Sample H

TEMPLATE 1:
SINGLE OOP HMO

EXPLANATION OF BENEFITS /MEMBER

DATE PREPARED: 11/10/XXXX PAGE 1

The Explanation Of Benefits (EOB) lists those services that have been billed to us by the provider(s) listed below processed according to the terms of your policy; and for which you have some personal financial responsibility as detailed below. Services paid in full will not be listed.

Dean Health Plan, Inc.
P.O. Box 56099
Madison WI 53705-9399
Customer Care Center
(608) 828-1301 OR (800) 279-1301

000853-000001-000002-001705 2403453 1720 EB012

COVERAGE CONTRACT: 000777777
DIVISION NUMBER: P004
CONTRACT YEAR: XXXX

John Q Member
123 Main St
Madison, WI 53714

MEMBER NAME: **MEMBER NUMBER:**

Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible Amount	Copay-ment Amount	Coinsurance Amount	Remarks See Explanation Below	Amount Paid*
PROVIDER NUMBER/NAME: **XXXXXXXXXX/Dr Smith**						ACCOUNT NUMBER: XXXXXXXX		CLAIM NUMBER: XXXXXXXXXX		
01 99283	**EMERGENCY DEPARTMENT**	**XX/XX/XX**	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**	**111 222 333 444**	**0.00**
		TOTALS:	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**		**0.00**

TOTAL PATIENT RESPONSIBILITY **59.64**

REMARKS
111 **(MED) MEDICARE COMMERCIAL ACCEPT ASSIGNMENT SECONDARY EQUATION**
222 **CONTRACTED RATE**
333 **MEDICAL EXACT DUPE - 1**
444 **ADDITIONAL REASON CODE**

* **THIS AMOUNT HAS BEEN PAID TO THE PROVIDER UNLESS A CHECK HAS BEEN SENT TO YOU.**

	DEDUCTIBLE	YEAR TO DATE	REMAINDER	OUT OF POCKET	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2000	57.90	1942.10

Complete details of your claim(s), including a break-down of charges and member payment responsibility are available on Secure Access to Member Tools at deanconnect.com. To access Secure Access to Member Tools go to deanconnect.com and click on the Secure Access to Member Tools logo in the upper-right corner. Once you are logged into Secure Access to Member Tools click on Claims Itemization to view your EOB details. If you do not have a Secure Access to Member Tools account you may register and receive a password immediately via email. You may also request, free of charge, any provisions or criterion used to make this payment determination.

TEMPLATE 2: SINGLE OOP PPO & POS

EXPLANATION OF BENEFITS /MEMBER

DATE PREPARED: 11/10/XXXX PAGE 1

The Explanation Of Benefits (EOB) lists those services that have been billed to us by the provider(s) listed below processed according to the terms of your policy; and for which you have some personal financial responsibility as detailed below. Services paid in full will not be listed.

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Customer Care Center
(608) 828-1301 OR (800) 279-1301

000853-000001-000002-001705 2403453 1720 EB012

John Q Member
123 Main St
Madison, WI 53714

COVERAGE CONTRACT: 000777777
DIVISION NUMBER: P004
CONTRACT YEAR: XXXX

MEMBER NAME: **MEMBER NUMBER:**

Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible Amount	Copay-ment Amount	Coinsurance Amount	Remarks See Explanation Below	Amount Paid*
PROVIDER NUMBER/NAME: **XXXXXXXXX/Dr Smith**						ACCOUNT NUMBER: XXXXXXXXX		CLAIM NUMBER: XXXXXXXXXXXX		
01 99283	**EMERGENCY DEPARTMENT**	**02/XX/XX**	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**	**111 222 333 444**	**0.00**
		TOTALS:	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**		**0.00**

TOTAL PATIENT RESPONSIBILITY **59.64**

REMARKS
111 **(MED) MEDICARE COMMERCIAL ACCEPT ASSIGNMENT SECONDARY EQUATION**
222 **CONTRACTED RATE**
333 **MEDICAL EXACT DUPE - 1**
444 **ADDITIONAL REASON CODE**

* **THIS AMOUNT HAS BEEN PAID TO THE PROVIDER UNLESS A CHECK HAS BEEN SENT TO YOU.**

In Network	DEDUCTIBLE	YEAR TO DATE	REMAINDER	OUT OF POCKET	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2000	57.90	1942.10
Out of Network	DEDUCTIBLE	YEAR TO DATE	REMAINDER	OUT OF POCKET	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2000	57.90	1942.10

Complete details of your claim(s), including a break-down of charges and member payment responsibility are available on Secure Access to Member Tools at deanconnect.com. To access Secure Access to Member Tools go to deanconnect.com and click on the Secure Access to Member Tools logo in the upper-right corner. Once you are logged into Secure Access to Member Tools click on Claims Itemization to view your EOB details. If you do not have a Secure Access to Member Tools account you may register and receive a password immediately via email. You may also request, free of charge, any provisions or criterion used to make this payment determination.

