

PAF Articles



EXPLANATION OF BENEFITS (EOB)

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Understanding Your Explanation of Benefits (EOB)

Every time you receive care from a provider, or file a claim for services you received, your insurer will send you an "Explanation of Benefits." This form is not a bill. It explains what medical treatments and/or services were provided and the amount the insurance company will pay towards each covered charge.

It is important to examine the following information on your EOB:

- The name of the patient and provider seen
- The date in which the service was performed
- The procedure code and description of the service performed
- The billed amount as well as the allowed amount for the service
- The amount the insurance paid as well as the amount the patient is responsible for paying
- Any instructions related to appeal rights, including timeline for appeal submissions

The information presented within the EOB should make it easy to match bills from providers and ensure accuracy.

Explaining Your Explanation of Benefits

Although most people have heard of an Explanation of Benefits, commonly referred to as an EOB, they may be unsure of what it means. You will receive your EOB after you have visited a doctor, clinic, or hospital and it will be an itemized list summarizing the services provided to you. This is sent to you by your insurance provider and explains what portion of your medical services your insurance will cover versus what portion you are responsible for paying.

An EOB is the result of a claims process, it is not a bill. If your medical service is part of your insurance provider network, the medical provider will send a bill to your insurance company to have your discount calculated. If there is another insurance company involved, for example, if you have supplemental insurance, the insurance companies will work together to determine which plan is responsible for the charges.

If your medical provider is not in network, they may send the bill straight to you if they do not send it to your insurance company. If the bill is sent to you, it is your responsibility to send the bill to your insurance company so they may review the claim to determine your benefits.

Your insurance company will then review the medical services you received to determine your benefits and send you an EOB for each subsequent claim submitted. Your EOB will likely identify:

- The patient name, date and service provided
- The amount charged by the medical provider
- The amounts covered and not covered under your plan benefits
- The amounts covered and not covered under your plan benefits
- The amounts paid to your medical provider
- The amount you are responsible for
- Your total to-date deductible and out-of-pocket costs for the plan year

It is important to review your EOB and compare it to your actual invoice to ensure you are being billed appropriately. Pay close attention to things like the amount owed, amount paid, and date of service.

Saving your EOB and related invoices for your personal records is incredibly important should you run into discrepancies in the future. Additionally, you may need to provide a copy of your EOB for any number of reasons including tax purposes, financial budgeting, and any disputes you may run into.

Each EOB has your insurer's contact information and your rights associated with the plan. If you ever have any questions about your EOB, this will be the best way to reach them.

What Is Included on Your EOB?

EOB formatting will vary from insurance company; however, all EOBs should contain the following information:

- **Enrollee Name and Policy Number:** Identifies the policyholder. This is usually the name of the person who carries the insurance. For children, this would most likely reference the adult associated with the plan.
- **Enrollee Address:** Indicates the address of the enrollee; this should be verified with each claim. A wrong address can cause problems in claims payment.
- **Patient Name and Patient ID #:** Identifies the patient who was treated or received care and the identification number for the patient. This may be a member number or other unique identification number.
- **Claim # and Date Processed:** A number assigned by the insurance company to identify the claim in their computer system. The date indicates the time in which the claim (or revision) was processed by the insurance company and serves as a log of information.

