MVP Select Care, Inc.
P.O. Box 2207 625 State Street
Schenectady, NY 12301

0001287-0001-0002-0002515-0087 -C05

Explanation of Benefits

THIS IS NOT A BILL

Member MVP ID#	
Name of Group or Plan	MVP SERVICE CORP
Claim Number	E06241810200
Service Provider	
Date(s) of Service	12/20/2014
Claim Rec'd Date	12/22/2014
Claim Processed Date	12/28/2014

A claim for services you received has been submitted to MVP, on behalf of your group health plan. This explanation of benefits is being provided to help you understand the amount charged by your provider and the amount of benefits paid by your plan. It also includes any Copayment, Coinsurance, Deductible and any Non-Covered Charges for which you are responsible.

Claim E06241810200 Summary

Benefits Paid by Plan	**112.81**
Total Due from Patient	**15.00**

The amount shown above may include amounts you paid to your provider at the time of service. If you received covered services from a participating provider, that provider has agreed to accept the Allowed Amount, minus any Copayment, Coinsurance and Deductible, as payment in full. If you received services from a non-participating provider you may also be responsible for the difference between the Billed Charges and the Allowed Amount.

Date(s) of Service From / To Billed Charges	Type of Service Not Allowed / Not Covered: Not Due From Patient	Due From Patient	Allowed Amount	COB Adjustment	Patient Responsibility: Copayment Amount	Coinsurance Amount	Deductible Amount	Benefits Paid By Plan	Reason Codes
12/20/2014 12/20/2014	Office or other outpatient visit for the evaluation and management of								
166.00	38.19	0.00	127.81	0.00	15.00	0.00	0.00	112.81	

2014 Limit Summary

Limit Name	Current Amount	Maximum Amount
YEARLY INDIVIDUAL IN-NETWORK OUT-OF-POCKET	15.00	6,350.00
YEARLY FAMILY IN-NETWORK OUT-OF-POCKET	15.00	12,700.00

At MVP, we're tough on health care fraud. Help us fight this costly problem by reporting any activities you suspect. If the information provided on the Explanation of Benefits does not match your records, please contact our Special Investigations Unit, toll free at 1-(877)-TELL-MVP. All calls will be kept confidential.

Words You Need to Know

Allowed Amount: The amount your plan will allow for this service. This is the maximum amount of benefits that MVP will pay for covered services under your coverage. The Allowed Amount is determined based upon: (1) MVP's fee agreement with participating providers; (2) the lesser of billed charges or a percentage of Medicare, or (3) law. If you received covered services from a participating pr[illegible] accept the Allowed Amount, minus any Copayment, Coinsurance and D[illegible]u receive services from a non-participating provider you may also be responsi[illegible]een the billed and allowed amount.

Benefits Paid by Plan: This is the amount that MVP is sending to your provider. It can also mean the amount MVP is sending to you if you paid your provider directly and then submitted a claim to MVP.

Billed Charges: Amount billed for the service

COB Adjustment: MVP allowed amount minus any patient responsibility.

Coinsurance: The percentage of allowed amount(s) that you are required to pay your provider. This is percentage of the Allowed Amount described in your MVP contract, certificate of coverage or your health plan's summary plan description or plan booklet that you are required to pay as your share of the cost of certain covered services. MVP subtracts any Co-insurance that you owe from the Allowed Amount.

Co-pay: The fixed dollar amount you are required to pay your provider for this service. This amount is described in your MVP contract, certificate of coverage or your health plan's summary plan description or plan booklet. You are required to pay this amount at the time you receive services as your share of the cost of a covered service. Any reduction in benefits for failure to obtain pre-certification or prior authorization is also displayed in this field. MVP subtracts any Copayment amount that you owe from the Allowed Amount.

Date(s) of Service: The date you received the services recorded on the statement.

Deductible: An amount you must pay toward the cost of services each Plan year before your plan pays any benefit. This is a fixed dollar amount described in your MVP contract, certificate of coverage or your health plan's summary plan description or plan booklet, that you must pay before MVP makes any payment for covered services. MVP subtracts any Deductible that you owe from the Allowed Amount.

Limit Current Amount: The amount of this limit that has been satisfied.

Limit Maximum Amount: This is the maximum limit amount that is set for this limit name.

Limit Name: Within your contract, limits are set. This field will provide the limit names, which are described in your contract.

Not Covered: Any billed charges not covered by your policy including services provided by an out-of-network or non-participating provider.

Not Allowed: An adjustment made by your plan.

Reason Code: A code that provides additional information.

Service Provider: The provider who billed your plan for the service.

Total Due from Patient: The amount the provider may bill you. It includes amounts such as Copayments, Coinsurance and Deductible and any charges that are not covered under your contract, or are not medically necessary. These charges are your liability, as described in your MVP contract, certificate of coverage or your health plan's summary plan description or plan booklet

You may request clarification about this statement, appeal MVP's decision, or designate a representative (such as a family member, friend or doctor) to act on your behalf when requesting clarification from MVP or filing an appeal.

To request clarification, file an appeal or designate a representative, call MVP at 1-800-229-5851 or write to: MVP Select Care, Inc., P.O. BOX 2207 625 STATE STREET, SCHENECTADY, NY 12301, Attention: Member Appeals. An MVP Customer Care Representative is available to take your call. You may also contact a Customer Care Representative via e-mail from our Web site www.mvpselectcare.com.

Any appeal regarding a claim described on this statement must be filed within 180 days (60 business days for Medicaid and Family Health Plus) after the date you receive this statement. Notices are deemed received 3 days from the date of mailing. If you fail to file an appeal as described above, that failure may lead to forfeiture of your right to challenge a denial or rejection, even when a request for clarification has been made.