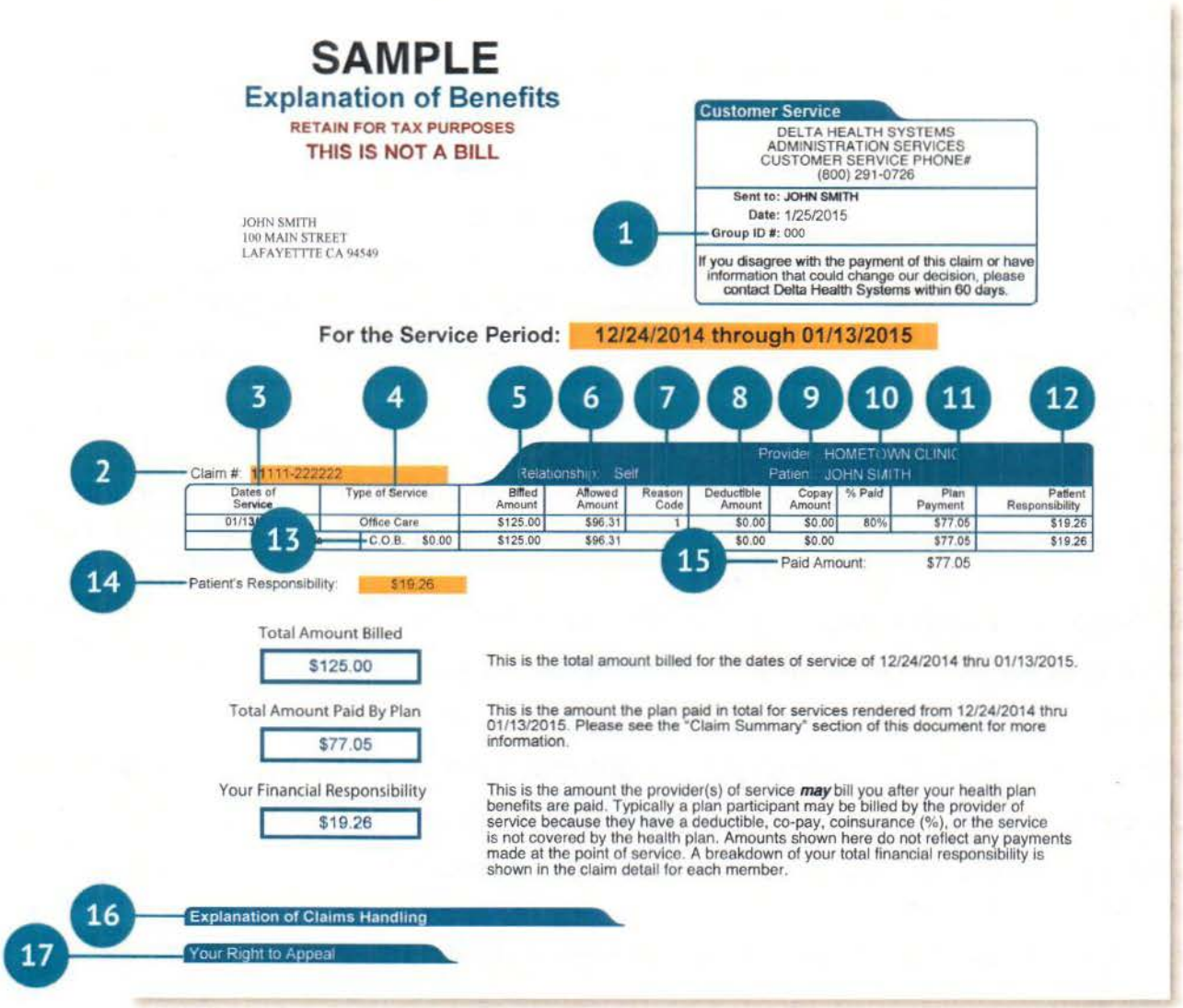
UNDERSTANDING YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT

An episodic Explanation of Benefits (EOB) statement will be sent to you twenty-one (21) days after you receive services that includes all services falling in that time period. Your EOB **verifies** that a claim was received, **documents** how a claim was processed, **outlines** the reason(s) why a claim was denied, and **summarizes** the amount paid by the plan, what portion the patient is responsible for paying, if any, and the amount the provider will need to either write off if the services were provided in-network or attempt to collect if the services were provided out-of-network.

