



12712 Park Central Dr St. 100  
Dallas, TX 75251



000000-000001-000000-000001 180026 5305ST01\_  
JOHN DOE  
999 PURPLE LN  
ANYCITY, TX 99999

## MONTHLY STATEMENT

Member ID	SP1000CB0
Billing Period	01/01/2019-01/31/2019
Due On	03/22/2019

### ACCOUNT SUMMARY

Outstanding Balance	\$10.00
Payments Made	\$0.00
Current Charges	\$82.76
<b>Amount Due</b>	<b>\$92.76</b>

Pay online at <https://acap.secureconduit.net>. You may also detach and mail the bottom portion of this statement with your payment.

## OUT-OF-POCKET MAXIMUM

JOHN DOE	JANE DOE	Family
Spent \$0.00	Spent \$82.76	Spent \$82.76
Remaining \$4,000.00	Remaining \$3,992.24	Remaining \$7,992.24

Please detach at the perforation and return with your payment.



12712 Park Central Dr St. 100  
Dallas, TX 75251

New contact information? Check here and provide on back of this payment stub.

Member ID SP1000CB0  
Balance Due \$92.76  
Payment Due Date 03/22/2019

Amount Enclosed

\$

**Remit To:**  
SimplePay  
12712 Park Central Dr St. 100  
Dallas, TX 75251

JOHN DOE  
999 PURPLE LN  
ANYCITY, TX 99999



# MONTHLY STATEMENT

DATE OF SERVICE	CLAIM ID	PATIENT NAME	SERVICE	PROVIDER	SIMPLEPAY AMOUNT
01/29/19	3285133901297G	JANE DOE	ESCITALOPRAM TAB 20MG	KROGER PHARMACY	\$4.02
01/29/19	3285186901293G	JANE DOE	LAMOTRIGINE TAB 200MG	KROGER PHARMACY	\$3.74
04/08/19	57070900	JANE DOE	Unknown - Specialist Visit	MR DOCTOR MD	\$30.00
04/10/19	CHMIEL000	JOHN DOE	Chiropractor - Specialist Visit	DR CHIROPRACTOR DC	\$45.00
<b>TOTAL</b>					<b>\$82.76</b>



### Patient Benefit Summary

\$82.76 has been applied to your \$8,000.00 family out of pocket maximum

### Explanation of Benefits

This document contains important information that you should retain for your records.

- Out of Pocket Max:** A predetermined limited amount of money that an individual must pay out of their own savings, before an insurance company or (self-insured employer) will pay 100 percent for an individual's health care expenses
- Patient Responsibility:** This amount might include your copay, SimplePay's, any amount over the maximum reimbursable charge, or products/services not covered by your plan
- SimplePay:** An amount similar to a "co-pay" an individual must pay for healthcare services as determined by the individual's health benefits plan

### Begin using this address for my statements

Name		
Street		
City	State	Zip
Phone 1	Phone 2	
Email		



## MONTHLY STATEMENT

**To Submit Payment**

To submit a payment online, please visit <https://acap.secureconduit.net> or submit a check to SimplePay, 12712 Park Central Dr St. 100, Dallas, TX 75251. To review additional claim information, please visit <https://acap.secureconduit.net> and go to the Claim History tab.

For a limited time, SimplePay Health members who need to pay initial SimplePay patient balances off over a period of time may do so without interest with equal payments over a period of twelve months. Future SimplePay balances will also be eligible for payments over a twelve month period at a reasonable rate of interest.

The claim(s) above were processed in accordance with the group health plan described in your Summary Plan Description (SPD). If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan, and this document serves as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information.)

You may access additional information regarding this claim, including the diagnosis and treatment codes and their meanings, by contacting your SimplePay Health Pro. You may also request copies of all documents related to a claim at no cost to you. This may include internal rules or protocols used to make this decision. If our decision is based on medical necessity, experimental treatment, or a similar exclusion, it may also include an explanation of the scientific/clinical judgment for the decision based on your medical situation. You can e-mail this request to [healthpro@simplepayhealth.com](mailto:healthpro@simplepayhealth.com) or call your SimplePay Health Pro at 1-800-606-3564.

**Notice of Right to Appeal & ERISA Rights**

**Right to Appeal.** If you disagree with the denial or partial denial of your claim or think this determination was made in error, you are entitled to a full and fair review of your claim by individuals associated with the Plan but who were not involved in making the initial denial of your claim. You may provide us with additional information, and you may request to receive copies of information that pertains to your claim. You or your authorized representative may file an appeal by submitting a written request for review within 180 days of the date of this notice. Your request should include the date of your request, your printed name and address (and name and address of any authorized representative), the identification number and claim number from this member statement, the date of service, and any additional information you wish to provide. Send your request to: SimplePay Health, c/o Meritain Health Appeal Department, P.O. Box 41980, Minneapolis, MN 55441-0970. If your dispute relates solely to the cost-sharing determination based on the provider you utilized, please contact us at 1-800-606-3564 or [healthpro@simplepayhealth.com](mailto:healthpro@simplepayhealth.com). We will review our decision following each request and provide you with a written reply. If the original decision is upheld, the written reply will advise you of any additional appeal or external review rights you may have.

**Expedited Appeal.** If your situation meets the definition of urgent under the law, your review will generally be conducted within 48 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal, or you may contact us at 1-800-606-3564 or [healthpro@simplepayhealth.com](mailto:healthpro@simplepayhealth.com).

**Authorized Representative.** If needed, you can appoint an authorized representative to act for you by submitting an Appeal Authorized Representative Form, available at <https://www.meritain.com/tools-resources/FormSearch>.

For additional information on your appeal rights, please refer to your benefits plan document or contact us at 1-800-606-3564 or [healthpro@simplepayhealth.com](mailto:healthpro@simplepayhealth.com).

**Other Resources.** For assistance in understanding your appeal rights, you can also contact the Employee Benefits Security Administration at (866) 444-EBSA (3272) or the state consumer assistance program applicable to your Plan. If the final decision after you have exhausted your appeal rights is an adverse benefit determination and if you have employer group coverage subject to the Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of ERISA.

**The following language is required by law and is for informational purposes only.** This language is intended to assist those plan participants who may not speak English as their predominant language.

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-606-3564.

**繁體中文 (Chinese) 注意:** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-606-3564。

**Tiếng Việt (Vietnamese) CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-606-3564.

**한국어 (Korean) 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-606-3564. 번으로 전화해 주십시오.

**Tagalog (Tagalog -- Filipino) PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-606-3564.

**Русский (Russian) ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-606-3564.

**العربية (Arabic) ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-606-3564.

**Kreyòl Ayisyen (French Creole) ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-606-3564.

**Français (French) ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-606-3564.

**Polski (Polish) UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-606-3564.

**Português (Portuguese) ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-606-3564.

**Italiano (Italian) ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-606-3564.

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-606-3564.

**日本語 (Japanese) 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-606-3564。まで、お電話にてご連絡ください。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

فراهم می باشد. با 1-800-606-3564 تماس بگیرید.