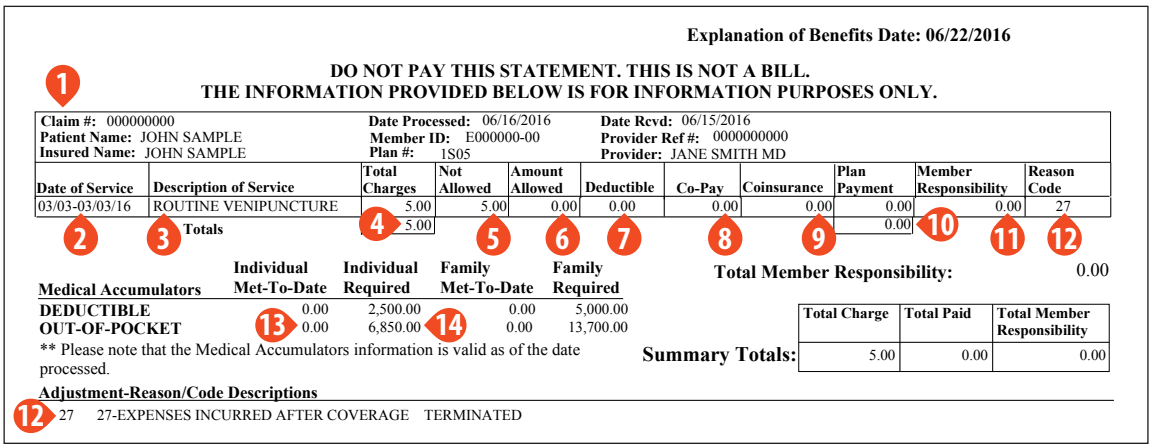
UNDERSTANDING YOUR EXPLANATION OF BENEFITS

The term guide below is provided to help you understand your Explanation of Benefits (EOB). Your EOB is not a bill; it is a list of the services you received and a detailed explanation for how the claims your provider submitted were covered by Health Choice Insurance Co. (Health Choice)



Explanation of Benefits Date: 06/22/2016

1 **DO NOT PAY THIS STATEMENT. THIS IS NOT A BILL.**
THE INFORMATION PROVIDED BELOW IS FOR INFORMATION PURPOSES ONLY.

Claim #: 000000000 **Date Processed:** 06/16/2016 **Date Rcvd:** 06/15/2016
Patient Name: JOHN SAMPLE **Member ID:** E000000-00 **Provider Ref #:** 0000000000
Insured Name: JOHN SAMPLE **Plan #:** 1S05 **Provider:** JANE SMITH MD

2 Date of Service	Description of Service	4 Total Charges	5 Not Allowed	6 Amount Allowed	7 Deductible	8 Co-Pay	9 Coinsurance	10 Plan Payment	11 Member Responsibility	12 Reason Code
03/03-03/03/16	ROUTINE VENIPUNCTURE	5.00	5.00	0.00	0.00	0.00	0.00	0.00	0.00	27
3 Totals		5.00						0.00		

Medical Accumulators	Individual Met-To-Date	Individual Required	Family Met-To-Date	Family Required
DEDUCTIBLE	0.00	2,500.00	0.00	5,000.00
OUT-OF-POCKET	13 0.00	6,850.00	14 0.00	13,700.00

** Please note that the Medical Accumulators information is valid as of the date processed.

Total Member Responsibility: 0.00

Summary Totals:

Total Charge	Total Paid	Total Member Responsibility
5.00	0.00	0.00

Adjustment-Reason/Code Descriptions

12 27 27-EXPENSES INCURRED AFTER COVERAGE TERMINATED

COMMON TERMS IN EXPLANATIONS OF BENEFITS:

1. **Claim:** A request for payment that your healthcare provider submits to Health Choice when you receive items or services you think are Covered Benefits. If you are required to pay for out-of-network emergency care at the time of services, the claim may be submitted by you to Health Choice.

2. **Date of Service (DOS):** The date you received healthcare service.

3. **Description of Service:** A brief description of the healthcare services provided to you on the Date of Service.

4. **Total Charges:** The amount your healthcare provider bills for the services provided to you. This amount may be reduced by a number of factors, such as: charges in excess of the Amount Allowed, non-Covered Benefits, services received before or after coverage was in effect.

5. **Not Allowed:** The amount not covered by your insurance.

6. **Amount Allowed:** Maximum amount on which payment is based for covered healthcare services. If your provider charges more than the Amount Allowed, you are not responsible for paying the remaining amount. If you receive a bill for Covered Benefits from an in-network provider please contact Member Services at 855-452-4242.

7. **Deductible:** The set amount you must pay in a plan year for certain healthcare services before your health plan coverage begins to pay.

8. **Co-Pay:** A fixed amount you pay for a covered healthcare service, subject to any Out-of-Pocket Maximums.

9. **Coinsurance:** Your share of the costs of a covered healthcare service, calculated as a percent of the Amount Allowed. You pay Coinsurance plus any Deductibles you owe. Your insurance pays the rest of the Amount Allowed.

10. **Plan Payment:** The amount Health Choice has paid your healthcare provider.

11. **Member Responsibility:** The total amount you are required to pay to your provider. This amount may include Co-Pays, Deductibles, Coinsurance, and the amount of non-Covered Benefits.

12. **Reason Code:** Indicates the reason why a claim was adjusted or denied; if there is no Reason Code then no adjustment was made.

13. **Out-of-Pocket Met-to-Date:** The total amount paid by the member, plan year to date. This includes Deductible, Co-Pay and Coinsurance. This does not include non-Covered Benefits.

14. **Out-of-Pocket Required:** The maximum amount a member is responsible for in a plan year. This includes Deductible, Co-Pay and Coinsurance.

Health CHOICE INSURANCE CO.