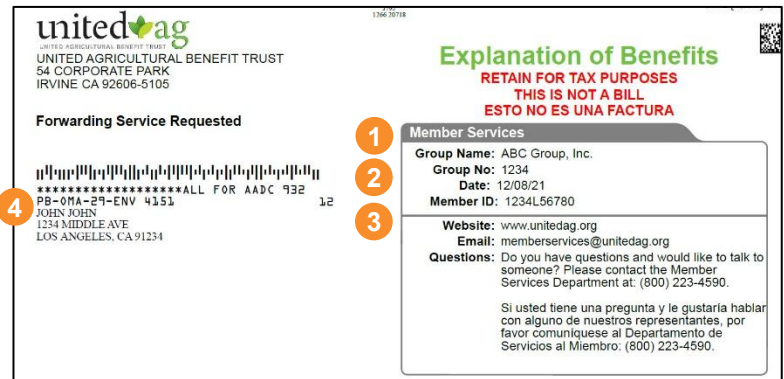


Your Explanation of Benefits (EOB) has details about your healthcare benefits. You'll get an EOB in the mail after you visit a doctor or seek medical treatment. Be sure to carefully read your EOBs, and always keep it for future reference. Here are a few tips to help you understand your EOB:

- Group Name:** Name of the subscribed members employer associated with UnitedAg.
- Group No:** Number of the subscribed members employer associated with UnitedAg.
- Member ID:** The member's (subscriber) unique UnitedAg Identification number.
- Patient Mailing Address:** The address the EoB was mailed to connected to the patient. (Patients over the age of 18 will receive their own EoB and mailed to their address on file)
- Service Period:** This range of dates are the dates of service of the claims received and processed on the EoB



## 5 For Dates of Service: 11/02/2021 thru 11/13/2021

<b>Total Billed Amount</b>	This is the total amount your provider(s) charged for services received from 11/02/2021 through 11/13/2021
\$1,234.03	
<b>Total Amount Paid By Plan</b>	This is the amount the plan paid on your behalf for services you received. Please see the claim detail section below for more information.
\$49.17	
<b>Your Financial Responsibility</b>	This is the amount the provider(s) of service may bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.
\$446.91	

6	7	8	9	10	11	12	13	14	15	16	17
Claim #	Dates of Service	Patient Name	Billed Amount	Discount Amount	Ineligible Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Pre-Paid Other Ins.	Plan Payment	Patient Responsibility
2021-XXXXXX-0000	11/02/2021-11/02/2021	John John	\$649.03	\$368.58	\$0.00	\$280.45	\$280.45	\$0.00	\$0.00	\$0.00	\$280.45
2021-XXXXXX-0000	11/08/2021-11/08/2021	John John	\$193.00	\$98.83	\$0.00	\$94.17	\$0.00	\$45.00	\$0.00	\$49.17	\$45.00
2021-XXXXXX-0000	11/11/2021-11/11/2021	John John	\$270.00	\$148.54	\$0.00	\$121.46	\$121.46	\$0.00	\$0.00	\$0.00	\$121.46
2021-XXXXXX-0000	11/13/2021-11/13/2021	John John	\$122.00	\$122.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Column Totals			\$1,234.03	\$737.95	\$0.00	\$496.08	\$401.91	\$45.00	\$0.00	\$49.17	\$446.91

- Claim Summary:** Overview of the claims incurred within the service period.
- Dates of Service:** Dates when patient was treated.
- Patient Name:** Member who received benefit services under this explanation.
- Billed Amount:** The amount billed for services provided.
- Discount Amount:** This is the Network Discount
- Ineligible Amount:** Amount that is not eligible for benefits under the Plan.
- Allowed Amount:** Total amount billed less Network Discount for each benefit service received under the Plan.
- Deductible Amount:** The amount incurred by the member before benefits are payable under the terms of the Plan.
- Co-pay Amount:** Amount applied to either the patient's co-pay and/or deductible.
- Pre-paid Other Insurance:** Amount paid by other insurance plan(s).
- Plan Payment:** Total Payment sent to Provider and/or Member by UnitedAg.
- Patient Responsibility:** Remaining balance owed/due to the provider after co-pay, total allowed, and network discount have been applied to the claim. Payable by the Member directly to the provider.

19

Claim: 2021-XXXXXX-0000

21

Member ID: 1234L56780

26

Oper #: 10

27

Provider: ADVENTIST HEALTH PHYSICIANS NE

20

Patient: John John

21

Patient Account #:1234567S123456

27

Provider #: 680357690

22	Dates of Service	23	Procedure	24	Remark Code	Network	25	Billed Amount	Discount Amount	Ineligible Amount	Allowed Amount	Deductible Amount	Co-Pay Amount	Co-Insurance	Remaining Paid At	Payment Amount
	11/11/2021-11/11/2021		PROCEDURE		1 13	1		\$270.00	\$148.54	\$0.00	\$121.46	\$121.46	\$0.00	\$0.00	70%	\$0.00
	Column Totals							\$270.00	\$148.54	\$0.00	\$121.46	\$121.46	\$0.00	\$0.00		\$0.00

Patient Responsibility to Provider...

\$121.46

Patient Responsibility to Provider...	\$121.46
---------------------------------------	----------

18. **Claim Detail:** Detailed information regarding the claims incurred within the service period and with the claims listed in the Claim Summary (see item 5).
19. **Claim #:** Unique number assigned to your claim by UnitedAg. You will need to refer to the claim number when calling UnitedAg with questions about the claim.
20. **Patient Account #:** Provider assigned patient account number.
21. **Operator #:** UnitedAg examiner who processed the claim.
22. **Dates of Service:** Dates when patient was treated.
23. **Procedure:** Service type received from the provider.
24. **Remark Code:** When present, this code is connected to notes (see item 28) that provide general information about the claim.
25. **Network:** The network tied to the benefits used to process the claim (see item 30).
26. **Provider:** Doctor, location or physician who rendered your benefit services. This may also be the billing facility which produced the billed charges identified on the EoB.
27. **Provider #:** The assigned provider number.
28. **Remark Code Description:** Detailed notes that help explain any adjustments associated with the claim.

28	
	Remark Code Description
1	Applied To Deductible
13	PPO Benefits Applied
15	Co-Benefits Applied

29	Description	Accumulators	
		Amount Met	Amount Remaining
	Individual In-Network   Deductible	\$923.18	\$3,076.82
	Individual In-Network   Out of Pocket		\$6,627.46
	Individual Out-of-Network   Deductible	\$0.00	\$8,000.00
	Individual Out-of-Network   Out of Pocket		\$30,000.00

30 Network Information	
1	These claims are being paid pursuant to your contract with Blue Shield of California. Blue Shield of California, an independent member of the Blue Shield Association, provides network access only, and no network access is available from Blue Cross Blue Shield plans outside of Blue Shield of California's service area. Blue Shield of California provides no claims payment services and does not assume financial risk or obligation with respect to claims.

[illegible]

## 29. Accumulators:

This includes details on the individual's deductible and out-of-pocket amounts, both in-network and out-of-network. For each, it shows the amount applied and the amount remaining.

### 30. Network Information:

Information on the network the claim was paid under.

### 31. Patient Appeal Rights:

Information that outlines the patient's rights to appeal any benefits determination and the process to do so.

**If you have questions about your Explanation of Benefits, please call Member Services at 800.223.4590 or email [memberservices@unitedag.org](mailto:memberservices@unitedag.org).**

