ALLIED

Allied Benefit Systems LLC
200 W Adams St Ste 500
Chicago IL 60606-5215

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

[-AC]

Forwarding Service Requested

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VAISHNAVI BHOOMAGOUD-VENKATESH
2436 CATSKILL CT
IOWA CITY IA 52245

Customer Service

For questions, please visit us at
www.NGBSselffunded.com
or contact us at
(888) 292-0272
Electronic Claim Submission
Please refer to the member's ID card

Date: 1/12/2021
Enrollee: VAISHNAVI BHOOMAGOUD-VENKAT
Group#: L180386
Group: TECHSMART GLOBAL INC

Dates of Service: 11/09/2020 thru 11/09/2020

Dear VAISHNAVI BHOOMAGOUD-VENKATESH ,

The information below is a summary of the healthcare claims you incurred for the period 11/09/2020 through 11/09/2020. This information is commonly referred to as an *"Explanation of Benefits" (EOB)*. This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may recieve from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed
$248.00
This is the total amount billed for the dates of service of 11/09/2020 thru 11/09/2020.

Total Amount Paid By Plan
$131.14
This is the amount the plan paid in total for services rendered from 11/09/2020 thru 11/09/2020. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility
$35.00
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.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Patient Responsibility	Payment Amount
4582364101	VAISHNAVI BHOOMAGOU	$248.00	$0.00	$81.86	$166.14	$0.00	$35.00	$35.00	$131.14
	Totals	$248.00	$0.00	$81.86	$166.14	$0.00	$35.00	$35.00	$131.14

Claim#: 4582364101
Patient: VAISHNAVI BHOOMAGOUD-

Patient#: PB232222590
Provider: STONE MD, MARY S

Dates of Service	Service Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
11/09-11/09/2020	34	$248.00	$0.00	a6	$81.86	$166.14	$0.00	$35.00	$131.14	100%	$131.14
	Column Totals	$248.00	$0.00		$81.86	$166.14	$0.00	$35.00	$131.14		$131.14
										Other Credits or Adjustments	$0.00
Patient's Responsibility:		**$35.00**								**Total Net Payment**	$131.14

Service Code Description

34 OFFICE/HOME VISIT

Reason Code Description

46 Bill has been discounted by your PPO/EPO network.
a6 DISCOUNTED PER YOUR COFINITY/AETNA AGREEMENT