Helping Administer Your Success…

Employee Benefit Systems

Sarpy County

Partial Self-Funding

(Partial Self-Funding applies to In-Network services ONLY)

EBS

EBS can help:

Employee Benefit Systems Third Party Administration Services

Partial Self– Funding Claims Process

This flowchart is for health insurance claims only, because they go through the insurance carrier first and then to Employee Benefit Systems (EBS). As a rule, your health care provider will file claims directly to the insurance carrier. Please consult your benefits book for complete details. Here is how a claim goes through the system for settlement and payments by the insurance carrier first and then by Employee Benefit Systems (EBS) through the Partial Self-Fund portion of your health insurance:

The insurance carrier receives the claim filed by your provider of service.

↓

The claim is processed by the insurance carrier according to the benefits and limitations of the Plan

↓

The insurance carrier sends an Explanation of Benefits (EOB) to your home and an electronic copy of the EOB to Employee Benefit Systems (EBS), the Partial Self-Fund Administrator. ALWAYS retain your copy. The EOB shows Employee Benefit Systems (EBS) what charges are covered and how the insurance carrier addressed them.

↓

Employee Benefit Systems (EBS) will process the claims according to your Partial Self-Funding Plan (see PSF Illustration)

↓

Employee Benefit Systems (EBS) creates their own in-house EOB that will show how the claim was processed through the insurance carrier and also how it was processed through the PSF portion. EBS' statement will also show your accumulated deductible and out of pocket maximum. You can cross-reference the statement details with the insurance carrier's EOB you receive at home.

↓

The PSF benefit checks will be administered in accordance with the contractual agreement in place between the insured Group and EBS. To further assist you in tracking your claims, you may want to take advantage of EBS' Customer Service tool at www.ebs-tpa.com -- click on "Employees/Members". Once you register and are granted a password, you can log in to view paid claim information, review explanation of benefits statements, and other additional features including links to answer many health questions.

Contact Us

Employee Benefit Systems ▪ 214 North Main Street ▪ Burlington, IA 52601
Phone: 800-373-1327 ▪ Fax: 319-753-6114 ▪ www.ebs-tpa.com

EBS

EBS can help:

Employee Benefit Systems Third Party Administration Services

Partial Self–Funded Illustration

Sarpy County

Employee Plan In Network

Deductible:
$500 for a Single Plan
$1,000 for a Family Plan

Out of Pocket Maximum:
$3,500 for a Single Plan
$7,000 for a Family Plan

Coinsurance:
You pay 30% for In-network

Doctor's Office Co-pay:
$30/$75

Ambulance Co-pay:
$100/trip

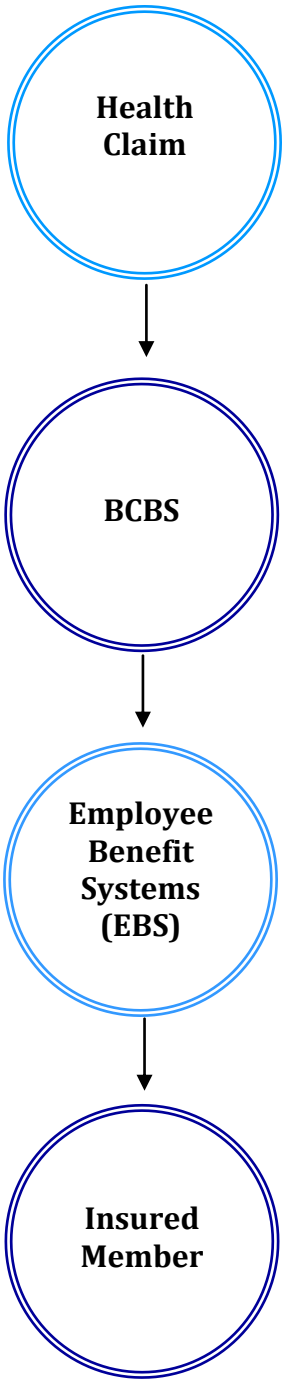
Emergency Room Co-pay:
$250

Urgent Care Co-pay:
$45

Telehealth Co-pay:
$10

Prescription Deductible:
$100 single / $200 family

Prescription Co-pay:
$10-Generic
$40-Selected Brand Name
$75-Brand Name
$100 Specialty



1. You incur medical services

Your medical provider will file your claim with BCBS using the information from your BCBS Identification Card.

