Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

201803153302

[redacted]

345

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 03/08/2018

EOB

ENV 23448 1 OF 1

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	KLEIN MD PA PHYSICIAN	02/28-02/28/2018	222.00	115.73	31.27	0.00	75.00	100%	75.00
02	KLEIN MD PA XRAY	02/28-02/28/2018	97.00	71.12		0.00	25.88	100%	25.88
		TOTALS	319.00	186.85	31.27	0.00	100.88		100.88

Provider Payment Amount	100.88
Amount You May Owe Provider	31.27

Payee	Amount
KLEIN MD PA	100.88

Claim Remarks Line No.	Explanation
1	(Line 01-$31.27)MAXIMUM BENEFIT PAID PER SCHEDULE
1,2	Cigna Healthcare discount. Patient not liable.
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

If your claim was denied in whole or in part, this notice explains the reason for denial. If you would like assistance with identifying the specific claim denied or have any questions about an Explanation of Benefits determination, please call the Customer Service phone number listed on your ID card and ask for the determination to be reviewed. This informal review is not an Appeal nor a substitute for an Appeal. Nor must you ask for an informal review to request an Appeal.

If the amount you owe to a facility based provider or emergency care provider, after copayments, deductibles and coinsurance is greater than $500; and the health benefit claim is for out-of-network emergency care rendered or a health care or medical service or supply provided by an out-of-network facility-based provider in a facility that is a preferred provider or that has a contract with the administrator; you may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that is eligible for mediation by contacting the Texas Department of Insurance at www.tdi.texas.gov/consumer/complfrm.html and 1-800-252-3439.

P2009003015 201904113301

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

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[redacted]
155

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 04/08/2019

EOB

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	PREMIER DERMATOLOGY L PHYSICIAN	04/03-04/03/2019	218.30	138.32		0.00	79.98	100%	79.98
		TOTALS	218.30	138.32	0.00	0.00	79.98		79.98

Provider Payment Amount 79.98
Amount You May Owe Provider 0.00

Payee	Amount
PREMIER DERMATOLOGY LLC	79.98

Claim Remarks Line No.	Explanation
1	Cigna Healthcare discount. Patient not liable.
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

P2009003015

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

201901173302

ALL FOR AADC 331
11470 0.3820 AB 0.405
[redacted]
157

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 01/14/2019

EOB

ENV 11470 1 OF 1

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	HOMMEN ORTHOPEDIC INS PHYSICIAN	01/08-01/08/2019	1,150.00	1,028.77	46.23	0.00	75.00	100%	75.00
		TOTALS	1,150.00	1,028.77	46.23	0.00	75.00		75.00
								Provider Payment Amount	75.00
								Amount You May Owe Provider	46.23

Payee	Amount
HOMMEN ORTHOPEDIC INSTITUTE	75.00

Claim Remarks Line No.	Explanation
1	(Line 01-$46.23)MAXIMUM BENEFIT PAID PER SCHEDULE
1	Cigna Healthcare discount. Patient not liable.
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

[redacted] 156

Questions? Contact us at
(800) 387-9027

000294
0101

Claim No.: 190290012-N
Plan #: 75GUAR5/
Insured: [redacted]
Policy/Certificate: 75GU535090
Claimant: [redacted]
Patient ID: 6542255894
Settlement Date: 01/29/2019

EOB

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	QUEST DIAGNOSTICS LABORATORY	01/21-01/21/2019	74.25	63.00		0.00	11.25	100%	11.25
02	QUEST DIAGNOSTICS LABORATORY	01/21-01/21/2019	146.23	132.98		0.00	13.25	100%	13.25
03	QUEST DIAGNOSTICS LABORATORY	01/21-01/21/2019	148.10	130.10	17.50	0.00	0.50	100%	0.50
04	QUEST DIAGNOSTICS LABORATORY	01/21-01/21/2019	21.37	19.27	2.10	0.00	0.00	0%	0.00
05	QUEST DIAGNOSTICS LABORATORY	01/21-01/21/2019	47.59	42.09	5.50	0.00	0.00	0%	0.00
06	QUEST DIAGNOSTICS LABORATORY	01/21-01/21/2019	241.07	211.23	29.84	0.00	0.00	0%	0.00
		TOTALS	678.61	598.67	54.94	0.00	25.00		25.00

