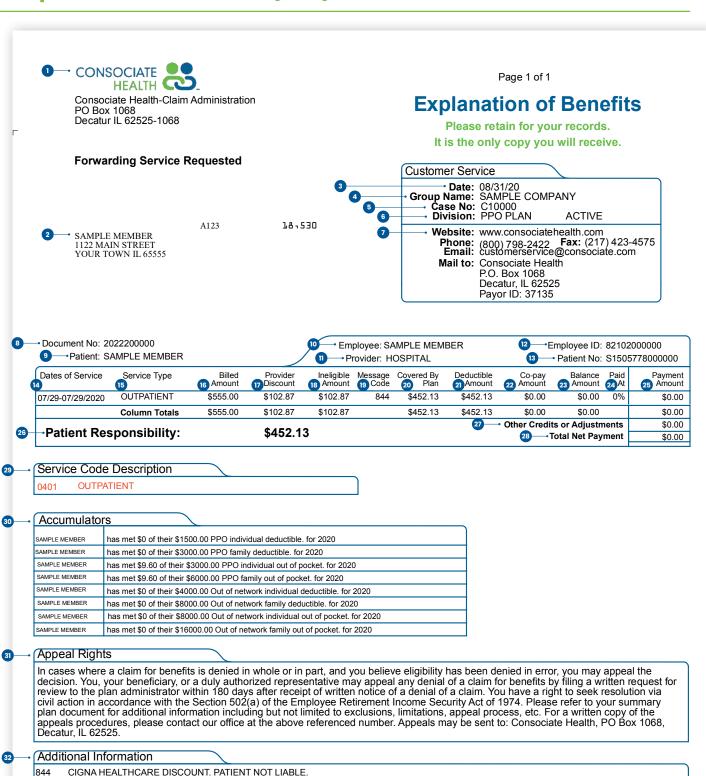
# **How To Read Your**

#### **Explanation of benefits (EOB)**



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- 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.
- 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.

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### **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.