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PB-CHI-13-ENV 14685 38
AJINKYA SHEKHAR SALVI
315 S PEORIA ST 909A
CHICAGO IL 60607-3682

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Customer Service Information

Need help understanding your benefits?
Contact us at: (866) 596-5817

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www.myallstatehealthsolutions.com
OR by scanning this QR code:

Claim #: 637CJ91
Prepared on: 11/25/23
Plan name: SHORT TERM MEDICAL-STD PLN 8
Carrier: National Health Insurance Company
Member name: SALVI, AJINKYA SHEKHAR
Member ID: 2020672959
Patient relationship to member: SELF
Benefit period start: 11/05/23
Benefit period end: 01/05/24

Important Note: The provider Network Indicator is updated when eligible expenses are processed.

Provider Tax ID: 911780160 **IN-NETWORK** ☑ **OUT-OF-NETWORK** ☐
Provider: SHARON BYRD
Provider address: 1653 W CONGRESS PKWY
CHICAGO, IL 60612

Patient #: 2268519560
Patient: SALVI, AJINKYA SHEKHAR

Treatment Date(s)	Service Code	Description	Billed Amount	Not Covered	Reason Code	PPO Discount	Allowed Amount	Penalty Amount	Deductible Amount	Other Fee	Co-pay Amount	Coinsurance %	Payment Amount
11/20/23-11/20/23	70450 /	ER SERVICES	$137.00	$0.00	a	$55.30	$81.70	$0.00	$81.70	$0.00	$0.00	0%	$0.00
		Column Totals	**$137.00**	**$0.00**		**$55.30**	**$81.70**	**$0.00**	**$81.70**	**$0.00**	**$0.00**		$0.00

Other Insurance Credits: $0.00
What We Paid: $0.00

What you may owe: **$81.70**

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Family Deductible	$2,627.98 of $30,000.00
Individual Deductible	$2,627.98 of $10,000.00
Individual Out-of-Pocket	$0.00 of $0.00
Policy Maximum	$0.00 of $1,000,000.00

Reason code description

a. Provider discount through AETNA PPO (APM). Patient not responsible for this amount.
637CJ91 * Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

This document contains important information that you should retain for your records.
If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit

Reason code description

determination. (Please refer to the reason(s) provided for additional information).

If you think this determination was made in error, you have the right to appeal (see the Important Information about Your Appeal Rights in this EOB document). This claim was processed in accordance with your Plan Document.

You should know

This notice is NOT a bill. The amount identified as patient responsibility may have already been paid to the provider at the time of service or you may have paid a different amount at that time. Please contact your provider with any billing questions.

Important notes: If you are covered by more than one Plan, you should file all your claims with each respective Plan. The Provider Network Indicator is updated when eligible expenses are processed.

Your Medical and Pharmacy benefits (if purchased) are paid differently. Some exclusions or limitations set forth in your plan may not apply to your pharmacy claims. Payment of a pharmacy claim does not guarantee payment of medical claims related to the same medical condition and does not impact our right to investigate medical claims with the same medical condition to determine eligibility for payment under your plan.

Notice: The diagnosis and treatment codes (and their meaning), related to the service that is the subject of this Explanation of Benefits (EOB), are available upon request made to the carrier.

The following language assistance notice is required by law and is for informational purposes only. This language notice is intended to assist those plan participants who may not speak English as their predominant language.

SPANISH (Español): Para obtener asistencia en español, por favor póngase en contacto con el número de teléfono que aparece arriba.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjį' nikáʼa'doowołgo, t'áá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodíílnih.

Important information about your appeal rights

Allstate Health Solutions is committed to helping you make the most of your benefits. If you have any questions regarding how your claims were processed, please call the Customer Service number on the front of this notice.

When submitted claims are denied payment

What if I don't agree with this decision? You, an authorized representative, or the provider acting on behalf of the claimant has the right to appeal any decision. If there is a disagreement, an appeal can be filed.

