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PO Box 9200
Milwaukee, WI 53201

Address Service Requested

Account Number	1234
Statement Number	1689423
Statement Period	2/11/2015 - 3/10/2015
Payment Due Date	4/10/2015

ACCOUNT SUMMARY

Previous Balance	2,114.68
Less Payment (-)	2,114.68
Less Adjustments (-)	0.00
Subtotal (=)	0.00
New Charges (+)	332.37
Total Amount Due	$322.37

REFER TO THE FOLLOWING PAGES FOR DETAILS OF YOUR BALANCE

BILL WRIGHT
1234 SAMPLE STREET
TEST WI 53202

Your SuperEOB® Invoice

Questions?

Customer Care is available for assistance at 888.477.7968, 7 a.m. - 8 p.m. CT (Monday - Thursday), 7 a.m. - 5 p.m. (Friday) and 9 a.m. - 1 p.m. (Saturday) or via email at customercare@hps.md.

Additional Payment Options:

- Pay online at hps.md/pay-now
- You may qualify for financial assistance through your provider. Visit hps.md/financialhelp or contact 877.477.7968 for details.

Improved User Experience to Member Portal Coming Soon!

PAYMENT COUPON - DETACH HERE

118711-14

IF PAYING BY CREDIT/DEBIT CARD

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

CARD NUMBER	SECURITY CODE	EXP DATE

I hereby authorize Health Payment Systems to charge the above Credit Card or Debit Card.

SIGNATURE

Account Number	1234
Member Name	BILL WRIGHT
Statement Number	1689423
Statement Period	2/11/2015 - 3/10/2015
Payment Due Date	4/10/2015
Total Amount Due	$322.37

Amount Enclosed $_____

PLEASE MAKE CHECKS PAYABLE TO HPS & SEND PAYMENTS TO:

Health Payment Systems, Inc.
PO Box 1450
Milwaukee, WI 53201-1450

- Please allow 5 to 7 days for delivery and processing when sending payment by mail.
- To save time and postage, you may make payments online at hps.md/pay-now or call 888.477.7968.

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Your Health Care Transaction Summary

Account Number	1234
Statement Number	1689423
Statement Period	2/11/2015 - 3/10/2015
Payment Due Date	4/10/2015
Total Amount Due	$332.37

ACCOUNT SUMMARY

PREVIOUS BALANCE	LESS PAYMENTS (-)	LESS ADJUSTMENTS (-)	SUBTOTAL (=)	NEW CHARGES (+)	AMOUNT DUE (=)
$2,114.68	$2,114.68	$0.00	$0.00	$332.37	$332.37

PAYMENTS & ADJUSTMENTS

Date	Payment Type	Description	Payment /Adjustment
		YOUR PREVIOUS BALANCE Web	$2,114.68
2/15/2015	Web Payment - Credit/Debit	Credit Card Payment received.	200.00
2/18/2015	LB Payment - Check	LOCKBOX PAYMENT CHECK DATE 1/14/15	298.79
2/28/2015	Payment - Other	HSA Account Payment	1,615.89
		TOTAL PAYMENTS & ADJUSTMENTS	**$2,114.68**

Financial Assistance Available
You may qualify for financial assistance through your provider. Visit hps.md/financialhelp or contact 888.477.7968 for details.

Other Insurance Coverage
If you or a dependent on your health insurance plan have secondary health insurance, please complete the section below with your other insurance coverage information and return in the enclosed envelope. You may also contact Customer Care at 888.477.7968 to update this information. If your secondary insurance information is not updated, you will continue to receive a SuperEOB® and be responsible for payment.

PAYMENT COUPON - DETACH HERE

IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE

FIRST	MIDDLE	LAST	
ADDRESS			
CITY	STATE	ZIP	
TELEPHONE ( ) ☐ - Separated ☐ - Divorced ☐ - Widowed	EMAIL ADDRESS	MARITAL STATUS ☐ - Single ☐ - Married ☐ - Separated ☐ - Divorced ☐ - Widowed	
NAME OF SECONDARY INSURANCE	POLICY HOLDER		
POLICY NUMBER	GROUP NUMBER/NAME	EFFECTIVE DATE	
CLAIMS ADDRESS	PHONE NUMBER		
DEPENDENTS COVERED UNDER SECONDARY INSURANCE			

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Your Health Care Transaction Summary

