# Explanation of Benefits
## for Major Medical Plans Without a PPO Network

PLAN ADMINISTERED BY: Star Marketing and Administration, Inc.
PO BOX 2942
CLINTON, IA 52733-2942

EXAMPLE ONLY

| Questions? | **Contact us:** |
|---|---|
| Toll-Free: | (800) 522-1246 |
| Website: | TrustmarkSB.com |

JOHN EXAMPLE
123 MAIN STREET
ANYWHERE, USA 12345

| | |
|---|---|
| Group Number | 00000000 |
| Employer | COMPANY NAME |
| Print Date | December 18, 2020 |

*Consolidated Explanation of Benefits*
*This is not a Bill*

MARY EXAMPLE

| Patient's Name Code & Description Provider | Service Date(s) | Charged Amount | Discount Amount | Allowed Amount | Other Plan Payment | Other Adjustments | Patient Responsibility After Payments: Ineligible | Copay/Enc Fee Acces Fee | Deductible | Co-Insurance | Benefit | Explanation Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

**JOHN EXAMPLE** Patient Relation:Member

**Claim #: A00000000-00 Pat Acct #00000** **Issued: 9/30/2020**

| Code & Description | Service Date(s) | Charged Amount | Discount Amount | Allowed Amount | Other Plan Payment | Other Adjustments | Ineligible | Copay/Enc Fee Acces Fee | Deductible | Co-Insurance | Benefit | Explanation Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 99213 - PHYSICIAN MEDICAL FEES - FAMILY HEALTH | 11/02/2020 | 250.00 | 0.00 | 200.00 | 0.00 | 50.00 | 0.00 | 35.00 | 0.00 | 0.00 | 165.00 | ARF |
| 87804 - LABORATORY- FAMILY HEALTH | 11/02/2020 | 50.00 | 0.00 | 24.50 | 0.00 | 25.50 | 0.00 | 0.00 | 24.50 | 0.00 | 0.00 | ARF |
| | Totals: | 300.00 | 0.00 | 224.50 | 0.00 | 75.50 | 0.00 | 35.00 | 24.50 | 0.00 | 165.00 | |

**Payment has been made to the health care provider.**

**Patient Responsibility 59.50**

**The Patient is not responsible for any amounts noted in the "Other Adjustments"column. If you receive a bill from the provider for any of these amount(s), call Customer Service at 800.522.1246. Representatives are available Monday through Friday between 7 a.m. and 5 p.m., CT.**

**Claim #: A00000001-00 Pat Acct #00000**

| Code & Description | Service Date(s) | Charged Amount | Discount Amount | Allowed Amount | Other Plan Payment | Other Adjustments | Ineligible | Copay/Enc Fee Acces Fee | Deductible | Co-Insurance | Benefit | Explanation Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PHO - PREVENT CARE - CENTRAL HOSPITAL | 11/16/2020 | 777.50 | 0.00 | 111.70 | 0.00 | 665.80 | 0.00 | 0.00 | 0.00 | 0.00 | 111.70 | ARF |
| | Totals: | 777.50 | 0.00 | 111.70 | 0.00 | 665.80 | 0.00 | 0.00 | 0.00 | 0.00 | 111.70 | |

**Payment has been made to the health care provider.**

**Patient Responsibility 0.00**

**The Patient is not responsible for any amounts noted in the "Other Adjustments"column. If you receive a bill from the provider for any of these amount(s), call Customer Service at 800.522.1246. Representatives are available Monday through Friday between 7 a.m. and 5 p.m., CT.**

**Claim #: A00000001-01 Pat Acct #:100000**

| Code & Description | Service Date(s) | Charged Amount | Discount Amount | Allowed Amount | Other Plan Payment | Other Adjustments | Ineligible | Copay/Enc Fee Acces Fee | Deductible | Co-Insurance | Benefit | Explanation Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PHO - PREVENT CARE - CENTRAL HOSPITAL | 11/16/2020 | 345.20 | 233.50 | 111.70 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 111.70 | AMP |
| EXCEPTION PAYMENT - CENTRAL HOSPITAL | 11/16/2020 | 432.30 | 0.00 | 432.30 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 432.30 | AMP |
| Payment Adjustment | 11/16/2020 | 0.00 | 0.00 | 0.00 | 0.00 | 111.70 | 0.00 | 0.00 | 0.00 | 0.00 | (111.70) | |
| | Totals: | 777.50 | 233.50 | 544.00 | 0.00 | 111.70 | 0.00 | 0.00 | 0.00 | 0.00 | 432.30 | |

