CEDAR HEALTH PLAN

PO BOX 24170 | AUSTIN, TX 78755

EXPLANATION OF BENEFITS

YOUR CLAIM AT A GLANCE

Claim: CLM-260415-04217

Date processed: 04/22/2026

Date of service: 04/15/2026

Billed: $600.00

Plan paid: $326.00

Your responsibility: $74.00

AVERY MORGAN
4607 WILLOW BEND LN APT 204
AUSTIN, TX 78731

SUBSCRIBER INFORMATION

CEDAR CHOICE PPO - EMPLOYEE-ONLY COVERAGE
Member ID: CHP0842719 Group: GRP-04217

Questions? (512) 555-0120
members.cedarhealth.example

Dear Avery Morgan,

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

HELPFUL INFORMATION

Check the patient name, service date and provider on the claim-detail page.
For questions about your benefits or a possible billing error, contact Member Services.
This is an explanation of your benefits, not a request for payment.

GLOSSARY OF TERMS - **We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.**

Amount Billed: The amount your provider billed for the service(s) rendered.

Amount Covered (Allowed): Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

Coinsurance: The percentage of the allowed amount you pay as your share of the bill. For example, if your plan pays 80% of the allowed amount, 20% would be your coinsurance.

Copay Amount (Also known as Copayment): The set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit (Maximum): Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this.

GRITWORKS SYNTHETIC SAMPLE | NOT AN ISSUED RECORD | GW-IN-04217

CEDAR HEALTH PLAN

SUBSCRIBER INFORMATION
CEDAR CHOICE PPO
Member: CHP0842719 Group: GRP-04217
Member Services: (512) 555-0120

CLAIM DETAIL **(1 of 1)**
PATIENT: AVERY MORGAN
PROVIDER: ALDER CREEK MEDICAL GROUP
CLAIM #: CLM-260415-04217 **PROCESSED:** 04/22/2026

Amount Billed	**$600.00**
Discounts and Reductions	**- $200.00**
Health Plan Responsibility	**- $326.00**
You may owe your health care provider for these services	**$74.00**

			YOUR BENEFITS APPLIED			YOUR RESPONSIBILITY				
Service Description	**Service Dates**	Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	**Your Total Costs**
Office visit	04/15/2026	250.00	70.00	180.00	150.00	0.00	30.00	0.00	0.00	30.00
CBC / differential	04/15/2026	100.00	30.00	70.00	56.00	0.00	0.00	14.00	0.00	14.00
Metabolic panel	04/15/2026	250.00	100.00	150.00	120.00	0.00	0.00	30.00	0.00	30.00
CLAIM TOTALS		**$600.00**	**$200.00**	**$400.00**	**$326.00**	**$0.00**	**$30.00**	**$44.00**	**$0.00**	**$74.00**

Approved payment: $326.00 to ALDER CREEK MEDICAL GROUP on 04/22/2026.

The $200.00 contractual reduction is not owed by the patient.

The deductible was met before this claim. Office visit: $30 copay. Laboratory services: 20% coinsurance.

Your $74.00 responsibility includes the $30.00 already paid at the visit. Remaining provider balance: $44.00.

Benefit period: 01/01/2026 - 12/31/2026

Year-to-date out-of-pocket: $524.00 of $6,000.00 maximum.

Prior accumulated amount $450.00 + this claim $74.00 = $524.00.

THIS IS NOT A BILL. Keep this explanation with your provider invoice and payment records.

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