If you think a coding error was the reason a claim was denied, you can request to have billing and diagnosis codes sent to you.

How do I file an appeal? You, an authorized representative, or the provider can submit an appeal. The appeal must be submitted in writing. Written appeals should be sent to:

Allstate Health Solutions
Attn: **Correspondence**
P.O. Box 2070
Milwaukee, WI 53201-2070

Please include your reason for appeal and any additional information you think is relevant to the case.

Can I request copies of the documentation relevant to my claim? Yes, upon request we will provide you, free of charge, copies of all relevant documentation, information and records. You may call the Customer Service number located on the front of this notice, or you can send a written request to:

Allstate Health Solutions
Attn: **Correspondence**
P.O. Box 2070
Milwaukee, WI 53201-2070

After an appeal is submitted, what happens? When we receive a written appeal, we will review the initial claim determination based on information you provide in your appeal. After review, we will process the appeal in accordance with your Plan and applicable law and provide you with our determination in writing.

Additional resources available to you:

For more information on how to file a request for an external review, we recommend your first step be to contact the Customer Service number located on the front of this notice.

Some states have an additional Consumer Assistance program (CAP) to assist you, if necessary. Use the link below to find contact information for your state's CAP. If your state doesn't have a CAP, the map points you to other consumer resources including phone numbers, email addresses, as well as links to your state's Department of Insurance that may also provide answers to your questions.

http://www.healthcare.gov/using-insurance/managing/consumer-help/index.html

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AJINKYA SHEKHAR SALVI
315 S PEORIA ST 909A
CHICAGO IL 60607

Explanation of Benefits

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Claim #: 637CZ86
Prepared on: 11/27/23
Plan name: SHORT TERM MEDICAL-STD PLN 8
Carrier: National Health Insurance Company
Member name: SALVI, AJINKYA SHEKHAR
Member ID: 2020672959
Patient relationship to member: SELF
Benefit period start: 11/05/23
Benefit period end: 01/05/24

Important Note: The provider Network Indicator is updated when eligible expenses are processed.

Provider Tax ID: 362174823 **IN-NETWORK** ☑ **OUT-OF-NETWORK** ☐
Provider: EILEEN MANOJLOVIC
Provider address: 1653 W CONGRESS PKWY
CHICAGO, IL 60612

Patient #: 91868762000100
Patient: SALVI, AJINKYA SHEKHAR

Treatment Date(s)	Service Code	Description	Billed Amount	Not Covered	Reason Code	PPO Discount	Allowed Amount	Penalty Amount	Deductible Amount	Other Fee	Co-pay Amount	Coinsurance %	Payment Amount
11/19/2023	80053 /	ER SERVICES	$245.14	$0.00	a	$98.79	$146.35	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/19/2023	84443 /	ER SERVICES	$158.62	$0.00	a	$63.92	$94.70	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/19/2023	84484 /	ER SERVICES	$130.00	$0.00	a	$52.39	$77.61	$0.00	$68.66	$0.00	$0.00	0%	$0.00
11/19/2023	85025 /	ER SERVICES	$124.00	$0.00	a	$49.97	$74.03	$0.00	$74.03	$0.00	$0.00	0%	$0.00
11/19/2023	81003 /	ER SERVICES	$41.20	$0.00	a	$16.60	$24.60	$0.00	$24.60	$0.00	$0.00	0%	$0.00
11/19/2023	70450 /	ER SERVICES	$1,665.63	$0.00	a	$671.25	$994.38	$0.00	$994.38	$0.00	$0.00	0%	$0.00
11/19/2023	99283 /	ER SERVICES	$2,050.00	$0.00	a	$826.15	$1,223.85	$0.00	$1,223.85	$0.00	$0.00	0%	$0.00
11/19/2023	93005 /	ER SERVICES	$269.28	$0.00	a	$108.52	$160.76	$0.00	$160.76	$0.00	$0.00	0%	$0.00
		Column Totals	**$4,683.87**	**$0.00**		**$1,887.59**	**$2,796.28**	**$0.00**	**$2,546.28**	**$0.00**	**$0.00**		$0.00
												Other Insurance Credits:	$0.00
												What We Paid:	$0.00