2. BCBS settles your claim

All claims are submitted to BCBS first for settlement under your high deductible plan. BCBS will make a payment if applicable to your provider of service and send you an Explanation of Benefit (EOB).

3. EBS settles your claim

EBS receives the EOB from BCBS for processing the claim on your low deductible plan. EBS will make a payment if applicable to your provider of service. You will receive an EOB that summarizes how much EBS paid and how much you, the member, are responsible for.

** Insured member is always responsible for deductibles, out-of-pocket maximums and co-pays on the EBS plan.

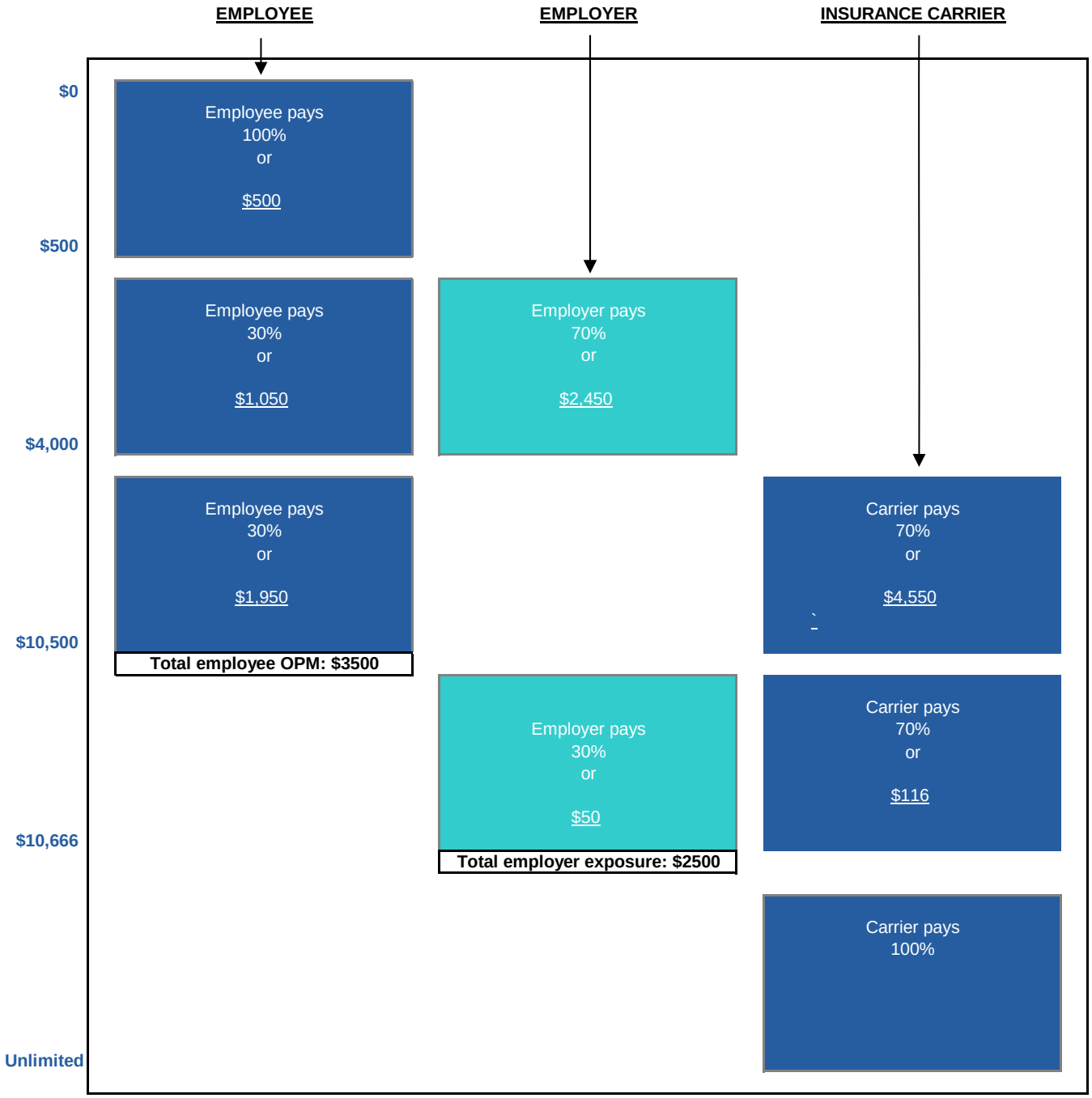
Contact Us

Employee Benefit Systems ▪ 214 North Main Street ▪ Burlington, IA 52601
Phone: 800-373-1327 ▪ Fax: 319-758-8562 ▪ www.ebs-tpa.com

EBS

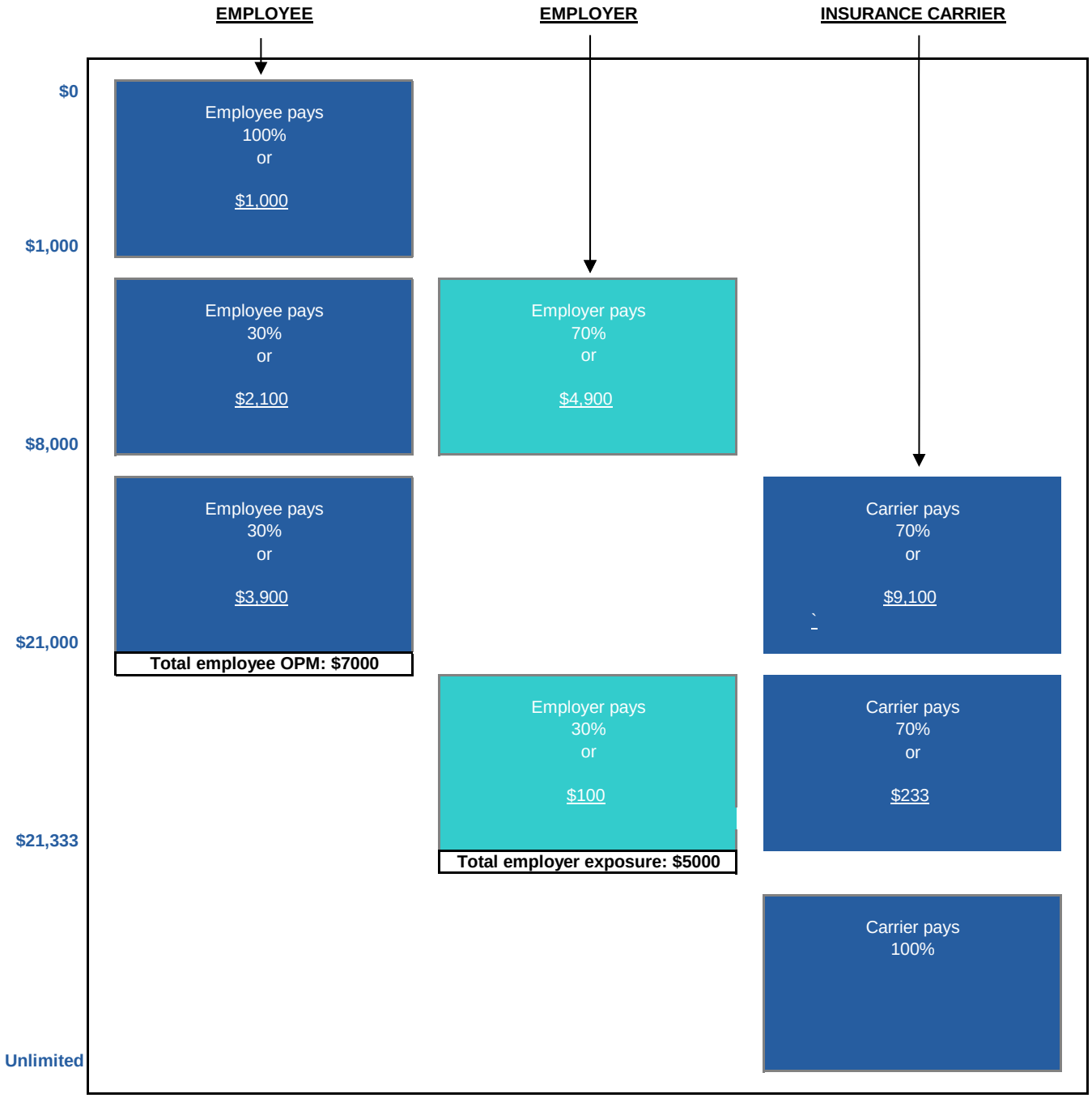
	Employee Plan	Shared Funding®	Insurance Policy
Deductible (single)	500		4,000
Coinsurance Level	30%	70%	70%
Out-of-Pocket Max	3,500	2,500	6,000
Rx Copay			
OV Copay			

