HealthSmart®

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 (see pages 4 to 9 for an example of an 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. Customer Service:
Contact information for HealthSmart Benefit Solutions in regards to claim processing.

4. Group Name:
The name of your group.

5. Group Number:
The identification number for your group. Please refer to this number if you call or write about your claim.

6. Location Number:
The number assigned to your location within the group.

7. Participant:
The name of the covered member.

8. Participant ID:
Member's NYSUT ID number (last 4 digits only). Refer to this ID Number if you call or write about your claim.

9. Plan Number:
The number assigned to your benefit plan within the group.

10. Paid Date:
If a check was issued, the date it was issued.

11. Contact Information For Reporting Suspected Fraudulent Activity:
If the services shown are incorrect, contact HealthSmart immediately.

12. Provider:
The name of the person, practice or facility that rendered the service or provided the supplies.

13. Dates of Service:
The date(s) on which services were rendered.

14. Procedure Code:
The medical billing codes listed on the provider's bill.

15. Amount Billed:
The charge for each service.

16. Charges Not Covered:
Charge that is not eligible for benefits under the plan. If there are charges not covered, they would be indicated in this section.

17. Remark Code:
Used to request additional information or provide further explanations of the claim payment (discounts applied, charges not covered, etc.).

18. Discount Amount:
Identifies the savings received from a Preferred Provider Organization (PPO), if applicable.

19. Allowed Amount:
Maximum allowed charge as determined by your benefit plan after subtracting Charges Not Covered and the Provider Discount from the Amount Billed.

20. Deductible Amount:
The amount of allowed charges that apply to your plan deductible that must be paid before benefits are payable.

21. Copay Amount:
The amount of allowed charges, specified by your plan, that you must pay before benefits are paid.

22. Covered Amount:
Eligible charges considered under your plan.

23. Paid At:
The percentage of the Covered Amount that will be considered under your benefit plan.

24. Payment Amount:
Benefits payable by the plan for services provided.

25. Column Totals:
The sum of each column.

26. Patient Responsibility:
After all benefits have been calculated, this is the amount of the participant's responsibility for this claim.

27. Other Credits or Adjustments:
Represents adjustments based upon the benefits of other health plans or insurance carriers, including Medicare.

28. Total Payment:
The sum of the "Payment Amount" column after other credits or adjustments are applied.

29. Paid To:
Individual, practice, or facility to whom benefits are paid.

30. Check Number:
The unique number assigned to the check.

31. Check Amount:
Total benefit amount paid on each claim processed in the period.

32. Remark Code Description:
Additional explanation of the Remark or Discount Code will appear in this section.

33. Plan Status:
Deductible/out of pocket status for the current year.

34. Going Green:
HealthSmart offers participants the option to receive electronic, paperless Explanation of Benefits (EOB) notifications.

35. Foreign Language Assistance:
Multilingual contact information.

36. Important Information:
Statement explaining your entitlement to a review of the benefit determination on the Explanation of Benefits (EOB). This information varies according to each plan.

Healthsmart Benefit Solutions
1 PO Box 1014
Charleston, WV 25324-1014

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

FNAMEA LNAMEA
2 107 MAIN STREET
CLIENTVILLE NY 10314

11 Your cooperation is needed to stop fraud!
If these services were not rendered,
please contact HealthSmart immediately at the number above.

3 **Customer Service**

Questions for Customer Service? Please call
844-552-7805
between the hours of
8:00am - 5:00pm EST, Monday thru Friday
Or visit us at healthsmart.com/nysut
Or write
HealthSmart Benefit Solutions, Inc.
P.O. Box 1014
Charleston, WV 25324-1014

Participant Information

4 **Group:** NYSUT TESTING PLANS
5 **Group No:** 5959
6 **Location:** 01
7 **Participant:** FNAMEA LNAMEA
8 **Participant ID:** XXXXX0002
9 **Plan No:** 01
10 **Paid Date:** 02/26/2018

Notice

For detailed payment information, visit healthsmart.com/nysut, click on “How to and Questions,” click on “Check Claim Status” and log in to the MyHealth portal, click on “Access My Benefits and Claims,” Select “Claims” on the home page to view all claims, or choose Advanced Search to filter for the claim in question. Select ”Claim Number” in the claim results box for details.

For the Period: 05/04/2017 thru 05/04/2017

Dear FNAMEA LNAMEA,

The information below is a summary of the claims you incurred for the period 05/04/2017 through 05/04/2017. This information is commonly referred to as an ***"Explanation Of Benefits" (EOB).*** **This is not a bill.** It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or noncovered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department number listed above.

