1 MACo Health Care Trust
P.O. Box 1966
Missoula, MT 59806

Explanation of Benefits

Please retain for your records.

THIS IS NOT A BILL
It is the only copy you will receive.

Forwarding Service Requested

**********SCH 3-DIGIT 590
26 1 AT 0.406 1

2 SARAH SMITH
1919 SAMPLE WAY
ANYTOWN MT 59047-1509

Customer Service

3 **Group Name:** SAMPLE GROUP
Group #: 1234567 4
5 **Date:** 03/12/2014
EOB #: 1234567890

6 status information or verification of benefits may be obtained 24 hours a day by accessing our website at www.askallegiance.com or our Interactive Voice Response (IVR) system at (406) 523-3199.
7 For answers to other questions please contact Customer Service at (800) 735-1923.

8 Claim Summary

Claim Number	Patient Name	11 Total Charge	12 Ineligible Amount	13 Plan Discount	14 Deductible Amount	15 Co-pay Amount	16 Co-Insurance	17 Patient Responsibility	18 Payment Amount
201401234567	SARAH SMITH	$40.00	$0.00	$3.77	$36.23	$0.00	$0.00	$36.23	$0.00
9 201412345679	10 SARAH SMITH	$50.00	$0.00	$0.00	$50.00	$0.00	$0.00	$50.00	$0.00
	Totals	$90.00	$0.00	$3.77	$86.23	$0.00	$0.00	$86.23	$0.00

Claim: 201401234567 19 Member ID: 123456789012
Patient: SARAH SMITH DOB: 09/06/XXXX 20 Employee: SARAH SMITH 21 Patient Account #: 1234
Provider: ELIZABETH PROVIDER, MD

22 Treatment Dates	23 Procedure	Billed Amount	Ineligible Amount	24 Reference Code	Plan Discount	Deductible Amount	Co-pay Amount	Co-Insurance	25 Paid At	Payment Amount
02/24-02/24	chiropract manj 1-2 regions	$40.00	$0.00	I3108	$3.77	$36.23	$0.00	$0.00	0%	$0.00
	Column Totals	$40.00	$0.00		$3.77	$36.23	$0.00	$0.00		$0.00
								26 **Other Insurance Credits**		$0.00
Patient's Responsibility.....		**$36.23**						**Adjusted Payment**		$0.00

27

Claim: 201412345679 Member ID: 123456789012
Patient: SARAH SMITH DOB: 09/06/XXXX Employee: SARAH SMITH Patient Account #: 1234
Provider: ELIZABETH PROVIDER, MD

Treatment Dates	Procedure	Billed Amount	Ineligible Amount	Reference Code	Plan Discount	Deductible Amount	Co-pay Amount	Co-Insurance	Paid At	Payment Amount
02/27-02/27/2014	chiropract manj 3-4 regions	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	0%	$0.00
	Column Totals	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00		$0.00
									Other Insurance Credits	$0.00
Patient's Responsibility.....		**$50.00**							**Adjusted Payment**	$0.00

28 Reference Code Description

Code	Description
I3108	Allegiance Benefit Plan Management Direct Discount The patient is not responsible for this amount.

29 Appeal Rights

Appeal procedures are printed as the last page of this document.

30 Deductible/Out of Pocket Summary

Member Name	Description	Current Period	Amount Met
SARAH S	MAJOR MEDICAL DED	01/01/14	$594.69
SARAH S	MAJOR MEDICAL OOP	01/01/14	$594.69

How to Read an Explanation of Benefits

Below is a description of your Explanation of Benefits (EOB). The numbers correspond with the numbers on the sample copy of the EOB.