Provider Payment Amount	25.00
Amount You May Owe Provider	54.94

Payee	Amount
QUEST DIAGNOSTICS	25.00

Claim Remarks

Line No.	Explanation
1,2,3,4,5,6	Quest Diagnostics discount. Patient not responsible for this amount.
3,4,5,6	(Line 03-$17.50)(Line 04-$2.10)(Line 05-$5.50)(Line 06-$29.84)MAXIMUM BENEFIT PAID PER SCHEDULE
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

P2009003015

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

201802223304

ALL FOR AADC 335
13700 0.3820 AB 0.405
[redacted]
163
[redacted] 34695-4518

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 02/21/2018

EOB

ENV 13700 1 OF 1

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	BAYSIDE URGENT CARE CE PHYSICIAN	02/14-02/14/2018	175.85	55.85	37.00	0.00	83.00	100%	83.00
02	BAYSIDE URGENT CARE CE OP URG CARE	02/14-02/14/2018	109.70	109.70		0.00	0.00	0%	0.00
03	BAYSIDE URGENT CARE CE PHYSICIAN	02/14-02/14/2018	60.93	60.93		0.00	0.00	0%	0.00
		TOTALS	346.48	226.48	37.00	0.00	83.00		83.00
								Provider Payment Amount	83.00
								Amount You May Owe Provider	37.00

Payee	Amount
BAYSIDE URGENT CARE CENTER	83.00

Claim Remarks Line No.	Explanation
1,2,3	Cigna Healthcare discount. Patient not liable.
1,3	(Line 01-$37.00)MAXIMUM BENEFIT PAID PER SCHEDULE
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

P2009003015

201908223301

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

[redacted]2 160

Questions? Contact us at
(800) 387-9027

003838
0101

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 08/20/2019

EOB

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	LAKEWOOD RANCH HOSP MISC	08/13-08/13/2019	107.00	99.87	7.13	0.00	0.00	0%	0.00
02	LAKEWOOD RANCH LABORATORY	08/13-08/13/2019	2,586.00	2,414.03	135.97	0.00	36.00	100%	36.00
03	LAKEWOOD RANCH CAT SCAN	08/13-08/13/2019	16,752.00	15,637.82	932.18	0.00	182.00	100%	182.00
04	LAKEWOOD RANCH EMRGCY ROOM	08/13-08/13/2019	4,688.00	4,376.18	8.82	0.00	303.00	100%	303.00
		TOTALS	24,133.00	22,527.90	1,084.10	0.00	521.00		521.00
								Provider Payment Amount	521.00
								Amount You May Owe Provider	1,084.10

Payee	Amount
LAKEWOOD RANCH	521.00

Claim Remarks Line No.	Explanation
1	(Line 01-$7.13)Hospital Miscellaneous Charges are not covered
1,2,3,4	Cigna Healthcare discount. Patient not liable.
2,3,4	(Line 02-$135.97)(Line 03-$932.18)(Line 04-$8.82) Maximum benefit paid per schedule
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of the policy/certificate.

Any expenses erroneously applied to a deductible or copay, if applicable, or paid under any section or provision of the policy/certificate shall not constitute a waiver or modification of any conditions, terms, definitions or limitations contained in the policy/certificate.

THIS IS NOT A BILL

P2009003014

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

201901310105

ALL FOR AADC 331
17915 0.5738 AB 0.409
[redacted]
235

Questions? Contact us at
(800) 387-9027

Claim No. [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID:
Settlement Date: 01/29/2019

