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TPSC Benefits
P.O. Box 1894
Tacoma, WA 98401-1894

Member Service Number: 1-800-426-9786 x210
(253) 564-5611 x210

SAMPLE CORPORATION

Group Number XXXX
Claimant Number XXXX XXXX

SAMPLE MEMBER
1234 SAMPLE STREET
SAMPLE CITY, ST 00000-0000

This represents the amount your plan has paid for services

Explanation of Benefits
This is not a Bill

Patient's Name / Type of Service	Service Date	Billed Charges	Non Patient Obligations: PPO Disc.	Non Patient Obligations: Inelig	Expl. Codes	Patient Obligations: Ineligible	Patient Obligations: Co-Pay	Patient Obligations: Deductible	Patient Obligations: Co-Ins	Percentage: Patient	Percentage: Plan	Benefit Payable
SAMPLE1												
SAMPLE RX												
Claim Number: 0000000000												
PRESC DRUGS	8/00/00	14.14					10.00			0%	100%	4.14
Patient Account Number:	Totals:	14.14					10.00				Net Payment	4.14

This is your financial responsibility for each service

Patient Portion: $10.00

SAMPLE2												
SAMPLE PROVIDER												
Claim Number: 0000000001												
O/P PHYS THERAP	4/0/00	60.00	32.75		K01				5.45	20%	80%	21.80
O/P PHYS THERAP	4/0/00	52.00	27.24		K01				4.95	20%	80%	19.81
Patient Account Number: 00000000	Totals:	112.00	59.99						10.40		Net Payment	41.61

Patient Portion: $10.40

Claim Number: 0000000002												
O/P PHYS THERAP	4/0/00	120.00	65.50		K01				10.90	20%	80%	43.60
O/P PHYS THERAP	4/0/00	62.00	25.89		K01				7.22	20%	80%	28.89
Patient Account Number: 00000001	Totals:	182.00	91.39						18.12		Net Payment	72.49

This is a monthly summary of services for each provider involved in your care

Patient Portion: $18.12

September 2021 Statement Summary

Service Provider / Date Benefit Paid	Patient Name	Total Charge	PPO Discount	Ineligible	Prior Payments	Other Plan Payments	Benefit Payments	Patient Portion
SAMPLE PROVIDER								
Date Benefit Paid 8/17/2021	SAMPLE2	182.00	91.39				72.49	18.12
Date Benefit Paid 8/17/2021	SAMPLE2	112.00	59.99				41.61	10.40
	Totals:	294.00	151.38				114.10	
						This is the amount that the SAMPLE family owes SAMPLE PROVIDER		28.52
SAMPLE RX								
Date Benefit Paid 9/14/2021	SAMPLE1	14.14					4.14	10.00
	Totals:	14.14					4.14	
						This is the amount that the SAMPLE family owes SAMPLE RX		10.00

Explanations:

K01 K01-Cigna Healthcare discount. Patient not liable.

These notes explain more about the costs, charges and paid amounts for our visit or service

This section summarizies deductible status and out of pocket expenses for the current plan year

2021

YOU HAVE MET 1,500.00 OF YOUR FAMILY 2021 4,500.00 MEDICAL DEDUCTIBLE.

YOU HAVE MET $692.80 OF YOUR 2021 $9,000.00 FAMILY OUT OF POCKET MAXIMUM.

SAMPLE1
YOU HAVE MET 150.00 OF YOUR 2021 1,500.00 MEDICAL DEDUCTIBLE.

YOU HAVE MET $62.23 OF YOUR 2021 $3,000.00 OUT OF POCKET MAXIMUM.

SAMPLE2
YOU HAVE MET 1,500.00 OF YOUR 2021 1,500.00 MEDICAL DEDUCTIBLE.

YOU HAVE MET $630.57 OF YOUR 2021 $3,000.00 OUT OF POCKET MAXIMUM.

REMINDER: To encourage Plan participants to obtain preventive care services on an annual basis, any Covered Person who has a Preventive Care exam during the current Calendar Year will be credited with $150 toward the next Calendar Year's deductible. See your plan benefits or contact TPSC Benefits Member Services for details.

Your next monthly explanation of benefits, if any claims are submitted, will be mailed the week of October 24, 2021

Electronic EOB's are now available! When medical claims have been paid for any family member you may receive your family EOB via your personal e-mail address. To enroll for electronic EOB's simply e-mail both your name and your group number listed on this EOB to: benefitsupport@tpscbenefits.com

You've got mail! Follow these instructions to "go green" and elect to have future EOB's sent via email

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at (800) 426-9786 if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part) within 180 days of receipt.

How do I file an appeal? Your initial appeal must be in writing and may include any additional information that supports your claim. You may use the form below or any other written request. Mail your appeal to TPSC Benefits, P.O. Box 2950, Tacoma, WA 98401-2950, or FAX to (253) 564-5881. See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may orally request an expedited appeal by calling (800) 426-9786 to file your initial internal appeal. If you believe that completing the internal appeal would seriously jeopardize your life or health, or your ability to regain maximum function, you may also request an expedited external review either in writing or orally.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate a representative by providing us with the name, address, and contact information of your representative in writing. You and your authorized representative must both sign your designation.

Can I provide additional information about my claim? Yes, you may supply additional information to TPSC Benefits at any time before your appeal has been completed.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this by calling us at (800) 426-9786, by mail at TPSC Benefits, P.O. Box 2950, Tacoma, WA 98401-2950, or by FAX to (253) 564-5881.

What happens next? If you appeal, we will review our decision and provide you with a written determination within 15 days for pre-service appeals or within 30 days for denial of a claim for services already provided. If we continue to deny the payment, coverage, or service requested, you may file a second, and final, internal appeal within 60 days of receipt of the denial by following the same process as for an initial appeal above. You may provide additional information to support your final appeal. You will receive a determination on your final appeal within 15 days for pre-service appeals or within 30 days for denial of a claim for services already provided. If you do not receive a timely decision, or you disagree with the final decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your request for an external review must be made within 4 months of receipt of the denial of your final internal appeal.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at (866) 444-EBSA (3272).

Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____

Circle one: Covered person Patient Authorized Representative

Contact information of person filing appeal (if different from patient)
Address:_____ **Daytime phone:**_____ **Email:**_____

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Are you requesting an urgent appeal? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

_____

_____

Send this form and your denial notice to: TPSC Benefits, P.O. Box 2950, Tacoma, WA 98401-2950, or FAX to (253) 564-5881.
Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.