What you may owe: **$2,796.28**

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Family Deductible	$2,627.98 of $30,000.00
Individual Deductible	$2,627.98 of $10,000.00
Individual Out-of-Pocket	$0.00 of $0.00

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Policy Maximum	$0.00 of $1,000,000.00

Reason code description

a. Provider discount through AETNA PPO (APM). Patient not responsible for this amount.
637CZ86 * Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

This document contains important information that you should retain for your records.
If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information).

If you think this determination was made in error, you have the right to appeal (see the Important Information about Your Appeal Rights in this EOB document). This claim was processed in accordance with your Plan Document.
Emergency Room/Urgent Care Access Fee.

You should know

This notice is NOT a bill. The amount identified as patient responsibility may have already been paid to the provider at the time of service or you may have paid a different amount at that time. Please contact your provider with any billing questions.

Important notes: If you are covered by more than one Plan, you should file all your claims with each respective Plan. The Provider Network Indicator is updated when eligible expenses are processed.

Your Medical and Pharmacy benefits (if purchased) are paid differently. Some exclusions or limitations set forth in your plan may not apply to your pharmacy claims. Payment of a pharmacy claim does not guarantee payment of medical claims related to the same medical condition and does not impact our right to investigate medical claims with the same medical condition to determine eligibility for payment under your plan.

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SPANISH (Español): Para obtener asistencia en español, por favor póngase en contacto con el número de teléfono que aparece arriba.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjį' niká'a'doowołgo, t'áá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodíílnih.

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315 S PEORIA ST 909A
CHICAGO IL 60607

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Explanation of Benefits

RETAIN FOR TAX PURPOSES

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Claim #: 637H296
Prepared on: 11/29/23
Plan name: SHORT TERM MEDICAL-STD PLN 8
Carrier: National Health Insurance Company
Member name: SALVI, AJINKYA SHEKHAR
Member ID: 2020672959
Patient relationship to member: SELF
Benefit period start: 11/05/23
Benefit period end: 01/05/24

Important Note: The provider Network Indicator is updated when eligible expenses are processed.

Provider Tax ID: 911780160 **IN-NETWORK** ☑ **OUT-OF-NETWORK** ☐
Provider: EILEEN MANOJLOVIC
Provider address: 1653 W CONGRESS PKWY
TOWER 1ST FLOOR
CHICAGO, IL 60612

Patient #: 2268725840
Patient: SALVI, AJINKYA SHEKHAR

Treatment Date(s)	Service Code	Description	Billed Amount	Not Covered	Reason Code	PPO Discount	Allowed Amount	Penalty Amount	Deductible Amount	Other Fee	Co-pay Amount	Coinsurance %	Payment Amount
11/19/23-11/19/23	99284 /	ER SERVICES	$293.00	$0.00	a	$71.67	$221.33	$0.00	$221.33	$0.00	$0.00	0%	$0.00
		Column Totals	**$293.00**	**$0.00**		**$71.67**	**$221.33**	**$0.00**	**$221.33**	**$0.00**	**$0.00**		$0.00
												Other Insurance Credits:	$0.00
												What We Paid:	$0.00

What you may owe: **$221.33**

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Family Deductible	$2,849.31 of $30,000.00
Individual Deductible	$2,849.31 of $10,000.00
Individual Out-of-Pocket	$0.00 of $0.00
Policy Maximum	$0.00 of $1,000,000.00

Reason code description

a. Provider discount through AETNA PPO (APM). Patient not responsible for this amount.
637H296 * Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

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If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit

Reason code description

determination. (Please refer to the reason(s) provided for additional information).

