Quartz Align

Administered by Brighton Health Plan Solutions, LLC
1600 Stewart Avenue, Ste. 700
Westbury, NY 11590

BRIGHTON health plan SOLUTIONS

First Name Last Name
Address 1, Address 2
City, State Zip

ACMEInc.

Group Name: xxx
Group Street Address
City, State Zip
Reference: 0000000000
Participant I.D.: 000000000000
Patient: First Name Last Name
Plan Name: xxx

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Explanation Of Benefits

Summary of Medical Claims
mm/dd/yy - mm/dd/yy

CLAIM SUMMARY FOR THIS PERIOD

What was billed:

Total Billed Amount	$0.00
Discount	$0.00
Allowed	**$0.00**

What was paid:

Other Insurance Payment	$0.00
Plan Payment	$0.00
Covered	**$0.00**

What you may owe:

Co-Insurance	$0.00
Co-Pay	$0.00
Deductible	$0.00
Not Covered Charges	$0.00
What You May Owe*	**$0.00**

YEAR TO DATE CLAIM SUMMARY

What was billed:

Total Billed Amount	$0.00
Discount	$0.00
Allowed	**$0.00**

What was paid:

Other Insurance Payment	$0.00
Plan Payment	$0.00
Covered	**$0.00**

What you may owe:

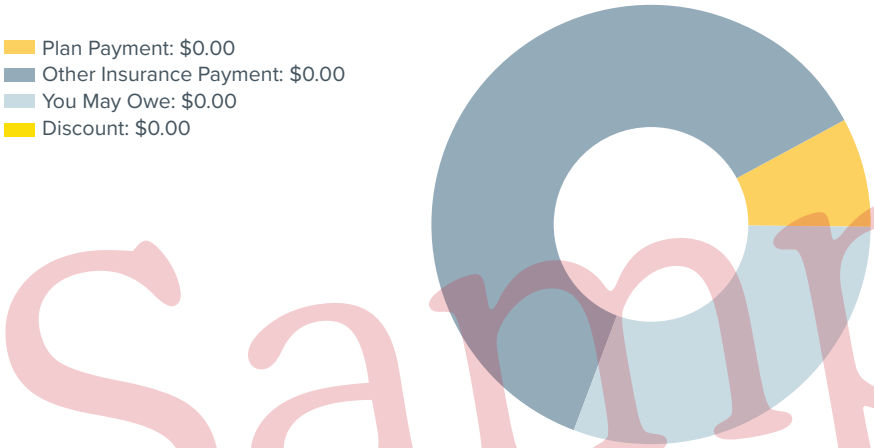
Co-Insurance	$0.00
Co-Pay	$0.00
Deductible	$0.00
Not Covered Charges	$0.00
What You May Owe*	**$0.00**

*Your healthcare professional may bill you directly for any amount you may owe.

BRIGHTON health plan SOLUTIONS

Reference: **000000000** | Participant I.D.: **000000000000** | Patient: **First Name Last Name**

CLAIM SUMMARY FOR THE PAY PERIOD: 10/01/20-10/31/20



Your total savings for this period $0.00

This includes your plan payment(s) and discount(s).

DEDUCTIBLES AS OF 02/15/2017

	In-network		Out-of-network	
	Family Deductible : $000.00		Family Deductible : $000.00	
	Individual Deductible : $000.00		Individual Deductible : $000.00	
Family	$0.00		$0.00	$0.00
Richard (Self)	$0.00	$0.00	$0.00	$0.00

Definition of key terms in this Explanation of Benefit Statement

Total Billed Amount: Charges submitted by your Medical Provider for the services rendered

Discount: Rededuction in charges based on the negotiated rates or upon fees and/or policies determined by your plan

Allowed: The amount that will be paid for a service before considering plan limitations.

Other Insurance Payment: The amount paid by your other insurance carrier

Plan Payment: The amount paid under the rules of the plan

Covered: The sum of all amounts that were paid by the plan and/or other insurance

Co-Insurance: Portion of the cost that you are responsible for. Usually a percentage

Co-Pay: A fixed amount you pay when you go to your doctor or fill a prescription. Copays vary by service, including prescription drugs, provider and facility visits

Deductible: The amount you pay anually out of your pocket for covered medical services or prescription, before your health plan begins to pay.

Not Covered Charges: Any charges that were not covered under the rules of your plan

Rsn Code: Reason Code explaining the reduction in benefits.

Reference: **000000000** | Participant I.D.: **000000000000** | Patient: **First Name Last Name**

SERVICE DESCRIPTION	WHAT WAS BILLED			WHAT WAS PAID			WHAT YOU MAY OWE					
	Total Billed Amount	Discount	Allowed	Other Insurance Payments	Plan Payment	Covered	Co-Insurance	Co-pay	Deductible	Not Covered Charges	Total	
CLAIM # XXXXXXXXX Service Dates: mm/mm/yyyy - mm/mm/yyyy Services (In Network)												
LABEL PLACEHOLDER	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	XX
CLAIM TOTAL	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	
CLAIM # XXXXXXXXX Service Dates: mm/mm/yyyy - mm/mm/yyyy Services (In Network)												
LABEL PLACEHOLDER	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	XX
LABEL PLACEHOLDER	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	XX
LABEL PLACEHOLDER	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	XX
LABEL PLACEHOLDER	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	XX
CLAIM TOTAL	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	
GRAND TOTAL	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	$0.00	$0.00	$0.00	**$0.00**	

REASON CODE EXPLANATION

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Custom text In the event a claim is denied:

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Custom Text Rights and Protections Against Surprise Medical Bills for Emergency Services and Certain Services from Out-of-Network Providers at an In-Network Hospital or Ambulatory Surgical Center

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CONTACT

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