Trustmark Health Benefits
PO Box 2920
Clinton, IA 52733-2920

Trustmark
benefits beyond benefits

Questions? Contact us:

All Claims: 1-800-222-1958
Website: myTrustmarkBenefits.com

[redacted]

Group Number [redacted]
Print Date June 14, 2016

Consolidated Family Explanation of Benefits
This is not a Bill

[redacted]

The claims listed below were NOT prefunded by Simplicity. You owe the amounts listed below as Deductible or Co-Ins directly to the provider(s) of service.

Patient's Name Type of Service	Service Date(s)	Billed Charges	Discount Amount	Other Adjust-ments	Other Plan Payment	Patient Responsibility After Payments				Plan Benefit	Plan Paid At	Reason Codes
						Ineligible	Co-Pay	Deductible	Co-Ins			
[redacted]												
Claim #: [redacted] **Pat. Acct. #:** [redacted] **Provider:** [redacted] **Network:** [redacted]												**Issued: 5/31/16**
X-RAY	05/11/2016	270.50	14.88	0.00	0.00	0.00	0.00	0.00	51.12	204.50	80%	AET
	Totals:	270.50	14.88	0.00	0.00	0.00	0.00	0.00	51.12	204.50		

Patient Responsibility to Provider **51.12**

SIMPLICITY®
Simplifying Healthcare Payments

The claims pre-paid by Simplicity are listed below. Please note that amounts in Co-Ins and Deductible were paid in advance to your provider for your convenience if any amount was due. Please log onto *www.SimplicityPayments.com* to make payments or set up a payment plan today if anything is owed!

Patient's Name / Type of Service	Service Date(s)	Billed Charges	Discount Amount	Other Adjust-ments	Other Plan Payment	Patient Responsibility After Payments: Ineligible	Co-Pay	Deductible	Co-Ins	Plan Benefit	Plan Paid At	Reason Codes
Claim #: [redacted] **Pat. Acct. #:** [redacted] **Provider:** [redacted] **Network:** [redacted]												**Issued: 5/31/16**
X-RAY	05/03/2016	2,068.25	118.25	0.00	0.00	0.00	0.00	750.00	240.00	960.00	80%	AET 014
Totals:		2,068.25	118.25	0.00	0.00	0.00	0.00	750.00	240.00	960.00		

Patient Responsibility to Provider **0.00**
Sum of Deductible and Co-Ins **990.00**

Claim #: [redacted] **Pat. Acct. #:** [redacted] **Provider:** [redacted] **Network:** [redacted]												**Issued: 5/31/16**
X-RAY	05/03/2016	165.00	76.43	0.00	0.00	0.00	0.00	0.00	17.71	70.86	80%	AET
Totals:		165.00	76.43	0.00	0.00	0.00	0.00	0.00	17.71	70.86		

Patient Responsibility to Provider **0.00**
Sum of Deductible and Co-Ins **17.71**

SIMPLICITY®
Simplifying Healthcare Payments

Total of All Deductible and Co-Ins amounts Funded by Simplicity: $1,007.71

Reason Code Descriptions:

014 DEDUCTIBLE REACHED

AET PATIENT IS NOT RESPONSIBLE FOR AETNA PPO DISCOUNT

		MEDICAL 2016
[redacted]	PREF PROV CY DEDUCTIBLE Met (of $750.00)	$750.00
	PREF PROV OUT-OF-POCKET Met (of $3,000.00)	$1,182.97
	NONPREF PROV CY DEDUCTIBLE Met (of $1,500.00)	$750.00
	NONPREF PROV OUT-OF-POCKET Met (of $6,000.00)	$1,182.97
Family	PREF PROV OUT-OF-POCKET Met (of $6,000.00)	$1,182.97
	NONPREF PROV OUT-OF-POCKET Met (of $12,000.00)	$1,182.97

Please see your Summary Plan Description for a more detailed explanation of your plan benefits, exclusions, and maximums. The dollars displayed on this statement are as of the Print Date and are subject to change. Your next Consolidated Explanation of Benefits, if any claims are processed, will be issued no later than the week of: 07/17/2016

This document contains important information including your Appeal Rights that you should retain for your records.
This document serves as notice of any adverse benefit determination. Benefits under your self-funded benefit plan, which are denied in whole or in part for the requested treatment or service, are described in the attached Explanation of Benefits (EOB). If you think this determination was made in error, you have the right to appeal.

