Understanding Your Explanation of Benefits (EOB)

After submitting a claim for medical treatment, you may receive an Explanation of Benefits (EOB) from your insurance company. The EOB is a form that insurance companies send to their members to explain what part of a claim was paid by insurance, what part was not paid, and why. It is important to understand what this statement means.

Many people find EOBs difficult to understand since they differ from one insurance company to another. Some insurance companies combine several dates of service or several providers on a single EOB form. Others prepare separate forms for each date of service and provider you see.

Typically, most EOBs include the following information:

- Name and address of the policyholder
- Name of the patient
- The group number
- The member ID number
- Claim number
- Date the claim was processed
- Date of service
- Name of the health care facility andthe provider name
- Name of the procedure or service and the billing code
- Amount that was billed to the insurer by the provider
- The portion of the bill that is eligible for insurance coverage
- The reason why the non-covered portion was not covered
- The amount of the charges that are subject to the patient's deductible
- The amount paid by insurance company

The main purpose of your EOB is to help you determine if your claim has been paid, how much has been paid by your insurance company, and how much is your responsibility. Then, you will know which invoices to pay and how much.

To figure out who has been paid, match the treatment dates and providers from the invoices to the dates of service and providers listed on your EOB. Make sure your provider gives you an itemized invoice so you can effectively match your EOB to your invoices.

Keep in mind that insurance companies rarely pay 100 percent of a claim. You need to pay your part in applicable deductibles, coinsurance and copayments.

Below are some common reasons for partial payment of a claim by your insurance company:

- Part or all of the claim was charged to you to satisfy your deductible
- Part of the claim was charged to you in the form of a copayment
- Part or all of the claim was charged to you to satisfy your coinsurance requirement
- The charges for the services exceeded the maximum benefit available for the service
- Your insurance policy was not in force on the date of service
- The claim was a duplicate and had been previously paid
- The charges exceeded the insurance company's reasonable and customary limitation (this happens more frequently when using out-of-network providers)
- The charges are for a non-covered service (i.e., cosmetic surgery)
- The charge was for a pre-existing medical condition that is excluded from coverage

If you receive an EOB showing that your insurance company did not pay for your entire claim, first determine the reason why, and then determine if the reason is valid. If you believe there has been an error, contact your health plan's member services department to ask them to review the claim.

We're here to help! Contact Sentinel Benefits & Financial Group for the guidance you need.

This article is not intended to be exhaustive nor should any discussion be construed as legal or financial advice.