT OF POCKET	366.86	4,633.14

*PATIENT NOT RESPONSIBLE FOR DISCOUNT - NETWORK: PIEDMONT HEALTH ALLIANCE

SEE BACK FOR MORE INFORMATION →

EMPLOYER: EOB TESTING

Network name

Shows to date accumulations and remainder

PROVIDER PAID 103.73
GRACE HOSPITAL
2201 S STERLING ST
MORGANTON, NC 20655-404401

Formula To Calculate Total Plan Benefit

If more than one page is required because of multiple lines this amount will display the total paid from both pages

Effective on the first day of plan years beginning July 1, 2002, but no later than January 1, 2003, to appeal an adverse benefit decision for claims filed after July 1, 2002, send a written appeal to the address indicated below within 180 days of receipt of this notice (except in the case of any reduction or termination of a course of treatment, the Plan Administrator will provide you with sufficient notice to allow you to appeal and obtain a determination before the benefit is reduced or terminated). Your appeal will be forwarded to your Plan's Benefit Committee for review. You may submit written comments, documents, records or other information. You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. The Benefit Committee will conduct its review without deference to the initial determination and will take into account all comments, documents, records and other information you submit. In deciding an appeal based on medical judgement, the Benefit Committee will consult with an appropriate health care professional. The Benefit Committee will identify to you any medical or vocational experts whose advice was obtained for your appeal. In the case of an Urgent Care claim, the Benefit Committee will provide for an expedited review process. The expedited appeal may be submitted orally or in writing and all necessary information, including the Plan's determination, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method. You will be notified of the Plan's appeal decision: for Urgent Care Claims, not later than 72 hours after receipt of your appeal; for Pre-Service Claims, not later than 30 days after receipt of your appeal; for Post-Service Claims, not later than 60 days after receipt of your appeal. If a period of time is extended due to your failure to submit necessary information, the appeal period will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office or state insurance regulatory agency. If you disagree with the appeal decision, you may also bring a civil action under the Employee Retirement Income Security Act of 1974(ERISA) 502(a).
Mail appeals to: Plan Administrator, c/o HealthSmart Benefit Solutions, Inc., PO Box 3262, Charleston, WV 25322

BEV2B 04/2012

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 888.440.7342 BETWEEN 7:00AM AND 7:00PM, MONDAY THRU FRIDAY, OR WRITE HEALTHSMART BENEFIT SOLUTIONS,INC., P.O. BOX 2451, CHARLESTON,WV 25329-2451. WHEN CONTACTING US, PLEASE REFER TO THE CLAIM NUMBER. WHEN CLAIMS ARE SUBMITTED, PLEASE INCLUDE THE COMPANY NAME AND NUMBER.

For web access go to www.healthsmart.com and click 'For Client, Employee, Provider'.

EXPLANATION OF REMARK CODES:

K3 NONMEDICAL SUPPLIES ARE NOT COVERED
R9 THIS AMOUNT IS YOUR $250.00 EMERGENCY ROOM CO-PAYMENT

NOT COVERED:

10.00

Remark Code and Explanation from Page 1

Address to submit claims and appeals

The toll free number to reach the Customer Service Department at HealthSmart Benefit Solutions, Inc.

Amounts not covered from Page 1 will be displayed here