# How To Read Your

## Explanation of benefits (EOB)

1 CONSOCIATE HEALTH

Consociate Health-Claim Administration
PO Box 1068
Decatur IL 62525-1068

**Forwarding Service Requested**

2 SAMPLE MEMBER
1122 MAIN STREET
YOUR TOWN IL 65555

A123 18,530

Page 1 of 1

## Explanation of Benefits

**Please retain for your records.**
**It is the only copy you will receive.**

Customer Service

3 **Date:** 08/31/20
4 **Group Name:** SAMPLE COMPANY
5 **Case No:** C10000
6 **Division:** PPO PLAN ACTIVE
7 **Website:** www.consociatehealth.com
**Phone:** (800) 798-2422 **Fax:** (217) 423-4575
**Email:** customerservice@consociate.com
**Mail to:** Consociate Health
P.O. Box 1068
Decatur, IL 62525
Payor ID: 37135

8 Document No: 2022200000
9 Patient: SAMPLE MEMBER
10 Employee: SAMPLE MEMBER
11 Provider: HOSPITAL
12 Employee ID: 82102000000
13 Patient No: S1505778000000

| 14 Dates of Service | 15 Service Type | 16 Billed Amount | 17 Provider Discount | 18 Ineligible Amount | 19 Message Code | 20 Covered By Plan | 21 Deductible Amount | 22 Co-pay Amount | 23 Balance Amount | 24 Paid At | 25 Payment Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 07/29-07/29/2020 | OUTPATIENT | $555.00 | $102.87 | $102.87 | 844 | $452.13 | $452.13 | $0.00 | $0.00 | 0% | $0.00 |
| | **Column Totals** | $555.00 | $102.87 | $102.87 | | $452.13 | $452.13 | $0.00 | $0.00 | | $0.00 |

26 **Patient Responsibility:** **$452.13**

27 **Other Credits or Adjustments** $0.00
28 **Total Net Payment** $0.00

29 Service Code Description

0401 OUTPATIENT

30 Accumulators

| | |
|---|---|
| SAMPLE MEMBER | has met $0 of their $1500.00 PPO individual deductible. for 2020 |
| SAMPLE MEMBER | has met $0 of their $3000.00 PPO family deductible. for 2020 |
| SAMPLE MEMBER | has met $9.60 of their $3000.00 PPO individual out of pocket. for 2020 |
| SAMPLE MEMBER | has met $9.60 of their $6000.00 PPO family out of pocket. for 2020 |
| SAMPLE MEMBER | has met $0 of their $4000.00 Out of network individual deductible. for 2020 |
| SAMPLE MEMBER | has met $0 of their $8000.00 Out of network family deductible. for 2020 |
| SAMPLE MEMBER | has met $0 of their $8000.00 Out of network individual out of pocket. for 2020 |
| SAMPLE MEMBER | has met $0 of their $16000.00 Out of network family out of pocket. for 2020 |

31 Appeal Rights

In cases where a claim for benefits is denied in whole or in part, and you believe eligibility has been denied in error, you may appeal the decision. You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for review to the plan administrator within 180 days after receipt of written notice of a denial of a claim. You have a right to seek resolution via civil action in accordance with the Section 502(a) of the Employee Retirement Income Security Act of 1974. Please refer to your summary plan document for additional information including but not limited to exclusions, limitations, appeal process, etc. For a written copy of the appeals procedures, please contact our office at the above referenced number. Appeals may be sent to: Consociate Health, PO Box 1068, Decatur, IL 62525.

32 Additional Information

844 CIGNA HEALTHCARE DISCOUNT. PATIENT NOT LIABLE.

# How To Read Your

## Explanation of benefits (EOB)

1. ***Claim Processing Office:*** This is the location of the claims processing office. You can write to customer service at this location.
2. ***Address:*** The name and address where the EOB is being mailed.
3. ***Date:*** The date the EOB was issued.
4. ***Group Name:*** The name of your Group (in most cases, this is your employer).
5. ***Case No:*** The identification number for your Group. Please refer to this number if you call or write about your claim.
6. ***Division:*** The identification name for your location/plan used within the claims processing system.
7. ***Customer Service:*** Contact information to obtain additional information regarding your claim.
8. ***Document No:*** The unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.
9. ***Patient:*** The name of the individual for whom services were rendered or supplies were furnished.
10. ***Employee:*** The name of the employee (policy holder).
11. ***Provider:*** The name of the person or organization who rendered the service or provided the medical supplies.
12. ***Employee ID:*** The Employee's unique identification number. Refer to this ID number if you call or write about your claim.
13. ***Patient No:*** This is your account number assigned by the service provider.
14. ***Claim Summary:*** One line summary of the claim payment information.
15. ***Service Type:*** Brief description of the services rendered.
16. ***Billed Amount:*** The total amount of Provider charges.
17. ***Provider Discount:*** Identifies the discount received from a Network Provider, if applicable.
18. ***Ineligible Amount:*** Amount that is not eligible for benefits under the plan (i.e. duplicates, not covered service). Some amounts may be patient responsibility. Please refer to message codes (#19, 31) for more information.

*The C.O.B. provisions are applied as outlined in your Summary Plan Description. Amounts not paid by your primary carrier may or may not be paid in full by this plan.*

# How To Read Your

## Explanation of benefits (EOB)

19. ***Message Code:*** Code relating to the "ineligible" amount. This is used to request additional information or provide further explanations of the claim denial/ payment. See #31 for Additional information.
20. ***Covered By Plan:*** Amount allowed under the Plan (Billed Amount less Provider Discount or any ineligible charges).
21. ***Deductible Amount:*** The amount of allowed charges that apply to your plan deductible that must be paid by the plan participant before benefits are payable. Patient Responsibility
22. ***Co-pay Amount:*** The amount of allowed charges, specified by your plan, you must pay before benefits are paid (i.e. $40 office visit copay). Patient Responsibility
23. ***Balance Amount:*** The amount remaining after deductible, copay, provider discount, and any ineligible amounts. This amount, along with the Paid At %, is used to determine member co-insurance responsibility.
24. ***Paid At:*** The Co-insurance level applied to the Balance Amount.
25. ***Payment Amount:*** Benefits payable by the plan to the provider for the services provided.
26. ***Patient Responsibility:*** After all the benefits have been calculated, this is the amount for which the patient is responsible. This is a total of deductible, copay, coinsurance, and potentially ineligible amounts.
27. ***Other Credits or Adjustments:*** Represents adjustments/payments based upon the benefits of other health plans or insurance carriers.
28. ***Total Net Payment:*** The sum of the "Payment Amount" column for that claim.
29. ***Service Code Description:*** Explanation of the Service Type (#15).
30. ***Accumulators:*** Summary of Deductible and Out of Pocket accumulators for the current plan year as of the date of the EOB.
31. ***Appeal Rights:*** Outline of your rights under your plan when an adverse claim determination is made.
32. ***Additional Information:*** Meaning of the Message Code (#19). This includes additional information about the claims for the plan participant. Coordination of Benefits and Accident Information requests would appear here.

*The C.O.B. provisions are applied as outlined in your Summary Plan Description. Amounts not paid by your primary carrier may or may not be paid in full by this plan.*