

Understanding your Explanation of Benefits (EOB)

Service Center
Address
City, State, Zip
Phone: 1-888-888-8888

Have more questions about your claim?
Visit (name of member website)
for all your claim and benefit information

Date

John Johnson
Address
City, State, Zip

1

Member/Patient Information

Member/Patient: John Johnson
Member ID: 123456789
Group Name: ABC Company
Group #: 1234567



Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

2

Claims Summary Detailed claim information is located on following page(s)

Dollar Amount	Description
\$229.00	Amount Billed This is the total amount that your provider billed for the services that were provided to you.
\$32.23	Plan Discounts Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
\$75.00	Your Plan Paid This is the portion of the amount billed that was paid by your plan.
\$121.77	Total Amount You Owe the Provider The portion of the charges you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care or any amount that may have been paid to you. This amount may include your deductible, co-pay, coinsurance and / or non covered charges.

Use this EOB statement as a reference or retain as needed

Page 1 of 4

1. Patient

The name of the person who received the medical care.

2. Claims Summary

Summary section shows the “math” with details on how much your plan pays, plan discounts, and how much you may owe your provider.



Your EOB may look different depending on your plan.

Claim detail page

Service Center Address City, State, Zip Phone: 1-888-888-8888		Date	
		Have more questions about your claim? Visit (name of member website) for all your claim and benefit information	
Claim Detail for John Johnson		Claim Number: 53199111101	Patient Account Number: 3201858-11
Provider: Dr. Martin			

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-) Plan Discounts (-)	Your Plan Paid (=)	Your Itemized Responsibility to Provider**				Total Amount You Owe the Provider
						Deductible (+)	Copay (+)	Coinsurance (+)	Non Covered (=)	
7/15/12	Office Visits	IX	\$104.00	\$32.23	\$0.00	\$66.77	\$0.00	\$5.00	\$0.00	\$71.77
7/15/12	DX Services		\$125.00	\$0.00	\$75.00	\$25.00	\$0.00	\$25.00	\$0.00	\$50.00
Claim Total:			\$229.00	\$32.23	\$75.00	\$91.77	\$0.00	\$30.00	\$0.00	\$121.77

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

6
Notes*

IX- THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER BUT HAS ACCEPTED A REDUCTION IN CHARGES ON THIS CLAIM THROUGH MULTIPLAN. THE MEMBER IS RESPONSIBLE FOR THE TOTAL AMOUNT INDICATED IN THE AREA OF THIS STATEMENT SHOWING WHAT THE PATIENT OWES. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROFESSIONAL FOR A REFUND.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call (866) 633-2474.

You have the right to receive, upon request and free of charge, a copy of the internal rule, guideline or protocol that we relied upon in making the non-coverage decision for your claim.

MEDICAL CLAIMS ONLY

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: Health Plan Claims Appeal Address. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

Use this EOB statement as a reference or retain as needed Page 2 of 4

3. Service Description

Description of service provided. Remark code text is listed below the Service Details box.

4. Your Plan Paid

The amount of benefits paid to the employee or provider.

5. Deductible/Copay

Itemized Responsibility - This section shows your responsibility for the services provided.

6. Notes

Section with more details on why claim was paid or not paid. This section also shows your appeals options and other helpful information.

Claim detail page

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Notes*	
<p>Meet Your Needs Online At almost anytime day or night, you can review claims, check eligibility, locate a network physician, request an ID card, refill prescriptions if eligible, and more: For immediate secure self-service, visit (name of member website).</p> <p>How to Register? You can register and begin using (name of member website) in the same session. Navigate to (name of member website) to register. The information required for registration is on your insurance ID card (first name, last name, member, ID ,group number and date of birth).</p> <p>Maintaining the privacy and security of an individuals' personal information is very important to us at your Health Plan. To protect your privacy we implemented strict confidentiality practices. These practices include the ability to use an unique individual on your Health Plan correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBS), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer care professional at the number shown at the top of this page.</p>	
Use this EOB statement as a reference or retain as needed Page 3 of 4	

Claim detail page

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7 Account Summary

Summary of Deductible and Out-Of-Pocket Maximum Plan Year 2012

JOHN

Relationship: EE	Total Plan Year Amount	(-) Applied to (=) Date	Remaining Balance
In-Network			
Deductible	\$750.00	\$750.00	Met
Out-of-Pocket Max	\$2,500.00	\$500.00	2,000.00
Out-of-Network			
Deductible	\$1,500.00	\$0.00	\$1,500.00
Out-of-Pocket Max	\$5,500.00	\$0.00	\$5,500.00

FAMILY

	Total Plan Year Amount	(-) Applied to (=) Date	Remaining Balance
In-Network			
Deductible	\$2,500.00	\$900.00	1,600.00
Out-of-Pocket Max	\$5,750.00	\$600.25	5,149.75
Out-of-Network			
Deductible	\$4,500.00	\$0.00	\$4,500.00
Out-of-Pocket Max	\$8,000.00	\$0.00	\$8,000.00

8

Definitions of Key Terms

Deductible: The amount of money you pay before your plan starts to pay.

Coinurance: The money you pay for health services after you satisfied the deductible.

Out of Pocket Maximum: The most you have to pay for health services every year. Once you have paid this amount, your insurance company usually pays 100 percent of your health care costs, subject to any policy limitations.

Plan Year: The dates your plan benefit maximums are applicable.

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Page 4 of 4

7. Account Summary

Shows the year-to-date deductible and maximum amounts for you and your covered dependents.

8. Definitions

This section defines the key terms used to explain your claim.