EXPLANATION OF BENEFITS (EOB)

Policyholder:
Group #:
Patient:
Member #:
Claim #:
Provider of Service:
Account #:
Processed Date:

Total Member Responsibility for this Claim (see below for details)	**$41.84**

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-XXX-XXXX.

*This claim is from a participating provider. The "Amount Not Covered" below *without* any remark codes are *not* 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.

Service Code and Description	Date of Service	Amount Billed	Amount Allowable	Copay	Co-ins	Deductible	Amount COB	*Amount Not Covered	Remark Code	Paid/ Capitated
98940 CHIROPRACTIC MANIPULATIVE TRE	01/25/19-01/25/19	$72.00	$41.84	$0.00	$0.00	$41.84	$0.00	$30.16		$0.00
	TOTALS:	$72.00	$41.84	$0.00	$0.00	$41.84	$0.00	$30.16		$0.00

Accumulation Information - Data shown below is as of the EOB print date	
Benefit Accum Code	**Benefit Accumulation Description**
00500	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

THIS IS NOT A BILL