IPMG
INSURANCE PROGRAM MANAGERS GROUP

Insurance Program Managers Group
225 Smith Road
St. Charles IL 60174-5208

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********SNGLP
5 1 SP 0.490 1
JOHN SAMPLE
1234 MAIN ROAD
SAINT CHARLES IL 60174-5208

1 Customer Service Information

For questions regarding your EOB, please contact Customer Service (800) 423-1841 Monday - Friday 8:00 AM - 5:00 PM www.ipmg.com

Employee Name:	SAMPLE, JOHN
Patient:	JOHN A SAMPLE
Member ID:	123-123456789
Group Name:	SAMPLE GROUP
Group ID:	ABC
Network:	
Location #:	000001
Claim #:	20140101
Check #:	
Processed Date:	01/01/14
Voucher #:	

Patient: JOHN SAMPLE
Claim #: 20140101

Account #: 987654321
Provider: SAMPLE PROVIDER, MD

2 Service Dates	3 Description of Service	4 Total Charge	5 Reduced By	6 Code	7 Not Covered	8 Code	9 Deductible Amount	10 Eligible Expense	11 Paid At %	12 Benefit Amount	13 Patient Liability
01/01-01/01/14	PHYSICIAN/MED SRV	$550.00	$25.00	E	$0.00		$0.00	$0.00	0%	$0.00	$25.00
Column Totals:		**$550.00**	**$25.00**		**$0.00**		**$0.00**	**$0.00**		**$0.00**	**$25.00**

14 Amount Paid By Primary Plan: **$0.00**
15 Total Payment This Claim: **$500.00**

16 Code Description

E Charges in excess of the usual and customary amount for this service are not covered under your plan and are therefore the patient's liability.

17 Payment Details

Paid To	Check No.	Amount
SAMPLE PROVIDER GROUP	1168	$500.00

18 Accumulators

Plan	Single	Family
Deductible	$25.00	$0.00
Applied to date	$25.00	$0.00
Left to satisfy	$0.00	$0.00

19 Right of Review and Appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you are not satisfied with this decision, you can start the appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time is permitted by your plan). Please follow the steps below to make sure that your appeal is processed in a timely manner.

1) Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the Plan. Contact Customer Service if you need help or have further questions.
2) Be sure to include: A) Your name B) Claim Number from this form C) Your Insurance ID Number from this form D) Name of patient and relationship and E) The words "Attention: IPMG Claim Appeals" on all supporting documents.
3) Contact Customer Service at the number on this form to request access to and copies of all documents,records and other information about your claim; free of charge.
4) You will be notified of the final decision in a timely manner, as described in your Plan materials. If your Plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.

How To Read Your EOB Key

1. **Customer Service**: If you have questions, please give us a call at the toll free number located at the top of your Explanation of Benefits Statement. Our friendly and knowledgeable Customer Service representatives are available to assist you Monday through Friday from 7:30 a.m. to 8:00 p.m. Central Standard Time.

2. **Service dates**: Represents the patient's date(s) of treatment.

3. **Description of Service**: Briefly describes the nature of the services rendered. Examples include doctor office visits, inpatient or outpatient hospital services, and independent laboratory and x-ray services.

4. **Total Charge**: Billed charges before negotiated adjustments, network discounts, copays, deductibles or any denied charges.

5. **Reduced By**:

6. **Code**: Reference for reason amount was reduced.

7. **Not Covered**: Amount not covered by the plan.

8. **Code**: Reference for reason amount was not covered.

9. **Deductible Amount**: Amount member is responsible for prior to any payment by the health plan. Amounts will vary between in-network and out- of- network charges. The deductible may not apply to all services.

10. **Eligible Expense**: Final provider expense eligible to be applied against the health plan benefits.

11. **Paid At %**: Percentage of balance payable under plan.

12. **Benefit Amount**:

13. **Patient Liability**: The amount for which the patient is responsible for including any coinsurance, copays, deductibles and non-covered services.

14. **Amount Paid By Primary Plan**: Amount of benefit payment made by the member's primary insurance carrier.

15. **Total Payment This Claim**: Actual health plan payment amount made to provider or insured.

16. **Code Description**: A descriptive field that explains any non-covered service or payment reduction.

17. **Payment Details**: Explains who is receiving the payment and the details associated with the payment.

18. **Accumulators**: The amount of allowed expense applied toward the plan deductible and out-of-pocket maximums which have accumulated during the health plan benefit period.

19. **Right of Review and Appeal**: Information and procedures instructing on how to file a formal review for any denied claim.