BENEFITS, INC

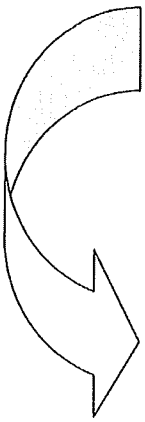
Insurance & Benefit Solutions

Partially Self -Funded Claims Flow Chart

PRIMARY INSURANCE

Step 1:

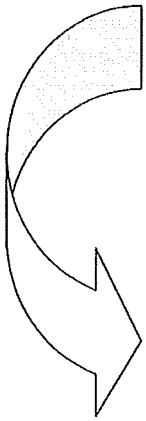
Show your Medical Provider your Health Insurance ID card. Your Medical Provider will send your claims to Wellmark. The address is located on your ID card.



PARTIALLY SELF FUNDED PAYMENT

Step 2:

When you receive your Explanation of Benefits from Wellmark, we will also receive a copy of it at Benefits, Inc. We can then automatically process the partially self-funded payment for you.



PAYMENT OF CLAIM
&
EXPLANATION OF BENEFITS

Step 3:

BI will then send any payment due to the medical provider. At the same time BI will mail you a copy of the Explanation of Benefits. This will explain how the claim was paid and what you are responsible to pay.

Explanation Of Benefits

Benefits, Inc.

PO BOX 410
Decorah, IA 52101
563-387-0789

***** THIS IS NOT A BILL *****

Client	
Insured	
Claimant	
Patient ID	
Prov Name	KOSSUTH REGIONAL HEALTH CENTER
Prov ID	55015 Date 05/28/14
Charge	643.00 Check 010673
Claim	14-013323 ID

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Service	From	To	Charge	Incl	CD	Deduct	Allowable	Pct	Payable
2	3	3	4	5	6	7	8	9	10
OPS	05/06/14	05/06/14	643.00	228.24	08	117.80	296.96	70	207.87
OUTPATIENT SERVICES									
			11	12		13	14		15
Totals			643.00	228.24		117.80	296.96		207.87

Description of Ineligible Codes 16 Insured Responsibility 206.89

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08 Discount given by the provider of service. Patient not responsible.

2014 YTD Deductible Met	$ 2,000.00	Single	$ 2,000.00	Family
2014 YTD Coinsurance Met	$ 108.59	Single	$ 108.59	Family
2014 YTD Copay Met	$ 490.00	Single	$ 490.00	Family
2014 YTD Out of Pocket	$ 2,598.59	Single	$ 2,598.59	Family

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All charges are processed in accordance to PLAN provisions and limitations. Within 60 days after receipt of the Explanation of Benefits, you may request a review of the handling of this claim. If there are such questions, please submit your comments in writing, or request a review of pertinent documents upon which the decision was based, and the matter will be given further considerations. Be sure to refer to our Claim Number.

There are hand written numbers in each section of this Explanation of Benefits. These hand written numbers are explained on the following page. So please refer to the following page to better understand what this Explanation of Benefits is telling you.

If you should have any questions or just don't understand your Explanation of Benefits, please give Benefits, Inc. a call at 1-877-461-1424.

THIS IS AN EXAMPLE ONLY

You have the $2,000 Deductible plan through your employer, it is a plan that is partially self-funded by your employer. This means that your employer is funding a high deductible plan that they buy from Wellmark down to your $2,000 deductible plan. When this is done, Benefits, Inc. (BI) is the third party administrator that processes those claims. You will receive an Explanation of Benefits (EOB) from BI showing you how the claim was paid.

This is an explanation of the information that you will find on the Explanation of Benefits from BI. Please look at the corresponding numbers on the Explanation of Benefits to understand what each part of the EOB is telling you.

1) Client Name, Employee Name, Claimant Name, information concerning the claim (Claim Number, Group Name, Provider Name, Process Date, etc.)
2) Service Category – The type of service that you had.
   Here is a listing of the service categories:

AMB – Ambulance	CHIR – Chiropractor
DME – Durable Medical Equipment	ER – Emergency Room
IPS – In Patient Services	OPS – Out Patient Services
OVI – Office Visit In Network	OVIO – Office Visit 100%
PHA – Pharmacy RX	PIP – Physician Service In Patient
POP – Physician Services Out Patient	THP – Therapy
WLNS – Wellness	LXOO, LXRD, LXRO – Lab X-ray

   There could be others. Call if you have any questions about the Service Categories.
3) Date of Service – Date that you had services done.
4) Total Charges – Total amount that was billed by the provider for this service.
5) Ineligible – Charges that are not being paid by you or Benefits, Inc.
6) Ineligible Codes – See #16.
7) Deductible – The amount that you will pay toward your Deductible.
8) Allowable – Amount of the bill that has to be paid by you or Benefits, Inc. after you have met your deductible.
9) Percentage – The percentage that the plan will pay of the allowable..
10) Payable – This is the amount that the plan will pay toward this charge.
11) This is the Total Charge for this claim.
12) This is the Total Amount that is Ineligible for this claim.
13) This is the Total Amount of your Deductible that you will have to pay.
14) This is the Total Allowable amount for this claim.
15) This is the Total Payable Amount for this claim. This is the amount that your Employer is paying toward this claim to bring it down to the Deductible and Coinsurance amounts that you are responsible for.
16) Description of Ineligible Codes – This gives you the description of the codes used in #6.
17) Insured Responsibility – This tells you the Total Amount Payable by you for this claim.
18) This box tells you how much of the Deductible you have met and how much of your Family Deductible have you met. It also does that for the Coinsurance and your Copays. Remember, you're Deductible plus your Coinsurance plus your Medical Copays equals your Out-of-Pocket.

If you should have any questions, concerns or just don't understand your Explanation of Benefits, please give BI a call at 877-461-1424.