EOB

ENV 17915 1 OF 2

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	MISCELLANEOUS PROVIDE PHYSICIAN	12/27-12/27/2018	104.07		29.07	0.00	75.00	100%	75.00
02	MISCELLANEOUS PROVIDE PHYSICIAN	12/27-12/27/2018	41.63		41.63	0.00	0.00	0%	0.00
03	MISCELLANEOUS PROVIDE PHYSICIAN	12/27-12/27/2018	23.79		23.79	0.00	0.00	0%	0.00
04	MISCELLANEOUS PROVIDE XRAY	12/27-12/27/2018	267.61		217.61	0.00	50.00	100%	50.00
05	MISCELLANEOUS PROVIDE GENERIC DRUG	12/27-12/27/2018	16.35		6.35	0.00	10.00	100%	10.00
06	MISCELLANEOUS PROVIDE GENERIC DRUG	12/27-12/27/2018	29.73		19.73	0.00	10.00	100%	10.00
07	MISCELLANEOUS PROVIDE SUPPLY	12/27-12/27/2018	32.71		32.71	0.00	0.00	0%	0.00
08	MISCELLANEOUS PROVIDE PRESC DRUGS	12/27-12/27/2018	115.97		85.97	0.00	30.00	100%	30.00
09	MISCELLANEOUS PROVIDE MRI	12/27-12/27/2018	690.35		390.35	0.00	300.00	100%	300.00
10	MISCELLANEOUS PROVIDE SUPPLY	12/27-12/27/2018	21.64		21.64	0.00	0.00	0%	0.00
11	MISCELLANEOUS PROVIDE SUPPLY	12/27-12/27/2018	371.96		371.96	0.00	0.00	0%	0.00
12	MISCELLANEOUS PROVIDE PHYS THERAPY	12/28-12/28/2018	74.34		74.34	0.00	0.00	0%	0.00
		TOTALS	1,790.15	0.00	1,315.15	0.00	475.00		475.00
								Amount You May Owe Provider	1,315.15

Payee	Amount
[redacted]	475.00

Claim Remarks Line No.	Explanation
1,2,3,4,5,6,8,9	(Line 01-$29.07)(Line 02-$41.63)(Line 03-$23.79)(Line 04-$217.61)(Line 05-$6.35)(Line 06-$19.73)(Line 08-$85.97)(Line 09-$390.35)MAXIMUM BENEFIT PAID PER SCHEDULE
12	(Line 12-$74.34)Physical Therapy, Speech Therapy and Occupational Therapy are not covered
7,10,11	(Line 07-$32.71)(Line 10-$21.64)(Line 11-$371.96)Durable Medical Equipment and Medical Supplies are not covered
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

ALL FOR AADC 342
15149 0.7648 AB 0.436
[redacted]
210

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 08/04/2020

ENV 15149 1 OF 3

EOB

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	QUEST DIAGNOSTIC LABORATORY	07/29-07/29/2020	74.25	61.24		0.00	100.00	100%	100.00
02	QUEST DIAGNOSTIC LABORATORY	07/29-07/29/2020	146.23	134.14	12.09	0.00	0.00	0%	0.00
03	QUEST DIAGNOSTIC LABORATORY	07/29-07/29/2020	148.10	130.65	17.45	0.00	0.00	0%	0.00
04	QUEST DIAGNOSTIC LABORATORY	07/29-07/29/2020	59.00	41.64	17.36	0.00	0.00	0%	0.00
05	QUEST DIAGNOSTIC LABORATORY	07/29-07/29/2020	264.06	223.69	40.37	0.00	0.00	0%	0.00
06	QUEST DIAGNOSTIC LABORATORY	07/29-07/29/2020	226.10	203.39	22.71	0.00	0.00	0%	0.00
		TOTALS	917.74	794.75	109.98	0.00	100.00		100.00

Provider Payment Amount	100.00
Amount You May Owe Provider	22.99

Payee	**Amount**
QUEST DIAGNOSTIC	100.00

Claim Remarks Line No.	**Explanation**
1,2,3,4,5,6	Cigna Healthcare discount. Patient not liable.
2,3,4,5,6	(Line 02-$12.09)(Line 03-$17.45)(Line 04-$17.36)(Line 05-$40.37)(Line 06-$22.71) Maximum benefit paid per schedule
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of the policy/certificate.

Any expenses erroneously applied to a deductible or copay, if applicable, or paid under any section or provision of the policy/certificate shall not constitute a waiver or modification of any conditions, terms, definitions or limitations contained in the policy/certificate.