Total Amount Billed

$42,697.57

This is the total amount billed for the dates of service of 05/04/2017 thru 05/04/2017.

Total Amount Paid By Plan

$6,856.00

This is the amount the plan paid in total for services rendered from 05/04/2017 thru 05/04/2017. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$35,841.57

This is the amount you may be responsible for after your various plans, including the Catastrophe Major Medical (CMM) Plan, have paid after processing your claim. Amounts shown in this section may reflect a balance due to your provider(s) following the processing of claims for each patient shown in the following claims detail.

Claim Summary For: FNAMEA

Dates of Service	Patient Name	Amount Billed	Not Covered	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Covered Amount	Payment Amount
01/30- 01/30/2017	FNAMEA	$710.00	$360.00	$0.00	$710.00	$0.00	$0.00	$710.00	$350.00
03/01- 03/30/2017	FNAMEA	$5,000.00	$2,912.00	$0.00	$5,000.00	$0.00	$0.00	$5,000.00	$2,088.00
02/01- 02/01/2017	FNAMEA	$1,017.00	$370.00	$0.00	$1,017.00	$0.00	$0.00	$1,017.00	$647.00
08/01- 08/15/2017	FNAMEA	$678.00	$50.00	$0.00	$678.00	$0.00	$0.00	$678.00	$628.00
03/06- 03/15/2017	FNAMEA	$9,500.00	$7,500.00	$0.00	$9,500.00	$0.00	$0.00	$9,500.00	$2,000.00
12/15- 12/15/2017	FNAMEA	$200.00	$0.00	$0.00	$200.00	$0.00	$0.00	$200.00	$200.00
02/01- 02/01/2017	FNAMEA	$750.00	$450.00	$0.00	$750.00	$0.00	$0.00	$750.00	$300.00
04/01- 04/01/2017	FNAMEA	$1,000.00	$600.00	$0.00	$1,000.00	$0.00	$0.00	$1,000.00	$400.00
09/16- 09/30/2017	FNAMEA	$743.00	$500.00	$0.00	$743.00	$0.00	$0.00	$743.00	$243.00
04/01- 04/30/2017	FNAMEA	$20,000.00	$20,000.00	$0.00	$20,000.00	$0.00	$0.00	$20,000.00	$0.00
	Totals	$39,598.00	$32,742.00	$0.00	$39,598.00	$0.00	$0.00	$39,598.00	$6,856.00

Claim Summary For: FNAMEA

Dates of Service	Patient Name	Amount Billed	Not Covered	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Covered Amount	Payment Amount
09/25- 09/25/2017	FNAMEA LNAMEA	$599.57	$0.00	$0.00	$599.57	$599.57	$0.00	$0.00	$0.00
01/01- 01/01/2017	FNAMEA LNAMEA	$500.00	$500.00	$0.00	$500.00	$0.00	$0.00	$500.00	$0.00
05/04- 05/04/2017	FNAMEA LNAMEA	$2,000.00	$2,000.00	$0.00	$2,000.00	$0.00	$0.00	$2,000.00	$0.00
	Totals	$3,099.57	$2,500.00	$0.00	$3,099.57	$599.57	$0.00	$2,500.00	$0.00

Claim #: 0000001
Patient: FNAMEA
Patient#: 1
(12) **Provider:** JESSE STOFF MD

(13) Dates of Service	(14) Proc. Code	(15) Amount Billed	(16) Not Covered	(17) Rmk Code	(18) Discount Amount	(19) Allowed Amount	(20) Deductible Amount	(21) Co-Pay Amount	(22) Covered Amount	(23) Paid At %	(24) Payment Amount
01/01- 01/01/17	80048	$25.00	$0.00		$0.00	$25.00	$0.00	$0.00	$25.00	100%	$25.00
01/01- 01/01/17	G0008	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	$50.00	100%	$50.00
01/01- 01/01/17	84153	$75.00	$0.00		$0.00	$75.00	$0.00	$0.00	$75.00	100%	$75.00
01/01- 01/01/17	99386	$200.00	$0.00		$0.00	$200.00	$0.00	$0.00	$200.00	100%	$200.00
01/02- 01/02/17	84153	$60.00	$60.00	G9	$0.00	$60.00	$0.00	$0.00	$60.00	0%	$0.00
01/20- 01/20/17	S9453	$150.00	$150.00	E	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
01/30- 01/30/17	99386	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
(25) Column Totals		$710.00	$360.00		$0.00	$710.00	$0.00	$0.00	$710.00		$350.00

