

[Insert logo image here]

[Fund name  
Address  
City, State, Zip Code]

Mary Smith  
123 Sample Street  
Baltimore, MD 21227

Explanation of Medical Benefits	
Page 1 of 1	
Issue Date:	03/06/2019
Total Payment:	\$681.30

RIGHT TO APPEAL: If your claim is denied, in whole or in part, you have the right to appeal the denial. Please refer to the Plan's appeal procedure (Article XVI of Plan Regulations)

MEMBER NAME		MEMBER ID	PATIENT		RELATION	PROVIDER NAME			PROVIDER NUMBER	CLAIM NUMBER	
Mary Smith		XXX-XX-6789	Mary Smith		M	PROFESSIONAL BILLING PROVIDERS			555555555	C01481	
FROM DATE - THRU DATE	BENEFIT DESCRIPT.	AMOUNT BILLED	AMOUNT EXCLUDED	PLAN ALLOWED	LESS DEDUCT/ COPAY APPLIED	%	PLAN COVERED	COB ADJUST	PLAN BENEFIT	PATIENT LIABILITY	COMMENTS
01/01-01/01/19	MISCELLANEOUS	\$232.00	\$0.00	\$232.00	\$0.00	90	\$208.80		\$208.80	\$23.20	B
02/02-02/02/19	MISCELLANEOUS	\$125.00	\$0.00	\$125.00	\$0.00	90	\$112.50		\$112.50	\$12.50	A
TOTALS		\$357.00	\$0.00	\$357.00	\$0.00		\$321.30	\$0.00	\$321.30	\$35.70	

Comment/Denial:  
A.  
B. This service is only covered once a year.

MEMBER NAME		MEMBER ID	PATIENT		RELATION	PROVIDER NAME			PROVIDER NUMBER	CLAIM NUMBER	
Mary Smith		XXX-XX-6789	Mary Smith		M	PROFESSIONAL BILLING PROVIDERS			555555555	C01482	
FROM DATE - THRU DATE	BENEFIT DESCRIPT.	AMOUNT BILLED	AMOUNT EXCLUDED	PLAN ALLOWED	LESS DEDUCT/ COPAY APPLIED	%	PLAN COVERED	COB ADJUST	PLAN BENEFIT	PATIENT LIABILITY	COMMENTS
02/01-02/01/19	MISCELLANEOUS	\$150.00	\$0.00	\$150.00	\$0.00	90	\$135.00		\$135.00	\$15.00	B
01/01-01/01/19	MISCELLANEOUS	\$250.00	\$0.00	\$250.00	\$0.00	90	\$225.00		\$225.00	\$25.00	A
TOTALS		\$400.00	\$0.00	\$400.00	\$0.00		\$360.00	\$0.00	\$360.00	\$40.00	

Comment/Denial:  
A.  
B. The patient's individual plan year deductible has been met.