OhioHealthy

Understanding your Explanation of Benefits

UNDERSTANDING YOUR EXPLANATION OF BENEFITS

Your explanation of benefits (EOB) shows your medical claims and payments made by your health benefit plan. You'll receive an EOB after you see your doctor or have a test done.

This guide will help you understand your EOB and all the information on it. Each numbered definition below corresponds to one of the numbers on the sample EOB on the following pages.

1. **Group Number** – Number assigned to your employer
2. **Print Date** – Date the EOB was issued
3. **Patient Name** – Name of person who received care
4. **Type of Service** – Description of the visit (e.g., physician visit)
5. **Claim Number** – Identifies the claim in our system
6. **Service Date** – The date you received care
7. **Billed Charges** – Services that have been billed to your health benefit plan
8. **Discount Amount** – The amount that has been reduced from the provider
9. **Other Adjustments** – Negotiated or ineligible amounts that are not your responsibility
10. **Other Plan Payment** – A payment made by another health plan due to coordination of benefits
11. **Ineligible** – Amount of submitted charges not covered by the plan
12. **Copay** – A predetermined charge that the provider can collect from you at the time of service
13. **Deductible** – The amount of the covered charge that you are responsible for paying before your health plan starts sharing costs
14. **Co-Insurance** – A percentage of the covered expenses you are responsible for paying
15. **Plan Benefit** – Total amount your plan will pay for the submitted charge(s)
16. **Plan Paid At** – Percentage of the covered expense paid by your plan, after any applicable deductible
17. **Reason Codes and Code Explanations** – Used to explain why a portion of submitted charges is not covered by the plan. A number, or reason code, shown on the EOB corresponds with an explanation. (See page 2 of sample.)
18. **Patient Account Number** – Account number assigned by the facility or provider
19. **Provider** – Name of facility or provider
20. **Issued** – Date the claim was released and sent to processing
21. **Patient Responsibility** – The total you are responsible for paying
22. **Family** – Dollars applied toward the employee and covered dependents
23. **Current Year** – Benefit payments made during this year

Depending on how the claim was paid, these columns may appear differently. The claim will be paid with in-network, out-of-network, or PPO rates. These columns will include payments toward your deductible, out-of-pocket costs, and lifetime medical maximum allowance.

SAMPLE EXPLANATION OF BENEFITS

The items appearing on the explanation of benefits (EOB) sample are for reference only. This sample shows claims and benefits for a family of five. Each family member's claims are shown separately.

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Questions? Contact us:
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Sally Sample
123 Main Street
Anywhere, USA 12345

OHIO MEDICAL PRODUCTS

1 Group Number OHY
2 Print Date Month Day, Year

Consolidated Family Explanation of Benefits
This is not a Bill

Page 1 of 2

Page 1 of 2 Type of Service	Service Date(s)	Billed Charges	Discount Amount	Other Adjust-ments	Other Plan Payment	Patient Responsibility After Payment				Plan Benefit	Plan Paid At	Reason Codes
						Ineligible	Co-Pay	Deductible	Co-Ins			
3 Patient #1 Name	18		19								20	
5 Claim #: 122221-100-01	Pat. Acct. #: 6888201200500		Provider: OAKWOOD HOSPITAL & MED CTR			Network: **NSA**						Issued: MM/DD/YY
OFFICE VISIT	MM/DD/YY	100.00	0.00	0.00	0.00	0.00	0.00	0.00	10.00	90.00	90%	RC2
4	6	7	8	9	10	11	12	13	14	15	16	17
	Totals:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	10.00	90.00		

The qualifying payment is $500

21 **Patient Responsibility** **10.00**

Patient #2 Name
Claim #: 122456-167-01 Pat. Acct. #: 6888201200500 Provider: OAKWOOD HOSPITAL & MED CTR Network: **NSA** Issued: MM/DD/YY

DIAGNOSTIC PROF	MM/DD/YY	29.00	11.73	0.00	3.27	0.00	0.00	75.00	0.00	14.00	100%	
	Totals:	29.00	11.73	0.00	3.27	0.00	0.00	75.00	0.00	14.00		

Patient Responsibility **0.00**

SAMPLE EXPLANATION OF BENEFITS

The items appearing on the explanation of benefits (EOB) sample are for reference only.

Reason Code Descriptions: 17

RC2 THIS IS A SURPRISE BILL. THE ALLOWED AMOUNT IS EQUAL TO THE BILLED AMOUNT. BALANCE BILLING IS PROHIBITED.

			MEDICAL 23
			YEAR
3	Patient 1	NETWORK OUT-OF-POCKET Met (of $1,000.00)	$10.00
		NON-NETWORK OUT-OF-POCKET Met (of $1,500.00)	$0.00
		NON-NETWORK DEDUCTIBLE Met (of $500.00)	$0.00
3	Patient 2	NETWORK OUT-OF-POCKET Met (of $1,000.00)	$0.00
		NON-NETWORK OUT-OF-POCKET Met (of $1,500.00)	$0.00
		NON-NETWORK DEDUCTIBLE Met (of $500.00)	$0.00
22	Family	NETWORK OUT-OF-POCKET Met (of $2,000.00)	$10.00
		NON-NETWORK OUT-OF-POCKET Met (of $3,000.00)	$0.00
		NON-NETWORK DEDUCTIBLE Met (of $1,000.00)	$0.00

Please see your Summary Plan Description for a more detailed explanation of your plan benefits, exclusions, and maximums. The dollars displayed on this statement are as of the Print Date and are subject to change. Your next Consolidated Explanation of Benefits, if any claims are processed, will be issued no later than the week of MM/DD/YYYY