(26) **Patient Responsibility:** $360.00
(27) **Other Credits or Adjustments** $0.00
(28) **Total Payment** $350.00

Claim #: 0000003
Patient: FNAMEA
Patient#: TEST
Provider: JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
03/01- 03/30/17	0581-	$5,000.00	$2,912.00	B9	$0.00	$5,000.00	$0.00	$0.00	$5,000.00	100%	$2,088.00
Column Totals		$5,000.00	$2,912.00		$0.00	$5,000.00	$0.00	$0.00	$5,000.00		$2,088.00

Patient Responsibility: $2,912.00
Other Credits or Adjustments $0.00
Total Payment $2,088.00

Claim #: 0000004
Patient: FNAMEA
Patient#: TEST
Provider: JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
01/01- 01/01/17	77061	$220.00	$0.00		$0.00	$220.00	$0.00	$0.00	$220.00	100%	$220.00
01/01- 01/01/17	88150	$30.00	$0.00		$0.00	$30.00	$0.00	$0.00	$30.00	100%	$30.00

Claim #: 0000004 **Patient#:** TEST
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
01/01- 01/01/17	99396	$247.00	$0.00		$0.00	$247.00	$0.00	$0.00	$247.00	100%	$247.00
02/01- 02/01/17	77061	$220.00	$220.00	G9	$0.00	$220.00	$0.00	$0.00	$220.00	0%	$0.00
02/01- 02/01/17	88143	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
02/01- 02/01/17	99396	$150.00	$0.00		$0.00	$150.00	$0.00	$0.00	$150.00	100%	$150.00
	Column Totals	$1,017.00	$370.00		$0.00	$1,017.00	$0.00	$0.00	$1,017.00		$647.00

Patient Responsibility: $370.00

Other Credits or Adjustments $0.00
Total Payment $647.00

Claim #: 0000006 **Patient#:** TEST
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
06/01- 06/05/17	G0108	$172.00	$0.00		$0.00	$172.00	$0.00	$0.00	$172.00	100%	$172.00
06/06- 06/09/17	G0270	$156.00	$0.00		$0.00	$156.00	$0.00	$0.00	$156.00	100%	$156.00
06/09- 06/15/17	G0447	$100.00	$0.00		$0.00	$100.00	$0.00	$0.00	$100.00	100%	$100.00
06/15- 06/29/17	G0446	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	$50.00	100%	$50.00
07/01- 07/02/17	G0270	$50.00	$50.00	N9	$0.00	$50.00	$0.00	$0.00	$50.00	0%	$0.00
07/15- 07/20/17	98962	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	$50.00	100%	$50.00
07/20- 07/30/17	G0446	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	$50.00	100%	$50.00
08/01- 08/15/17	G0109	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	$50.00	100%	$50.00
	Column Totals	$678.00	$50.00		$0.00	$678.00	$0.00	$0.00	$678.00		$628.00

Patient Responsibility: $50.00

Other Credits or Adjustments $0.00
Total Payment $628.00

Claim #: 0000013 **Patient#:** TEST
Patient: FNAMEA **Provider:** MCDONOUGH CAPERTON

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
01/01- 01/05/17	0559-	$500.00	$500.00	E	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
01/06- 01/12/17	0551-	$500.00	$68.00	Y2	$0.00	$500.00	$0.00	$0.00	$500.00	100%	$432.00
01/13- 01/16/17	0551-	$500.00	$500.00	E	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
01/17- 01/30/17	0581-	$1,500.00	$564.00	Y2	$0.00	$1,500.00	$0.00	$0.00	$1,500.00	100%	$936.00
02/01- 02/06/17	0581-	$500.00	$500.00	E	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
02/07- 02/15/17	0559-	$1,500.00	$924.00	Y2	$0.00	$1,500.00	$0.00	$0.00	$1,500.00	100%	$576.00
02/16- 02/20/17	0559-	$1,500.00	$1,500.00	E	$0.00	$1,500.00	$0.00	$0.00	$1,500.00	0%	$0.00
03/01- 03/05/17	0551-	$1,500.00	$1,444.00	B9	$0.00	$1,500.00	$0.00	$0.00	$1,500.00	100%	$56.00
03/06- 03/15/17	0551-	$1,500.00	$1,500.00	E	$0.00	$1,500.00	$0.00	$0.00	$1,500.00	0%	$0.00
	Column Totals	$9,500.00	$7,500.00		$0.00	$9,500.00	$0.00	$0.00	$9,500.00		$2,000.00

