

## How to Read an Insurance Explanation of Benefits (EOB)

A bill (also called a 'claim') is submitted to your insurance company following any doctor appointment or hospital visit. A claim lists the services provided to you. The insurance company uses the information in the claim to pay the doctor or hospital for those services.

When the insurance company pays your doctor, they will usually send you a report called an Explanation of Benefits (EOB), outlining what was paid. You need to be able to read and understand the EOB in order to know what your insurance company is paying for, what it's not paying for, and why.

Keep in mind: **An EOB is not a bill.** Any amounts you owe should be billed through a statement from your provider.

A standard Explanation of Benefits (EOB) will include the following information:

- **Services Provided By** - Hospital or facility where treatment occurred
- **Date of Service (DOS)** - Day or range of dates the physician or hospital provided the service(s)
- **Service Code** - Internal code assigned by your health insurance plan which classifies the type of service you received (i.e. office visit, immunization, etc.)

Verify you were provided the noted services on the date(s) indicated by the physician or hospital listed. If not, immediately contact your health insurance plan.

The EOB will also detail the amount you and your health insurance plan have been charged by your physician or hospital and the amount that is due after all contracted discounts and rules have been applied.

- **Total Charge** - Amount of money charged to your health insurance plan by the physician or hospital
- **Charges Not Covered** - Amount NOT covered by your health insurance plan. This usually indicates the amount of money you will have to pay for the services provided.
- **Reason Code** - Internal code used by your health insurance plan to explain the reason for the ineligible amount. This may also be referred to as the denial reason.
  - May include: cosmetic services (not covered by most plans), bundling (when physicians itemize services that are part of a package), no pre-certification or authorization, not a plan benefit, etc.
  - All denial reasons are not the patient's responsibility. Often when the physician or hospital is in breach of contract the services are denied but it is not the financial responsibility of the patient. Beware!!! Many

physicians and hospitals will try to pass the bill on to you. Contact your health insurance plan if you suspect this.

- **Discount / Negotiated Amount** - Amount of discount applied to charges.
  - Insurance companies have contracts with physicians and hospitals for a discounted charge amount for many services provided. This amount does NOT have to be paid by you or your health insurance plan.
- **Covered By Plan** - Amount of money actually PAID to the physician or hospital by your health insurance plan on your behalf.
- **Deductible Amount** - Amount of money you owe the physician or hospital that is applied towards your yearly deductible. The amount of your deductible depends on the plan in which you are enrolled.
  - Most insurance plans have in-network and out-of-network physicians. A deductible is usually not owed for in-network physicians.
  - Before enrollment in any insurance plan, you should verify that your physician is an in-network provider.
- **Co-Pay Amount** - Amount of money that is due and paid by you at the time the health service is rendered.
  - Many physicians require a co-payment before the service is rendered.
  - If the EOB shows a co-payment amount that you did not pay at the time of service, you may owe an additional amount.
- **Balance** - Amount due after all discounts, deductibles, and co-pays have been subtracted.
- **Percentage** - The percentage of charges your insurance company paid your health service provider.
  - This is dependent on your health plan contract. Many HMOs pay at 100%, while PPOs pay at 80%.
- **Total Amount Payable** - Amount of money that was paid by your health insurance plan to the health provider.

