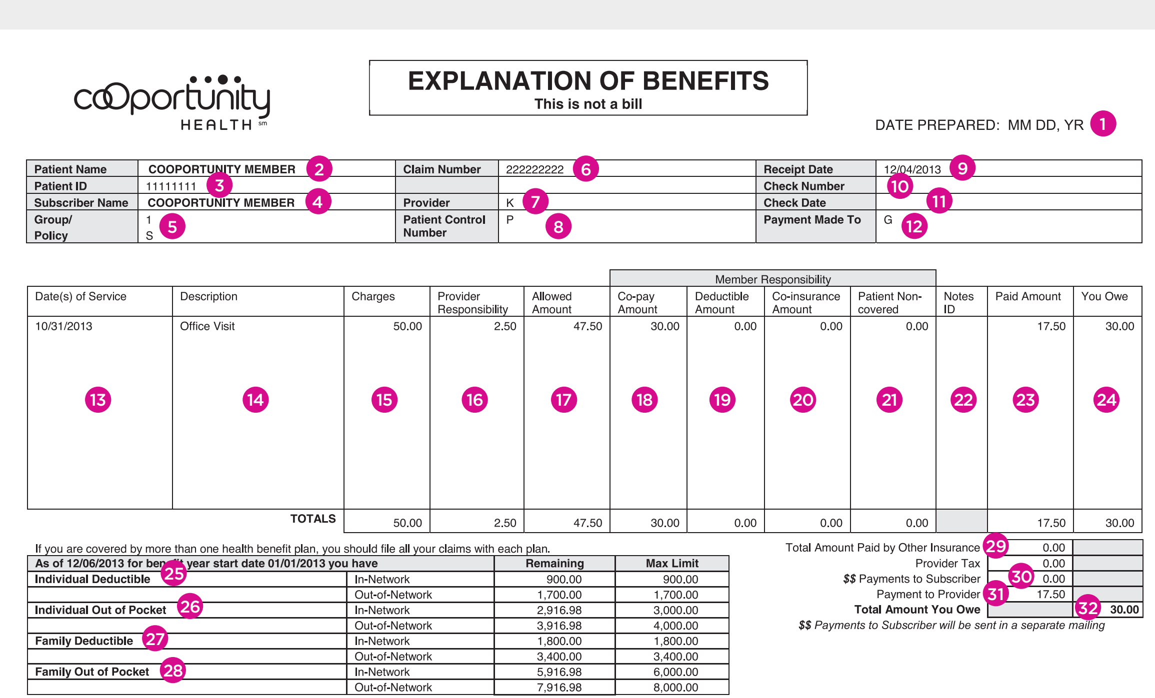
1.888.324.2064
coOportunityhealth.com

Explanation of Benefits

Understanding your EOB



coOportunity HEALTH

EXPLANATION OF BENEFITS
This is not a bill

DATE PREPARED: MM DD, YR (1)

Patient Name	COOPORTUNITY MEMBER (2)	Claim Number	222222222 (6)	Receipt Date	12/04/2013 (9)
Patient ID	11111111 (3)			Check Number	(10)
Subscriber Name	COOPORTUNITY MEMBER (4)	Provider	K (7)	Check Date	(11)
Group/ Policy	1 S (5)	Patient Control Number	P (8)	Payment Made To	G (12)

					Member Responsibility						
Date(s) of Service	Description	Charges	Provider Responsibility	Allowed Amount	Co-pay Amount	Deductible Amount	Co-insurance Amount	Patient Non-covered	Notes ID	Paid Amount	You Owe
10/31/2013	Office Visit	50.00	2.50	47.50	30.00	0.00	0.00	0.00		17.50	30.00
(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)
	TOTALS	50.00	2.50	47.50	30.00	0.00	0.00	0.00		17.50	30.00

If you are covered by more than one health benefit plan, you should file all your claims with each plan.

As of 12/06/2013 for benefit year start date 01/01/2013 you have		Remaining	Max Limit
Individual Deductible (25)	In-Network	900.00	900.00
	Out-of-Network	1,700.00	1,700.00
Individual Out of Pocket (26)	In-Network	2,916.98	3,000.00
	Out-of-Network	3,916.98	4,000.00
Family Deductible (27)	In-Network	1,800.00	1,800.00
	Out-of-Network	3,400.00	3,400.00
Family Out of Pocket (28)	In-Network	5,916.98	6,000.00
	Out-of-Network	7,916.98	8,000.00

Total Amount Paid by Other Insurance (29)	0.00	
Provider Tax	0.00	
$$ Payments to Subscriber (30)	0.00	
Payment to Provider (31)	17.50	
Total Amount You Owe		(32) **30.00**

$$ Payments to Subscriber will be sent in a separate mailing

The remaining amount shows the dollars applied when this EOB was prepared. It does not reflect any pending or unapplied charges.

If you have already paid the amount shown as "Total Amount You Owe" to the provider of this care or service, you do not owe any money. If you owe any money, you can expect to receive a bill from the provider.

1. Date EOB was Generated
2. Patient's Name
3. Patient's Member Number
4. Member/Owner of Policy (Not Necessarily Patient)
5. Employer's Group Number and Policy Name
6. Claim Reference Number
7. Provider of Care
8. Patient Control Number
9. Date Claim was Received
10. Check Number
11. Date of Check
12. Check Issued to
13. Dates of Patient Care
14. Description of Care
15. Total Charges
16. Provider's Responsibility
17. Provider's Discounted Charge
18. Member's Cost Based on Copay
19. Member's Cost Based on Deductible
20. Member's Cost Based on Coinsurance
21. Amount of Services Not Covered by Insurance
22. Reference to Notes on Non-Covered Amounts
23. Amount Paid by Coopportunity Health
24. Amount Member Owes
25. Individual Deductible Balance (In- and Out-of-Network)
26. Individual Out-of-Pocket Balance (In- and Out-of-Network)
27. Family Deductible (In- and Out-of-Network)
28. Family Out-of-Pocket Balance (In- and Out-of-Network)
29. Amount Paid by Patient's Other Benefit Plan (If Applicable)
30. Total Plan Covered Amount Payable to Member
31. Total Plan Covered Amount Payable to Provider
32. Total Member Liability – What You Owe

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M-00248 (05/14)