If you think this determination was made in error, you have the right to appeal (see the Important Information about Your Appeal Rights in this EOB document). This claim was processed in accordance with your Plan Document.

You should know

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TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjį' nikáʼaʼdoowołgo, tʼáá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodíilnih.

Important information about your appeal rights

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When submitted claims are denied payment

What if I don't agree with this decision? You, an authorized representative, or the provider acting on behalf of the claimant has the right to appeal any decision. If there is a disagreement, an appeal can be filed.

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Attn: **Correspondence**
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Milwaukee, WI 53201-2070

Please include your reason for appeal and any additional information you think is relevant to the case.

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Milwaukee, WI 53201-2070

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http://www.healthcare.gov/using-insurance/managing/consumer-help/index.html

Allstate HEALTH SOLUTIONS

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Richardson TX 75085

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**********ALL FOR AADC 606
PB-CHI-13-ENV 16859 49
AJINKYA SHEKHAR SALVI
315 S PEORIA ST 909A
CHICAGO IL 60607-3682

Explanation of Benefits

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Claim #: 637HU74
Prepared on: 11/30/23
Plan name: SHORT TERM MEDICAL-STD PLN 8
Carrier: National Health Insurance Company
Member name: SALVI, AJINKYA SHEKHAR
Member ID: 2020672959
Patient relationship to member: SELF
Benefit period start: 11/05/23
Benefit period end: 01/05/24

Important Note: The provider Network Indicator is updated when eligible expenses are processed.

Provider Tax ID: 454083503 **IN-NETWORK** ☑ **OUT-OF-NETWORK** ☐
Provider: AFIA AHMED
Provider address: 7222 W CERMAK RD
SUITE 700
NORTH RIVERSIDE, IL 60546

Patient #: 2268813320
Patient: SALVI, AJINKYA SHEKHAR

Treatment Date(s)	Service Code	Description	Billed Amount	Not Covered	Reason Code	PPO Discount	Allowed Amount	Penalty Amount	Deductible Amount	Other Fee	Co-pay Amount	Coinsurance %	Payment Amount
11/22/23-11/22/23	99385 /	OFFICE VISIT	$250.00	$250.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/22/23-11/22/23	99401 /	OFFICE VISIT	$82.00	$0.00	b	$23.37	$58.63	$0.00	$58.63	$0.00	$0.00	0%	$0.00
11/22/23-11/22/23	90686 /	MEDICINE	$66.00	$66.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/22/23-11/22/23	90471 /	MEDICINE	$65.00	$65.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
		Column Totals	**$463.00**	**$381.00**		**$23.37**	**$58.63**	**$0.00**	**$58.63**	**$0.00**	**$0.00**		$0.00
												Other Insurance Credits:	$0.00
												What We Paid:	$0.00

What you may owe: $439.63

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Family Deductible	$2,907.94 of $30,000.00
Individual Deductible	$2,907.94 of $10,000.00
Individual Out-of-Pocket	$0.00 of $0.00
Policy Maximum	$0.00 of $1,000,000.00

Reason code description

a. (Short Term Medical): Charges for preventive treatment, services or supplies except as otherwise covered in the Benefits section.

Reason code description

b. Provider discount through AETNA PPO (APM). Patient not responsible for this amount.
637HU74 * Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

This document contains important information that you should retain for your records.
If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information).

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TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjį' nikáʼa'doowołgo, t'áá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodíílnih.

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Forwarding Service Requested

**********ALL FOR AADC 606
PB-CHI-13-ENV 12039 31
AJINKYA SHEKHAR SALVI
315 S PEORIA ST 909A
CHICAGO IL 60607-3682

Explanation of Benefits

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OR by scanning this QR code:

Claim #: 637NY13
Prepared on: 12/05/23
Plan name: SHORT TERM MEDICAL-STD PLN 8
Carrier: National Health Insurance Company
Member name: SALVI, AJINKYA SHEKHAR
Member ID: 2020672959
Patient relationship to member: SELF
Benefit period start: 11/05/23
Benefit period end: 01/05/24

Important Note: The provider Network Indicator is updated when eligible expenses are processed.

