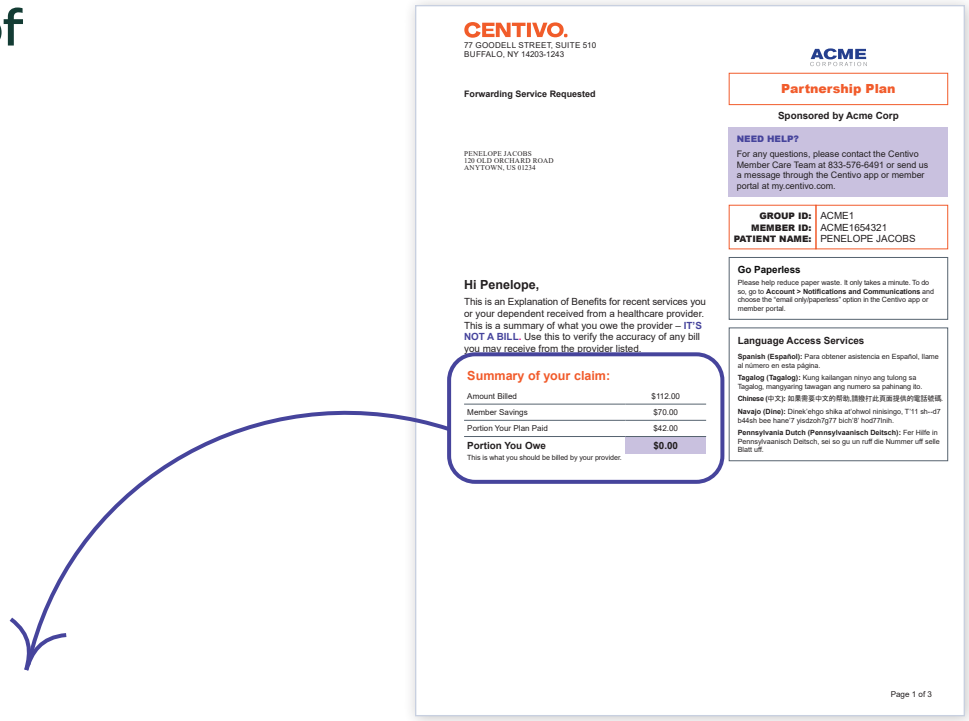
# How to read your Explanation of Benefits statement

The Explanation of Benefits statement **(EOB)** outlines the cost of the care you received, what your plan covers and what you may owe directly to the provider.

**As a reminder, the EOB isn't a bill.** Your doctor's office will send you a bill if you owe them a payment for your visit.

Below are some tips for understanding what you may see on your EOB. You can always call Centivo Member Care at the number on the back of your ID card if you're having trouble understanding anything on your EOB.

## Summary of your claim


CENTIVO.
77 GOODELL STREET, SUITE 510
BUFFALO, NY 14203-1243

Forwarding Service Requested

PENELOPE JACOBS
120 OLD ORCHARD ROAD
ANYTOWN, US 01234

ACME CORPORATION

Partnership Plan

Sponsored by Acme Corp

NEED HELP?
For any questions, please contact the Centivo Member Care Team at 833-576-6491 or send us a message through the Centivo app or member portal at my.centivo.com.

| | |
|---|---|
| GROUP ID: | ACME1 |
| MEMBER ID: | ACME1654321 |
| PATIENT NAME: | PENELOPE JACOBS |

Go Paperless
Please help reduce paper waste. It only takes a minute. To do so, go to **Account > Notifications and Communications** and choose the "email only/paperless" option in the Centivo app or member portal.

Hi Penelope,

This is an Explanation of Benefits for recent services you or your dependent received from a healthcare provider. This is a summary of what you owe the provider – **IT'S NOT A BILL.** Use this to verify the accuracy of any bill you may receive from the provider listed.

Summary of your claim:

| | |
|---|---|
| Amount Billed | $112.00 |
| Member Savings | $70.00 |
| Portion Your Plan Paid | $42.00 |
| **Portion You Owe** | **$0.00** |

This is what you should be billed by your provider.

Language Access Services

**Spanish (Español):** Para obtener asistencia en Español, llame al número en esta página.

**Tagalog (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog, mangyaring tawagan ang numero sa pahinang ito.

**Chinese (中文):** 如果需要中文的帮助,请拨打此页面提供的电话号码。

**Navajo (Dine):** Dinek'ehgo shika at'ohwol ninisingo, T'11 sh--d7 b44sh bee hane'7 yisdzoh7g77 bich'8' hod77inih.

**Pennsylvania Dutch (Pennsylvaanisch Deitsch):** Fer Hilfe in Pennsylvaanisch Deitsch, sei so gu un ruff die Nummer uff selle Blatt uff.

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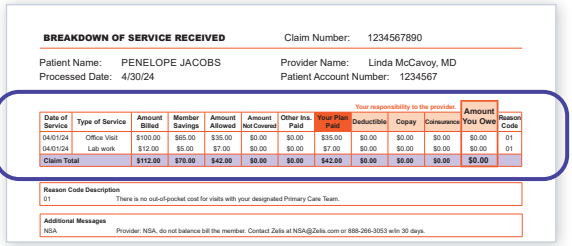
### Summary of your claim:

| | | |
|---|---|---|
| Amount Billed | $112.00 | This is the amount that your provider billed to Centivo. |
| Member Savings | $70.00 | This is your savings for being a Centivo plan member. |
| Portion Your Plan Paid | $42.00 | This is the total amount that your plan paid to your provider. |
| **Portion You Owe**<br>This is what you should be billed by your provider. | **$0.00** | This is the total amount that you owe the provider. Remember, this is not a bill, so be sure to match this amount to the bill that you receive from the provider, when it arrives. |

CENTIVO.

