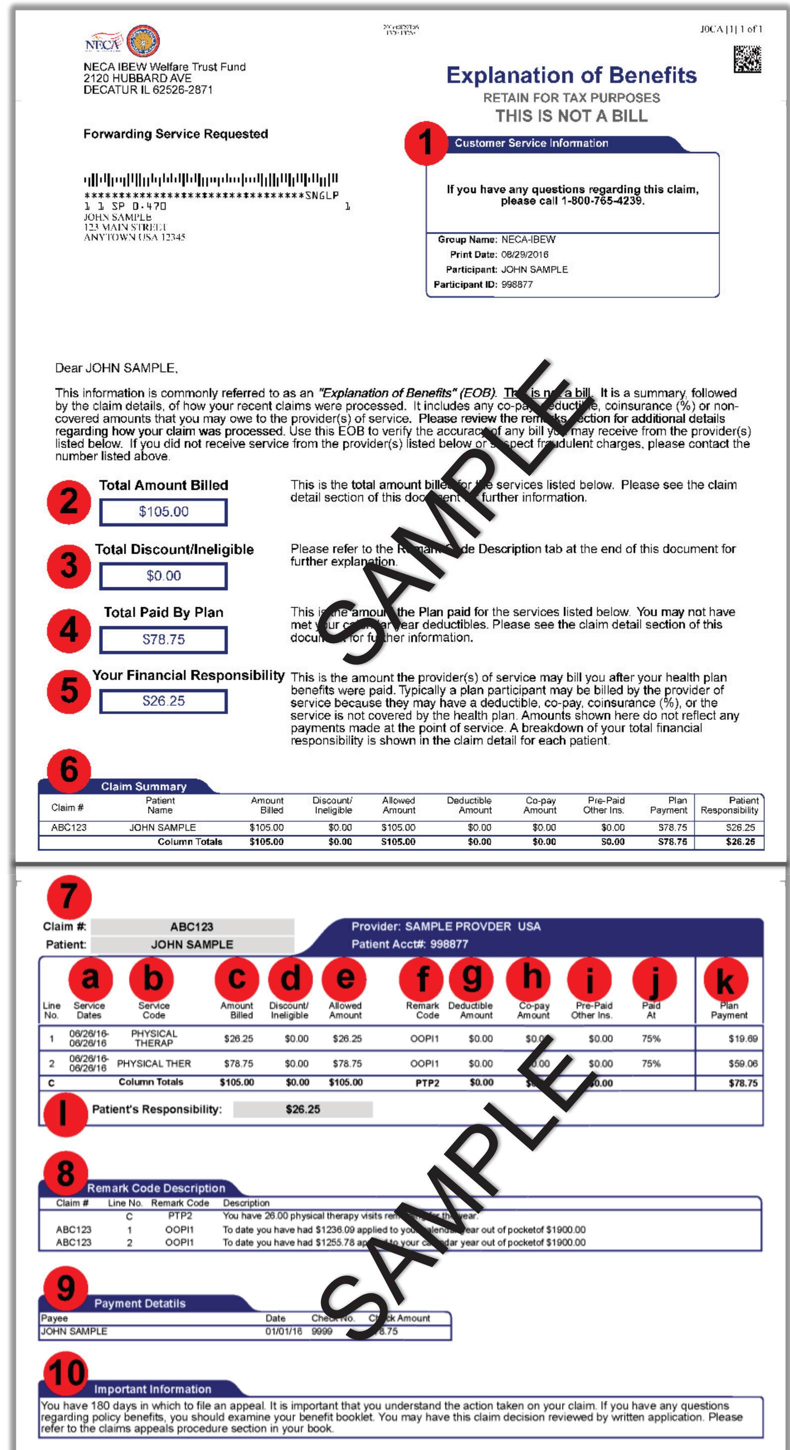
How To Read Your EOB

1. **Customer Service:** If you have questions, please give us a call at the number located at the top of your Explanation of Benefits Statement. Our friendly and knowledgeable staff are available to assist you Monday through Friday from 7:00 AM to 4:30 PM Central Standard Time.
2. **Total Amount Billed:** This is the total amount billed for all claims on the document.
3. **Total Discount/Ineligible:** This is the total discounted or ineligible amount for all claims on the document.
4. **Total Paid By Plan:** This is the total amount paid by the plan for all the claims on the document.
5. **Your Financial Responsibility:** This is the total amount you may be responsible to pay for all claims on the document.
6. **Claim Summary:** This gives you an overview of each claim on the document.
7. **Claim Detail Information**
    a. **Service Dates:** Represents the patient's date(s) of treatment
    b. **Service Code:** Code used to identify the nature of the services rendered
    c. **Amount Billed:** Amounts providers are billing
    d. **Discount/Ineligible:** Amount not covered under plan
    e. **Allowed Amount:** Amount allowed after discounts or ineligibles
    f. **Remark Code:** Code for details on claim line; See #8
    g. **Deductible Amount:** Amount applied to the deductible
    h. **Co-Pay Amount:** Amounts applied to office visit Co-Pays
    i. **Pre-Paid Other Insurance:** Amounts paid by other insurance plan(s)
    j. **Paid At:** Benefit percentage of payment
    k. **Plan Payment**: Amount paid by plan
    l. **Patient's Responsibility:** Amount provider may bill you for the claim
8. **Remark Code Description:** A descriptive field that explains any Remark Code from #7f.
9. **Payment Details:** If applicable, details on who was paid.
10. **Important Information:** Information and procedures instructing on how to file an appeal for any denied claim.



