Sample Explanation of Benefits Statement

Below is an example of a standard EBMS Explanation of Benefits. The standard EOB will include additional information regarding your rights to appeal any final decision on the submitted claim on the front or back of the EOB as space permits.

Employee Benefit Management Services
As Administered by EBMS
PO Box 21367
Billings MT 59104-1367

Forwarding Service Requested

**********SNGLP 630
1 1 SP 0.460 1
MARY SAMPLE
4321 MY STREET
BILLINGS MT 59999-9999

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

EBMS PHONE NUMBER

Customer Service

If you have any questions, please call
800-777-3575
or visit **www.ebms.com**

Visit **miBenefits** at *www.ebms.com* to receive your EOB electronically!!

24/7 ACCESS TO ALL CURRENT AND HISTORICAL CLAIMS INFORMATION THROUGH MIBENEFITS

Date: 9/4/2013
Employee: MARY SAMPLE
Division: BIL BILLINGS

IMPORTANT INFORMATION FOR MEMBERS TO HAVE WHEN CALLING EBMS.

TYPE OF CLAIM

Document #: 1324700004
Patient: MARY SAMPLE

Patient #: **ID #:** 999999999
Provider: PROVIDER NAME

Date(s) of Service	Nature of Service	Billed Amount	Discount / Adjustment	Ineligible Amount	Reason Code	Eligible Amount	Deductible Amount	Co-pay Amount	Paid At	Total Payable By Plan
09/01-09/01/2013	OFFICE VIS	$350.00	$0.00	$70.47	1	$279.53	$0.00	$0.00	100%	$279.53
	Column Totals	$350.00	$0.00	$70.47			$0.00	$0.00		$279.53
								Other Carrier Payment		$0.00
								Total Net Payment		$279.53

DEDUCTIBLE INFORMATION

Patient's Responsibility: **$70.47**

AMOUNT YOU MAY BE BILLED BY YOUR PROVIDER

REASON CODE INFORMATION

THIS IS THE PAYMENT AMOUNT THE PLAN WILL MAKE TO YOU OR YOUR PROVIDER

Reason Code Description

1 - 999 - Amounts over usual, customary and reasonable(UCR) are excluded as defined by the plan. Please refer to the Pl… Plan
2 - 800 - Provider of service does not participate in benefit plan's network.

Accumulators

DEDUCTIBLE INFORMATION

Patient Medical Deductible Met to Date (PPO)	1250.00
Family Medical Deductible Met to Date (PPO)	2500.00
Patient Medial Out of Pocket Met to Date (PPO)	3000.00
Family Medical Out of Pocket Met to Date (PPO)	6000.00

*** *Reflects accumulators as of this claim.*
Please visit www.ebms.com or call for the most current accumulator total.

Payment Details

Paid To	Check No.	Amount
PROVIDER NAME	99999	$279.53

IF THERE IS NO CHECK, PLEASE REFER TO THE "PAYMENT" FIELD. THE CHECK MAY HAVE BEEN SENT DIRECTLY TO THE PROVIDER.

THESE ARE YOUR RIGHTS TO APPEAL ANY FINAL DECISION ON THE CLAIM

Appeal Language

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at (800) 777-3575 if you need assistance understanding this notice or our decision to deny you a service or coverage.

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

How do I file an appeal? You may submit an appeal letter with written comments, documents, records and other information regarding the claim within 180 days from the date of this notice. Direct your appeal to the Plan Administrator or Claims Administrator at: EBMS, Appeals Department, PO Box 21367, Billings, MT 59104. Your appeal should include, at a minimum, your plan name and ID number, your name and contact information, the claim number and the reason for your appeal.