TEMPLATE 3: RX DEDUCTIBLE

EXPLANATION OF BENEFITS /MEMBER

DATE PREPARED: 11/10/XXXX PAGE 1

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Customer Care Center
(608) 828-1301 OR (800) 279-1301

000853-000001-000002-001705 2403453 1720 EB012

COVERAGE CONTRACT: 000777777
DIVISION NUMBER: P004
CONTRACT YEAR: XXXX

John Q Member
123 Main St
Madison, WI 53714

MEMBER NAME: **MEMBER NUMBER:**

Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible Amount	Copay-ment Amount	Coinsurance Amount	Remarks See Explanation Below	Amount Paid*
PROVIDER NUMBER/NAME: **XXXXXXXXX/Dr Smith**					ACCOUNT NUMBER: XXXXXXXXX			CLAIM NUMBER: XXXXXXXXXXX		
01 99283	**EMERGENCY DEPARTMENT**	**XX/XX/XX**	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**	**111 222 333 444**	**0.00**
		TOTALS:	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**		**0.00**

TOTAL PATIENT RESPONSIBILITY **59.64**

REMARKS
111 **(MED) MEDICARE COMMERCIAL ACCEPT ASSIGNMENT SECONDARY EQUATION**
222 **CONTRACTED RATE**
333 **MEDICAL EXACT DUPE - 1**
444 **ADDITIONAL REASON CODE**

*** THIS AMOUNT HAS BEEN PAID TO THE PROVIDER UNLESS A CHECK HAS BEEN SENT TO YOU.**

In Network	MEDICAL DEDUCT	YEAR TO DATE	REMAINDER	PHARMACY DEDUCT	YEAR TO DATE	REMAINDER	OUT OF POCKET	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1500	500	1000	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2500	500	2000	2000	57.90	1942.10
Out of Network	MEDICAL DEDUCT	YEAR TO DATE	REMAINDER	PHARMACY DEDUCT	YEAR TO DATE	REMAINDER	OUT OF POCKET	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	NA	NA	NA	1000	57.90	942.10
FAMILY	1000	57.90	942.10	NA	NA	NA	2000	57.90	1942.10

Complete details of your claim(s), including a break-down of charges and member payment responsibility are available on Secure Access to Member Tools at deanconnect.com. To access Secure Access to Member Tools go to deanconnect.com and click on the Secure Access to Member Tools logo in the upper-right corner. Once you are logged into Secure Access to Member Tools click on Claims Itemization to view your EOB details. If you do not have a Secure Access to Member Tools account you may register and receive a password immediately via email. You may also request, free of charge, any provisions or criterion used to make this payment determination.

TEMPLATE 4: DUAL OOP PPO & POS

EXPLANATION OF BENEFITS /MEMBER

DATE PREPARED: 11/10/XXXX PAGE 1

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Madison WI 53705-9399
Customer Care Center
(608) 828-1301 OR (800) 279-1301

000853-000001-000002-001705 2403453 1720 EB012

COVERAGE CONTRACT: 000777777
DIVISION NUMBER: P004
CONTRACT YEAR: XXXX

John Q Member
123 Main St
Madison, WI 53714

MEMBER NAME: **MEMBER NUMBER:**

Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible Amount	Copay-ment Amount	Coinsurance Amount	Remarks See Explanation Below	Amount Paid*
PROVIDER NUMBER/NAME: **XXXXXXXXX/Dr Smith**						ACCOUNT NUMBER: XXXXXXXXX		CLAIM NUMBER: XXXXXXXXXXX		
01 99283	**EMERGENCY DEPARTMENT**	**XX/XX/XX**	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**	**111 222 333 444**	**0.00**
		TOTALS:	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**		**0.00**

TOTAL PATIENT RESPONSIBILITY **59.64**

REMARKS
111 **(MED) MEDICARE COMMERCIAL ACCEPT ASSIGNMENT SECONDARY EQUATION**
222 **CONTRACTED RATE**
333 **MEDICAL EXACT DUPE - 1**
444 **ADDITIONAL REASON CODE**

* **THIS AMOUNT HAS BEEN PAID TO THE PROVIDER UNLESS A CHECK HAS BEEN SENT TO YOU.**

In Network	DEDUCTIBLE	YEAR TO DATE	REMAINDER	DEDUCT/CO-INS LIMIT	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2000	57.90	1942.10
Out of Network	DEDUCTIBLE	YEAR TO DATE	REMAINDER	DEDUCT/CO-INS LIMIT	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2000	57.90	1942.10

In Network	MEDICAL MAX OOP	YEAR TO DATE	REMAINDER
INDIVIDUAL	6350	250	6100
FAMILY	12700	250	12450

The following definitions critical for understanding your annual limits have been provided for you below.

Deductible: Covered Expenses the Member and/or family must pay each Contract Period before Dean will pay for Covered Expenses.

Deductible and Coinsurance Limit: Includes Deductible and Coinsurance amounts for medical expenses that a Member or family is required to pay when a covered service is provided.

Out-of-Pocket Expense Maximum: Maximum expenses for medical services the Member and/or Family is required to pay.

