Discovery Benefits, Inc.
PO Box 2926
Fargo, ND 58108

Employer: Discovery Benefits Inc
Employer Code: DBI
Date: 2/6/2018

Email

NOTIFICATION OF DENIED CLAIM(S) FOR:

Sample Participant
123 Frontier Ave
Fargo, ND 01234

Sample Participant:

Submission Date:	1/28/2018
Date of Service:	1/27/2018
Denial Date:	2/5/2018
Provider/Merchant:	DAKOTA PARTNERS
Recipient:	Sample Participant
Denied Amount:	$71.57
Total Claim Amount:	$71.57

Claim Number	Plan Name	Total Paid	Total Pending	Total Denied
10708180128D0000101	Medical FSA Carryover 500 01/01/2018-12/31/2018	$0.00	$0.00	**$71.57**

DENIAL EXPLANATION
DC24 - This claim, or a portion of this claim, cannot be approved because the date(s) and type(s) of service on the documentation
provided was either missing or unclear

ACTION REQUIRED
Your claim(s) or debit card transaction(s) has been denied. Your available options are:

Provide additional documentation that includes:
- What should be included in your receipt?
- date(s) of service
- description of service or item purchased
- name of provider
- dollar amount (patient responsibility only)
- doctor’s prescription or note if expense is for over-the-counter medicines or drugs

Repay your claim by returning the below payment voucher or using the repay option in your online account

If you do not have additional documentation that meets the requirements for this claim, you are able to provide receipt(s) for eligible expense(s) that you have not been reimbursed for with this plan.

If you disagree, in whole or in part, with our decision regarding your claim for benefits, and you are enrolled in a plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), you have the right to appeal our decision. Any appeal must be submitted within 180 days of the original denial date for this claim. To initiate an appeal, you (or your authorized representative) must send a written request to your Plan Administrator or Claims Administrator, as specified in the summary plan description via mail or e-mail using the Contact Information listed below. Your appeal must include your name, your employer's name, claim number, date of claim, amount of claim and the reason for your appeal. You may also include any additional comments, documents, records or other information or written comments in support of your appeal.

Upon request and free of charge, you will be provided (1) reasonable access to and copies of all documents, records and other information relevant to your claim; and (2) a copy of any specific rule, guideline or protocol relied upon in making the initial adverse benefit determination.

If you appeal our decision, the review will be conducted by someone who was not involved in the initial claim denial and who is not a subordinate of anyone who decided the initial claim denial. You will receive a response within 60 days of the date your appeal is received. If you do not agree with the final determination on review and your claim relates to a plan subject to ERISA, you have the right to bring a civil action under Section 502(a) of ERISA. However, you must exhaust the plan's review procedures before filing suit. In addition, any such action must be brought within the deadline described in your summary plan description. If your claims relates to a plan that is not subject to ERISA, you may have the right to appeal this decision. Review your benefit summary for a description of any appeal rights and procedures

CONTACT INFORMATION

Discovery Benefits, Inc.
Participant Services
PO Box 2926
Fargo, ND 58108

Phone Number: 866-451-3399
Fax Number: 866-451-3245
Email Address: customerservice@discoverybenefits.com

Sample Participant
123 Frontier Ave
Fargo, ND 01234

Amount Due	Amount Enclosed
$71.57	$

Discovery Benefits, Inc.
PO Box 2926
Fargo, ND 58108

Claim Number: 10708180128D0000101

Detach and return this form with your payment.
Make check or money order payable to Discovery Benefits, Inc.. Please do not send cash.

Discovery Benefits, Inc.
Repayment Request

Date: 2/6/2018

Sample Participant:

Your claim(s) or debit card transaction(s) has been denied and while your provider has been paid in full, it requires additional documentation or repayment from you.

Plan Name:	Medical FSA Carryover 500 01/01/2018-12/31/2018	Total Claim Amount:	$71.57
Submission Date	1/28/2018	Approved Amount:	$0.00
Date of Service:	1/27/2018	Denied Amount:	$71.57
Claim Number:	10708180128D0000101	Repaid Amount:	$0.00
		Amount Due:	$71.57

Additional information:

For more information please contact:

Discovery Benefits, Inc.
Participant Services
PO Box 2926
Fargo, ND 58108

Phone Number: 866-451-3399
Fax Number: 866-451-3245
Email Address: customerservice@discoverybenefits.com