- **Provider Name:** Identifies the name of the doctor or hospital that is billing for the services. The reviewer should always verify this matches the care received, keeping in mind that some services are performed without face-to-face interaction with the patient (including lab work, radiology, in facility pharmacy, etc.).
- **Service Details, including date and place of service:** Indicates the date of when the service was provided to the patient and the location the service was administered. The location can be important when reviewing because some services are only covered in specific locations.
- **Billing Code:** This number represents and identifies the service performed specific to your diagnosis, the equipment used, and the type of facility where care was received. This code is universal within the healthcare and insurance industry but is very specific to the services you received. This will play an important role in the payment allowances. Note: Some insurance companies may only supply this information by request, however it is your right to this detailed summary with codes.
- **Charge Amount:** Amount charged by the provider related to your care. This represents the normal fee that the provider has designated as appropriate for the services provided. Think of this as the retail price.
- **Allowed Amount:** This is the amount pre-negotiated by your insurance company and its network of providers for the services you received. This amount also considers what is referred to as “usual and customary” (UCR) charges and is impacted by geographic location of provider.
- **Not Covered:** Amount that the insurance company has designated as not covered within your plan and therefore not eligible for payment. This may be an out of network provider or a specific service that is outside of your plan benefits.
- **Reason Code & Description:** Any adjustments made to the amounts listed in the bill will be referenced here. If a service was denied, this provides explanation of why it was not covered within the plan specifics. Frequently, more details of these codes are listed in the footnotes or additional documentation section of the EOB. It can also be described next to the code.
- **Deductible:** This reflects the amount the patient must pay prior to having the insurance company make payment. Generally, each patient will have his or own deductible to meet according to the details in the plan. Some plans have different levels for in-network deductibles, out-of-network deductibles, and pharmacy deductibles. Amounts that are not covered by your insurance plan are not applied to the deductible.
- **Co-Pay:** This is the set amount required from the patient when seeking services from a provider and is described in the insurance plan language.
- **Benefit Amount / Payment Amount:** This is the percentage or amount which the insurance company will pay the providers on your behalf. The amount paid will be

determined by the schedule of benefits in your plan. Generally, participating and in-network providers will be paid a higher percentage where non-participating providers are paid a lower percentage of the entire bill.

- **Due from Patient / Patient Responsibility:** This is the amount the patient is responsible for paying to the provider. This includes the copay amount, amount towards deductible, as well as any non-covered charges associated with your care.
- **Customer Service Contact information:** This is the phone number and mailing address used to contact the customer service department of your insurance should you have any questions or concerns related to the statement.
- **Relevant policies and procedures:** This is an important section that outlines the procedures for additional follow-up related to your medical care and insurance reimbursement. Information regarding appeals is listed within this section and are frequently time sensitive. The process for resubmitting claims is also identified.

EOB vs Medical Bill, What's the Difference?

EOB

- Sent from your insurance plan to you as their insured member
- Is generated after insurer receives claim information from your provider about your visit
- Shows date of visit and total costs related to that visit
- Summarizes your insurance's coverage related to your visit, and shares what you will be responsible to pay
- Contains a summary of your total costs accumulated for the current plan year, and your progress towards meeting your deductible and out-of-pocket amounts
- Is for informational purposes only
- An electronic copy is filed online and viewable on your insurance providers website at any point
- Call your insurer if you have questions about the EOB

Medical Bill

- Sent directly from your doctor to you as their patient
- Lists individual items related to the services you received from that provider on the day of the visit. (If not, you can request this)
- If the provider submitted a claim to your insurance, the bill should show an adjustment or payment related to insurance approved costs for the services you received
- The bill should show any payment you already made, including copayments or co-insurance

- Describes options for bill payment methods and date your payment is due
- Includes bill payment coupon or portion that can easily be mailed back with your payment
- Most providers will include contact info for their billing office to discuss payment options or to clarify questions about the bill and services provided.

What Your EOB Contains & Why You Should Keep Them

The 'fine print' following the financial summary related to your specific medical service can contain important information regarding the policies and procedures related to future interaction, grievances, appeals and your rights governed by your insurance plan. This section also contains the best contact information for addressing your questions and concerns to your insurance provider, should you have any.

Long Term Tax Records, Financial, Budgeting and Insurance Disputes

In addition to the near-term aspect of billing, keeping a copy of your Explanation of Benefits may be important for end of year tax documentation, as well as managing your total out-of-pocket expenses throughout your insurance plan year. If you are applying for any type of financial aid, whether through your provider, a state or local resource or even through a charity, they will most likely request copies of the EOB in their application process. Should you find yourself needing to appeal an insurance decision or dispute a charge or service, whether related to this specific date of service or a future incident, you will need to include EOBs as documentation within that process.