Cigna.

Explanation Of Benefits (Participant Copy) Reference Sheet		
A	Claim Administrator and Employee information	
	1	Claim Administrator's claim address
	2	Claim Administrator's toll-free Customer Service number
	3	Employee's name and mailing address
	4	Date of the Explanation of Benefits
	5	Employee's Name
	6	CIGNA Behavioral Health Participant ID—an internally assigned number
B	Claim Summary	
	1	Participant name
	2	CIGNA Behavioral Health Participant ID—an internally assigned number
	3	Number assigned to document(s) for identification and tracking by CIGNA Behavioral Health based on the date claim was received
	4	Name of the Provider/Practitioner of services
C	Claim Payment Detail	
	1	Date service was rendered
	2	General description of the procedure rendered to the Participant by the above named Provider/Practitioner
	3	Amount billed for services rendered
	4	Amount over the contracted fee maximum. The Participant is not liable for this amount
	5	Amount for which the Provider/Practitioner is responsible. (Example: Medicare contracted rates, amounts over the fee maximum.) The Participant is not liable for this amount
	6	Total amount eligible for reimbursement by CIGNA Behavioral Health
	7	Amount for services that are not covered by CIGNA Behavioral Health. Refer to remarks for an explanation of any amounts not covered. These could be amounts excluded under the plan or amounts incorrectly submitted to the Mental Health/Substance Abuse claim administrator
	8	Eligible dollar amount applied towards the Participant's deductible. This amount does not reflect the total for the plan year, only the total for this charge. However, any amounts previously applied towards the deductible are taken into consideration when calculating this amount
	9	Fixed dollar amount set by the member's benefit plan—Participant responsibility
	10	Dollar amount based on a fixed percentage set by the participant's benefit plan—Participant responsibility. (Example: If a benefit is paid at 70%, this field will show the 30% the Participant will owe.)
	11	Total amount paid by CIGNA Behavioral Health on this charge
	12	Remark codes assigned to explain adjusted and noncovered amounts
	13	Summation of the amounts corresponding to the columns named above
	14	Amount paid by other insurance carrier and subtracted from the CIGNA Behavioral Health payment
	15	Total amount applied to Participant's deductible from all eligible charges detailed above plus the amounts not covered
	16	Total copay/coinsurance amounts due from participant from all eligible charges detailed above
	17	Total payment made for all eligible charges detailed above.
D	Payment Summary	
	1	Payment was made to (This indicates to whom the check was sent.): PROVIDER/PRACTITIONER—Provider/Practitioner of services or SUBSCRIBER—Employee
	2	Total amount paid for all claims detailed on the explanation of benefits
	3	Check number of the payment
	4	Remark code narrative/explanation referenced in #12 in the claim payment detail
	5	This is not a bill for the Participant to pay. The Provider/Practitioner will bill for any amounts due from the Participant

Revision Date: June 2013

CIGNA Behavioral Health (1)
11095 VIKING DRIVE
SUITE 350
EDEN PRAIRIE MN 55344
800.926.2273 (2)

SAMPLE COPY

A EMPLOYEE (4)
1234 MAIN STREET
ANYTOWN, US 12345

Date 00-00-0000 (3)

Subscriber Name EMPLOYEE (5)
Participant ID (6)
Control # 0000000000

BELOW IS AN EXPLANATION OF BENEFITS FOR SERVICES PROVIDED FOR THE FOLLOWING PARTICIPANT(S):

CLAIM DETAIL SECTION (IF THERE ARE NUMBERS IN THE 'SEE REMARKS' COLUMN, SEE THE REMARKS SECTION FOR EXPLANATION.)

B PARTICIPANT NAME (1) DOCUMENT NUMBER (2)
PROVIDER NAME (4) INVOICE # (3)

C

SERVICE DATE(S)	PROCEDURE	CHARGES	AGREEMENT ADJUSTMENT	PROV. RESP.	ALLOWED/ CONTRACTED	NOT COVERED	DEDUCT	COPAY	COINSURANCE	TOTAL PAYMENT	SEE REMARKS
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**

TOTALS: **(13)**
ADJUSTMENT DUE TO OTHER INSURANCE/PREVIOUSLY PAID **(14)**

BALANCE DUE FROM PARTICIPANT PT'S DED NOT COV 0.00 **(15)** TOTAL PAID: **(17)**
PT'S COINS/COPAY 0.00 = 0.00 **(16)**

D PAYMENT SUMMARY SECTION

Payment Made to Provider **(1)** TOTAL PAYMENT AMOUNT **(2)** CHECK # **(3)**

-REMARKS- **(4)**

THE PARTICIPANT'S EMPLOYEE BENEFIT PLAN PROVIDES REIMBURSEMENT FOR MEDICAL SERVICES PROVIDED TO THE PARTICIPANT THAT ARE DETERMINED TO BE COVERED UNDER THE PLAN. THE EMPLOYEE BENEFIT PLAN AND ITS CONTRACTORS DO NOT DETERMINE WHAT MEDICAL SERVICES WILL BE PROVIDED TO THE PARTICIPANT. THE PARTICIPANT MUST MAKE THE DETERMINATION OF THE MEDICAL SERVICES HE OR SHE WISHES TO RECEIVE IN CONSULTATION WITH HIS OR HER PROVIDER, AND THE PARTICIPANT WILL BE FINANCIALLY RESPONSIBLE FOR MEDICAL SERVICES NOT COVERED BY THE PLAN.

THIS IS NOT A BILL (5)