THIS IS NOT A BILL

Freedom Life Insurance
Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

ALL FOR AADC 342
15149 0.7648 AB 0.416
[redacted]
210

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 08/05/2020

EOB

ENV 15149 2 OF 3

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	ALLCARE MEDICAL CENTE PHYSICIAN	07/29-07/29/2020	266.00	174.31		0.00	250.00	100%	250.00
02	ALLCARE MEDICAL CENTE LABORATORY	07/29-07/29/2020	15.00	12.00	3.00	0.00	0.00	0%	0.00
		TOTALS	281.00	186.31	3.00	0.00	250.00		250.00

Provider Payment Amount 94.69
Amount You May Owe Provider 0.00

Payee	Amount
ALLCARE MEDICAL CENTERS PC	94.69
[redacted]	155.31

Claim Remarks

Line No.	Explanation
1,2	Cigna Healthcare discount. Patient not liable.
2	(Line 02-$3.00) Maximum benefit paid per schedule
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of the policy/certificate.

Any expenses erroneously applied to a deductible or copay, if applicable, or paid under any section or provision of the policy/certificate shall not constitute a waiver or modification of any conditions, terms, definitions or limitations contained in the policy/certificate.

THIS IS NOT A BILL

[redacted]

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

ALL FOR AADC 342
15149 0.7648 AB 0.416

[redacted]
210

[redacted]

3 OF 3

ENV 15149

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

FREEDOM LIFE INSURANCE COMPANY
300 Burnett Street, Suite 200
Fort Worth, TX 76102

88-123/1119

CHECK NO. 304471261
VOID 90 DAYS FROM ISSUE DATE
VOID IF OVER $20,000.00 WITHOUT 2 SIGNATURES
ISSUE DATE 08/05/2020

AMOUNT
***155.31*

1177245

PAY ***ONE HUNDRED FIFTY-FIVE AND 31/100 DOLLARS***

TO THE ORDER OF [redacted]

Claimant's Name: [redacted]
Policy/Certificate: [redacted]
Claim No: [redacted]

PROSPERITY BANK
FORT WORTH, TX 76102

Authorized Signature

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

[redacted]

[redacted]

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

202101280115

ALL FOR AADC 342
9909 0.5486 AB 0.416
[redacted]
176

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted]
Policy/Certificate: [redacted]
Claimant: [redacted]
Patient ID: [redacted]
Settlement Date: 01/27/2021

EOB

ENV 9909 1 OF 2

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	CHOICE DIAGNOSTICS MAMMOGRAM	01/19-01/19/2021	671.65	577.31		0.00	250.00	100%	250.00
02	CHOICE DIAGNOSTICS MAMMOGRAM	01/19-01/19/2021	300.00	261.04	38.96	0.00	0.00	0%	0.00
		TOTALS	971.65	838.35	38.96	0.00	250.00		250.00

Provider Payment Amount 133.30
Amount You May Owe Provider 0.00

Payee	Amount
CHOICE DIAGNOSTICS	133.30
[redacted]	116.70

Claim Remarks Line No.	Explanation
1,2	UnitedHealthcare Choice Plus-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Patient is not responsible for this amount.
2	(Line 02-$38.96) Maximum benefit paid per schedule
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of the policy/certificate.

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

FREEDOM LIFE INSURANCE COMPANY
300 Burnett Street, Suite 200
Fort Worth, TX 76102

56-704/412

CHECK NO. 305079335
VOID 90 DAYS FROM ISSUE DATE
VOID IF OVER $20,000.00 WITHOUT 2 SIGNATURES
ISSUE DATE 01/27/2021

AMOUNT
*****116.70***

PAY ***ONE HUNDRED SIXTEEN AND 70/100 DOLLARS***

TO THE ORDER OF [redacted]

7335960

Claimant's Name: [redacted]
Policy/Certificate:
Claim No:

KEYBANK

MINNETONKA, MN 55343

Authorized Signature

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

[redacted] ⑈00000116 70⑈

P200900301A

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

201804051408

MIXED ADC 335

270 5.0023 MB 1.752

[redacted]

47

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #:
Insured:
Policy/Certificate:
Claimant:
Patient ID:
Settlement Date: 04/02/2018

