Promise Health Plan
PO Box 4287
Clinton, IA 52733-4278

Questions? Contact us:
Medical: 000-000-0000

Website: myPromiseHealthPlan.com

SAMPLE MEMBER
1234 MAIN ST

TOWN NAME SC 00000

EMPLOYER NAME

Group Number 00000000
Print Date December 31, 2023

Consolidated Family Explanation of Benefits

This is not a Bill

SAMPLE MEMBER

Patient's Name Type of Service	Service Date(s)	Billed Charges	Discount Amount	Other Adjust-ments	Other Plan Payment	Patient Responsibility After Payments				Plan Benefit	Plan Paid At	Reason Codes
						Ineligible	Co-Pay	Deductible	Co-Ins			
SAMPLE MEMBER												
Claim #: 000000-000-00 Pat. Acct. #: X0000000000 Provider: SAMPLE PROVIDER Network:												**Issued: 12/18/23**
OFFICE VISITS	07/01/2023	150.00	0.00	0.00	0.00	0.00	17.00	0.00	0.00	133.00	100%	
OFFICE VISITS	07/01/2023	150.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	150.00	100%	
	Totals:	300.00	0.00	0.00	0.00	0.00	17.00	0.00	0.00	283.00		

Patient Responsibility 17.00

		MEDICAL 2023
SAMPLE MEMBER	NON-PREF PROV OUT OF POCKET Met (of $10,000.00)	$0.00
	PREF PROV OUT OF POCKET Met (of $6,000.00)	$17.00
	PROMISE HEALTH OUT OF POCKET Met (of $3,000.00)	$0.00
	NON-PREF PROVIDER DEDUCTIBLE Met (of $4,000.00)	$0.00
	PREFERRED PROVIDER DEDUCTIBLE Met (of $2,000.00)	$0.00
	PROMISE HEALTH PLAN DEDUCTIBLE Met (of $1,000.00)	$0.00
Family	NON-PREF PROV OUT OF POCKET Met (of $20,000.00)	$0.00
	PREF PROV OUT OF POCKET Met (of $12,000.00)	$17.00
	PROMISE HEALTH OUT OF POCKET Met (of $6,000.00)	$0.00

Please see your Summary Plan Description for a more detailed explanation of your plan benefits, exclusions, and maximums. The dollars displayed on this statement are as of the Print Date and are subject to change. Your next Consolidated Explanation of Benefits, if any claims are processed, will be issued no later than the week of: 01/21/2024

RIGHT OF REVIEW (Applies to those Employer Benefit Plans subject to The Employee Retirement Income Security Act of 1974 ERISA). You may appeal an adverse benefit determination of your claim. Such appeal must be in writing and must be received by us within 180 days from the date you receive this statement. Upon receipt of such appeal, we will provide a full and fair review of your claim and provide you with a written notice of our determination no later than 60 days of receipt of the appeal by us. If the denial of your claim was based on an internal rule or guidance, access to this information will be provided free of charge upon a written authorized request. If the denial of your claim was based on a medical necessity or experimental treatment limitation or exclusion, access to an explanation of a scientific or clinical judgment of the determination will be provided free of charge upon a written authorized request. You must exhaust the internal appeal process as outlined in the booklet prior to exercising your right to Civil Action.

If your Plan is governed by both ERISA and the insurance laws of your state, additional or different requirements and rights may apply. Please see your booklet for your state's appeal process. Plans that are not subject to ERISA may not have the same rights and may be subject to different state and/or federal laws.

Coordination of Benefits
If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

<u>This document contains important information including your Appeal Rights that you should retain for your records.</u>
This document serves as notice of any adverse benefit determination. Benefits under your self-funded benefit plan, which are denied in whole or in part for the requested treatment or service, are described in the attached Explanation of Benefits (EOB). If you think this determination was made in error, you have the right to appeal.

What if I need help understanding this denial? Contact Customer Service at the phone number provided on the attached EOB if you need assistance understanding this notice or the decision to deny you coverage under your benefit plan.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? Complete, detach, copy and send in the form below within one hundred eighty (180) calendar days from receipt of notification of the denial. See also the "Other resources to help you" section below for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled without immediate treatment. If you believe your situation is urgent, you may request an expedited appeal when filing your appeal request (see form below), or by filing a request for simultaneous external review, or by contacting Customer Service at the telephone number or website provided on the attached Explanation of Benefits.

Who may file an appeal? You or someone you name in writing to act for you (your authorized representative) may file an appeal.

Can I provide additional information about my claim? Yes, you may supply additional information in support of your claim to the address provided on the attached Explanation of Benefits.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting Customer Service at the telephone number or website provided on the attached Explanation of Benefits.

What happens next? If you appeal, we will review the decision and provide you with a written determination. If we continue to deny the payment or coverage requested, on behalf of your self-funded benefit plan, or you do not receive a timely decision, you may be able to request an external review of certain claims by an independent third party, who will review the denial and issue a final decision. External review applies to a rescission of coverage and an adverse benefit determination involving medical judgment, including but not limited to, to those plan requirements involving medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or experimental or investigational treatments or services.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

<u>Appeal Filing Form</u>

Detach this form and send to the address provided on the attached Explanation of Benefits. Be certain to keep copies of this form, your denial notice, and all documents related to this claim.

Covered Person's Name: _____ Patient Name: _____

Covered Person's ID #: _____ Claim Number: _____

Name of Person Filing Appeal: _____ Today's Date:_____

Check One: Covered person Patient Authorized Representative

Contact information of person filing appeal (if different from patient)

Address: _____ Phone: _____ Email: _____

If the person filing the appeal is other than the patient, the patient must indicate authorization by signing here:
_____

Are you requesting an urgent appeal? Yes No

Briefly describe why you disagree with this decision (you may use the back of this form, or attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim): _____

_____