Employee Benefit Systems (EBS) will administer the claims difference for the plan sponsor (employer). Claims must first be submitted to the insurance carrier.



	Employee Plan	Shared Funding®	Insurance Policy
Deductible (family)	1,000		8,000
Coinsurance Level	30%	70%	70%
Out-of-Pocket Max	7,000	5,000	12,000
Rx Copay			
OV Copay			

Employee Benefit Systems (EBS) will administer the claims difference for the plan sponsor (employer). Claims must first be submitted to the insurance carrier.



EMPLOYEE BENEFIT SYSTEMS
HELPING ADMINISTER YOUR SUCCESS

How to read your Explanation of Benefits (EOB)

Number and Processor to call

Employee Benefit Systems
214 N. Main
Burlington, IA 52601

For Questions call 319-752-3200 or 800-373-1327 or fax us @ 319-758-6271
Processed by:

Forward Service Requested

Employer Name

Social Security or ID Number of Employee

Provider/Member's Name
Street Address
City, State, Zip Code

Group #: 11
Group: Demo PSF Company
Insured:
SSN:
Claimant:
Employee #:
Patient Acct:
Provider Name:
Provider TIN:
Claim #:
Processed on:

Employee Name

Patient Name

Place patient was seen

Date claim was processed

Service Received

Dates of Service

Denied Service

Provider Write-off

Claim Summary

Total Amount Covered:	100.00
Paid by Other Insurance Co:	0.00
Total Paid by Plan:	56.02
Employee's Responsibility:	0.00

Dollar Amount you owe

Explanation of Benefits- This is NOT a Bill

Type of Service	Dates of Service	Total Charge	Not Covered	Discount	Eligible Expense	Remark Code	Co-Pay	Co-Ins	Deductible Applied	Paid at %	Plan Payment
Lab	1/1/06	$100	$0	$17	$83	3	$0	$14	$12.98	80	$56.02
	Total	$100	$0	$17	$83		0	$14	$12.98		$56.02

Billed Charges

Fixed %

Accumulators	
Deductible Remaining-Plan	0.00
Out of Pocket Remaining-Plan	150.00

Payment To	**Amount**	**Check #**	**Date**
	56.02	00001	6/6/06

Remarks

3 Applied to Deduct & Co-Insurance

Eligible Amount Covered after discount or Not Covered

Explanation Code Messages explained below

Amount Applied to Deductible

Amount you owe calculated with a fixed %

Amount paid by the Self-Funded Plan

Member's dollar responsibility left to meet

Member is responsible for fixed dollar amount for services rendered

P3456031001

ENV 2
1 OF 2

Employee Benefit Systems
214 N. Main St.
Burlington, IA 52601

Forwarding Service Requested

WHITE STOCK
200607050150

TEST

SINGLE PIECE

2 0.5176 SP 0.390

Joe Employee 1
1111 STREET
BURLINGTON, IA 52601

For Questions call 319-752-3200 or 800-373-1327 Or fax us @ 319-753-6114

Group #: 11
Group: Demo Partially Self Funded Compa
Insured: Joe Employee
SSN: 111-11-1112
Claimant: INSURED
Employee #: 1
Patient Acct: gao80002
Provider Name: .
Provider TIN: 99-9999999
Claim #: 2006-164000022-0000
Processed on: 06/22/2006

