Clear Chain
PO BOX 11746
ROANOKE VA 24022-1746

Forwarding Service Requested

Explanation of Benefits

THIS IS NOT A BILL
RETAIN FOR TAX PURPOSES

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JOHN SMITH, MD
123 MAIN STREET
ANYTOWN, VA 22222

Customer Care Information

Questions? Please contact us
Toll Free at 833-484-9985
or visit us online at

Group Name:
Date: 10/13/2020
Enrollee: **MICKEY MOUSE**

Employee Copy

Claim Summary

Claim Number	Patient Name	Total Charge	Non Covered	Discount Amount	Allowed Amount	Deductible Amount	Patient Responsibility	Payment Amount
2021-000000000-0000	MICKEY MOUSE	$18.00	$0.00	$12.03	$5.97	$5.97	$5.97	$0.00
	Totals	**$18.00**	**$0.00**	**$12.03**	**$5.97**	**$5.97**	**$5.97**	**$0.00**

Claim #: **2021-000000000-0000**
Patient: **MICKEY MOUSE**

JOHN SMITH, MD LLC **Enrollee:** MICKEY MOUSE
Provider #: 11111111
FID #:11111111

Treatment Dates	ServiceDescription	Billed Amount	Discount Amount	Allowed Amount	Deductible Amount	Not Covered	Coinsurance Amount	Remark Code	Co-pay Amount	Paid At	Payment Amount
10/06-10/06/2020	LABORATORY TEST OFFICE	$18.00	$12.03	$5.97	$5.97	$0.00	$0.00	13 1	$0.00	80%	$0.00
	Column Totals	**$18.00**	**$12.03**	**$5.97**	**$5.97**	**$0.00**	**$0.00**		**$0.00**		**$0.00**

Patient's Responsibility: **$5.97**

Other Insurance Credits: **$0.00**
Total Payment Amount: **$0.00**

Only Pay This

Accumulators

Description	Amount Remaining
Deductible Remaining - In Network	$78.99
Out of Pocket Remaining - In Network	$2,078.99

Remark Code/Description

Code	Description
1	DEDUCTIBLE AMOUNT
13	DISCOUNT APPLIED

Appeal Rights

The payment above is based on the terms of your benefit plan. On request, the internal rule, guideline, protocol, criterion or standard used in making this decision will be provided to you free of charge. If an adverse decision was based on medical necessity, experimental treatment or similar exclusion, an explanation of how the decision was made will also be provided free of charge upon request. You or your authorized representative may appeal this determination by following a 2-level appeal procedure. To file a Level 1 Appeal, send a written request within 180 days of this notice to P.O. Box 11746, Roanoke, VA 24022. The appeal will be reviewed and determined by someone other than the individual who made the original benefit determination. You will be notified of the Level 1 Appeal decision within 15 days (pre-service claim) or 30 days (post-service claim) of the date the Plan received the appeal. If the Level 1 appeal is denied, you may file a Level 2 Appeal within 60 days of the date of the Level 1 decision. Appeal procedures for Level 1 apply to Level 2 Appeals. If the Level 2 Appeal is denied, you may elect voluntary arbitration or bring civil action under Section 502(a) of ERISA if your plan is covered by ERISA. For further information, please consult your summary plan description.