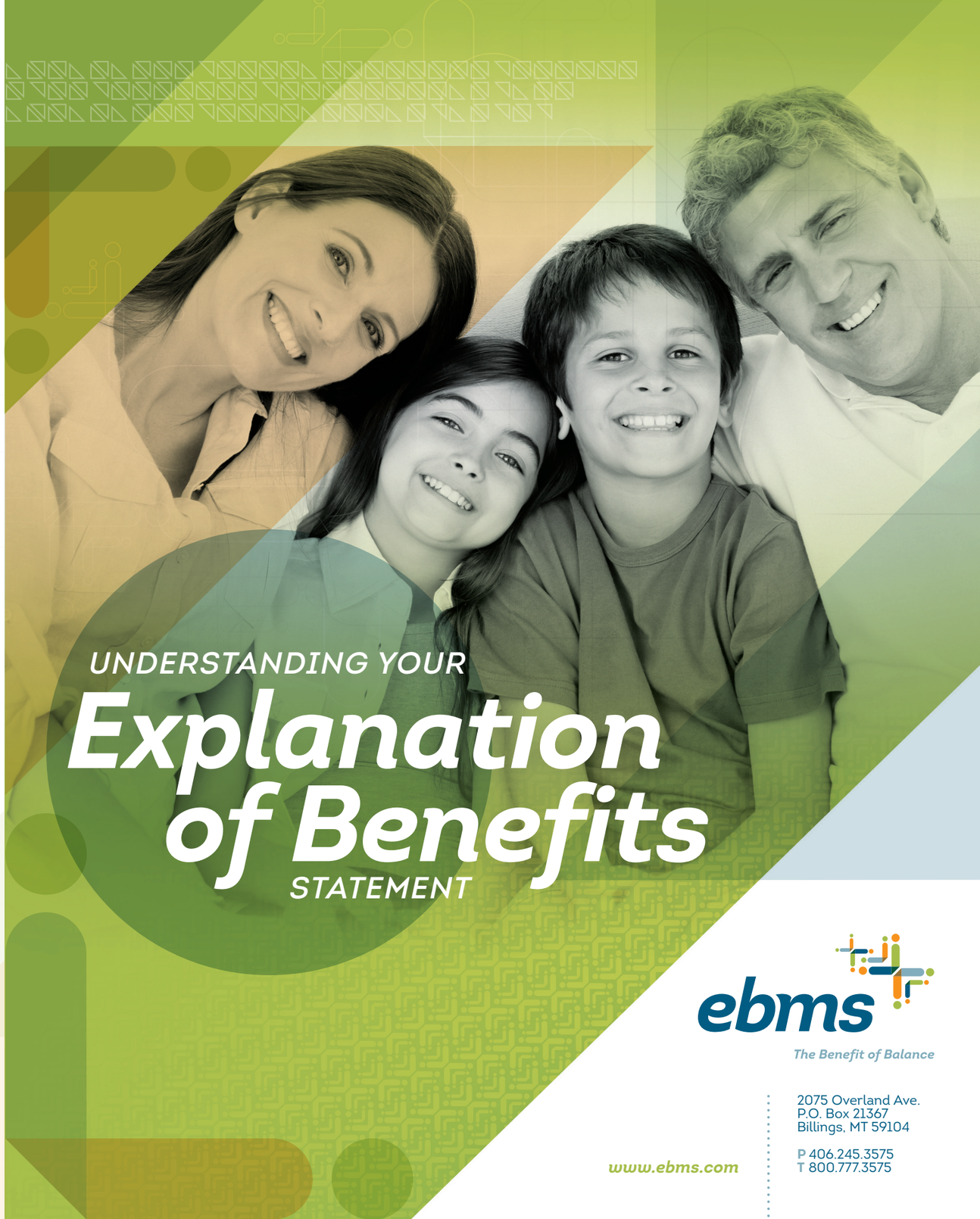
What if my situation is urgent? If your situation meets the definition of urgent under the law, an external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by fax to EBMS Appeals Department, (406) 652-5380, or login to your miBenefits account at www.ebms.com.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may contact EBMS at (800) 777-3575 for more information about how to appoint an authorized representative.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at (800) 777-3575.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

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). Visit www.ebms.com for contact information of your State Office of Health Insurance Consumer Assistance or Ombudsman.



UNDERSTANDING YOUR

Explanation of Benefits

STATEMENT

ebms
The Benefit of Balance

2075 Overland Ave.
P.O. Box 21367
Billings, MT 59104

P 406.245.3575
T 800.777.3575

www.ebms.com

EBMS Claim Reason Codes

When you receive services from a provider, you or your provider must submit a claim for those services in order to receive reimbursement. EBMS handles the payment of those claims on behalf of your benefit plan. To make sure that the claim is paid correctly, EBMS uses numerous resources, including your Plan Document, billing practice resources (eg. American Medical Association, Medicare, and Correct Coding Initiative), and claim payment practice guidelines.