Patient Responsibility: $7,500.00

Other Credits or Adjustments $0.00
Total Payment $2,000.00

Claim #: 0000047 **Patient#:** 1
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
12/15- 12/15/17	G8482	$50.00	$0.00		$0.00	$50.00	$0.00	$0.00	$50.00	100%	$50.00
12/15- 12/15/17	99213	$150.00	$0.00		$0.00	$150.00	$0.00	$0.00	$150.00	100%	$150.00
	Column Totals	$200.00	$0.00		$0.00	$200.00	$0.00	$0.00	$200.00		$200.00

Patient Responsibility: $0.00

Other Credits or Adjustments $0.00
Total Payment $200.00

Claim #: 0000104 **Patient#:** TEST
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
01/01- 01/01/17	80048	$150.00	$0.00		$0.00	$150.00	$0.00	$0.00	$150.00	100%	$150.00
01/01- 01/01/17	G0008	$150.00	$150.00	E	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
01/01- 01/01/17	84153	$150.00	$150.00	E G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
01/02- 01/02/17	99386	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
02/01- 02/01/17	S9453	$150.00	$0.00		$0.00	$150.00	$0.00	$0.00	$150.00	100%	$150.00
	Column Totals	$750.00	$450.00		$0.00	$750.00	$0.00	$0.00	$750.00		$300.00

Patient Responsibility: $450.00

Other Credits or Adjustments $0.00
Total Payment $300.00

Claim #: 0000111 **Patient#:** TEST
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
03/01- 03/01/17	77061	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
03/01- 03/01/17	88143	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
03/01- 03/01/17	99396	$200.00	$0.00		$0.00	$200.00	$0.00	$0.00	$200.00	100%	$200.00
04/01- 04/01/17	77061	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
04/01- 04/01/17	88143	$150.00	$150.00	G9	$0.00	$150.00	$0.00	$0.00	$150.00	0%	$0.00
04/01- 04/01/17	99396	$200.00	$0.00		$0.00	$200.00	$0.00	$0.00	$200.00	100%	$200.00
	Column Totals	$1,000.00	$600.00		$0.00	$1,000.00	$0.00	$0.00	$1,000.00		$400.00

Patient Responsibility: $600.00

Other Credits or Adjustments $0.00
Total Payment $400.00

Claim #: 0000112 **Patient#:** TEST
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
08/01- 08/10/17	G0108	$250.00	$250.00	N9	$0.00	$250.00	$0.00	$0.00	$250.00	0%	$0.00
08/11- 08/31/17	G0109	$250.00	$250.00	N9	$0.00	$250.00	$0.00	$0.00	$250.00	0%	$0.00
09/01- 09/15/17	G0446	$100.00	$0.00		$0.00	$100.00	$0.00	$0.00	$100.00	100%	$100.00
09/16- 09/30/17	G0270	$143.00	$0.00		$0.00	$143.00	$0.00	$0.00	$143.00	100%	$143.00
	Column Totals	$743.00	$500.00		$0.00	$743.00	$0.00	$0.00	$743.00		$243.00

Patient Responsibility: $500.00

Other Credits or Adjustments $0.00
Total Payment $243.00

Claim #: 0000115 **Patient#:** TEST
Patient: FNAMEA **Provider:** JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
01/01- 01/30/17	0551-	$5,000.00	$5,000.00	B9	$0.00	$5,000.00	$0.00	$0.00	$5,000.00	0%	$0.00
02/01- 02/28/17	0581-	$5,000.00	$5,000.00	B9	$0.00	$5,000.00	$0.00	$0.00	$5,000.00	0%	$0.00
03/01- 03/31/17	0559-	$5,000.00	$5,000.00	B9	$0.00	$5,000.00	$0.00	$0.00	$5,000.00	0%	$0.00
04/01- 04/30/17	0551-	$5,000.00	$5,000.00	B9	$0.00	$5,000.00	$0.00	$0.00	$5,000.00	0%	$0.00
	Column Totals	$20,000.00	$20,000.00		$0.00	$20,000.00	$0.00	$0.00	$20,000.00		$0.00

Patient Responsibility: $20,000.00

Other Credits or Adjustments $0.00
Total Payment $0.00

Claim #: 0000055 **Patient#:** 1
Patient: FNAMEA LNAMEA **Provider:** HOME

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount

Claim #: 0000055
Patient: FNAMEA LNAMEA
Patient#: 1
Provider: HOME

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
09/25- 09/25/17	99199	$599.57	$0.00		$0.00	$599.57	$599.57	$0.00	$0.00	0%	$0.00
	Column Totals	$599.57	$0.00		$0.00	$599.57	$599.57	$0.00	$0.00		$0.00
Patient Responsibility:		$599.57							Other Credits or Adjustments		$0.00
									Total Payment		$0.00

