## What is an Explanation of Benefits (EOB)?

Your Explanation of Benefits (EOB) is an important document. After receiving a medical service, a bill is submitted to your insurance company. Your insurance company will then send you an EOB in the mail or via an online patient portal. The EOB is a list of services you received from your physician, healthcare facility and/or other clinicians who care for you.

**Being an effective partner with your physician means you need to:**

- Be informed about your insurance coverage
- Understand how claims are submitted on your behalf
- Know what your insurance company pays your physician or healthcare facility and/or other clinicians
- Know how much you owe for the service you received

Your EOB outlines how expenses are divided between your physician or other clinicians, your insurance plan, and your own patient responsibility (ex: copay, deductible, co-insurance). This document is NOT a bill; you do not need to send any payment upon receipt. If you have patient responsibility that was not already paid at the time of service, the physician/clinicians/facilities will send you a bill or contact you for payment. The EOB may also show how much the insured individual has accumulated toward their deductible and out-of-pocket maximum so far that year.

Your EOB is a window into your medical billing history. **Review it carefully.**

- Make sure you received the services listed, on the date of service indicated, from the physician/clinicians/facilities indicated.
- Verify that your insurance processed the claim at the benefit level that you expect. Example: verify that the amount of your co-pay, co-insurance, and/or deductible is accurate.

- If your insurance is denying the claim as a non-covered service, leaving you or the physician/clinicians/facilities fully responsible for the balance, you may need to reach out to the insurance carrier to clarify the reason for the denial and how it can be resolved.

If your insurance lists your progress toward meeting your deductible or out-of-pocket expenses, verify that this amount matches your records of payments toward your healthcare expenses this year. Remember to include claims from ALL of your physicians/ other clinicians when calculating the amount, you have paid toward your deductible or out-of-pocket costs.

## How to read your EOB

A typical EOB has the following information, although the way it's displayed may be different from one insurance plan to another:

1. **Patient:** The name of the person who received the service. This maybe you or one of your dependents.
2. **Insured ID/Member ID Number:** The identification number assigned to you by your insurance company. This should match the number on your insurance card.
3. **Date of Service:** The beginning and end dates of the health-related service you received from the physician/clinicians/facilities. If the claim is for an outpatient physician/clinicians/facilities visit, the beginning and end dates will be the same.
4. **Provider:** The name of the physician/clinicians/facilities who performed the services for you or your dependent. This may be the name of a physician, medical group, laboratory, hospital, or other health care provider.
5. **Type of Service:** A code and/or brief description of the health-related service you received from the physician/clinicians/facilities.
6. **Claim Status**: The EOB may indicate whether the claim is considered approved or denied, and may indicate whether the claim processed in- or out-of-network.
7. **Amount Charged** (also known as Billed Charges): The amount your physician/clinicians/facilities billed your insurance company for the service. This amount has been established by your physician or other clinician based on the expenses associated with providing the service, including overhead, all personnel costs, insurance, medical technology and supplies and other direct and indirect expenses.
8. **Allowed charges** (plan’s share): The amount insurance covers for the service. It may be less than the amount the physician/clinicians/facilities charged. The allowed amount is equivalent to the total expected payment made to the physician/clinicians/facilities between both the insurance and the patient.

9. **Copay:** A copay is a fixed amount you pay for prescriptions, physician visits, and other types of care. You may have a different co-pay amount for your primary care provider versus specialist, or different amounts depending on whether you receive services in an inpatient vs. outpatient setting.
10. **Deductible**: If your insurance plan has an annual deductible, this is the amount that you must pay for your healthcare services before your insurance pays its share. Note: If a patient has a deductible, there are certain services for which the deductible/co-pay/co-insurance may not apply (ex: preventive care).
11. **Coinsurance**: Coinsurance is the percentage of costs you pay after you've met your deductible. For example: your insurance pays 80% of the allowed charges and the patient is responsible for 20% of the allowed charges.
12. **Amount the Health Plan Paid:** This is the amount that your health insurance plan actually paid the health care provider for the services you received. The amount the health plan pays is likely a smaller amount than the medical provider billed, based on the established allowed amount between the physician/clinicians/facilities and your insurance plan. If you are seeing a provider that is in-network with your insurance plan, the payment is made directly by the insurance plan to your physician/clinicians/facilities. In the case of out-of-network physician/clinicians/facilities, and whether your insurance coverage has out-of-network benefits, the insurance plan may either make direct payment to the provider or will make payment to the patient to then remit to the physician/clinicians/facilities.
13. **Total Patient Cost:** The amount of money you owe as your share of the claim. This amount depends on your health plan's out-of-pocket requirements, such as an annual deductible, copayments, and coinsurance. Also, you may have received a service that is not covered by your health plan in which case you are responsible for paying the full amount. This is the total amount you pay for this service. The EOB is not a bill. You may have already paid the total amount shown.
14. **Non-Covered Amount:** The amount of money that your insurance company did not pay your physician, other clinician, or facility. Next to this amount you may see a code that gives the reason the physician/clinicians/facilities was not paid a certain amount. A description of these codes is usually found at the bottom of the EOB, on the back of your EOB, or in a note attached to your EOB. Insurers generally negotiate payment rates with physician/clinicians/facilities, so the amount that ends up being paid (including the portions paid by the insurer and the patient) is typically less than the amount the physician/clinicians/facilities bills. The difference is indicated in some way on the EOB, with either an amount not covered, or a total covered amount that's lower than the billed charge. If you see an in-network physician/clinicians/facilities, the physician/clinicians/facilities will

not bill you for the difference between the total amount charges and the allowed amount established by the insurance carrier.

| Statement Date | 10/25/2022 |
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|---|---|
| ❶ Patient Name | Jane Doe |
| ❷ Patient Account Number | 198765432 |

| *Claim Details* | | | | *What Your Provider Can Charge You* | | *Your Responsibility* | | | *Total Claim Cost* | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **❸ Date of Service** | **❹ Health Care Provider** | **❺ Type of Service** | **❻ Claim Status** | **❼ Amount Charged** | **❽ Allowed Charges** | **❾ Co-pay** | **❿ Deductable** | **⓫ Co-insurance** | **⓬ Paid by Insurer** | **⓭ What you owe** | **⓮ Not Covered Amount** |
| 6/30/2022 | ABC | Office Medical Care | | $ 250.00 | $ 100.00 | $ 35.00 | | | $ 65.00 | $ 35.00 | $ 150.00 |
| 7/10/2022 | ABC | Office Laboratory | | $ 55.00 | $ 35.00 | | | | $ 35.00 | | $ 20.00 |
| | | | | | | | | | | | |
| | | | Total | $ 305.00 | $ 135.00 | $ 35.00 | $ - | $ - | $ 100.00 | $ 35.00 | $ 170.00 |

If you have questions about the services provided and the claims submitted on your behalf and how the claim was paid, you may contact your insurance company or your physician/clinicians'/facilities' billing office. Many insurance carriers also support the ability for patients to submit claim questions directly through the patient's online insurance portal.

Being informed about the financial aspects of the care you receive is an important step to becoming more actively involved in your care.

The following resources will help you learn even more about how to understand your EOB.

Sources


https://www.carepartnersct.com/wellness/how-read-your-explanation-benefits-eob
https://www.verywellhealth.com/understanding-your-eob-1738641
https://tuftshealthplan.com/documents/members/general/how-to-read-your-explanation-of-benefits
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https://www.healthsmart.com/PDFs/2013-HowtoReadanEOB-Final.pdf
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