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Benefits Spotlight:

For employees, dependents & retirees

Understanding Your Explanation of Benefits (EOB)

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- **Understanding Your Explanation of Benefits (EOB)**

Have you ever received an EOB in the mail from your insurance carrier and thought, "*I'll read this later...*"?

EOBs are "statements" from your insurance carrier that provide you with detailed information on **how** your claim was processed, **if** it was paid or denied, **or** if anything further is needed in order to complete the processing of your claim. Failure to respond to a request for more information will delay the processing of your claim and could result in denial. Reading and understanding your Explanation of Benefits (EOB) are extremely important. Below is an example of an EOB. Please take a moment to familiarize yourself with the format and language included on Coresource's EOBs.

CORESOURCE
a Trustmark Company

PO Box 2920
Clinton, IA 52733-2920

Forwarding Service Requested

SINGLE PIECE

3 D-7604 SP 0-370

7
Test Employee
P.O. Box 1523
Lancaster, PA 17603

This is an explanation of benefits payable under the patient's plan. Please refer to the remark section for any ineligible information. For questions regarding this claim, contact us at: 1-800-848-3012

EMPLOYEE NAME	PATIENT NAME	
1 Test Employee	2 Test	
COMPANY NUMBER	COMPANY NAME	
3 0999-00001	4 Test Company	
	DATE	AMOUNT
	5 11/30/2004	6 19.80

DEPT NO: Test
DIV: Test
CHECK NO: 1234363

PROVIDER/ TYPE OF SERVICE	DATE OF SERVICE	SUBMITTED EXPENSE	INELIG AMT & REMARK	COVERED EXPENSE	BASIC BENEFIT	DEDUCT-IBLE	CO-PAY FACTOR	MM/COM DENTAL BENEFIT	PLAN BENEFIT	EMPLOYEE RESPONS-IBILITY
Test Provider	8									
PATIENT ACCT	9 123									
DIAG XRAY AND LAB	11 10/09/04	12 22.00	13 2.20 1#901	14 19.80	15	16	17 100%	18 19.80	19 19.80	20
10				21 Claim # 0000123456						

22 901 THIS AMOUNT REPRESENTS THE DIFFERENCES BETWEEN THE PROVIDERS NORMAL CHARGE AND A REDUCED AMOUNT DUE TO A PREFERRED PROVIDER ARRANGEMENT. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT. REFER TO THE PREFERRED PROVIDER SECTION OF THE PLAN BOOKLET.

23 XYZ

Claim Status and Payment Information are available online at www.coresource.com
Amounts shown in the Ineligible Amt and Deductible columns have been applied according to the schedule of benefits listed in your plan document.

24 YEAR	DEDUCTIBLE	25 MEDICAL IND MET	26 MEDICAL FAM MET
2004	In Network	75.70	3000.00
	Out of Network	75.70	3306.00

PAYMENT MADE TO	DATE	CHECK NUMBER	CHECK AMOUNT
27 Test Provider	11/30/04	1234363	19.80

28 RIGHT OF APPEAL

If your Plan is not subject to ERISA, the following may not apply. You may request a review of a denied claim by making a written request to the Named Fiduciary within 180 cal. days from receipt of a notice of denial, include the reasons you feel the claim should not have been denied along with any additional information and comments relevant to the claim. You are entitled to recieve, upon request and free of charge, copies of all documents relevant to the denial including: any internal guidline or similar criterion that was relied on in making the determination; and an explaination of any scientific or clinical judgement on which any medical neccessity conducted by individuals who made the original determination or their subordinates.
If your claim is denied on appeal, you have the right to bring a civil action for benefits under Section 502(a) of ERISA.
Please see your Plan Document/Summary Plan Description for further details.

1. Employee Name	Name of covered employee
2. Patient Name	Name of covered person who received the service
3. Company Number	Group number assigned by Coresource
4. Company Name	Name of employer
5. Date	Date check was issued
6. Amount	Total amount paid
7. Employee Name & Address	The employee's full name and current address
8. Provider	Name of facility or professional provider who rendered the service
9. Patient Account	Patient account number assigned by the provider who rendered the service
10. Type of Service	Description of service provided
11. Date of Service	Date service was provided
12. Submitted Amount	Amount of total charges submitted for payment
13. Ineligible – Amount & Remark	Amount of submitted charges not covered by the plan (if any) and remark code
14. Covered Expense	Amount of submitted charges covered by the plan
15. Basic Benefit	Amount payable based on benefit plan, if applicable
16. Deductible	Amount of covered expense applied to the deductible or co-pay (if any)
17. Co-Pay Factor	Percentage of covered expense paid by the plan, after any applicable deductible
18. MM/Com Dental Benefit	Amount of medical & dental benefits payable by the plan
19. Plan Benefit	Total amount of benefits payable by the plan for the submitted charges
20. Employee Responsibility	Amount of covered expense that is the employee's responsibility to pay
21. Claim Number	This number identifies the claim in our system
22. Ineligible Remark Code Description	Remark code used for the amount of submitted charges not covered by the plan (if any), and corresponding description for code
23. PPO Indicator	Identifies the PPO Network that the provider belongs to
24. Year	Year in which the claim was incurred
25. Medical Individual Met	Cumulative amount of the Individual Medical Deductible met by the patient for the year in which the claim was incurred
26. Medical Family Met	Cumulative amount of the Family Medical Deductible met by the patient and/or covered persons in the patient's family for the year in which the claim was incurred.
27. Payment Made To	Payee
28. Employee Appeal Rights for ERISA Plans	

DON'T FORGET TO VISIT YOUR BENEFITS INFORMATION CENTER (BIC)!
To learn more about your District-sponsored benefit plans, please visit your Benefit Information Center (BIC) website:
www.peralta.pswbenefits.net or www.peraltaretirees.pswbenefits.net