SAMPLE EOB

See the back of this sheet for detailed descriptions of each of the numbered fields in blue circles below.



SAMPLE

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

JOHN SMITH
100 MAIN STREET
LAFAYETTE CA 94549

Customer Service

DELTA HEALTH SYSTEMS
ADMINISTRATION SERVICES
CUSTOMER SERVICE PHONE#
(800) 291-0726

Sent to: JOHN SMITH
Date: 1/25/2015
Group ID #: 000

If you disagree with the payment of this claim or have information that could change our decision, please contact Delta Health Systems within 60 days.

1

For the Service Period: 12/24/2014 through 01/13/2015

2 Claim #: 11111-222222

Relationship: Self

Provider: HOMETOWN CLINIC

Patient: JOHN SMITH

3 Dates of Service	4 Type of Service	5 Billed Amount	6 Allowed Amount	7 Reason Code	8 Deductible Amount	9 Copay Amount	10 % Paid	11 Plan Payment	12 Patient Responsibility
01/13	Office Care	$125.00	$96.31	1	$0.00	$0.00	80%	$77.05	$19.26
	13 C.O.B. $0.00	$125.00	$96.31		$0.00	$0.00		$77.05	$19.26

14 Patient's Responsibility: $19.26

15 Paid Amount: $77.05

Total Amount Billed

$125.00

This is the total amount billed for the dates of service of 12/24/2014 thru 01/13/2015.

Total Amount Paid By Plan

$77.05

This is the amount the plan paid in total for services rendered from 12/24/2014 thru 01/13/2015. Please see the "Claim Summary" section of this document for more information.

Your Financial Responsibility

$19.26

This is the amount the provider(s) of service ***may*** bill you after your health plan benefits are paid. Typically a plan participant may be billed by the provider of service because they have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

16 Explanation of Claims Handling

17 Your Right to Appeal

DELTA HEALTH SYSTEMS
Administration Services

UNDERSTANDING YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT CONTINUED...

EOB INFORMATION

Below are descriptions of the fields that correspond to the sample EOB on the front of this card:

1. **Group ID Number:** (Also referred to as the HEALTHCARE ID on your ID Card.) This unique number identifies you and your health plan without using any personal information. When contacting Delta Health Systems regarding questions about your EOB, be sure to have this number available to access claim information with ease.
2. **Claim Number:** A number that is generated for each benefit claim made under the health plan. When contacting Delta Health Systems regarding questions about your EOB, be sure to have this number available to access claim information with ease.
3. **Date(s) of Service:** The date care or treatment was received.
4. **Type of Service:** Indicates the types of services that were received (i.e., lab work, office visit, etc.).
5. **Billed Amount:** The amount your provider billed for the services he/she provided.
6. **Allowed Amount:** The amount your plan has agreed to pay for the services received.
7. **Reason Code:** This code corresponds to how a claim was processed; a detailed explanation of the code will be provided in the Explanations of Claims Handling section (Number 16 on the Sample EOB).
8. **Deductible Amount:** This box will show the amount of the claim that has been applied toward satisfying the deductible, if any.
9. **Copay Amount:** The amount of your copay for certain benefits (i.e., office visit, ER, chiropractic, etc.).
10. **%:** Indicates the percentage the plan will pay of the Allowed Amount (Number 6 on the Sample EOB). The percentage will vary depending on the plan you have selected and whether care was received from an in-network or out-of-network provider.
11. **Plan Payment:** The dollar amount the plan will issue to the appropriate party.
12. **Patient Responsibility:** The amount you are responsible for paying to the provider.
13. **C.O.B. Amount (Coordination of Benefits):** The amount paid by "other insurance", if any.
14. **Patient's Responsibility:** This section contains the total amount that the patient is responsible for.
15. **Paid Amount:** This will be the actual payment amount made to the provider or participant.
16. **Explanation of Claims Handling:** This section includes any additional notes or information as to what was covered or not covered.
17. **Your Right to Appeal:** This is the procedure and information needed to file a formal review for any denied claim.

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