Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

1206 West Campus Drive
Temple, TX 76502

Forwarding Service Requested

Explanation of Benefits
This is NOT a bill

QUESTIONS?

Customer service: (844) 843-3229
Hours: 7 a.m. to 7 p.m. CT
Website: bswh.swhp.org

John Smith
789 TEST STREET
REDCARD, MO 63141

Member ID: 12345678
Group Number: 050054
Group Name: BSWH SEQA
Print date: 02/18/2020

Hi John,

This document summarizes recent claims the Plan has processed for healthcare services. It confirms the amount charged by your provider(s) and the amount the Plan paid for those charges.

Cost breakdown	
Amount billed:	**$986.73**
Plan discount:	**$601.74**
Plan paid:	**$389.99**
Not covered:	**$0.00**

What you may owe

$0.00

This is the portion of the billed amount you may owe the provider(s) if payment was not collected at the time of service. This amount may include your deductible, copay, coinsurance, and/or non-covered amount.

Account Summary

Applied Amount		Total Amount
$0.00	Individual Deductible	$500.00 ($500.00 remaining)
$0.00	Individual Out-of-pocket max	$4,000.00 ($4,000.00 remaining)
$234.74	Family Deductible	$1,000.00 ($765.26 remaining)
$514.17	Family Out-of-pocket max	$8,000.00 ($7,485.83 remaining)

Place holder for misc. communications

Now...the Detailed Version

Here's a detailed breakdown or Explanation of Benefits for this service. In case there's any doubt - this is NOT a bill!

Subscriber:	**John Smith**
Member ID:	**12345678**
Group Name:	**BSWH SEQA**
Group Number:	**050054**

Patient: Ann Smith
Claim Number: 123x456x789
Provider: Test Provider 2

In-Network

Date of Service	Description	Amount Billed	Allowed Amount	Non-Covered Amount	Other Coverage Payment	Plan Paid	Copay	Deductible	Coinsurance	What You May Owe	Notes
2/04/20	REMOVAL INTRAUTERINE	$911.73	$309.99	$0.00	$0.00	$309.99	$0.00	$0.00	$0.00	$0.00	
Total		$911.73	$309.99	$0.00	$0.00	$309.99	$0.00	$0.00	$0.00	$0.00	

Patient: Ann Smith
Claim Number: 123x456x788
Provider: Test Provider 1

In-Network

Date of Service	Description	Amount Billed	Allowed Amount	Non-Covered Amount	Other Coverage Payment	Plan Paid	Copay	Deductible	Coinsurance	What You May Owe	Notes
2/04/20	OUTPATIENT OFFICE VI	$75.00	$75.00	$0.00	$0.00	$75.00	$0.00	$0.00	$0.00	$0.00	
Total		$75.00	$75.00	$0.00	$0.00	$75.00	$0.00	$0.00	$0.00	$0.00	

Notes:

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Helpful Definitions

Allowed Amount -The amount considered for payment based on our provider contracts and your benefits.

Amount Billed -The amount your provider billed for the services. Note: This amount does not reflect discounts that the plan has negotiated with the provider or facility.

Amount Paid -The amount we paid to you or your provider.

Copay -The amount you are responsible to pay for certain services, typically paid at the time of service.

Coinsurance - A percentage of the "allowed amount" you are responsible for paying for services after your deductible is met. Providers may require payment when you receive services.

Deductible - The amount you pay before the Plan begins to pay for covered services. Note: "Non-Covered" amounts don't count toward meeting the yearly deductible. Your provider may bill you for these charges.

Discount Amount -The amount you saved by using the plan's preferred providers.

Non-Covered Amount - The amount that is not coverd by your benefit Plan and you are responsible for paying. Also, if you've used an out-of-network provider, "non-covered amount" includes any amount the out-of-network provider bills in excess of the plan-negotiated network rates.

Other Coverage Payment -The amount paid by your other insurance carrier.

Out-of-Pocket Maximum -The most you have to pay for in-network health services every year. Once you have paid this amount, the Health Plan typically pays 100% of your allowed health care charges, subject to any policy limitations.

Report Fraud

If you suspect fraud, contact the Scott and White Health Plan Compliance HelpLine at (888) 484-6977.

Language Assistance/ Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call (844) 843-3229 (TTY: 711).

Scott and White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al (844) 843-3229 (TTY: 711).

Scott and White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số (844) 843-3229 (TTY: 711).

Scott and White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.