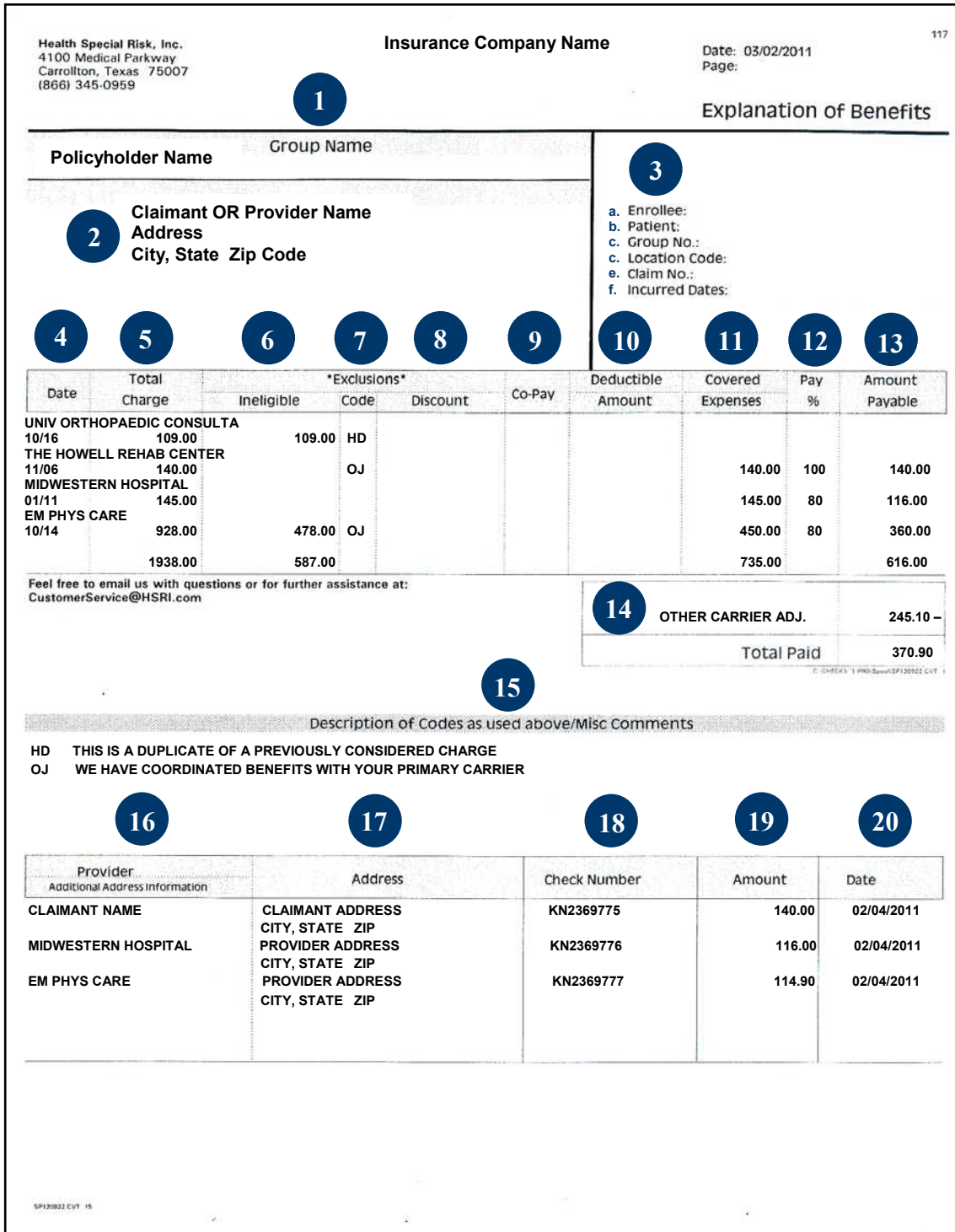

Health Special Risk, Inc.
4100 Medical Parkway
Carrollton, Texas 75007
(866) 345-0959

Insurance Company Name

117

Date: 03/02/2011
Page:

1

Explanation of Benefits

Policyholder Name

Group Name

2

Claimant OR Provider Name
Address
City, State Zip Code

3

a. Enrollee:
b. Patient:
c. Group No.:
c. Location Code:
e. Claim No.:
f. Incurred Dates:

4 Date	5 Total Charge	6 *Exclusions* Ineligible	7 Code	8 Discount	9 Co-Pay	10 Deductible Amount	11 Covered Expenses	12 Pay %	13 Amount Payable
UNIV ORTHOPAEDIC CONSULTA									
10/16	109.00	109.00	HD						
THE HOWELL REHAB CENTER									
11/06	140.00		OJ				140.00	100	140.00
MIDWESTERN HOSPITAL									
01/11	145.00						145.00	80	116.00
EM PHYS CARE									
10/14	928.00	478.00	OJ				450.00	80	360.00
	1938.00	587.00					735.00		616.00

Feel free to email us with questions or for further assistance at:
CustomerService@HSRI.com

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OTHER CARRIER ADJ.	245.10 –
Total Paid	370.90

15

Description of Codes as used above/Misc Comments

HD THIS IS A DUPLICATE OF A PREVIOUSLY CONSIDERED CHARGE
OJ WE HAVE COORDINATED BENEFITS WITH YOUR PRIMARY CARRIER

16 Provider / Additional Address Information	17 Address	18 Check Number	19 Amount	20 Date
CLAIMANT NAME	CLAIMANT ADDRESS CITY, STATE ZIP	KN2369775	140.00	02/04/2011
MIDWESTERN HOSPITAL	PROVIDER ADDRESS CITY, STATE ZIP	KN2369776	116.00	02/04/2011
EM PHYS CARE	PROVIDER ADDRESS CITY, STATE ZIP	KN2369777	114.90	02/04/2011

SP120922.CVT 15

How to read your Explanation of Benefits (EOB)

1. Group Name: The name of the policyholder with whom you are insured.
2. Name and address of provider/facility/claimant receiving EOB.
3. a. Enrollee: Individual who is primary on the policy.
   b. Patient: Individual who received services.
   c. Group No: Designated to identify the policyholder.
   d. Location code: Information used by HSR to identify your plan.
   e. Claim No: Number assigned for each bill received.
   f. Incurred Dates: Date(s) for services provided to you.
4. Date: Date of Service.
5. Total Charge: The actual cost the provider billed for the services you received.
6. Exclusions - Ineligible: The dollar amounts that are not eligible for benefits.
7. Exclusions - Code: Corresponds with a description of why the dollar amounts were ineligible.
8. Exclusions - Discount: The amount the provider should agree to write off from the billed amount.
9. Co-pay: The amount you would pay the provider at the time of service.
10. Deductible Amount: The amount that needs to be met before benefits are available.
11. Covered Expenses: The dollar amount of charges eligible for consideration.
12. Pay %: The percent used to calculate payment.
13. Amount Payable: The benefit amount available for this service.
14. C.O.B. Amount/Other Carrier Adjustment: The amount paid by the primary insurance company.
15. Description of the codes used under “Exclusions” in section six (6) and/or miscellaneous comments.
16. Provider/Payable To: Name of the provider/facility/claimant receiving check.
17. Address: The address of the provider/facility/claimant receiving check.
18. Check Number: Unique number identifying a check.
19. Amount: Benefit being issued to a provider/facility/claimant.
20. Date: The date the check was issued.