HEALTH PLANS
UNIVERSITY OF UTAH

EXPLANATION OF BENEFITS

Patient Name Member ID: 00000000000
Group: HEALTHY PREFERRED HDHP PPO

1

Claim Information
Reference Number: ABC-0000000
Date: 1/1/19
Provider: Provider Name
Service location: No Location/POS specified
Paid to: Hospital

Total cost of services	150.00
Plan Savings	-129.70
Covered by this plan	-10.30
Total expected cost	10.00

4

This is not a bill. There is no payment due for these services at this time.

2

Service Details

3

Date	Service	a. Billed	b. Allowed	c. Not Covered	d. Copay	d. De ductible	d. Co Insurance	e. Reason Code	Patient Total
1/1/19	Established patient office or other outpatient visit, Level I	150.00	20.30	0.00	10.00	0.00	0.00	C	10.00
	Claim Totals:	**150.00**	**20.30**	**0.00**	**10.00**	**0.00**	**0.00**		**10.00**

Code Summary

C - Contracted Rate Payment

1 ACCOUNT SUMMARY

Lists your account information with details like the patient's name, date/s, and claim number

2 CLAIM DETAILS

A list of the dates we provided the service and a description of the service

3 AMOUNTS

a. **Amount billed:** Cost of the services provided
b. **Allowed amount:** The amount your insurance has agreed to pay per their contract with the provider/facility, this reflects any money you saved by accessing care or medical products from within your plan's network of providers. This can usually be seen in section 4 as well.
c. **Amount not covered:** What costs your health plan did not cover
d. **Copayment/Deductible/Coinsurance amounts:** What you are responsible to pay toward these service, according to your plan.
e. **Reason Code:** Describes the type of payment made or a reason for a denial.

4 AMOUNT OF RESPONSIBILITY

You may be responsible to pay a portion of the charges/service costs to the provider or facility.

This may include copay, coinsurance, deductible or non-covered charges.