<b>EXPLANATION</b>	OF	<b>BENEFITS</b>	(EOB
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Policyholder:
Group #:
Patient:
Member #:
Claim #:
Provider of Service:

Account #:
Processed Date:

Total Member Responsibility for this Claim (see below for details)

\$41.84

acc below for details)

This is not a bill. Please remit payment to your provider of service upon receipt of an invoice if you have not previously paid.

## **Important Information -- Please Read**

This document serves as notice of a benefit determination. If we have declined to provide benefits, in whole or in part, for the requested treatment or service described below, and you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights). If you suspect fraud please call us toll-free at XXX-XXXX.

\*This claim is from a participating provider. The "Amount Not Covered" below <u>without</u> any remark codes are <u>not</u> your responsibility to pay. Any amount listed in the copay, coinsurance, or deductible columns remain your responsibility. Your insurance carrier has made payment to the provider for the amount listed in the Paid/Capitated column.

								*Amount		
	Date of	Amount	Amount		\		Amount	Not	Remark	Paid/
Service Code and Description	Service	Billed	Allowable	Copay	Co-ins	Deductible	СОВ	Covered	Code	Capitated
98940 CHIROPRACTIC		\$72.00	\$41.84	\$0.00	\$0.00	\$41.84	\$0.00	\$30.16		\$0.00
MANIPULATIVE TRE										
	TOTALS:	\$72.00	\$41.84	\$0.00	\$0.00	\$41.84	\$0.00	\$30.16		\$0.00
,		7								

Accumulation Information - Data shown below is as of the EOB print date				
Benefit Accum Code	Benefit Accumulation Description			
	YOU HAVE MET \$103.94 OF YOUR \$1,500.00 SINGLE DEDUCTIBLE			
00501	YOU HAVE MET \$103.94 OF YOUR \$1,500.00 FAMILY DEDUCTIBLE			
00504	YOU HAVE MET \$103.94 OF YOUR \$2,500.00 SINGLE OUT OF POCKET MAXIMUM			
00505	YOU HAVE MET \$103.94 OF YOUR \$2,500.00 FAMILY OUT OF POCKET MAXIMUM			
7				