Understanding Your Explanation of Benefits (EOB)

If, like millions of Americans, you have a health plan that allows you to receive out-of-network healthcare, you have probably received an "Explanation of Benefits" (EOB) from your insurer. Many people don't understand this form, and because it includes a notice that it is "not a bill", they discard it. But if you don't pay attention to your EOBs, you may not get the maximum value of the health benefits you are entitled to receive.

Information on Your EOB

Most EOBs start with identifying information specific to you and your plan. If any of this information is incorrect, make sure to contact your plan administrator.

The most important information on your EOB is a table that includes the specifics of the services or procedures you have received. For each service for which your provider is seeking reimbursement, there is a description of the service along with a corresponding code and the date the service was provided. If you have questions or require additional information, call the phone number or visit the website shown on the EOB.

Charges Covered by Your Insurance

Following the service description is a column called "billed" or "submitted" charges. This is the amount your provider billed you or your insurer for the service. The next column may be called "allowed charges," "negotiated amount" or "allowed amount" (terminology may differ between insurers) - this is the amount your plan agreed to pay network providers for the service. However if your provider is not in your health plan's network, this amount reflects the price upon which your insurer will base any reimbursement.

You will also see a column labeled "not covered," "not payable," or "pending" - these are the charges your plan *does not* cover. Typically this is the difference between what your provider billed and the allowed charge covered by the plan. This is the portion you are responsible for paying.

The next columns correspond to details of your health plan. "Co-pay amount" is what you are required to pay a provider for most visits. Generally you pay this at the time of your visit. Under "deductible amount," usually expressed as an annual total, you see the amount you are required to pay for covered healthcare services before your health plan will pay any benefits to you.

The next columns add and subtract the charges and deductions that appear previously on the EOB. Under "payable amount," or "plan pays," you will see the total amount your plan will cover. This is equal to the allowed charge minus your deductible, co-insurance (the percentage of covered charges that you

are responsible for), and co-pay amounts. The final column may be labeled “patient responsibility” or “member pays.” This is the amount you are responsible for paying your provider directly.

Don’t Make Payments Based on an EOB

Remember, don’t make any payments based on the EOB -- it is not a bill. If you haven’t already, you will receive a bill from your provider or healthcare facility for the amount you owe.

If the EOB relates to a claim for which you already paid the provider, it may contain a reimbursement check. If that is the case, you will see an area on the EOB labeled “payment enclosed” or “issued amount.” Make sure that you don’t throw away your EOB without removing this check!

If you have questions about your EOB, or believe that your claim was not resolved properly, contact your plan. The phone number is right there on the EOB.

While the EOB may be complicated, understanding it can help ensure that you and your family get the most out of your health insurance!