Provider Tax ID: 474909860 **IN-NETWORK** ☑ **OUT-OF-NETWORK** ☐
Provider: ROBERT DECRESCE
Provider address: 1653 WEST CONGRESS PKWY
CHICAGO, IL 60612

Patient #: 106651739-P
Patient: SALVI, AJINKYA SHEKHAR

Treatment Date(s)	Service Code	Description	Billed Amount	Not Covered	Reason Code	PPO Discount	Allowed Amount	Penalty Amount	Deductible Amount	Other Fee	Co-pay Amount	Coinsurance %	Payment Amount
11/19/2023	80053 /	OUTPATIENT	$31.05	$31.05	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/19/2023	81003 /	OUTPATIENT	$6.90	$6.90	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/19/2023	84443 /	OUTPATIENT	$43.00	$43.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/19/2023	84484 /	OUTPATIENT	$25.00	$25.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
11/19/2023	85025 /	OUTPATIENT	$20.00	$20.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
		Column Totals	**$125.95**	**$125.95**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		$0.00
												Other Insurance Credits:	$0.00
												What We Paid:	$0.00

What you may owe: **$0.00**

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Family Deductible	$2,907.94 of $30,000.00
Individual Deductible	$2,907.94 of $10,000.00
Individual Out-of-Pocket	$0.00 of $0.00
Policy Maximum	$0.00 of $1,000,000.00

Reason code description

a. The procedure code is inconsistent with the modifier used or a required modifier is missing.
637NY13 * Provider discount through AETNA PPO (APM). Patient not responsible for this amount.

This document contains important information that you should retain for your records.
If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information).

If you think this determination was made in error, you have the right to appeal (see the Important Information about Your Appeal Rights in this EOB document). This claim was processed in accordance with your Plan Document.

You should know

This notice is NOT a bill. The amount identified as patient responsibility may have already been paid to the provider at the time of service or you may have paid a different amount at that time. Please contact your provider with any billing questions.

Important notes: If you are covered by more than one Plan, you should file all your claims with each respective Plan. The Provider Network Indicator is updated when eligible expenses are processed.

Your Medical and Pharmacy benefits (if purchased) are paid differently. Some exclusions or limitations set forth in your plan may not apply to your pharmacy claims. Payment of a pharmacy claim does not guarantee payment of medical claims related to the same medical condition and does not impact our right to investigate medical claims with the same medical condition to determine eligibility for payment under your plan.

Notice: The diagnosis and treatment codes (and their meaning), related to the service that is the subject of this Explanation of Benefits (EOB), are available upon request made to the carrier.

The following language assistance notice is required by law and is for informational purposes only. This language notice is intended to assist those plan participants who may not speak English as their predominant language.

SPANISH (Español): Para obtener asistencia en español, por favor póngase en contacto con el número de teléfono que aparece arriba.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjį' niká'a'doowołgo, t'áá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodíílnih.

Allstate HEALTH SOLUTIONS

P.O. Box 853921
Richardson TX 75085

Forwarding Service Requested

**********ALL FOR AADC 606
PB-CHI-13-ENV 14817 41
AJINKYA SHEKHAR SALVI
315 S PEORIA ST 909A
CHICAGO IL 60607-3682

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Customer Service Information

Need help understanding your benefits?
Contact us at: (866) 596-5817

VISIT US ONLINE!
You can view your Explanation of Benefits at:
www.myallstatehealthsolutions.com
OR by scanning this QR code:

Claim #: 639Y917
Prepared on: 02/09/24
Plan name: SHORT TERM MEDICAL-STD PLN 8
Carrier: National Health Insurance Company
Member name: SALVI, AJINKYA SHEKHAR
Member ID: 2020672959
Patient relationship to member: SELF
Benefit period start: 11/05/23
Benefit period end: 01/05/24

Important Note: The provider Network Indicator is updated when eligible expenses are processed.