# Breakdown of the service(s) received



**BREAKDOWN OF SERVICE RECEIVED** Claim Number: 1234567890

Patient Name: PENELOPE JACOBS Provider Name: Linda McCavoy, MD

Processed Date: 4/30/24 Patient Account Number: 1234567

Your responsibility to the provider.

| Date of Service | Type of Service | Amount Billed | Member Savings | Amount Allowed | Amount Not Covered | Other Ins. Paid | Your Plan Paid | Deductible | Copay | Coinsurance | Amount You Owe | Reason Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 04/01/24 | Office Visit | $100.00 | $65.00 | $35.00 | $0.00 | $0.00 | $35.00 | $0.00 | $0.00 | $0.00 | $0.00 | 01 |
| 04/01/24 | Lab work | $12.00 | $5.00 | $7.00 | $0.00 | $0.00 | $7.00 | $0.00 | $0.00 | $0.00 | $0.00 | 01 |
| Claim Total | | $112.00 | $70.00 | $42.00 | $0.00 | $0.00 | $42.00 | $0.00 | $0.00 | $0.00 | $0.00 | |

Reason Code Description

01 There is no out-of-pocket cost for visits with your designated Primary Care Team.

Additional Messages

NSA Provider: NSA, do not balance bill the member. Contact Zelis at NSA@Zelis.com or 888-266-3053 w/in 30 days.

This is the date of your appointment/ service.

This is the amount that your provider billed to Centivo.

This is the amount allowed to be billed for this service or procedure under your plan.

This is the total amount that your plan paid to your provider.

This is the total amount that you owe to your provider and should match the amount on the bill that you receive from them.

Your responsibility to the provider.

| Date of Service | Type of Service | Amount Billed | Member Savings | Amount Allowed | Amount Not Covered | Other Ins. Paid | Your Plan Paid | Deductible | Copay | Coinsurance | Amount You Owe | Reason Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 04/01/24 | Office Visit | $100.00 | $65.00 | $35.00 | $0.00 | $0.00 | $35.00 | $0.00 | $0.00 | $0.00 | $0.00 | 01 |
| 04/01/24 | Lab work | $12.00 | $5.00 | $7.00 | $0.00 | $0.00 | $7.00 | $0.00 | $0.00 | $0.00 | $0.00 | 01 |
| **Claim Total** | | **$112.00** | **$70.00** | **$42.00** | **$0.00** | **$0.00** | **$42.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | |

This is the type of service or procedure that was billed by your provider.

This is your savings for being a Centivo plan member.

This is the amount that is not covered by your plan.

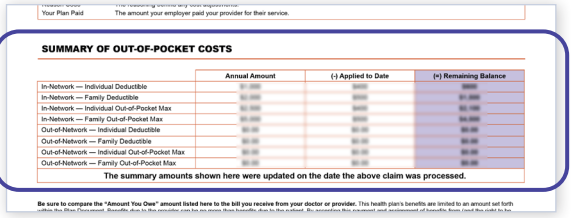
This is the amount you owe based on your plan's deductible, copays or coinsurance.

This is where you can find more details about your claim, if necessary.

**Reason Code Description**

01 There is no out-of-pocket cost for visits with your designated Primary Care Team.

# Summary of your out-of-pocket costs



Your Plan Paid The amount your employer paid your provider for their service.

**SUMMARY OF OUT-OF-POCKET COSTS**

| | Annual Amount | (-) Applied to Date | (=) Remaining Balance |
|---|---|---|---|
| In-Network — Individual Deductible | | | |
| In-Network — Family Deductible | | | |
| In-Network — Individual Out-of-Pocket Max | | | |
| In-Network — Family Out-of-Pocket Max | | | |
| Out-of-Network — Individual Deductible | | | |
| Out-of-Network — Family Deductible | | | |
| Out-of-Network — Individual Out-of-Pocket Max | | | |
| Out-of-Network — Family Out-of-Pocket Max | | | |

The summary amounts shown here were updated on the date the above claim was processed.

Be sure to compare the "Amount You Owe" amount listed here to the bill you receive from your doctor or provider. This health plan's benefits are limited to an amount set forth

This is what you've paid out of your pocket for healthcare services so far this plan year. These amounts may include pharmacy costs.

These rows display your annual deductible and out-of-pocket maximum, how much of your deductible you've met to date and your remaining balance to still be met. Once you meet your deductible, the plan will begin paying a portion of the cost of care.

**SUMMARY OF OUT-OF-POCKET COSTS**

| | Annual Amount | (-) Applied to Date | (=) Remaining Balance |
|---|---|---|---|
| In-Network — Individual Deductible | $1,000 | $400 | **$600** |
| In-Network — Family Deductible | $2,000 | $500 | **$1,500** |
| In-Network — Individual Out-of-Pocket Max | $2,500 | $400 | **$2,100** |
| In-Network — Family Out-of-Pocket Max | $5,000 | $500 | **$4,500** |

**Need help?** → Remember, you can always call Centivo Member Care at the number on the back of your ID card if you need help with understanding your EOB.