SAMPLE EXPLANATION OF BENEFITS (EOB)

Martha Jones
1234 Main Street
Your Town, USA 56789

DATE: 9/1/08

E X P L A N A T I O N O F B E N E F I T S

EMPLOYEE:
SSN: XXX-XX-XXXX
GROUP: **SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN**
GROUP ID: **E-50**

CLAIM:
INCURRED:
PATIENT:

TREATMENT DATES	SERV CODE	CHARGE AMOUNT	NOT COVERED	REASON CODE	PPO/EPO DISCOUNT	COVERED AMOUNT	DEDUCTIBLE AMOUNT	CO-PAY AMOUNT	PCT	PAYMENT AMOUNT
03/30/-03/30/06	411	92.25	.00	C7	38.42	53.83	.00	.00	100	53.83
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**
		92.25	.00		38.42	53.83	.00	.00		53.83

H-1

YOU HAVE SATISFIED $ 250.00 OF YOUR STANDARD DEDUCTIBLE
YOU HAVE SATISFIED $ 500.00 OF YOUR STANDARD FAMILY DEDUCTIBLE
YOU HAVE SATISFIED $ 250.00 OF YOUR PPO DEDUCTIBLE
YOU HAVE SATISFIED $ 500.00 OF YOUR PPO FAMILY DEDUCTIBLE

L	OTHER INSURANCE CREDITS	.00
M	TOTAL PAYMENT AMOUNT	53.83
N	PATIENT RESPONSIBILITY	.00

PAYMENT DISTRIBUTION

CODE **PAYEE**	**AMOUNT**	**CHECK NUMBER**	**ACCOUNT**
A)	$ 53.83		
EMP)	$ 0.00		

A-1

S E R V I C E C O D E	R E A S O N C O D E
411 PHYSICIAN XRAY / LAB SERVICE	C7 BLUE CROSS OF CA DISCOUNT.
B-1	**E-1**

M E S S A G E S

THIS IS YOUR ONLY COPY. PLEASE RETAIN FOR YOUR RECORDS.

EXPLANATION OF BENEFITS LEGEND

An Explanation of Benefits (EOB) summarizes your claim payment or reason for denial of services incurred through your Employer health plan.

Why is an EOB important?

1. An EOB verifies that a claim was received and documents payment and/or reason(s) for denial and patient responsibility.
2. An EOB provides the correct "contract allowance" that an in-network provider has agreed to accept as plan payment and clearly specifies your patient responsibility.
3. Secondary (i.e., spouse) insurance requires a primary EOB before releasing payment to your provider.

Below are descriptions of the fields that are included on an EOB:

A **Treatment Dates:** corresponds to the date(s) of treatment.

A-1 **Payment Distribution:** identifies the name of the payee, along with the payment amount and check number of each payment made on the explanation of benefits.

B **Service Code:** HealthComp's code for the type of service rendered.

B-1 **Service Code:** a description of the code in section "B".

C **Charge Amount:** the charges submitted by your provider for services rendered (please verify that this amount corresponds with the amount billed to you by the provider of service).

D **Not Covered:** charges that are "not covered" such as "over usual and customary fees" and other services listed in the section of your Summary Plan Description entitled "Exclusions and Limitations".

E **Reason Code:** HealthComp's "Reason Code" for charges that are not covered or require further explanation.

E-1 **Reason Code:** a description for the reason code in section "E".

F **PPO/EPO Discount:** the amount of the "PPO or EPO (if applicable) Discount".

G **Covered Amount:** the "Allowable Charges" under your Plan or the amount your PPO provider has agreed to accept for services incurred. For services incurred by a Non-PPO provider, this represents the Usual, Reasonable & Customary allowable expense, as defined in your Plan Document.

H **Deductible Amount:** charges applied to satisfy the Plan Year Deductible.

H-1 **Deductible Amount:** up-to-date information about both the Plan Year deductible and the Family Deductible.

I **Co-pay Amount:** any applicable co-payment(s).

J **PCT:** the percent the plan will pay of the "Allowed Amount", after any deductible requirements have been met. The percentage will vary depending on whether you are utilizing an in- or out-of-network provider.

K **Payment Amount:** amount paid for each service rendered.

L **Other Insurance Credits:** represents the amount paid by other insurance (i.e., spouse's plan, Medicare).

M **Total Payment Amount:** total payment made for this Explanation of Benefits.

N **Patient Responsibility:** amount to be paid to the provider(s), by the participant.