

# Explanation of Benefits

Tips for reading your explanation of benefits from Klais & Company, Inc.

**Total Charge** – This is the total amount billed by the provider of service.

**Provider Discount** – This is the Preferred Provider Discount (PPO discount). If the provider is in your network, they have agreed to specific billing rates. This discount is taken to match contracted rates and is not the patient's responsibility.

**Ineligible** – This amount is not covered by your plan. This amount may be owed to your provider. Refer to the comment section and or/consult the provider of the service.

**Check Number**

**Name and address of provider or person receiving payment.\***

**Amount Paid**

**Date Check Issued**

**Pay Pct** – Percentage at which eligible charges were paid.

**CD\*** - This column of codes directs you to the description box which explains why a charge is ineligible or the type of PPO discount applied.

**Co-Pay/Deductible** – This column represents any co-pay you might have in your plan/or any deductible amount not yet met. This is owed to the provider of service. \*\*

**Co-Insurance** – This amount is owed by you to the provider, plus any deductibles or co-pays.

**Amount Payable** - This is the amount Klais & co. Inc. paid to the provider. You do not owe this amount.

**KLAIS & COMPANY, INC.**  
 EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS  
 1061 WEST MARKET STREET  
 AKRON, OHIO 44313-6977  
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**EXPLANATION OF BENEFITS**      Date: **09/23/05**  
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Enrollee: **JOHN DOE**  
 Patient: **JOHN**  
 Claim #: **0000059.10**  
 Group #: **PLAN SPONSOR**  
 Location Code: **01**  
 Analyst: **NAME**

**JOHN DOE**  
 123 ELM STREET  
 AKRON, OH 44313

PROVIDER TYPE OF SERVICE	DATE OF SERVICE FROM	DATE OF SERVICE TO	TOTAL CHARGE	PROVIDER DISCOUNT	INELIGIBLE	CD*	CO-PAY/ DEDUCTIBLE	CO-INSURANCE	PAY PCT	AMOUNT PAYABLE
WILLIAM JONES, MD OFFICE VISIT	09/01	09/01	100.00	50.00		DP	10.00		100	40.00
SURGERY	09/01	09/01	1000.00	150.00		DP	100.00	75.00	90	675.00
JOSEPH SMITH, MD DIAGNOSTIC EXAM	09/10	09/10	200.00		40.00	19	160.00			
<b>TOTALS</b>			<b>1300.00</b>	<b>200.00</b>	<b>40.00</b>		<b>270.00</b>	<b>75.00</b>		<b>715.00</b>

LESS OTHER ADJUSTMENTS  
**AMOUNT PAID 715.00**

Patient responsibility includes Co-Pay/Deductible and Co-Insurance. Patient may also be responsible for any Ineligible charges; see Comments and/or consult the provider of service.

\* Description of Codes as used above/Misc. Comments:  
**DP - PPO DISCOUNT - NOT PATIENT'S RESPONSIBILITY**  
**19 - AMOUNT EXCEEDS REASONABLE & CUSTOMARY FOR SERVICE.**

	Satisfied Year to Date	Amount to be Satisfied
Network Deductible Individual	100.00	
Family	175.00	125.00
Non-Network Deductible Individual	160.00	140.00
Family	200.00	400.00

SEE REVERSE SIDE

Check Number	Check Issued To	Amount	Date
75642	WILLIAM JONES MD 1220 MARKET STREET AKRON, OH 44313	715.00	09/23/05

\* In some cases the EOB may also contain a check payable to the plan member.  
 \*\* You may have already paid all or a portion of this amount.