J0CA |1| 1 of 1

NECA IBEW Welfare Trust Fund
2120 HUBBARD AVE
DECATUR IL 62526-2871

Forwarding Service Requested

*******************************SNGLP
1 1 SP 0.470 1
JOHN SAMPLE
123 MAIN STREET
ANYTOWN USA 12345

Explanation of Benefits
RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

1 **Customer Service Information**

If you have any questions regarding this claim, please call 1-800-765-4239.

Group Name: NECA-IBEW
Print Date: 08/29/2016
Participant: JOHN SAMPLE
Participant ID: 998877

Dear JOHN SAMPLE,

This information is commonly referred to as an *"Explanation of Benefits" (EOB)*. Th[illegible] is n[illegible] a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pa[illegible] deducti[illegible]e, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Please review the rem[illegible]ks [illegible]ection for additional details regarding how your claim was processed. Use this EOB to verify the accurac[illegible] of any bill y[illegible] may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or s[illegible]spect fr[illegible]udulent charges, please contact the number listed above.

2 **Total Amount Billed**
$105.00
This is the total amount bille[illegible] for [illegible]e services listed below. Please see the claim detail section of this doc[illegible]ent [illegible] further information.

3 **Total Discount/Ineligible**
$0.00
Please refer to the R[illegible]de Description tab at the end of this document for further explanation.

4 **Total Paid By Plan**
$78.75
This i[illegible] the amou[illegible] the Plan paid for the services listed below. You may not have met [illegible]ur c[illegible]ar year deductibles. Please see the claim detail section of this docu[illegible] for fu[illegible]ther information.

5 **Your Financial Responsibility**
$26.25
This is the amount the provider(s) of service may bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may 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 patient.

6 **Claim Summary**

Claim #	Patient Name	Amount Billed	Discount/ Ineligible	Allowed Amount	Deductible Amount	Co-pay Amount	Pre-Paid Other Ins.	Plan Payment	Patient Responsibility
ABC123	JOHN SAMPLE	$105.00	$0.00	$105.00	$0.00	$0.00	$0.00	$78.75	$26.25
	Column Totals	**$105.00**	**$0.00**	**$105.00**	**$0.00**	**$0.00**	**$0.00**	**$78.75**	**$26.25**

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Claim #: ABC123
Patient: JOHN SAMPLE
Provider: SAMPLE PROVDER USA
Patient Acct#: 998877

Line No.	a Service Dates	b Service Code	c Amount Billed	d Discount/ Ineligible	e Allowed Amount	f Remark Code	g Deductible Amount	h Co-pay Amount	i Pre-Paid Other Ins.	j Paid At	k Plan Payment
1	06/26/16-06/26/16	PHYSICAL THERAP	$26.25	$0.00	$26.25	OOPI1	$0.00	$0.0[illegible]	$0.00	75%	$19.69
2	06/26/16-06/26/16	PHYSICAL THER	$78.75	$0.00	$78.75	OOPI1	$0.00	[illegible].00	$0.00	75%	$59.06
C	**Column Totals**		**$105.00**	**$0.00**	**$105.00**	**PTP2**	**$0.00**	[illegible]	[illegible]**0.00**		**$78.75**

l **Patient's Responsibility:** **$26.25**

8 **Remark Code Description**

Claim #	Line No.	Remark Code	Description
	C	PTP2	You have 26.00 physical therapy visits rem[illegible] th[illegible] year.
ABC123	1	OOPI1	To date you have had $1236.09 applied to you[illegible] year out of pocketof $1900.00
ABC123	2	OOPI1	To date you have had $1255.78 ap[illegible] to your ca[illegible]dar year out of pocketof $1900.00

9 **Payment Detatils**

Payee	Date	Check No.	Check Amount
JOHN SAMPLE	01/01/16	9999	[illegible]8.75

10 **Important Information**

You have 180 days in which to file an appeal. It is important that you understand the action taken on your claim. If you have any questions regarding policy benefits, you should examine your benefit booklet. You may have this claim decision reviewed by written application. Please refer to the claims appeals procedure section in your book.