1. **Claim Processing Office:** this is the location of the claims processing office. You can write to customer service at this location.
2. **Address:** the name and address where the EOB is being mailed.
3. **Group Name:** the name of your Group (in most cases, this is your employer).
4. **Group Number:** the identification number for your Group. Please refer to this number if you call or write about your claim.
5. **Date:** the date the EOB was issued.
6. **EOB Number:** reference number for Explanation of Benefit look up.
7. **Customer Service:** contact information to obtain additional information regarding your claim.
8. **Claim Summary:** one line summary of the claims payment information. A more detailed explanation of each line is outlined separately.
9. **Claim Number:** the unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.
10. **Patient:** the name of the individual for whom services were rendered or supplies were furnished.
11. **Total Charge:** the amount billed for each service.
12. **Ineligible Amount:** amount that is not eligible for benefits under the plan (i.e., duplicates, not covered service). Some amounts may be *patient responsibility*. Please refer to reference codes (#24, 28) for more information.
13. **Plan Discount:** identifies the savings received from a Network Provider, if applicable.
14. **Deductible Amount:** the amount of allowed charges that apply to your plan deductible that must be paid before benefits are payable. *Patient Responsibility.*
15. **Copay:** the amount of allowed charges, specified by your plan, you must pay before benefits are paid. (i.e., $20 office visit copay). *Patient Responsibility.*
16. **Coinsurance:** member's cost sharing on eligible expenses on a percentage basis usually after deductible (i.e., 20%). *Patient Responsibility.*
17. **Patient Responsibility:** after all benefits have been calculated, this is the amount of which the patient is responsible. This is a total of deductible, copay, coinsurance, and potentially ineligible amounts.
18. **Payment Amount:** benefits payable for services provided.
19. **Member ID:** employee's unique identification number. Refer to this ID number if you call or write about your claim.
20. **Provider:** the name of the person or organization who rendered the service or provided the medical supplies.
21. **Patient Account Number:** this is your account number assigned by the service provider.
22. **Treatment Dates:** the date(s) on which services were rendered.
23. **Procedure:** description of the services rendered.
24. **Reference Code:** code relating to the "ineligible" amount. This is used to request additional information or provide further explanations of the claim denial/payment. See #28 for additional information.
25. **Paid At:** the percentage your plan paid the eligible service under your benefit plan.
26. **Other Insurance Credits:** represents adjustments/payments based upon the benefits of other health plans or insurance carriers.
27. **Adjusted Payment:** the sum of the "Payment Amount" column for that claim.
28. **Reference Code Description:** explanation of the Reference Code #24 will appear in this section.
29. **Appeal Rights:** outline of your rights under your plan when an adverse claim determination is made.
30. **Deductible/Out of Pocket Summary:** deductible/out of pocket accumulators for the current year as of the date of the EOB.

Appeal Procedures

APPEAL PROCEDURES
TO CLAIMANT OR CLAIMANT'S DULY AUTHORIZED REPRESENTATIVE

It is important that you understand the action that we have taken on your claim for benefits. If you have a question concerning your benefits, you should refer to your Summary Plan Description Booklet, which contains the important features of your benefit plan. Benefit coverage is based solely upon the terms, conditions, limitations and exclusions in the Plan Document, which contains all of the provisions of your plan of benefits. You may call us concerning your claim at any time at 1-800-877-1122, or write to us at the address shown on the bottom of this form.

Plan design features (plan maximums, etc.) are determined solely at the discretion of the Plan Sponsor and cannot be appealed; however, if you do not agree with the decision made by the Plan regarding the specific benefit request described on the front of this document, the Plan provides two levels of review for reconsideration of the claim(s).

First Level of Review - The first level of review is done by the Plan Supervisor. You must file a written request for a review of the claims decision within one hundred eighty (180) days of the date of this notice. If you do not file a written request for review within one hundred eighty (180) days, your request for review will be denied. Your request should contain the reasons why you do not agree with the decision of the Plan, and along with your appeal, you should send any additional or supporting documentation you would like the Plan to review in order for the Plan to provide a full and fair reconsideration of the claim. You should send your written request and additional information to the address shown on the front of this document.

If you request a review within the 180-day period, the Plan Supervisor will review the claim. If the Plan needs additional information from you to reconsider the claim, the claims processing center will request the information needed from you, and you will have forty-five (45) days to provide it. Upon receipt of complete information from you, a decision will be provided to you within thirty (30) days from the date the Plan receives your request.

Second Level of Review - If you are not satisfied with the decision of the Plan Supervisor, you may appeal the decision to the Plan Administrator. To do so, you must file a written request for appeal within sixty (60) days after receiving the claim processing office's decision. If you do not file the written request within sixty (60) days, the Plan Administrator will not consider your appeal and the claim determination will become final. If you submit your request for appeal within sixty (60) days, the Plan Administrator will provide a final determination within thirty (30) days from the date the Plan receives your request. You have the right to bring a civil action under Section 502(1) of ERISA or other applicable law for non ERISA plans following an adverse benefit determination by the Plan Administrator on appeal.

Upon request, you or your authorized representative may request to review all of the information which was the basis for the denial of the disputed portion of the claim. You must submit your request for the information to the Plan at the address shown on the front of this document.

If you are covered under what is known as a Grandfathered Plan, you have no additional appeal rights other than those stated above.

If you are covered under what is known as a non-Grandfathered Plan, you may have an additional right to Independent External Review of appeals requiring medical expertise or involving issues of rescission of coverage, but only after you have utilized both levels of appeal described above.

To determine whether your coverage is through a non-Grandfathered plan you should consult your Summary Plan Description or your Plan Administrator.

After you exhaust the appeal process, you may also request and obtain an independent external review by an Independent Review Organization (IRO) . The review must be requested with a maximum of one hundred twenty (120) days after the final appeal decision of the Plan Administrator. The request for external review must be made in writing and sent to the Plan Supervisor at the address on the front of this document. The Plan Supervisor will forward your request to the IRO and provide you with additional information about the external review process. Please refer to your Certificate of Insurance or Summary Plan Description for further information.

All appeals should be mailed to P.O. Box 1269, Missoula, MT 59806