Claim #: 0000114
Patient: FNAMEA LNAMEA
Patient#: TEST
Provider: JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
01/01- 01/01/17	99199	$500.00	$500.00	DE	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
	Column Totals	$500.00	$500.00		$0.00	$500.00	$0.00	$0.00	$500.00		$0.00
Patient Responsibility:		$500.00							Other Credits or Adjustments		$0.00
									Total Payment		$0.00

Claim #: 0000116
Patient: FNAMEA LNAMEA
Patient#: TEST
Provider: JESSE STOFF MD

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Covered Amount	Paid At %	Payment Amount
05/01- 05/01/17	99199	$500.00	$500.00	DE	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
05/02- 05/02/17	99199	$500.00	$500.00	DE	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
05/03- 05/03/17	99199	$500.00	$500.00	DE	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
05/04- 05/04/17	99199	$500.00	$500.00	DE	$0.00	$500.00	$0.00	$0.00	$500.00	0%	$0.00
	Column Totals	$2,000.00	$2,000.00		$0.00	$2,000.00	$0.00	$0.00	$2,000.00		$0.00
Patient Responsibility:		$2,000.00							Other Credits or Adjustments		$0.00
									Total Payment		$0.00

29 Payment Details

Paid To	30 Check No.	31 Amount
JESSE STOFF MD		$0.00
JESSE STOFF MD	0000000000001037	$200.00
FNAMEA LNAMEA	0000000000001042	$350.00
FNAMEA LNAMEA	0000000000001043	$2,088.00
FNAMEA LNAMEA	0000000000001044	$647.00
FNAMEA LNAMEA	0000000000001045	$628.00
FNAMEA LNAMEA	0000000000001046	$2,000.00
FNAMEA LNAMEA	0000000000001047	$300.00
FNAMEA LNAMEA	0000000000001048	$400.00
FNAMEA LNAMEA	0000000000001049	$243.00

32 Remark Code Description

B9	CARE IS LIMITED TO $72 PER DAY AND $80,000 PER LIFETIME.
DE	SERVICES ARE NOT PAYABLE FOR THE DIAGNOSIS STATED.
E	PROCEDURE FEE EXCEEDS REASONABLE AND CUSTOMARY ALLOWANCE PER PLAN.
G9	CHARGES ARE LIMITED TO 1 VISIT PER YEAR.
N9	CHARGES ARE LIMITED TO 26 VISITS PER YEAR.
Y2	BENEFITS FOR THIS SERVICE ARE LIMITED BY THE PLAN

33 Plan Status

Deductible Information	To Date	Remaining
FAMILY DEDUCTIBLE	$0.00	$5,000.00
FAMILY OUT OF POCKET	$0.00	$14,700.00
INDIVIDUAL DEDUCTIBLE	$599.57	$4,400.43
INDIVIDUAL OUT OF POCKET	$0.00	$7,350.00

34 Going Green

Did you know you can choose to GO GREEN with our paperless option? Access www.healthsmart.com/healthsmartcustomers/members.aspx and login to opt out of receiving the paper version on future claims. You will receive an email notification when a claim has been processed and ready for viewing online. Our web site also provides you the ability to print copies of your EOBs as needed in a secure environment.

35 Foreign Language Assistance

Spanish (Español): Para obtener asistencia en español, comuníquese con el número anterior.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa mangyaring sa numero na nasa itaas.
Chinese (中文):要獲得中文幫助, 請聯繫上面的電話號碼.
Navajo (Dine): Navajo: Dinek'ehgo shika atohwol ninisingo, kwiijigo holne béésh bee hane' é binumber bikáá ' ígíí bish '.

36 Appeal Rights

Please refer to the CMM Plan Document for Plan details, including your appeal rights. Reconsideration of your claim will be subject to all Plan guidelines.To obtain a review, submit your request in writing to HealthSmart Benefit Solutions, Inc., PO Box 1014, Charleston, WV 25324-1014. You may request the diagnosis and treatment codes (and their meanings) if needed for your appeal. Your request should include your name and address, Participant ID, claim number, the reason for appealing and any data, documents and comments you would like to have considered. Written requests for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol, or an explanation of the clinical judgment for determination will be provided without charge, upon request. 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 requested or you do not receive a timely decision, you may be able to request an external review of your claim to review the denial and issue a final decision. For questions about your appeal rights, this notice, or for assistance, you can contact Customer Service at 1-844-552-7805.