

How to Read your Explanation of Benefits (EOB)

The box at the top right of the form contains the following information:

Claim Number – A unique number assigned to this claim. Including this number in any communications about the claim will ensure everyone is working on the same information.
Group Name – The name of the employee's school
Group Ident – The group identification number assigned to the school
Dept Code – Not used at this time.
Employee – The name of the employee through whom the patient involved in this claim is covered for benefits.
Patient – The name of the individual who received the services considered in this claim
Patient Acct – The account number the provider assigned to the patient
Provider – The health care professional or facility providing the services for which the charges were considered
Prepared On – The date the EOB was prepared

The second box just below the top right box on the form contains a summary of the charges which are the patient's responsibility for payment:

Amount Not Covered – Any charges which are not eligible for coverage under the plan
Co-Pay Amount – Any amounts which are the patient's responsibility under a co-payment feature of the plan
Deductible – Any amount which is applied toward satisfaction of a deductible, whether in or out of network
Co-Insurance – The patient's share of any charges subject to shared payment responsibility between the patient and the plan
Patient's Total Responsibility – The sum of all charges not paid by the plan which are the patient's responsibility
Other Insurance Payment – Payments made by another plan which are included in the benefit calculation

Claim Details are provided as follows:

Service Date – The date or range of dates during which the services were provided
Service Code – This number refers to the generalized description of the service shown in the box below the claim details
Proc. Code – This nationally standardized code is supplied by the health care professional or facility as part of the claim to define what service was delivered to the patient
Billed Amount – the gross amount billed by the provider before any discounts or other considerations
Surcharge Amount – An amount payable to certain governmental entities, generally New York State, who apply a tax or surcharge to certain services provided in their jurisdiction
Not Covered – Any part of the charge not eligible for consideration under the plan
Reason Code – An explanatory comment referenced in the box below the claim detail
PPO Discount – That part of the charge the provider has agreed to reduce in return for being included in the provider network
Covered Amount – The sum of the Billed Amount plus Surcharge Amount minus Not Covered minus PPO Discount. That part of the charges that will be included in the actual benefit calculation
Deductible Applied – Any part of the Covered Amount that goes toward satisfying the deductible requirement
Co-Pay Amount – Any part of the Covered Amount that is required to be paid by the patient that is not a deductible or co-insurance amount
Paid At – The percentage used in calculating the amount the plan will pay
Payment Amount – The amount of the charge the plan will pay, calculated by subtracting Deductible Applied and Co-Pay Amount from Covered Amount and multiplying the result by the Paid At percentage

The Accumulators section of the EOB provides a running total of amounts applied to the in or out of network deductibles and out of pocket limits for this patient since the beginning of the deductible period

The Payment To section provides the name of the person or entity to whom payment is made for this claim, along with the check number and amount. If more than one payment is made for this claim each payee is reported along with check number and amount.

The Messages section includes "standard" information regarding your right to request additional information about the claim and how to appeal a decision if you disagree. Additional messages may appear in this section providing additional specifics about this claim.