WELLFLEET
Wellfleet Group, LLC
PO Box 15369
Springfield MA 01115

Forwarding Service Requested

Explanation of Benefits

THIS IS NOT A BILL RETAIN FOR TAX PURPOSES

GUIDE TO UNDERSTANDING THE EXPLANATION OF BENEFITS

Customer Care Information

Wellfleet is the Claims Administrator on behalf of the University of Wisconsin-Madison Student Health Insurance Plan (SHIP). Questions 877-657-5031

Group Name:	1
Group #:	2
Member:	3
Member ID:	4
Date:	5

For the Period: MM/DD/YYYY through MM/DD/YYYY 6

Dear JOHN Q SAMPLE,

The information below is a summary of your healthcare claims for the period referenced above. This information is commonly referred to as an "Explanation of Benefits" (EOB). This 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 and validity of any bill you may receive from the provider(s) listed below.

Total Amount Billed

7

This is the total amount for bills received for the dates of service MM/DD/YYYY through MM/DD/YYYY

Total Amount Paid By Plan

8

This is the amount the plan paid for services billed. Please refer to the Claim Summary section of this document for more information.

Your Financial Responsibility

9

This is the amount the provider 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. 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	COB Amount	Discount Amount	Allowed Amount	Co-Pay Amount	Deductible Amount	Patient Responsible	Payment Amount
10	11	12	13	14	15	16	17	18	19	20
9										
	Totals	21								

Claim #: 22 Provider: 24

Patient: 23 Patient DOB: 25 Patient Act #: 26

Dates of Service	Proc. Code	Total Charge	Discount Amount	Ineligible Amount	COB Amount	Reason Code	Allowed Amount	Co-Pay Amount	Deductible Amount	Remaining Balance	Paid At	Plan Payment Amount
27	28	29	30	31	32	33	34	35	36	37	38	39
Column Totals 40												

Patient's Responsibility: 41 Total Net Payment 42

Claim #: Provider:

Patient: Patient DOB: Patient Act #:

Dates of Service	Proc. Code	Total Charge	Discount Amount	Ineligible Amount	COB Amount	Reason Code	Allowed Amount	Co-Pay Amount	Deductible Amount	Remaining Balance	Paid At	Plan Payment Amount
Column Totals												

Patient's Responsibility: Total Net Payment

SERVICES

Code	Description
43	44

REMARKS

Code	Description
45	46

APPEALS INFORMATION

There is an appeal process if you disagree with the determination. You have 90 calendar days following receipt of the notice of adverse benefit determination to submit your written appeal to Wellfleet Group, LLC Attn: Appeal Department PO Box 15369 Springfield, MA 01115-5369. Once your appeal is received a decision will be made in 15 calendar days. If you do not agree with our appeal decision you may file a second appeal within 90 calendar days following receipt of the first appeal decision. If you still do not agree with our appeal decision a third and final appeal may be submitted. For additional assistance, you may also contact customer service at the number listed above.

Key for the Explanation of Benefits

#	Explanation
1	Group Name – Univ of Wisconsin Madison
2	Group Number assigned by Wellfleet
3	Name of the primary SHIP member
4	Unique Member ID assigned by SHIP
5	The date the Explanation of Benefits is issued
6	Date of Service span for this EOB
7	Total amount the provider(s) billed for services(s)
8	Total amount that has been paid by the plan on behalf of SHIP
9	The amount the member is responsible for paying to the Provider. This amount may include not covered amounts, member deductible, member co-pay, member co-insurance
Claim Summary	Summary of all claims under this EOB
10	Unique claim number assigned by Wellfleet for this charge
11	Name of the patient who received services
12	The full amount the provider charged for this claim
13	The amount excluded or not covered by the plan
14	The amount paid by any other insurance for this claim
15	The network discount amount
16	Full amount covered by the plan for this claim
17	Member co-pay amount applied to this claim
18	Member deductible amount applied to this claim
19	Total patient responsibility for this claim
20	Total paid amount for this claim
21	Totals for each column
Claims Detail	Breakdown of each claim line
22	Unique claim number assigned by Wellfleet for this charge
23	Name of the patient who received services
24	Name of physician or facility whom is billing for service(s)
25	Patient's date of birth
26	Patient account number from the provider or facility who billed for service(s)
27	The date(s) services were rendered
28	Procedure code for the service billed
29	The amount the provider charges for the service(s)
30	The network discount amount
31	The amount excluded or not covered by the plan
32	The amount paid by any other insurance after coordination of benefits (COB) for this claim
33	Remark code displays the reason for any discount or ineligible amounts
34	Amount covered after any discounts and ineligible amounts
35	Member co-pay amount applied to this claim
36	Member deductible amount applied to this claim
37	The charges after any discount, ineligible, COB, co-pay and deductible amounts
38	The percentage of the remaining balance that has been paid by the plan
39	The amount that has been paid by the plan on behalf of SHIP
40	Totals for each column
41	The amount the member is responsible for paying to the Provider. This amount may include: not covered amounts, member deductible, member co-pay, member co-insurance
42	Total amount that has been paid by the plan
43	Procedure code for the service(s) billed
44	Procedure code description for the service(s) billed
45	Remark code displays the reason for any discount or ineligible amounts
46	Remark description

Common Insurance Terms

Co-Insurance – the percentage of your medical expenses for which you are responsible after any applicable Co-Pays or Deductible has been satisfied.

Co-Pay – a payment which you make upfront each time you receive certain medical services. When you visit your health care provider, you pay the copayment to the provider, and the plan considers coverage of the remaining expenses, subject to any applicable Deductible or Co-Insurance.

Deductible – the amount you must pay annually towards certain categories of medical expenses before insurance benefits begin.

Explanation of Benefits (EOB) – a document from the Claims Administrator, showing what the plan has covered, what discounts have been applied, and what your remaining financial responsibility (if any) is. THIS IS NOT A BILL, so do not send any balance due to Wellfleet. The provider will receive a separate notification from Wellfleet and should send you a revised bill for any remaining amount due.

Out-of-pocket expenses – the combined total of any Deductible and Coinsurance costs for which you are responsible.

In-Network Provider – a provider who belongs to your plans PPO Network who has a special agreement to accept a discounted rate. This means that the treatment costs are lower for you when you utilize one of these "In-Network" providers.

Out-of-Network Provider – a provider which has no special agreement with a PPO Network. Because there is no agreement, treatment costs and your deductible and co-insurance are higher.

If you require additional assistance with your claim, you can call the Wellfleet Customer Service Department at (877) 657-5031. You can also visit the SHIP office which is located on the 7th floor of University Health Services at 333 East Campus Mall, or call (608) 265-5232. The SHIP office is open from 9am-5pm, Monday through Friday. Alternatively, you can email the SHIP office at: shipmail@uhs.wisc.edu