P294002800C

Solstice
P. O. Box 19199
Plantation, FL 33318

WHITE STOCK
201801173363
TEST

EXPLANATION OF BENEFITS

This is NOT a bill. Please retain for your records.

This statement shows how we processed your claim.

1 OF 6 F

ENV 1

Electronic Service Requested

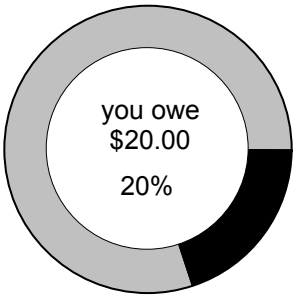
SINGLE PIECE

1 1.3360 SP 0.670

[Patient Name]
[Patient Address]

1

Claim ID:	[Claim Number]
Service Performed:	[Date(s) of Service]
Patient:	[Patient Name]
Member ID:	[Member ID]
Policy Holder:	[Policy Holder Name]
Relationship:	[Policy Relationship]
Group:	[Group Name]
Group ID:	[Group ID]
Plan:	[Plan Name]
Plan Type:	[Plan Type]
Provider:	[Provider Name]
Network Participation:	[Network Participation]



YOUR SOLSTICE BENEFITS:

- Insurance Saved You: **80%**
- Your Responsibility: **20%**

Have questions about this

Call us: 1-877-760-2247
TTY / TDD 711

Online: www.mysolstice.net

PROVIDER CLAIM SUMMARY

Claim submitted by [Patient Name] for provider service by [Network Participation] provider [Provider Name].

○ Submitted Charge:	$100.00	The total amount charged by your service provider
Network Discount:	$47.00	The amount you save when you use a provider who participates in our network. We negotiate special network discounts for our members.
Your Plan Paid:	$33.00	This is the amount that we paid for the service after subtracting applicable deductibles, coinsurance, and copayments (Details on page 2).
Paid by Other Insurance:	$0.00	The amount paid by other insurance company as a secondary payor of your policy. (Details on page 2).
■ Your Responsibility:	$20.00	The amount that you owe including applicable deductibles, co-insurance, co-payments, and any amount that is not covered. (Details on page 2)

VOID

P2940028000C

CLAIM DETAILS

Claim submitted by participating [Network Participation] provider [Provider Name].

Service Dates(s)	Code*	Service Charge	Approved Charge	Network Discount	Your Plan Paid	Other Insurance Paid	YOUR RESPONSIBILITY					
							Not Covered	Remarks*	Deductible	Copay	CoInsurance	Your Responsibility
08/01/2017	D0140	$60.00	$25.00	$35.00	$5.00	$0.00	$0.00		$0.00	$20.00	$0.00	$20.00
08/01/2017	D0274	$40.00	$28.00	$12.00	$28.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00
TOTALS		**$100.00**	**$53.00**	**$47.00**	**$33.00**	**$0.00**	**$0.00**		**$0.00**	**$20.00**	**$0.00**	**$20.00**

Provider Procedure Code Description:

D0140 Limited oral evaluation - problem focused

D0274 Bitewings - four radiographic images

Remarks:

TEST

20180117336J

Definitions of Key Terms

Approved Charge	-The amount negotiated for a service that is covered by your plan. It is used to calculate your benefits	Out of Network	-Service performed by provider who does not participate in our network.
Coinsurance	-Percentage of the service cost that you pay after deductible	Procedure Code	-Common Terminology for provider procedures
CoPay	-Fixed amount you pay as a shared cost for covered services after the deductible is met	Remarks	-Explains the reason if a service charge has been declined.
		Service Date	-The date when the actual service was performed
Deductible	-The amount that you pay for services out of your pocket before your health plan begins to pay	Submitted Charge	-The amount that the provider has billed for the service
		You Owe	-The amount that you owe for the service including applicable deductibles, coinsurance, copayments, and any amount that is not covered and paid.
In Network	-Service performed by provider who participates in our network		
Network Discount	-Your savings for choosing a participating in our network provider	Your Plan Paid	-The amount that we paid for the service after subtracting applicable deductibles, coinsurance, and copayments.
Not Covered	-Service billed which is not covered by your provider policy or billed by mistake		
Other Insurance Paid	-The amount paid by other insurance as a second payor		

VOID

Solstice

Solstice
Call: 1-877-760-2247

WHITE STOCK

Claim ID: [Claim Number]
Patient: [Patient Name]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

What if I Don't Agree With This Decision?

You have the right to appeal. To exercise it, file your appeal in writing within 12 calendar months after the date of this notice.

Who May File An Appeal?

You or someone you name to act for you (your authorized representative) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others also already may be authorized under State law to act for you.

If you want someone to act for you, you and your authorized representative must sign a HIPAA release form, date and send us a statement naming that person to act for you. You can call us at: 1-877-760-2247 to learn how to name your authorized representative.

How Do I File An Appeal?

You or your authorized representative should mail your written appeal to the address below:

Solstice
ATTN: Grievance & Appeals Coordinator
P.O. Box 19199
Plantation, FL 33318

Expedited Appeal

You may request that the complaint or appeal resolution be expedited if the above process would seriously jeopardize your life or health. A professional, in consultation with the treating provider, will decide if an expedited review is necessary. When a review is expedited, Solstice will respond orally with a decision within 72 hours, followed up in writing within two business days of the decision.

VOID

What Do I Include With My Appeal?

The letter should be labeled as a "Level One" Complaint/Appeal and should include:

- Patient identifying information
- Provider identifying information
- The date(s) of the experience
- Description of the intended provider service
- The nature of the deviation
- The patient financial obligation toward the provider, if any
- The overall temperament/attitude of the provider and his/her auxiliaries
- A review of your attempt, if any, to clarify/correct the provider deviation
- A review of the provider's attempt, if any, to clarify/correct the deviation
- A review of the Informal grievance process by yourself and Solstice if one had occurred

What Happens Next?

We will respond with a decision within 15 calendar days after we receive your request. If the review cannot be completed before 15 days, we will notify you on or before the 15th day of the reason for the delay. The review will be completed within 15 calendar days after that. If you are not satisfied with our decision, you may request a second level review.

Provider Rights

A provider may also initiate an appeal or request a peer to peer conversation prior to an appeals submittal to discuss a medical necessity denial. This can be accomplished by submitting a written notification by mail or email – (consultants@solsticebenefits.com), or telephone.

Contact Information:

Toll Free: 1-877-760-2247 TTY / TDD 711
Monday through Friday 8:00 AM to 6:00 PM

Your health is our concern

- ✔ Keep your pearly whites clean and healthy! Get your regular cleanings and keep gum diseases at bay.
- ✔ Avoid periodontal disease by brushing and flossing daily, and getting regular cleanings!
- ✔ Untreated gum disease can lead to tissue, bone and tooth loss. Regular cleanings at your provider's office can keep your smile healthy!
- ✔ Preventative care can save time, money and discomfort. Brush your teeth twice and day, floss daily and get your cleanings!

Top 10 Questions to Ask

Let us help keep your health care thoughts organized! Download the checklist online:
info.solsticebenefits.com\
top-10-questions-to-ask-provider

More about your health and how to get the most of your benefits:
blog.solsticebenefits.com\
solstice-member-blog