More definitions are available in the EOB definitions section. Complete details of your claim(s), including a break-down of charges and member payment responsibility are available on Secure Access to Member Tools at deanconnect.com. To access Secure Access to Member Tools go to deanconnect.com and click on the Secure Access to Member Tools logo in the upper-right corner. Once you are logged into Secure Access to Member Tools click on Claims Itemization to view your EOB details. If you do not have a Secure Access to Member Tools account you may register and receive a password immediately via email. You may also request, free of charge, any provisions or criterion used to make this payment determination.

TEMPLATE 5:
DUAL OOP HMO

EXPLANATION OF BENEFITS /MEMBER

DATE PREPARED: 11/10/XXXX PAGE 1

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Customer Care Center
(608) 828-1301 OR (800) 279-1301

000853-000001-000002-001705 2403453 1720 EB012

COVERAGE CONTRACT: 000777777
DIVISION NUMBER: P004
CONTRACT YEAR: XXXX

John Q Member
123 Main St
Madison, WI 53714

MEMBER NAME: **MEMBER NUMBER:**

Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible Amount	Copay-ment Amount	Coinsurance Amount	Remarks See Explanation Below	Amount Paid*
PROVIDER NUMBER/NAME: **XXXXXXXXXX/Dr Smith**						ACCOUNT NUMBER: XXXXXXXXX		CLAIM NUMBER: XXXXXXXXXXX		
01 99283	**EMERGENCY DEPARTMENT**	**XX/XX/XX**	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**	**111 222 333 444**	**0.00**
		TOTALS:	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**		**0.00**

TOTAL PATIENT RESPONSIBILITY **59.64**

REMARKS
111 **(MED) MEDICARE COMMERCIAL ACCEPT ASSIGNMENT SECONDARY EQUATION**
222 **CONTRACTED RATE**
333 **MEDICAL EXACT DUPE - 1**
444 **ADDITIONAL REASON CODE**

*** THIS AMOUNT HAS BEEN PAID TO THE PROVIDER UNLESS A CHECK HAS BEEN SENT TO YOU.**

	DEDUCTIBLE	YEAR TO DATE	REMAINDER	DEDUCT/CO-INS LIMIT	YEAR TO DATE	REMAINDER
INDIVIDUAL	500	57.90	442.10	1000	57.90	942.10
FAMILY	1000	57.90	942.10	2000	57.90	1942.10

In Network	MEDICAL MAX OOP	YEAR TO DATE	REMAINDER
INDIVIDUAL	6350	250	6100
FAMILY	12700	250	12450

The following definitions critical for understanding your annual limits have been provided for you below.

Deductible: Covered Expenses the Member and/or family must pay each Contract Period before Dean will pay for Covered Expenses.

Deductible and Coinsurance Limit: Includes Deductible and Coinsurance amounts for medical expenses that a Member or family is required to pay when a covered service is provided.

Out-of-Pocket Expense Maximum: Maximum expenses for medical services the Member and/or Family is required to pay.

More definitions are available in the EOB definitions section. Complete details of your claim(s), including a break-down of charges and member payment responsibility are available on Secure Access to Member Tools at deanconnect.com. To access Secure Access to Member Tools go to deanconnect.com and click on the Secure Access to Member Tools logo in the upper-right corner. Once you are logged into Secure Access to Member Tools click on Claims Itemization to view your EOB details. If you do not have a Secure Access to Member Tools account you may register and receive a password immediately via email. You may also request, free of charge, any provisions or criterion used to make this payment determination.

TEMPLATE 6: MEDICAID (no change)

EXPLANATION OF BENEFITS /MEMBER

DATE PREPARED: 11/10/2013 PAGE 1

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Customer Care Center
(608) 828-1301 OR (800) 279-1301

000853-000001-000002-001705 2403453 1720 EB012

John Q Member
123 Main St
Madison, WI 53714

COVERAGE CONTRACT: 000777777
DIVISION NUMBER: P004
CONTRACT YEAR: 2XXX

MEMBER NAME: **MEMBER NUMBER:**

Services	Description of Services	Service Date	Provider Charge	Amount Allowed	Amount Not Covered	Deductible Amount	Copay-ment Amount	Coinsurance Amount	Remarks See Explanation Below	Amount Paid*
PROVIDER NUMBER/NAME: **XXXXXXXXXX/Dr Smith**					ACCOUNT NUMBER: XXXXXXXXXX			CLAIM NUMBER: XXXXXXXXXX		
01 99283	**EMERGENCY DEPARTMENT**	**XX/XX/XX**	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**	**111 222 333 444**	**0.00**
		TOTALS:	**59.64**	**59.64**	**59.64**	**0.00**	**0.00**	**0.00**		**0.00**

TOTAL PATIENT RESPONSIBILITY **59.64**

REMARKS
111 **(MED) MEDICARE COMMERCIAL ACCEPT ASSIGNMENT SECONDARY EQUATION**
222 **CONTRACTED RATE**
333 **MEDICAL EXACT DUPE - 1**
444 **ADDITIONAL REASON CODE**

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