Account Number	1234
Statement Number	16894232/11/2015 -
Statement Period	3/10/2015 4/10/2015
Payment Due Date	
Total Amount Due	$332.37

NEW HEALTH CARE SERVICES & CHARGES

Date of Service	Patient Name	Health Care Provider	Claim Number	Non-Covered Charges	Allowed Amount	Paid by Insurance	Member Owes
2/26/2015	Ben Wright	Medical Group	144374221	$0.00	$219.97	$0.00	$219.97
2/26/2015	Ben Wright	Medical Group	144722841	$0.00	$32.40	$0.00	$32.40
2/3/2015	Katie Wright	PT Center of WI	174234570	$0.00	$103.66	$83.66	$20.00
2/10/2015	Katie Wright	PT Center of WI	174234571	$0.00	$103.66	$83.66	$20.00
2/17/2015	Katie Wright	PT Center of WI	174234572	$0.00	$103.66	$83.66	$20.00
2/24/2015	Katie Wright	PT Center of WI	174234573	$0.00	$103.66	$83.66	$20.00

- Refer to the following pages for additional claim details

TOTAL NEW HEALTH CARE SERVICES & CHARGES $332.37

HOW TO INTERPRET THE EOB PAGES THAT FOLLOW

Health Care Provider The name of the individual provider or the facility institution that provided services.
Claim Number Uniquely assigned number to identify the services once processed through your benefit plan.
Type of Service A general description of the services rendered by the Health Care Provider.
Amount Billed The total amount billed by the Health Care Provider for each service.
Non-Covered Charges (Member May Owe Healthcare Provider) - These non-covered charges - as determined by your health plan - may be owed by you directly to your provider of service. These charges are not included in the "New Balance Due" (above).
Provider Discounts These are negotiated reductions on billed services between HPS and the Health Care Provider.
Allowed Amount This is the amount to be allowed by your plan after discounts and non-covered charges are considered.
Paid by Insurance The amount paid by benefit plan.
Member Owes (Due to HPS) - This is the amount you owe after the discount, non-covered charges, and health plan payment. It is the sum of any deductible, coinsurance, or copayment amounts.
Remark Codes Additional messages that may explain how your claim was processed.

APPEAL LANGUAGE

This claim has been processed consistent with the benefit terms and conditions written in the Summary Plan Document. Contacting TPA at 800.999.1234 may resolve your questions regarding benefit determination. A claimant or their authorized representative has the right to appeal any claim, denied in whole or in part; and request free of charge a copy of any criteria or plan provision used in denying this claim. A review of this benefit determination may be requested in writing by submitting your appeal to us along with any additional material/information you have within 180 days of receipt of denial or the claimant loses the right to further appeal or file a suit in civil court. If you provide the plan with all information needed, you will receive a written reply no later than 60 days of receipt of the appeal. If your appeal is denied, you have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). For questions about your appeals rights, this notice, or for assistance, you may contact the TPA at 800.999.1234.

Send Appeals to: TPA
Attn: Appeals
PO Box 678
Milwaukee, WI 53202

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Account Number	1234
Statement Number	1689423
Statement Period	2/11/2015 - 3/10/2015

Explanation of Benefits (EOB)

Type of Service - Personal Health Information can not be displayed on this document. For more details please call TPA at 800.999.1234.
Member Owes - This is the combination of the deductible, co-insurance, and copay amounts determined by your health plan. This amount is owed to HPS as your provider had already been paid on your behalf.

Patient Name: BEN WRIGHT
Provider: Medical Group
Relationship to Insured: Dependent

Claim Number: 144374221

Dates of Service From-To	Type of Service	Amount Billed	Non-Cov. Charges (-)	Provider Discounts (-)	Allowed Amount (=)	Ins. Paid	Deductible Amount	Co-Pay Amount (+)	Co-Insurance (+)	Member Owes (=)	Remark Codes
2/26/15-2/26/15	MEDICAL OFFICE/OP VISITS	314.00	0.00	142.03	171.97	0.00	171.97	0.00	0.00	171.97	
2/26/15-2/26/15	DIAGNOSTIC LAB	80.00	0.00	32.00	48.00	0.00	48.00	0.00	0.00	48.00	
	Totals	**394.00**	**0.00**	**174.03**	**219.97**	**0.00**	**219.97**	**0.00**	**0.00**	**219.97**	