Claim Summary

Total Amount Covered:	572.70
Paid by Other Insurance Co:	0.00
Total Paid by Plan:	119.76
Employee's Responsibility:	452.94

Explanation of Benefits - This is NOT a Bill

Type of Service	Dates of Service	Total Charge	Not Covered	Discount	Eligible Expense	Remark Code	Co-Pay	Co-Ins	Deductible Applied	Paid at %	Plan Payment
Hospital Misc.	05/04/2006-05/04/2006	106.00	0.00	18.02	87.98	1	0.00	0.00	87.98	80	0.00
Hospital Misc.	05/08/2006-05/08/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/10/2006-05/10/2006	100.00	0.00	17.00	83.00	1	0.00	0.00	83.00	80	0.00
Hospital Misc.	05/12/2006-05/12/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/15/2006-05/15/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/17/2006-05/17/2006	100.00	0.00	17.00	83.00	3	0.00	14.00	12.98	80	56.02
Hospital Misc.	05/19/2006-05/19/2006	96.00	0.00	16.32	79.68	2	0.00	15.94	0.00	80	63.74
	TOTALS	690.00	0.00	117.30	572.70		0.00	29.94	423.00		119.76

Accumulators	
DEDUCTIBLE REMAINING - PLAN	0.00
OUT OF POCKET REMAINING - PLAN	970.06

Payment To	Amount	Check #	Date
.	119.76	00000001	06/23/2006

Remarks

1 Applied to Deductible
3 Applied to Deduct & Co-Insurance
2 Co-insurance Applied

VOID

P3456031001

ENV 2
1 OF 2

Employee Benefit Systems
214 N. Main St.
Burlington, IA 52601

Forwarding Service Requested

WHITE STOCK
200607050150

TEST

SINGLE PIECE

2 0.5176 SP 0.390

Joe Employee 1
1111 STREET
BURLINGTON, IA 52601

For Questions call 319-752-3200 or 800-373-1327 Or fax us @ 319-753-6114

Group #: 11
Group: Demo Partially Self Funded Compa
Insured: Joe Employee
SSN: 111-11-1112
Claimant: INSURED
Employee #: 1
Patient Acct: gao80002
Provider Name: .
Provider TIN: 99-9999999
Claim #: 2006-164000022-0000
Processed on: 06/22/2006

Claim Summary

Total Amount Covered:	572.70
Paid by Other Insurance Co:	0.00
Total Paid by Plan:	119.76
Employee's Responsibility:	452.94

Explanation of Benefits - This is NOT a Bill

Type of Service	Dates of Service	Total Charge	Not Covered	Discount	Eligible Expense	Remark Code	Co-Pay	Co-Ins	Deductible Applied	Paid at %	Plan Payment
Hospital Misc.	05/04/2006-05/04/2006	106.00	0.00	18.02	87.98	1	0.00	0.00	87.98	80	0.00
Hospital Misc.	05/08/2006-05/08/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/10/2006-05/10/2006	100.00	0.00	17.00	83.00	1	0.00	0.00	83.00	80	0.00
Hospital Misc.	05/12/2006-05/12/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/15/2006-05/15/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/17/2006-05/17/2006	100.00	0.00	17.00	83.00	3	0.00	14.00	12.98	80	56.02
Hospital Misc.	05/19/2006-05/19/2006	96.00	0.00	16.32	79.68	2	0.00	15.94	0.00	80	63.74
	TOTALS	690.00	0.00	117.30	572.70		0.00	29.94	423.00		119.76

Accumulators	
DEDUCTIBLE REMAINING - PLAN	0.00
OUT OF POCKET REMAINING - PLAN	970.06

Payment To	Amount	Check #	Date
.	119.76	00000001	06/23/2006

Remarks

1 Applied to Deductible
3 Applied to Deduct & Co-Insurance
2 Co-insurance Applied

VOID