CUSTOMER SERVICE
ROUTE 0501
P.O. BOX 9310
MINNEAPOLIS, MN 55440-9310

Explanation of Benefits

Subscriber: ANDREW SHARP
Subscriber ID: 984567643
Group/ Policy: PERFORCE SOFTWARE INC

015PEIPIBW0003005-04522-01
ANDREW SHARP
212 THOMPSON SQ
MOUNTAIN VIEW CA 94043-4219

Hi, ANDREW.

THIS IS NOT A BILL. This Explanation of Benefits (EOB) is a summary of services received and how plan benefits were applied.

To the right is the total amount you may owe for the services included in this statement – but, depending on when you receive this statement, that amount may not reflect payments you've already made. Visit Medica.com/SignIn to see the most up to date amounts.

Use this EOB as a reference or retain as needed.

Services in this statement occurred between Jan 6, 2025 - Jan 6, 2025

Provider charges	**$176.30**
Your total amount owed	**$11.11**

See claim details on following pages or go directly to Medica.com/SignIn to view.

Plan balances

As of 01/14/2025 for plan year 2025

Balances for ANDREW		**Maximum amount**	**Progress so far**	**Remaining amount**
Network	Deductible	$3,300.00	$11.11	**$3,288.89**
	Out-of-pocket limit	$3,300.00	$11.11	**$3,288.89**
Out-of-Network	Deductible	$5,000.00	$0.00	**$5,000.00**
	Out-of-pocket limit	$10,000.00	$0.00	**$10,000.00**

Got questions?
Get in touch with Member Services at **952-945-8000** or **800-952-3455**

Claim detail for ANDREW

Provider: QUEST DIAGNOSTICS NICHOLS INSTITUTE
Status: Network

Patient ID: 14773-984567643-00
Claim number: 06393627-00

		Billed	Allowed amounts		Amounts paid		Total you owe	
Services received	**Notes**	**Charges**	**Provider Responsibility**	**Allowed amount**	**Other coverage paid**	**Paid amount**	**Patient non-covered amount**	**Amount you owe****
Laboratory 01/06/2025	0032	$176.30	$165.19	$11.11	$0.00	$0.00	$0.00	$11.11
• **Deductible** $11.11 • **Copay:** $0.00 • **Coinsurance:** $0.00								
Total amount		$176.30	$165.19	$11.11	$0.00	$0.00	$0.00	$11.11

**May not reflect payments made at the time of service - that's why it's a good idea to hold off on making any payments until you receive a bill from the provider.

Explanation of your notes

Notes are used to identify specific types of adjustments relating to your claims. The corresponding details will help explain how your claim was processed.

0032 -- CHARGES EXCEED PROVIDERS ALLOWED PAYMENT AMOUNT. PROVIDER CAN NOT BILL OVER THIS ALLOWED PAYMENT AMOUNT.

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Your rights as a member continued

TTY users, please call 711

Procedures for complaints that do not involve a medical determination:

1..If you contact Medica to express a complaint verbally, Medica will communicate a decision to you within 10 calendar days from receipt of the complaint. If you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. If you need assistance with completing the complaint form Medica will help you. The complaint form can be mailed to the address listed above.

2..If you submit your complaint in writing, Medica will communicate a decision to you within 30 calendar days. If you remain dissatisfied with Medica's decision, you may pursue an appeal as described below under the section "Second Level of Review". Medica's second level of review must be completed before you have the right to submit a request for external review.

Procedures for complaints that require a medical determination: If this decision was based on medical necessity, you have one year following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 15 calendar days from receipt of your request. If waiting the standard 15-day turnaround time might jeopardize your life, health or ability to regain maximum function or if this timeframe would subject you to severe pain that cannot be managed without the care of treatment you are requesting, you or your attending provider may request an expedited, 72 hour appeal review. In such cases, you may also have the right to request an external review while your first level review is being conducted.

Second Level of Review

If you remain dissatisfied with Medica's decision after your first level review, you may pursue a second level of review. Your request must be submitted to Medica within one year following receipt of Medica's first level review decision. Generally, the second level review is optional if the complaint requires a medical determination and you may file a request for external review. Medica will inform you whether the second level of review is optional or required.

Medica's Second Level of Review Options:

-.Hearing. Under this process, you present your case to a committee, either in person or via teleconference. If this second

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Your rights as a member continued

crime. Your assistance in detecting fraudulent claims will help reduce cost of health care for all consumers."

This is a final determination of a claim under the medical plan and HRA account. If you have questions about the extent to which this claim for services has been paid, you should follow the appeal procedure on this document. Deductible and coinsurance amounts have been paid under the HRA account to the extent you have a positive balance in your HRA account.If you dispute or have questions about the amount identified as a deductible or co-pay, please follow the appeal procedure in this document.

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