Health Coverage Remark Codes

Patient Name: BEN WRIGHT
Provider: Medical Group
Relationship to Insured: Dependent

Claim Number: 144722841

Dates of Service From-To	Type of Service	Amount Billed	Non-Cov. Charges (-)	Provider Discounts (-)	Allowed Amount (=)	Ins. Paid	Deductible Amount	Co-Pay Amount (+)	Co-Insurance (+)	Member Owes (=)	Remark Codes
2/26/15-2/26/15	DIAGNOSTIC LAB	54.00	0.00	21.60	32.40	0.00	32.40	0.00	0.00	32.40	
	Totals	**54.00**	**0.00**	**21.60**	**32.40**	**0.00**	**32.40**	**0.00**	**0.00**	**32.40**	

Health Coverage Remark Codes

Patient Name: KATIE WRIGHT
Provider: PT Center of WI
Relationship to Insured: Dependent

Claim Number: 174234570

Dates of Service From-To	Type of Service	Amount Billed	Non-Cov. Charges (-)	Provider Discounts (-)	Allowed Amount (=)	Ins. Paid	Deductible Amount	Co-Pay Amount (+)	Co-Insurance (+)	Member Owes (=)	Remark Codes
2/3/15-2/3/15	PHYSICAL/OP THERAPY	146.00	0.00	42.34	103.66	83.66	0.00	20.00	0.00	20.00	
	Totals	**146.00**	**0.00**	**42.34**	**103.66**	**83.66**	**0.00**	**20.00**	**0.00**	**20.00**	

Health Coverage Remark Codes

Patient Name: KATIE WRIGHT
Provider: PT Center of WI
Relationship to Insured: Dependent

Claim Number: 174234571

Dates of Service From-To	Type of Service	Amount Billed	Non-Cov. Charges (-)	Provider Discounts (-)	Allowed Amount (=)	Ins. Paid	Deductible Amount	Co-Pay Amount (+)	Co-Insurance (+)	Member Owes (=)	Remark Codes
2/10/15-2/10/15	PHYSICAL/OP THERAPY	146.00	0.00	42.34	103.66	83.66	0.00	20.00	0.00	20.00	
	Totals	**146.00**	**0.00**	**42.34**	**103.66**	**83.66**	**0.00**	**20.00**	**0.00**	**20.00**	

Health Coverage Remark Codes

Patient Name: KATIE WRIGHT
Provider: PT Center of WI
Relationship to Insured: Dependent

Claim Number: 174234572

Dates of Service From-To	Type of Service	Amount Billed	Non-Cov. Charges (-)	Provider Discounts (-)	Allowed Amount (=)	Ins. Paid	Deductible Amount	Co-Pay Amount (+)	Co-Insurance (+)	Member Owes (=)	Remark Codes
2/17/15-2/17/15	PHYSICAL/OP THERAPY	146.00	0.00	42.34	103.66	83.66	0.00	20.00	0.00	20.00	
	Totals	**146.00**	**0.00**	**42.34**	**103.66**	**83.66**	**0.00**	**20.00**	**0.00**	**20.00**	

Health Coverage Remark Codes

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Account Number	1234
Statement Number	1689423
Statement Period	2/11/2015 - 3/10/2015

Explanation of Benefits (EOB)

Type of Service - Personal Health Information can not be displayed on this document. For more details please call TPA at 800.999.1234.

Member Owes - This is the combination of the deductible, co-insurance, and copay amounts determined by your health plan. This amount is owed to HPS as your provider had already been paid on your behalf.

Patient Name: KATIE WRIGHT
Provider: PT Center of WI
Relationship to Insured: Dependent

Claim Number: 174234573

Dates of Service From-To	Type of Service	Amount Billed	Non-Cov. Charges (-)	Provider Discounts (-)	Allowed Amount (=)	Ins. Paid	Deductible Amount	Co-Pay Amount (+)	Co-Insurance (+)	Member Owes (=)	Remark Codes
2/24/15-2/24/15	PHYSICAL/OP THERAPY	146.00	0.00	42.34	103.66	83.66	0.00	20.00	0.00	20.00	
	Totals	**146.00**	**0.00**	**42.34**	**103.66**	**83.66**	**0.00**	**20.00**	**0.00**	**20.00**	

Health Coverage Remark Codes

Financial Assistance Available
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Other Insurance Coverage
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