IU Health Plans
PO Box XXX
City State Zip

mailing information - please
make sure this will fit in window

Need to update your information or have Questions?

If you need to update your mailing address or have questions regarding this document or your benefits, visit our website at iuhealthplans.org or call the number below:

[(000) 000-0000]

Subscriber Name:
Member ID #: [00000000000]
Member Name:
Plan Name: IUHLTH
Group Name: IU Health
EOB Printed Date: 11/09/16

Explanation of Benefits - This is not a bill.

An Explanation of Benefits (EOB) summarizes a recent claim for services received and filed with your insurance plan, the cost associated with those services, and who is responsible for paying those costs. Your healthcare provider or facility may bill you directly for any amount owed.

To ensure you have a good record of your health care expenses for the year and there are no errors or incorrect charges against your IU Health Plans benefits, keep your EOBs for your records along with any other health care bills. You can also access your EOB online via the IU Health Plans member portal at www.iuhealthplans.org.

Summary of Claim(s) Submitted (individual claims are included following this page)

	Term:	This Means:	Your Totals:
PLAN DISCOUNTS	**Billed Amount**	This is the amount your provider billed to your plan for the services you received. *Please Note: this amount does not reflect discounts the plan has negotiated with your provider.*	$0.00
	Allowed Amount	This is the payment amount that IU Health Plans and your provider have agreed will be accepted for the type of services you received.	$0.00
	Adjusted Amount	This is the difference between the Billed Amount and Allowed Amount. This represents your savings based on the rate IU Health Plans has negotiated with your provider.	$0.00
PLAN PAID	**IU Health Plans Paid**	This is the amount IU Health Plans paid to **your provider.**	$0.00
	Other Insurance Paid	This is the amount paid by your other insurance carrier, if you have one, to your provider.	$0.00
MEMBER RESPONSIBILITY	**Deductible**	This is the amount applied to the yearly deductible amount you are responsible for paying before IU Health Plans begins to pay for your covered services. *Please Note: "Non-Covered" amounts will not count towards meeting the yearly deductible and your provider may bill you directly for these charges.*	$0.00
	Co-pay	This is the fee you are responsible to pay for certain services per your health plan.	$0.00
	Co-insurance	This is the percentage of the Allowed Amount you are responsible for after your yearly deductible has been met	$0.00
	Non-Covered	This is the amount you are responsible for paying because a service was non-covered by your plan, or a provider or facility was outside of IU Health Plans' network.	$0.00
	Amount You Owe	This is the amount you may be responsible for paying. *Please Note: This may not include co-pays.*	$0.00

Plan Status (for 1/1/16 - 12/31/16)

These totals are correct as of the last claim shown on this document. If you received services more recently, unprocessed claims for those services will not yet be reflected in the totals shown here. Check your IU Health Plans member portal for your most up-to-date claims.

Individual Deductible: This is the amount applied to your individual deductible for the plan year.

$0.00 of $1500 met for your Tier 1 Calendar Year Deductible (In-Network Benefits)

$0.00 of $2000 met for your Tier 2 Calendar Year Deductible (Secondary Network Benefits)

$0.00 of $2500 met for your Tier 3 Calendar Year Deductible (Out of Network)

Individual Out of Pocket Max: This is the amount applied to your individual out of pocket max for the plan year.

$0.00 of $1500 met for your Tier 1 Calendar Year Deductible (In-Network Benefits)

$0.00 of $2000 met for your Tier 2 Calendar Year Deductible (Secondary Network Benefits)

$0.00 of $2500 met for your Tier 3 Calendar Year Deductible (Out of Network)

Family Deductible: This is the amount applied to your family deductible for the plan year.

$0.00 of $3750 met for your Tier 1 Calendar Year Max Out of Pocket (In-Network Benefits)

$0.00 of $5500 met for your Tier 2 Calendar Year Max Out of Pocket (Secondary Network Benefits)

$0.00 of $6500 met for your Tier 3 Calendar Year Max Out of Pocket (Out of Network)

Family Out of Pocket Max: This is the amount applied to your family out of pocket max for the plan year.

$514.54 of $3750 met for your Tier 1 Calendar Year Max Out of Pocket (In-Network Benefits)

$514.54 of $5500 met for your Tier 2 Calendar Year Max Out of Pocket (Encore Benefits)

$514.54 of $6500 met for your Tier 3 Calendar Year Max Out of Pocket (Out of Network)

Health Plans

Service Dates: 11/02/16 - 11/10/16
Member ID #: 00000000000
Plan Name: IUHLTH
Group Name: IU Health
EOB Printed Date: 11/09/16

Claim Detail: Below is a detailed view of your recently submitted claims

Claim #: 0003948522 for services provided at GROUP NAME

Service Dates	Procedure Code	Benefit Description	Explanation Code	Billed Amount	Allowed Amount	Adjusted Amount	Deductible	Co-Pay	Co-Insurance	Non-Covered	IU Health Plans Paid	Other Insurance Paid	Amount You Owe
11/02/16	99213	Office or Outpatient Visit	1,2,3	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11/02/16	87804	Influenza Assay with OPTIC	1,2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
			Statement Totals	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Explanation Code Description

Explanation Code	Description
1	$75.79 deductible was applied toward your Individual Tier 1 $1500 Calendar Year Deductible
2	$75.79 was applied toward your Individual Tier 1 $3750 Calendar Year Out Off Pocket Maximum (OOP)
3	$75.79 was applied toward your Family Tier 1 $750 Calendar Year Out Off Pocket Maximum (OOP)

What if I need to make an appeal to a claim?

If you disagree with the decision on your claim, you (or a representative you have authorized) may file a written appeal. The appeal will need to be filed within the timeframes allowed by your specific plan, generally within 180 days of the denial of your claim.

Your appeal must give the reason(s) you believe the claim was improperly denied and include any additional relevant information or documents in support of your appeal. Failure to file a timely appeal may prevent you from any further review of this benefit decision in State or Federal Court of Law. Send your appeal to: IU Health Plans, 950 N. Meridian Street, Suite 200, Indianapolis, IN 46204, Attention: Appeals.

IU Health Plans will notify you of the decision on your request no later than 60 days from the date your request is received. To access your complete Member Contract, sign-in to the IU Health Plans Member Portal at www.iuhealthplans.org. Once logged in, click on ‘My Plan Documents’.

Upon your request, you are entitled to receive, free of charge, copies of all documents, records, and the identity of medical or vocational experts consulted by the Plan in determining benefits. In lieu of copies, you may be given reasonable access to the documents.