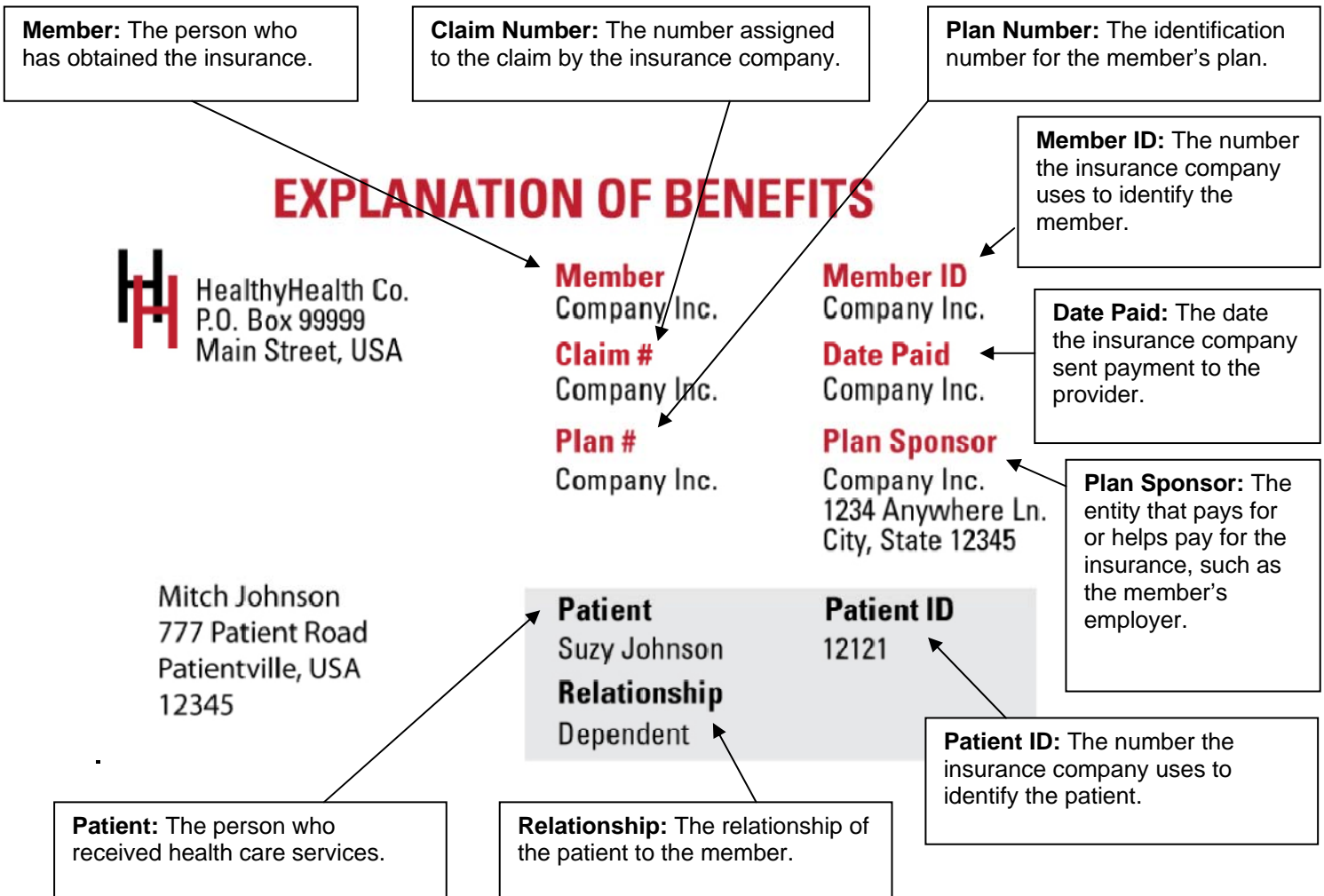
The EOB may also indicate who the payment was sent to and the actual check number for reference.

Each Explanation of Benefits ends with an ERISA Statement, which informs you that you are entitled to appeal all health insurance denials by federal law. Most plans allow for two appeals. Each insurance plan will provide you with a full description of these rights upon request.

### Tips

- ❖ Always open and review your EOB's in a timely manner.
- ❖ Keep all health related receipts in a designated area and check them against your EOB's.
- ❖ Contact your insurance plan immediately if there are any discrepancies or if you have any questions regarding information on an EOB.
- ❖ If more than 60 days have passed and your insurance company still hasn't paid your doctor, contact your insurance company.

## EOB Example



## Continued Example