You and your provider will receive an Explanation of Benefits (EOB) notification of the outcome for the processing of the claim.

When you receive the EOB, you may notice a message code located beside some of the charges in the ineligible column under reason code. Each of these codes will mean something different to the outcome of the claim. Some you will need to follow up on, some are the provider's responsibility, and others are related to the way the provider billed.

Here is a list of the most frequently used message codes that you will see. If you do see one on your EOB that is not listed below, please feel free to contact EBMS for additional clarification.

ACC: The Plan has a provision relating to Accidental Injury or Illness. To correctly apply this provision to your claim we need information regarding the accident. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that there is an accident diagnosis billed on the claim. Before the claim can be processed, EBMS needs verification that there is not another individual or insurance policy that may need to make payment on the claim. Please complete the letter you will receive in the mail, sign it, and return the letter to EBMS or complete the information by going to www.ebms.com and clicking on Forms and Documents located under Health Resources in your miBenefits account. Timely completion will ensure that the claim is paid as quickly as possible.

COB: The Plan has a provision relating to Coordination of Benefits. To apply this provision to your claim we will need information regarding any primary insurance coverage you may have. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that initial or annual verification of other insurance on your dependents has not been received. You may satisfy this request by going to www.ebms.com and clicking on Forms and Documents located under Health Resources in your miBenefits account or by contacting EBMS at the toll free telephone number provided on the back of your ID card, or 1-800-777-3575. The representative on the telephone will take this information for you and the claim will be reconsidered.

PTR: The Plan has a provision requiring prescribed treatment for therapy. To correctly apply this provision to your claim we need a prescription for ongoing therapy treatment indicating frequency and duration. Future claims may not be considered eligible under the plan provisions. Please provide the requested information within 45 days of this notice.

This message indicates that your Plan Document requires that the billed treatment be prescribed by your physician. Your provider of the therapy will typically respond with the receipt of needed information. However, if you choose, you may expedite the needed information by contacting your provider. The provider may then send the information to EBMS for proper processing of the claim.

PTT: The Plan has a provision relating to Medical Necessity. To correctly apply this provision to your claim we need a prescription for ongoing therapy treatment indicating frequency and duration. For further consideration, please provide the requested information within 45 days, otherwise this notice constitutes formal determination of the claim.

The message indicates that your Plan Document requires that the billed treatment must be prescribed by a physician. Your provider of the therapy will typically respond with the receipt of needed information. However, if you choose, you may expedite the needed information by contacting your provider.

EOB: The Plan has a provision relating to Coordination of Benefits. To correctly apply this provision to your claim we need a copy of your primary insurance plan's explanation of benefits. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that EBMS has a record of other insurance available that should pay this claim first. If that is not the case, please contact EBMS to update your other insurance record. There will be additional information necessary to process the claim, which may include the date the other insurance coverage terminated, reason for termination, and other pertinent information. If you do have other insurance, please submit the EOB provided by the other insurance company. Your provider may also have a copy of this information. You or the provider may then send the information to EBMS for proper processing of the claim.

OIC: We are in receipt of correspondence that indicates that there may be other insurance coverage in place. In order to correctly apply this plan's coordination of benefits provision, an immediate update is required. A letter has been sent requesting specific information. Please provide this information within 45 days of this notice. If the requested information is not provided within 45 days, this constitutes formal determination of the claim.

This code will appear on your explanation of benefits when we have received information with a claim (such as an EOB from another insurance company) that indicates the possibility of other insurance.

ITM: The Plan has a provision relating to how to submit a claim. In order to correctly apply this provision to your claim, we need an itemized bill for the above services. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that an itemization of the charges is needed to properly process the claim. Typically this is only necessary for claims that have billed charges over $25,000. Your provider will typically respond with the needed information. However, if you choose, you may expedite the receipt of needed information by contacting your provider. The provider may then send the information to EBMS for proper processing of the claim.