EOB

ENV 270 1 OF 23

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	MORTON PLANT HOSPITAL HOSP MISC	01/29-01/29/2018	16,105.82	2,206.46		3,000.00	10,899.36	100%	10,899.36
02	MORTON PLANT HOSPITAL SUPPLY	01/29-01/29/2018	13,588.00	1,861.61		0.00	11,726.39	100%	11,726.39
03	MORTON PLANT HOSPITAL AMB SURG FAC	01/29-01/29/2018	55,334.00	7,580.74		0.00	47,753.26	100%	47,753.26
		TOTALS	85,027.82	11,648.81	0.00	3,000.00	70,379.01		70,379.01
								Provider Payment Amount	70,379.01
								Amount You May Owe Provider	3,000.00

Payee	Amount
MORTON PLANT HOSPITAL	70,379.01

Claim Remarks Line No.	Explanation
1,2,3	Cigna Healthcare discount. Patient not liable.
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

THIS IS NOT A BILL

P2009003002

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

202101120111

ALL FOR AADC 303
2820 0.3820 AB 0.416
59

Questions? Contact us at
(800) 387-9027

Claim No.:
Plan #:
Insured:
Policy/Certificate:
Claimant:
Patient ID:
Settlement Date:

EOB

ENV 2820 1 OF 1

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Eligible Expense	Paid At	Balance Paid By Plan
01	MISCELLANEOUS PROVIDE CRITICAL ILL	12/02-12/02/2020	11,310.00			0.00	11,310.00	100%	11,310.00
		TOTALS	11,310.00	0.00	0.00	0.00	11,310.00		11,310.00
								Amount You May Owe Provider	0.00

Payee	Amount
	11,310.00

Claim Remarks

Line No.	Explanation
1	The policy maximum has been allowed for this benefit.
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of the policy/certificate.
	Any expenses erroneously applied to a deductible or copay, if applicable, or paid under any section or provision of the policy/certificate shall not constitute a waiver or modification of any conditions, terms, definitions or limitations contained in the policy/certificate.

FREEDOM LIFE INSURANCE COMPANY OF AMERICA
300 Burnett Street, Suite 200
Fort Worth, TX 76102

56-704/412

CHECK NO. 305011713
VOID 90 DAYS FROM ISSUE DATE
VOID IF OVER $20,000.00 WITHOUT 2 SIGNATURES
ISSUE DATE 01/11/2021

AMOUNT
*****11,310.00***

PAY ***ELEVEN THOUSAND THREE HUNDRED TEN AND 00/100 DOLLARS***

TO THE ORDER OF

Claimant's Name:
Policy/Certificate:
Claim No:

KEYBANK

MINNETONKA, MN 55343

VOID

Authorized Signature

⑈000113100⑈

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

SINGLE PIECE
197 6.7056 SP 2.200
2

Questions? Contact us at
(800) 387-9027

Claim No.:
Plan #:
Insured:
Policy/Certificate:
Claimant:
Patient ID:
Settlement Date:

EOB

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Provider Discount	Excluded Charges	Deductible	Benefit Amount	Paid At	Amount Paid By Plan
01	OSCEOLA REG MED CTR HOSP INDEMN	12/25-12/28/2019	7,863.00		6,663.00	0.00	1,200.00	100%	1,200.00
02	OSCEOLA REG MED CTR ICU	12/20-12/25/2019	17,686.25		13,686.25	0.00	4,000.00	100%	4,000.00
03	OSCEOLA REG MED CTR HOSP MISC	12/20-12/28/2019	57,715.17	27,628.58	26,886.59	0.00	3,200.00	100%	3,200.00
04	OSCEOLA REG MED CTR SUPPLY	12/20-12/28/2019	30,493.99	14,597.77	15,896.22	0.00	0.00	0%	0.00
05	OSCEOLA REG MED CTR LABORATORY	12/20-12/28/2019	49,166.84	23,536.63	25,630.21	0.00	0.00	0%	0.00
06	OSCEOLA REG MED CTR XRAY	12/20-12/28/2019	12,244.75	5,861.68	6,383.07	0.00	0.00	0%	0.00
07	OSCEOLA REG MED CTR CAT SCAN	12/20-12/28/2019	129,064.50	61,784.46	67,280.04	0.00	0.00	0%	0.00
08	OSCEOLA REG MED CTR HOSP MISC	12/20-12/28/2019	233,264.50	111,666.04	121,598.46	0.00	0.00	0%	0.00
09	OSCEOLA REG MED CTR HOSP MISC	12/20-12/28/2019	70,787.25	33,886.56	36,900.69	0.00	0.00	0%	0.00
10	OSCEOLA REG MED CTR PHYS THERAPY	12/20-12/28/2019	6,959.50	3,331.57	3,627.93	0.00	0.00	0%	0.00
11	OSCEOLA REG MED CTR OCCUP THERPY	12/20-12/28/2019	2,559.00	1,225.01	1,333.99	0.00	0.00	0%	0.00
12	OSCEOLA REG MED CTR SPEECH THRPY	12/20-12/28/2019	1,284.50	614.90	669.60	0.00	0.00	0%	0.00
13	OSCEOLA REG MED CTR EMRGCY ROOM	12/20-12/28/2019	34,626.75	16,576.16	17,800.59	0.00	250.00	100%	250.00
		TOTALS	653,716.00	300,709.36	344,356.64	0.00	8,650.00		8,650.00

