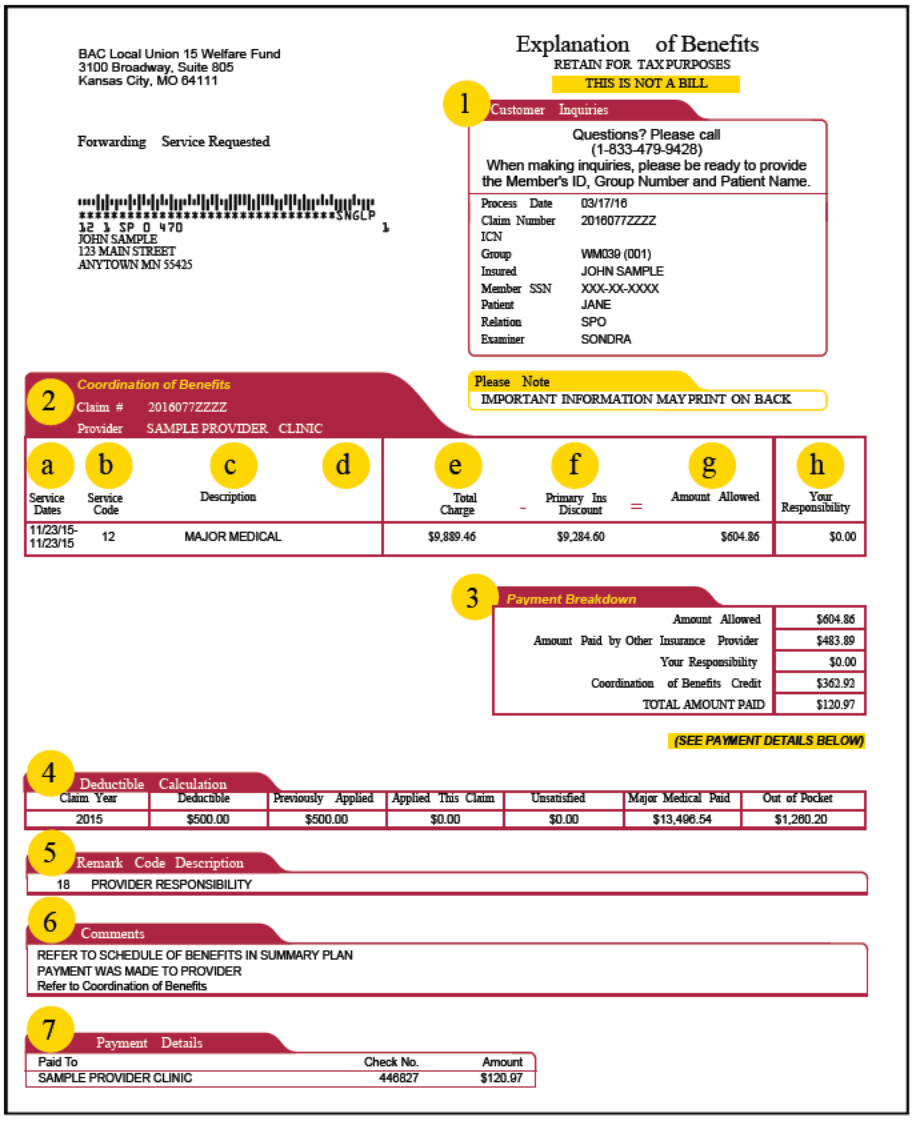
How To Read Your EOB

A brand new look, same excellent service…

As we continuously focus on ways to enhance the service we provide to you, we are pleased to announce some changes to the Explanation of Benefits (EOB). The EOB is the form which you receive after using your healthcare benefits. We have redesigned the EOB with a new layout which makes the document much easier to read and understand.

Below you will see an example of the newly redesigned EOB along with very helpful information on "How to Read Your EOB". Please review the information contained in the "How to Read Your EOB" and make note of where important information is now located.

