PO Box 54139
Lubbock TX 79453

20180712T02
J148
1288 20280

Explanation of Benefits

SKP[EF-]

HOW TO READ YOUR EOB

Forwarding Service Requested

This is Not a Bill
Retain for Tax Purposes

J148 1

Jane Doe
1222 New Drive DR APT
100
SAN ANTONIO TX 78238

(1) Customer Service Information

If you have any questions, please call 90 Degree Benefits at (806) 783-9995 or (800) 747-9446

Date: 05/18/2018
Group #: 1234
Group Name: SAMPLE GROUP
Employee: Jane Doe
Case:U91601
Document #:18130014555
EoB #:20180511-171

Provider: QUEST DIAGNOSTICS DALLAS
Claim#: 1813001429

Patient: Jane Do
Employee: Jane Do
Patient Account #: 506xxxxx
Member ID: 706xxxxxxxx

Dates of Service (2)	Type of Service (3)	(4) Total Charge	(5) Discount or Penalty	(6) Not Covered	(7) Remark Code	(8) Eligible Expense	(9) Co-Pay	(10) Deductible Applied	(11) Paid %	(12) Benefits Paid
03/28-03/28/2018	PREVENTIVE CARE	$74.25	$0.00	$74.25	T09	$0.00	$0.00	$0.00	0%	$0.00
03/28-03/28/2018	PREVENTIVE CARE	$132.73	$0.00	$132.73	T09	$0.00	$0.00	$0.00	0%	$0.00
03/28-03/28/2018	LAB SERVICES	$42.13	$0.00	$0.00		$42.13	$0.00	$0.00	40%	$16.85
03/28-03/28/2018	LAB SERVICES	$47.59	$0.00	$4.83	T21	$42.76	$0.00	$0.00	40%	$17.10
03/28-03/28/2018	LAB SERVICES	$60.25	$0.00	$0.00		$60.25	$0.00	$0.00	40%	$24.10
03/28-03/28/2018	LAB SERVICES	$241.84	$0.00	$0.00		$241.84	$0.00	$0.00	40%	$96.74
03/28-03/28/2018	LAB SERVICES	$130.49	$0.00	$26.96	T21	$103.53	$0.00	$0.00	40%	$41.41
	Claim Totals:	**$729.28**	**$0.00**	**$238.77**		**$490.51**	**$0.00**	**$0.00**		**$196.20**

(13) **Total Amount Covered**	**$490.51**
(14) **Paid by Other Insurance**	**$0.00**
(15) **Total Paid by Plan**	**$196.20**

Patient Responsibility: $533.08 (16)

(17) Claim Totals

# of Claims	Total Charge	Adjustment	Ineligible Amount	Co-pay	Deductible Ammount	Co-insurance Amount	Plan Payment	Patient Responsibility
1	$729.28	$0.00	$238.77	$0.00	$0.00	$294.31	$196.20	$533.08

Comments (19)

THESE CHARGES ARE NOT COVERED UNDER YOUR POLICY.
CHARGES IN EXCESS OF REASONABLE AND CUSTOMARY ARE NOT ALLOWABLE EXPENSES.
DX I10 IS NOT PREVENTIVE

21 **Claims Review & Appeal**

Please contact Customer Service at the number shown above if you need assistance understanding this notice or our decision to deny you a service or coverage. You are entitled to a review of the benefit determination if you do not agree. To obtain a review, submit your request in writing to the address shown above within 180 days from receipt of the adverse benefit determination. You may request the diagnosis and treatment codes (and their meanings) if needed for your appeal. Your request should include your name and address, Enrollee ID, claim number, the reason for appealing and any data, documents and comments you would like to have considered. Written requests for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, then upon request internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge. If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. For questions about your rights, this notice, or for assistance, you can contact: U.S. Department of Labor Employee Benefits Security Administration 200 Constitution Ave., NW Washington, DC 20210 (866) 4-USA-DOL (866-487-2365) http://www.dol.gov/ebsa/consumer_info_health.html

************** Assignment of Benefits shall mean an arrangement by which the Patient assigns their right to seek and receive payment of eligible Plan Benefits, less deductible, co-payments and the coinsurance percentage not paid by the Plan, to the Provider. When Provider accepts Assignment of Benefits, unless prohibited by the Plan Document, Provider’s rights to receive benefits are equal to those of the Patient. The Plan limits eligible payment to the terms of the applicable benefit plan document and amounts in excess are not covered.

(Español): Para obtener asistencia en Español, llame al 844-858-3232

(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-858-3232

(中文): 如果需要中文的帮助,请拨打这个号码 844-858-3232

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 844-858-3232

Additionally, you can contact your consumer assistance program at
U.S. Department of Labor
Employee Benefits Security Administration
Dallas Regional Office
525 South Griffin Street, Room 900
Dallas, TX 75202
(972) 850-4500
(866) 444-EBSA (3272)
http://www.dol.gov/ebsa/ (website)

SKP[EF-]

Reference Info

Date:
Group: SAMPLE GROUP

How To Read Your EOB Key

1. **Customer Service**: If you have questions or need further clarification, please give us a call at the toll free number located here. Our friendly and knowledgeable Customer Service representatives are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. Central Standard Time, or log in to www.caprockhp.com.

2. **Date of Service**: Represents the patient's date(s) of treatment.

3. **Type of Service:** Briefly describes the nature of the services rendered. Examples include doctor office visits, inpatient or outpatient hospital services, and laboratory and x-ray services.

4. **Total Charge**: Total presented charges by provider.

5. **Discount of Penalty**: Reduction of total charge amount.

6. **Not Covered**: Dollar amount not covered by the Plan.

7. **Rmk Code**: Reference code; description under 18 Remark Code Description.

8. **Eligible Expense**: Provider expense eligible under the Plan.

9. **Co-Pay:** Dollar amount you are responsible for at the time of service.

10. **Deductible Applied**: Amount member is responsible for prior to any payment by the Health Plan. Amounts may vary between PPO and Non-PPO charges. The deductible may not apply to all services.

11. **Paid %**: Percent payable by Plan.

12. **Benefits Paid**: Amount paid by the Plan for that service.

13. **Total Amount Covered:** Amount of dollars covered by this plan.

14. **Paid By Other Insurance**: Amount of benefit payment made by the member's primary insurance carrier.

15. **Total Paid by Plan**: Actual Plan payment amount made to provider or insured.

16. **Patient Responsibility**: The amount patient owes for the services rendered.

17. **Claim Totals:** Totals on all claims paid on this document.

18. **Remark Code Description**: A descriptive field that explains any discount, penalty or Not Covered services.

19. **Comments:** Additional comments that explain the processing of your claim.

20. **Additional Remarks:** Additional information about how your plan benefits may work.

21. **Claims Review & Appeal:** Instructions on how to file a Review & Appeal of your claim if you do not agree with how it was processed.