Provider Payment Amount 8,650.00
Amount You May Owe Provider 344,356.64

Payee	Amount
OSCEOLA REG MED CTR	8,650.00

Claim Remarks Line No.	Explanation
1,2	Service rendered by network provider are w/in contractual agreement
1,2,3,13	(Line 01-$6,663.00)(Line 02-$13,686.25)(Line 03-$26,886.59)(Line 13-$17,800.59) Maximum benefit paid per schedule
10,11,12	(Line 10-$3,627.93)(Line 11-$1,333.99)(Line 12-$669.60) Physical Therapy, Speech Therapy and Occupational Therapy are not covered
12,13	Cigna Healthcare discount. Patient not liable.

Freedom Life Insurance Company of America

300 Burnett Street
Suite 200
Fort Worth, TX 76102
Return Service Requested

201708240110

ALL FOR AADC 342
26640 0.3820 AB 0.400

[redacted] DEVOLDER
[redacted] LAKE DR
SARASOTA, FL 34232-1919

294

Questions? Contact us at
(800) 387-9027

Claim No.: [redacted]
Plan #: [redacted]
Insured: [redacted] DEVOLDER
Policy/Certificate: [redacted]
Claimant: [redacted] DEVOLDER
Patient ID:
Settlement Date: 08/17/2017

EOB-ACC

ENV 26640 1 OF 1

EXPLANATION OF BENEFITS

Line No.	Provider Description	Date(s) Of Service	Total Charges	Other Insurance Payment	Excluded Charges	Deductible	Eligible Expense	Paid At	Balance Paid By Plan
01	SARASOTA MEMORIAL HOSP INDEMN	05/28-05/28/2017	800.00		800.00	0.00	0.00	0%	0.00
02	SARASOTA MEMORIAL HOSP INDEMN	05/29-05/31/2017	1,600.00			0.00	1,600.00	100%	1,600.00
		TOTALS	2,400.00	0.00	800.00	0.00	1,600.00		1,600.00

Payment To:		**Amount**
DEVOLDER	BRANDON	1,600.00

Claim Remarks

Line No.	**Explanation**
1	(Line 01-$800.00)1 Day Elimination Period
1,2	The policy maximum has been allowed for this benefit.
2	No Charges Considered for Discharge Day
***	The Company does not waive and specifically reserves its right to assert and rely upon any/all reasons for which coverage for this claim may not be available under the terms of your coverage.

FOR SECURITY PURPOSES, THE FACE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

FREEDOM LIFE INSURANCE COMPANY
300 Burnett Street, Suite 200
Fort Worth, TX 76102

88-2322/1149

CHECK NO. 302112563
VOID 90 DAYS FROM ISSUE DATE
VOID IF OVER $10,000.00 WITHOUT 2 SIGNATURES
ISSUE DATE 08/17/2017

AMOUNT
***1,600.00*

PAY ***ONE THOUSAND SIX HUNDRED AND 00/100 DOLLARS***

TO THE ORDER OF [redacted] DEVOLDER
[redacted] LAKE DR
SARASOTA, FL 34232-1919

FROST BANK
FORT WORTH, TX 76102

Cynthia B. Kemp

Authorized Signature

Claimant's Name: [redacted] DEVOLDER
Policy/Certificate: 52S060331P
Claim No: 172220024 -

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈302112563⑈ ⑆114923222⑆299993290⑈ ⑈0000160000⑈