



Understanding Your Explanation of Benefits

After submitting claims for medical expenses, Trilogy Health Insurance, Inc. will send an Explanation of Benefits (EOB) that illustrates how your claim was processed. The EOB will be sent to you and your provider. The actual EOB you receive may have expanded information in some fields. Please contact Customer Service with any questions. The following is a SAMPLE EOB:



Trilogy
Health Insurance
18000 West Sarah Lane, Suite 310
Brookfield, WI 53045



1 Forwarding Service Requested

2 Please see the enclosed document for additional information

3 For questions or review of the decision, please phone:

4 Customer Service
262-432-9150
866-429-3242

5 Policy #: 10
Policy Name: [REDACTED]
Employee Name: [REDACTED]
Patient: [REDACTED]
Dependent #: [REDACTED]
Patient Acct #: [REDACTED]
CLAIM #: [REDACTED]
Date: 7/16/2007
Check #: [REDACTED]

6 EXPLANATION OF BENEFITS – THIS IS NOT A BILL
PLEASE RETAIN FOR TAX PURPOSES

7

Dates of Service	Service Code	Claim Submitted	Not Member Responsibility	Code	Allowed Amount	Amount Not Covered	Credit to Deductible	Coinsurance	Copayment	Code	Amount Paid
07022007	H0E	154.00	43.12	06	110.88	0.00	110.88	0.00	0.00		0.00
TOTALS		154.00	43.12			0.00	110.88	0.00	0.00		0.00

8 PROVIDER: [REDACTED]

9 Explanation of Codes / ANSI Codes
Code 05 Preferred provider will write amount off; TRILOGY HEALTH
ANSI 41 Discount agreed to In Preferred Provider contract

10 Deductible Remaining

11 Out-of-Pocket Maximum Remaining

12 INDIVIDUAL PREFERRED: 389.12
FAMILY PREFERRED: 1,389.12
INDIVIDUAL NON-PREFERRED: 1,000.00
FAMILY NON-PREFERRED: 3,000.00

13 Annual Maximum Remaining

INDIVIDUAL PREFERRED: 1,889.12
FAMILY PREFERRED: 3,889.12
INDIVIDUAL NON-PREFERRED: 4,000.00
FAMILY NON-PREFERRED: 8,000.00

Lifetime Maximum Remaining
4,999.889.12

Messages
NO BENEFITS ARE PAYABLE AT THIS TIME -- PLEASE SEE ABOVE
YOUR APPEAL RIGHTS

If you have a question about your claim, we want to help you find answers. Follow these steps when you need information or want to file an appeal about a claim. You can request a review of your claim by calling a Trilogy Health Insurance, Inc. (Trilogy) Customer Service Representative at 262-432-9150 or 866-429-3242. Contact us when you:

- Do not understand the reason for the denial;
- Do not understand why the cost was not fully covered;
- Cannot find the applicable provision in your Certificate of Coverage and Schedule of Benefits;
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim is not resolved to your satisfaction, you may write a letter of appeal. The purpose of the Member Appeals Process is to provide an opportunity for you as a member to appeal a decision made by Trilogy concerning the payment of a claim. Examples of claim disputes where an appeal may be appropriate include:

- A claim has been denied in whole or in part and you believe it was denied in error;
- You believe your benefits have not been applied correctly;
- You believe a claim payment to a non-participating provider does not appropriately represent usual and customary allowances.

Please state the reason you believe the claim was processed in error and submit any additional data, questions or comments you may have along with the claim. All information will be evaluated and you will be informed of the decision in accordance with the Trilogy Grievance Procedure outlined in your Certificate of Coverage. The appeal should be sent to:

Member Advocate
Trilogy Health Insurance, Inc.
18000 West Sarah Lane, Suite 310
Brookfield, WI 53045

Employee Copy

1. Mailing Name and Address

Name and address of the employee

2. Customer Service Number

Please call this number with any questions regarding your EOB

3. Claim Identifiers

These include:

- Policy # - Policy number for the employer group
- Policy Name – Name of the employer group
- Employee Name – Name of the employee
- Patient – Name of employee or dependent who received treatment
- Dependent # - ID suffix of employee or dependent who received treatment
- Patient Account # - Number assigned to the patient by the provider
- Claim # - Number assigned to this claim
- Date – Date this EOB was generated
- Check # - Number of check used to pay claim

4. Claim Summary

Summary information detailing payments made on this claim

5. Total Employee Responsibility

Amount not paid by Trilogy Health Insurance, Inc. - amount you are responsible to pay

6. Charge Line Detail

This includes:

- Dates of Service – The date the patient received the treatment for this claim
- Service Code – Code assigned to the procedure or treatment provided
- Claim Submitted – Amount billed by the provider
- Not Member Responsibility – Amount provider cannot collect from you
- Allowed Amount – Amount that includes any negotiated discounts
- Amount Not Covered – Amount that is not covered by your plan
- Credit to Deductible – Amount that is credited toward your deductible
- Coinsurance – Coinsurance amount that is your responsibility
- Copayment - Any copayments that are your responsibility
- Amount Paid – Amount paid by Trilogy Health Insurance, Inc. for this claim

7. Provider

Name of the doctor or facility that provided the service or treatment for this claim

8. Explanation of Codes/ANSI Codes

Explanation of codes entered in Section 6

9. Deductible Remaining

The portion of the annual deductible that has not yet been met

10. Out-of-Pocket Maximum Remaining

The portion of the out-of-pocket patient responsibility that has not yet been met

11. Annual Maximum Remaining

12. Lifetime Maximum Remaining

13. Your Appeal Rights

Outline of the appeal process