

Customer Service Number: 1-800-426-9786 x210 (253) 564-5611 x210

#### **Your Employer Name**

Sample Member 123 Member Way

Tacoma WA 98401

Group Number Your Group Number

Claimant Number 987654321

# Here is the amount that your plan has paid for a service.

# Explanation of Benefits This is not a Bill

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Patient's Name	Service Billed		Other Plan	n Expl.	Patient Responsibility				Plan	Benefit	
Type of Service	Date(s)	Charges	Adjustment	Payment	Codes	Ineligible	Co-Pay	Deductible	Co-Ins	Pays	Payment
Patient # 1										$\overline{}$	
EOB Number: 201260629-989		MCKENNA CH	HIROPRACTIC (	CENTER							
98941-CHIROPRACTIC	05/26/2012	48.00	4.80		091				8.64	80%	34.56
Patient Account Number:	Totals:	48.00	\$4.80	0.00		0.00	0.00	0.00	8.64		34.56
12345678						<b>*</b>	Patient Re	sponsibility: 8.64			
D-1'1 # 0									_		

Patient # 2

EOB Number: 20120629-141

#### TODAYS DENTAL GROUP

Here is your responsibility for each service.

D2330-DENT BASIC	06/05/2012	101.00	101.00		281					0%	0.00
D3346-DENT BASIC	06/05/2012	560.00							112.00	80%	448.00
Patient Account Number: 12345678	Totals:	661.00	\$101.00	0.00		0.00	0.00	0.00	112.00		448.00

## This is a monthly summary of your services by

provider ———

#### July 2012 Statement Summary

Patient Responsibility: 112.00

		, =0 := 0 1411		,		
Payee Name Date Benefit Paid	Patient Name	Total Charge	Negotiated Adjustment	Other Plan Payments	Benefit Payments	Patient Portion
MCKENNA CHIROPRACTIC CENTER						
Date Benefit Paid: 6/30/12	Patient # 1	48.00	4.80	0.00	34.56	8.64
	Totals:	48.00 This is the a	4.80 amount the Member's	0.00 s family owes MCKENN.	34.56 A CHIROPRACTIC CE	NTER: 8.64
TODAYS DENTAL GROUP						
Date Benefit Paid: 6/30/12	Patient # 2	661.00	101.00	0.00	448.00	112.00
	Totals:	661.00 Thi	101.00 is is the amount the	0.00 Member's family owes T	448.00 ODAYS DENTAL GRO	UP: 112.00

#### **Explanations:**

091 \*\*\*THE FIRST CHOICE PPO DISCOUNT AMOUNT IS REFLECTED IN THE SAVINGS(s) OR NEGOTIATED ADJUSTME EXPLANATION OF BENEFITS.\*\*\*

281 PLEASE SUBMIT VALID TOOTH NUMBER AND/OR SURFACE.

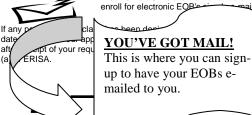
This is your current status on deductibles and out of pocket expenses.

### Deductible/Out-of-Pocket Summary Table

	In-N	etwork	Out-o		
Family / Patient Name	Deductible Met	Out of Pocket Met	Deductible Met	Out of Pocket Met	Plan Year
FAMILY	\$735.23	\$360.59			2012
Family Member #1	\$400.00	\$242.57			2012
Family Member #2	\$217.21	\$0.00			2012

#### Your next monthly explanation of benefits, if any claims are submitted, will arrive the week of: 8/6/12

Electronic EOB's are now available! When medical claims have been paid for any family member you may receive your family EOB via your personal e-mail address. To enroll for electronic EOB benefitsupport@trusteedplans.com



br your authorized representative has the right to appeal any adverse benefit determination or claim denial within 180 days of the lendersonville, TN 37077, Attn: Appeal Department. You will be notified of the Plans decision on review no later then 60 days pwing the review, and the Plan's appeal procedures have been exhausted, you have the right to bring civil action under section 502

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