Provider Tax ID: 911780160 **IN-NETWORK** ☑ **OUT-OF-NETWORK** ☐
Provider: SHARON BYRD
Provider address: 1653 W CONGRESS PKWY
CHICAGO, IL 60612

Patient #: 2273912380
Patient: SALVI, AJINKYA SHEKHAR

Treatment Date(s)	Service Code	Description	Billed Amount	Not Covered	Reason Code	PPO Discount	Allowed Amount	Penalty Amount	Deductible Amount	Other Fee	Co-pay Amount	Coinsurance %	Payment Amount
11/20/23-11/20/23	70450 /	ER SERVICES	$137.00	$137.00	a	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00
		Column Totals	**$137.00**	**$137.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		$0.00

Other Insurance Credits: $0.00
What We Paid: $0.00

What you may owe: **$0.00**

Plan status: Accumulators+

+The Plan Accumulators are updated based on when above claim(s) were processed.

	Satisfied
Family Deductible	$2,907.94 of $30,000.00
Individual Deductible	$2,907.94 of $10,000.00
Individual Out-of-Pocket	$0.00 of $0.00
Policy Maximum	$0.00 of $1,000,000.00

Reason code description

a. This charge was previously processed under claim #637CJ91. Please refer to previous submission for patient responsibility.
639Y917 * Provider discount through AETNA PPO (APM). Patient not responsible for this amount.

This document contains important information that you should retain for your records.
If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit

Reason code description

determination. (Please refer to the reason(s) provided for additional information).

If you think this determination was made in error, you have the right to appeal (see the Important Information about Your Appeal Rights in this EOB document). This claim was processed in accordance with your Plan Document.

You should know

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NAVAJO (Dine): Dinék'ehjį' nikáʼa'doowoɬgo, t'áá shǫǫdi hódahdi béésh bee hane'é binumber bikáá'igíí bish'į' hodíilnih.

Important information about your appeal rights

Allstate Health Solutions is committed to helping you make the most of your benefits. If you have any questions regarding how your claims were processed, please call the Customer Service number on the front of this notice.

When submitted claims are denied payment

What if I don't agree with this decision? You, an authorized representative, or the provider acting on behalf of the claimant has the right to appeal any decision. If there is a disagreement, an appeal can be filed.

If you think a coding error was the reason a claim was denied, you can request to have billing and diagnosis codes sent to you.

How do I file an appeal? You, an authorized representative, or the provider can submit an appeal. The appeal must be submitted in writing. Written appeals should be sent to:

Allstate Health Solutions
Attn: **Correspondence**
P.O. Box 2070
Milwaukee, WI 53201-2070

Please include your reason for appeal and any additional information you think is relevant to the case.

Can I request copies of the documentation relevant to my claim? Yes, upon request we will provide you, free of charge, copies of all relevant documentation, information and records. You may call the Customer Service number located on the front of this notice, or you can send a written request to:

Allstate Health Solutions
Attn: **Correspondence**
P.O. Box 2070
Milwaukee, WI 53201-2070

After an appeal is submitted, what happens? When we receive a written appeal, we will review the initial claim determination based on information you provide in your appeal. After review, we will process the appeal in accordance with your Plan and applicable law and provide you with our determination in writing.

Additional resources available to you:

For more information on how to file a request for an external review, we recommend your first step be to contact the Customer Service number located on the front of this notice.

Some states have an additional Consumer Assistance program (CAP) to assist you, if necessary. Use the link below to find contact information for your state's CAP. If your state doesn't have a CAP, the map points you to other consumer resources including phone numbers, email addresses, as well as links to your state's Department of Insurance that may also provide answers to your questions.

http://www.healthcare.gov/using-insurance/managing/consumer-help/index.html