Understanding your Explanation of Benefits (EOB)

AmeriBen

What is an EOB?

An explanation of benefits (EOB) statement often arrives via mail and closely resembles a medical bill, but an EOB is **not** a bill.

The EOB provides details about a medical insurance claim that has been processed and explains what portion was paid to the health care provider and what portion of the payment, if any, is the patient's responsibility.

An EOB will also indicate if the claim was not able to be processed because additional information is needed or if action is needed by the patient or billing provider.

Where does an EOB come from?

The EOB is generated when your provider submits a claim to the claims processing company (Ameri-Ben) for the services the patient received. The claims processing company sends you EOBs to clarify:

- the cost of the care the patient received
- any savings received by visiting in-network provider(s)

What to look for on the EOB

Important things to look for on the EOB:

- the services the patient received
- the date the patient received the services
- the provider(s) financial responsibility
- how much is covered by the insurance plan
- if the plan has a deductible, co-pay, or coinsurance
- the amount owed
- if no payment was issued or services were not covered, be sure to read any message codes indicating whether additional information or action is needed in order to process the claim

If you have questions about your EOB, please call AmeriBen at 833-951-1376

Anthem AmeriBen INSURANCE Elko County School District Learning For All

Elko County School District
Learning For All

Explanation of Benefits

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Administered by AmeriBen
PO Box 7186
Boise ID 83707-1186

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

MICKEY MOUSE
PO BOX 12345
PHOENIX AZ 85072-3093

Customer Service

Group Name: TEST GROUP
Provider: MICKEY MOUSE
Date: 08/25/14
Division: TEST GROUP
EOB: 111111-6
Check #: 123456

Contact AmeriBen
Si usted necesita asistencia, por favor llame.
(208)955-1448 or (800)448-1129
www.MyAmeriBen.com

Document #: 1222222221
Patient MICKEY MOUSE **Relationship:** SELF

Employee:MICKEY MOUSE

1 Dates of Service	2 Description Of Service	3 Billed Amount	4 Provider Discount	5 Ineligible Amount	6 Message Code	7 Covered By Plan	8 Deductible Amount	9 Co-pay Amount	10 Coinsurance Amount	11 Balance Amount	Paid At	Payment Amount
08/12-08/12/2014	OFFICE VISIT	$150.00	$0.00	$0.00		$150.00	$0.00	$0.00	$0.00	$150.00	100%	$150.00
Column Totals		$150.00	$0.00	$0.00		$150.00	$0.00	$0.00	$0.00	$150.00		$150.00
											Adjustments	$0.00
											Total Net Payment	$150.00

1. DATES OF SERVICE
The date the patient received services from the provider

2. DESCRIPTION OF SERVICE
A brief description of the service provided

3. BILLED AMOUNT
The amount the provider billed for the service

4. PROVIDER DISCOUNT
The discount amount negotiated by the plan

5. INELIGIBLE AMOUNT
Charges for which there are no insurance benefits

6. MESSAGE CODE
This code will have the description or note listed in the message section

7. COVERED BY PLAN
Charges that are covered under the plan

8, 9 and 10. DEDUCTIBLE, CO-PAY AND COINSURANCE
These are the amounts for which the patient is responsible

11. BALANCE AMOUNT
The amount remaining after deductions

12. PAYMENT DETAILS
If a check has been issued on this Explanation of Benefits, this section will note who the check was made to and for what amount

Message Code/Description 6

Patient Responsibility: $0.00

Payment Details 12

Paid To	Amount
TEST PROVIDER	$150.00

Appeal Rights

The Plan relies on internal rules, guidelines, and protocols to make its determinations. A copy of the relevant information used to make the determination will be provided free of charge upon request. If applicable, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances will be provided free of charge upon request. You may appeal this determination to the plan administrator within 180 days after receiving this notice. Appeals will be decided no later than 30 days after they are received and the decision will be provided to you in writing. There are two levels of review. If you remain dissatisfied after completing both levels, you may pursue civil action under Section 502(a) of ERISA. A complete description of the Plan's appeals process is in the participant's summary plan description.