What if I need help understanding this denial? Contact Customer Service in writing or at the phone number provided on the attached EOB if you need assistance understanding this notice or the decision to deny you coverage under your benefit plan.

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).

How do I file an appeal? Complete, detach, copy and send in the form below within one hundred eighty (180) calendar days from receipt of notification of the denial. See also the "Other resources to help you" section below 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 severe pain that cannot be adequately controlled without immediate treatment. If you believe your situation is urgent, you may request an expedited appeal when filing your appeal request (see form below), or by filing a request for simultaneous external review, or by contacting Customer Service at the telephone number or website provided on the attached Explanation of Benefits.

Who may file an appeal? You or someone you name in writing to act for you (your authorized representative) may file an appeal.

Can I provide additional information about my claim? Yes, you may supply additional information in support of your claim to the address provided on the attached Explanation of Benefits.

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 information by contacting Customer Service in writing, or at the telephone number or website provided on the attached Explanation of Benefits.

What happens next? If you appeal, we will review the decision and provide you with a written determination. If we continue to deny the payment or coverage requested, on behalf of your self-funded benefit plan, or you do not receive a timely decision, you may be able to request an external review of certain claims by an independent third party, who will review the denial and issue a final decision. External review applies to a rescission of coverage and an adverse benefit determination involving medical judgment, including but not limited to, to those plan requirements involving medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or experimental or investigational treatments or services.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Appeal Filing Form

Detach this form and send to Trustmark at the address provided on the attached Explanation of Benefits. Be certain to keep copies of this form, your denial notice, and all documents related to this claim.

Covered Person's Name: _____ Patient Name: _____

Covered Person's ID #: _____ Claim Number: _____

Name of Person Filing Appeal: _____ Today's Date:_____

Check One: Covered person Patient Authorized Representative

Contact information of person filing appeal (if different from patient)

Address: _____ Phone: _____ Email: _____

If the person filing the appeal is other than the patient, the 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 use the back of this form, or attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim): _____

_____

Right of Appeal

If your Plan is not subject to ERISA, the following may not apply. You may request a review of a denied claim by making a written request to the Named Fiduciary within 180 calendar days from receipt of a notice of denial, include the reasons you feel the claim should not have been denied along with any additional information and comments relevant to the claim You are entitled to receive, upon request and free of charge, copies of all documents relevant to the denial including: any internal guideline or similar criterion that was relied on in making the determination; and an explanation of any scientific or clinical judgment on which any medical necessity conducted by individuals who made the original determination or their subordinates. You will be notified of the decision within a reasonable period of time but not later than 60 days after the plan receives your request for review. If your claim is denied on appeal, you have the right to bring a civil action for benefits under Section 502(a) of ERISA. Please see your Plan Document/Summary Plan Description for further details.

Employment Retirement Income Security Act (ERISA)

If you are enrolled through an employer-sponsored or other group health benefit plan that is subject to ERISA, and receive an adverse benefit determination on your appeal (s), you may bring a civil action under Section 502(a) of ERISA. In general, ERISA does not cover group health plans established or maintained by governmental entities (Federal, state, and municipal) for their employees or by churches for their employees. To determine whether ERISA applies to your group health benefit plan, please contact your Employer, Group Administrator, or Plan Sponsor.

Stop Health Care Fraud: If you suspect fraud. Call our Fraud Hotline 877-45-FRAUD

If you would like to receive an ekectronic version of this EOB instead of paper, please go to TrustmarkHB.com