**Payment has been made to the health care provider.**
**CLAIM HAS BEEN ADJUSTED TO REFLECT ADDITIONAL PAYMENT**

**Patient Responsibility 0.00**

**Explanation Code Descriptions:**

AMP CLAIM ALLOWANCE BASED ON AN AGREEMENT WITH AMPS.
DIFFERENCE NOT BILLABLE TO PATIENT.

ARF CHARGE EXCEEDS REASONABLE FEE.
SEE PLAN DOCUMENT FOR DETAILS.

| | | 2020 |
|---|---|---|
| JOHN EXAMPLE | Medical Deductible Remaining | $940.50 |
| | Medical Out of Pocket Remaining | $1,940.50 |
| | | |
| Family | Medical Deductible Remaining | $1,940.50 |
| | Medical Out of Pocket Remaining | $3,940.50 |
| | | |

Accumulator information available upon request for any blank fields

**Please see your Plan Document 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: 1/25/2021**

If you are covered by more than one health benefit plan, you should file all your claims with each plan. This is a sample Explanation of Benefits. An actual Explanation of Benefits contains additional language regarding appeal rights.

# Understanding Your Explanation of Benefits

**The following is an illustrative example of an Explanation of Benefits (EOB) statement.**

The letters A – W appearing on the EOB sample are for reference clarification only and correspond to details, definitions and terminology below.

- A **Group Number:** Number assigned to the employer by Star Marketing and Administration, Inc.
- B **Print Date:** Date the EOB was issued.
- C **Patient's Name:** Name of person who received the service.
- D **Code & Description:** Procedure code and description of the service (i.e. physician visit).
- E **Provider:** Name of facility or professional provider that rendered the service.
- F **Service Date(s):** The date(s) the provider indicated the services billed were received or rendered.
- G **Charged Amount:** This is the fee charged by the provider for the treatment or services rendered.
- H **Discount Amount:** This reflects a reduction in charges for which you should not be billed. If you are billed for the discount, contact your provider. If the discount amount is not removed from your bill, contact Customer Service at 800.522.1246, ext. 26300.
- I **Allowed Amount:** The charges to be considered after discounts and ineligible amounts have been applied.
- J **Other Plan Payment:** Benefit paid by other health plan, auto insurance or government plan such as Medicare, for which your policy or certificate would be a secondary payor.
- K **Other Adjustments:** This is an ineligible amount. Refer to the Explanation Code column and corresponding description for details.
- L **Ineligible:** A charge that was previously considered or the amount is not covered by your plan. (If a dollar amount was shown here, refer to the Explanation Code column and corresponding description for details.)
- M **Copay:** The charge to you for each regular (non-emergency) visit to a participating physician's office. This fee may or may not apply to your plan.
- N **Deductible:** The amount of covered charges that must be incurred by you before benefits will be paid. *Note: Certain plans have a separate deductible for prescription drugs.*
- O **Coinsurance:** The coinsurance amount is the percentage of the allowed amount for which you are responsible.
- P **Benefit:** The amount payable to a provider and/or to you after any copay, deductible or coinsurance percentage has been subtracted from the allowed amount. Adjustments and deductions for other coverage may need to be considered before payment is made.
- Q **Explanation Code(s):** Used to explain why a portion of submitted charges is not covered by the plan. A number or letter code, as shown on the EOB corresponds with an explanation.
- R **Claim Number:** This number identifies the claim.
- S **Patient Account Number:** Account number assigned by the facility or professional provider that rendered the service.
- T **Issued:** Date the claim was paid and/or an EOB was issued.
- U **Check Distribution:** Lists who received payment for the indicated services. In addition to the member, this will include any provider you have authorized to receive payment of your benefits.
- V **Patient Responsibility:** Portion of charged amount for which the member is responsible.
- W **Family:** Dollars remaining toward the deductible and out-of-pocket expenses for the employee and covered dependent(s).

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