As always, we aim to provide the highest level of customer service and hope that the redesigned EOB offers a benefit to you and your family. Remember, do not hesitate to contact the Fund Office with any questions regarding your benefits.



BAC Local Union 15 Welfare Fund
3100 Broadway, Suite 805
Kansas City, MO 64111

Forwarding Service Requested

12 1 SP 0 470
JOHN SAMPLE
123 MAIN STREET
ANYTOWN MN 55425

Explanation of Benefits
RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

1 Customer Inquiries
Questions? Please call (1-833-479-9428)
When making inquiries, please be ready to provide the Member's ID, Group Number and Patient Name.

Process Date	03/17/16
Claim Number	2016077ZZZZ
ICN	
Group	WM039 (001)
Insured	JOHN SAMPLE
Member SSN	XXX-XX-XXXX
Patient	JANE
Relation	SPO
Examiner	SONDRA

2 Coordination of Benefits
Claim # 2016077ZZZZ
Provider SAMPLE PROVIDER CLINIC

Please Note
IMPORTANT INFORMATION MAY PRINT ON BACK

a Service Dates	b Service Code	c Description	d	e Total Charge	-	f Primary Ins Discount	=	g Amount Allowed	h Your Responsibility
11/23/15-11/23/15	12	MAJOR MEDICAL		$9,889.46		$9,284.60		$604.86	$0.00

3 Payment Breakdown

Amount Allowed	$604.86
Amount Paid by Other Insurance Provider	$483.89
Your Responsibility	$0.00
Coordination of Benefits Credit	$362.92
TOTAL AMOUNT PAID	$120.97

(SEE PAYMENT DETAILS BELOW)

4 Deductible Calculation

Claim Year	Deductible	Previously Applied	Applied This Claim	Unsatisfied	Major Medical Paid	Out of Pocket
2015	$500.00	$500.00	$0.00	$0.00	$13,496.54	$1,260.20

5 Remark Code Description
18 PROVIDER RESPONSIBILITY

6 Comments
REFER TO SCHEDULE OF BENEFITS IN SUMMARY PLAN
PAYMENT WAS MADE TO PROVIDER
Refer to Coordination of Benefits

7 Payment Details

Paid To	Check No.	Amount
SAMPLE PROVIDER CLINIC	446827	$120.97

1. **Customer Inquiries:** If you have questions, please give us a call at the number(s) located at the top of your Explanation of Benefits Statement. Our friendly and knowledgeable staff are available to assist you Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Standard Time.
2. **Coordination of Benefits:**
   a. **Service Dates:** Represents the patient's date(s) of treatment.
   b. **Service Code:** Code used to identify the nature of the services rendered.
   c. **Description:** Used to identify the nature of services rendered.
   d. **Remark Code (if applicable):** Reason for Ineligible amount.
   e. **Total Charge**: Billed charges before negotiated adjustments, network discounts, copays, deductibles or any denied charges.
   f. **Primary Insurance Discount:** Amount of discount under the primary insurance plan.
   g. **Amount Allowed:** The amount allowed after negotiated adjustments, network discounts or any denied charges.
   h. **Your Responsibility:** Amount you are responsible for after your other insurance and this plan have processed the claim.
3. **Payment Breakdown:** A summary of the allowed amount, amount paid by other insurance, your responsibility, if any, and total amount paid by this plan.
4. **Deductible Calculation:** The amount of allowed expense applied toward the plan deductible and out-of-pocket maximums which have accumulated during the health plan benefit period.
5. **Remark Code Description (if applicable):** A descriptive field that explains any non-covered service or payment reduction.
6. **Comments:** General notes pertaining to the claim that may also include notes regarding a payment that was made to a provider.
7. **Payment Details:** If applicable, details on who was paid.
8. **Appeal Information:** Information and procedures instructing on how to file a formal review for any denied claim. Please note this tab typically prints on the back side of your EOB. Please see your EOB for the full verbiage for this section.