DME: The Plan has a provision relating to Medical Necessity. To correctly apply this provision to your claim we need a prescription or evidence of medical necessity including purchase/rental price. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that there is further documentation, medical records or pricing information, that will assist in determining the correct reimbursement for this claim. Your provider will typically respond with the needed information. However, if you choose, you may expedite the receipt of needed information by contacting your provider. The provider may then send the information to EBMS for proper processing of the claim.

CBR: According to our records your Cobra premium has not been received. Please refer to your original Cobra Notification for timely payments. If the premium is not received within the appropriate time period, this notice constitutes denial of the submitted claim.

This message indicates that a Cobra premium has not been received. If it is still within the 30-day grace period, this could serve as a reminder that you need to make your monthly payment, if you enrolled in a Cobra policy. Please contact EBMS at the toll free telephone number provided on your Cobra notice or 1-800-777-3575.

MED: The Plan has a provision relating to Medical Necessity. To apply the provision to your claim, we need medical records. The provider should have received a letter indicating the information needed. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

This message indicates that the services provided must be reviewed to make sure they are medically necessary. This is accomplished through a review of the medical records. EBMS uses standards of care and medical reviews to determine medical necessity. Your provider will typically respond with the needed information. However, if you choose, you may expedite the receipt of needed information by contacting your provider. The provider may then send the information to EBMS for proper processing of the claim.

SOT: The Plan has a provision relating to Medical Necessity. To apply the provision to your claim, we need the initial evaluation report from the speech or occupational therapy provider for this course of therapy. For further consideration, please provide the requested information within 45 days of this notice. If not provided within 45 days, this notice constitutes formal determination of the claim.

The message indicates that your Plan Document requires that the billed treatment must meet medical necessity which is established by the evaluation. Your provider of the therapy will typically respond with the needed information. However, if you choose, you may expedite the receipt of needed information by contacting your provider.

The next set of codes are used when the provider has not billed in line with the industry standard billing practices. Your provider should not be bill you after the Plan has paid for these specific codes. However, the provider may re-bill for additional reimbursement, or to correct the original billing. Your provider will typically respond with any needed information however, you may expedite the processing by contacting your provider.

UUD/UUS: The submitted procedure code is inappropriately billed with other principal procedures and, as such, has been denied. Please refer to the Usual and Reasonable language in the Definitions section of your plan document.

This message indicates your claim has been denied because the procedure code used has been inappropriately billed with other procedures codes.

UIS/UID: This procedure code has been identified as being incidental and is therefore denied. Please refer to the Usual and Reasonable language in the Definitions section of your plan booklet.

TRA: The submitted procedure code is inappropriately billed with other principal procedure and has been rebundled. Please refer to the Usual and Reasonable language in the Definitions section of your plan.

This code is usually utilized when a non-PPO provider has been used and is a result of procedures being billed as separate charges rather than one bundled charge.

Finally, this last set of codes show that a service was denied. Reconsideration of this charge should be done through a formal written appeal.

515: The claim for these services is a duplication of a previously considered claim. Please refer to an earlier explanation of benefits.

519: These services were incurred after your coverage terminated.

551: Services are denied as Not Medically Necessary under the terms of the plan. Please refer to the Not Medically Necessary Exclusion in your Plan. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the medical circumstances will be provided free of charge, upon request.

591: These services are not a benefit under the plan. Please refer to the Routine Care exclusion in the Plan Exclusions section of your plan booklet.

527: These services are for a newborn child that has not been enrolled for coverage. Please refer to the Enrollment section of your plan booklet.

528: Your plan has a provision relating to Eligibility. To correctly apply this provision, we will need student status verification. Please provide written certification from the school's registrar of records within 45 days from receipt of this notice. If this information is not provided within 45 days, this notice constitutes denial of the submitted claim.

508: These services exceed the maximum benefits available under the plan. Please refer to the plan's Annual and Maximum benefit requirements in the Schedule of Benefits section of your plan booklet.

549: Services are denied as Experimental/Investigational under the terms of the plan. Please refer to the Experimental/Investigational exclusion in your Plan. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the medical circumstances will be provided free of charge, upon request.

To obtain additional claims payment information, login to your personal account on miBenefits (www.ebms.com) or contact one of EBMS' knowledgeable, friendly Client Service Representatives on your group's dedicated toll free number (listed on the back of your ID card).

Visit miBenefits at ***www.ebms.com*** to receive your EOB electronically