How to Read an Explanation of Benefits (EOB)

An EOB is not a bill. An EOB is statement that is sent by the Teamsters Local 631 Security Fund of Southern Nevada (the "**Fund**") whenever you use your health plan for services or products from a healthcare provider. It shows how your benefits cover the cost of a service from your provider and what you may owe or may have already paid for the service.

#1 Treatment Dates – This entry shows the date you used your health plan for services described in the EOB.

#2 Service Code – This entry shows the code for the type of services or products you received from your provider. The "Services Code/Description" box provides additional detail or explanation for the code. Here the code "POV" is described as "Physician Visit - Outpatient"

#3 CPT Code – This entry shows the Current Procedural Terminology (CPT) code, which is the medical code for the type of services or products received. The numbers range from 00000 to 99999. This number is useful for the claims processors to track and properly pay for the services. Here the code is 99214.

#4 Billed Amount – This entry shows the full amount billed by your provider to your health plan. Here the full amount billed by the provider is $277.50;

#5 Not Covered – This entry shows the portion of the Billed Amount that was not covered or eligible for payment under your plan. Examples include charges for duplicate claims, an amount related to not getting a pre-approval for service, and any charges submitted that are above the maximum amount your plan pays for out-of-network care. Here, no portion of the Billed Amount is not covered ($0).

#6 Provider Name – This shows which provider treated you or gave you products.

#7 Reason Code – This entry and the related "Reason Code/Description" box provide general information about the claim. For example, if here the Reason Codes explain that a buyer discount was received and copayment was charged.

#8 PPO Discount – This entry shows the discounts received from the provider because it is a PPO provider. Here, amount discounted off of the full amount billed is $124.79. This leaves a total charge of $152.71 that must be paid.

#9 Covered Amount – This entry shows the amount that is eligible to be paid by the health plan. Here, the plan will pay $142.71. (The remaining $10 should paid by you. See Co-Pay Amount).

#10 Deductible Amount - Your deductible is the amount you need to pay each year for covered services before your plan starts paying benefits. Here the Deductible Amount is $0 because the deductible does not apply to outpatient office visits.

#11 Co-Pay Amount – The Co-Pay Amount is a set amount you pay for certain covered services such as office visits or prescriptions. Copays are usually paid at the time of service. Here the Co-Pay Amount is $10.

#12 Paid At & Coinsurance Total – The Paid At entry is the percentage of the Covered Amount that is paid by the health plan. The Coinsurance Total is the amount that you pay when there is a percentage of the Covered Amount that is not paid by the health plan.

#13 Plan Payment Amount – This entry shows the total amount paid by the health plan for the services.

#14 Patient's Responsibility – This entry shows the amount that you are responsible to pay and for which the provider may invoice you for payment. Here, the patient's responsibility is a $10 copayment that would have been paid at the time of service. No additional amounts should be charged.

#15 Claim Denial Information – This entry explains that the EOB could be considered an adverse benefit determination because it shows that the patient was responsible for all or part of the charges for the providers services. This is important because you have the right to appeal any adverse benefit determination.

#16 Your Benefit Accumulators – This box show the current information on how much of your annual deductibles and lifetime maximum have been met at the time the services were performed.

#17 Appeal Rights - This box provides additional information on how you can appeal how the claim was treated or paid.

#18 Payment Details – This entry shows specific details on the amount paid by the health plan and the check number sent by the health plan to pay the provider.

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

**********MIXED AADC 890
34419 1 FP 0.458 98

Customer Service

Questions? Please Call:
(702) 415-2185 or
Toll Free (877) 304-6702

Group Name: 531 SECURITY FND
Group No: V20
Paid Date: 02/13/2018
Check #: 294753
Statement Date: 02/16/2018

Claim #:001/20218068629900
Patient:I
Provider:NEW BEGINNINGS OB GYN
Employee
Patient Acct:20180[illegible]CJ504380

Treatment Dates	Service Code	CPT Code	Billed Amount	Not Covered	Reason Code	PPO Discount	Covered Amount	Deductible Amount	Co-pay Amount	Paid At	Plan Payment Amount
02/07-02/07/2018	POV	99214	$277.50	$0.00	IH 11	$124.79	$142.71	$0.00	$10.00	100%	$142.71
	Column Totals		$277.50	$0.00		$124.79	$142.71	$0.00	$10.00		$142.71

Coinsurance Total: $0.00
Patient's Responsibility: $10.00
Network Name: BLUE CROSS PRUDENT BUYER NETWORK
Other Insurance Payment $0.00
Plan Payment $142.71

Claim Denial Information

This document contains important information that you should retain for your records.
This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (See Appeal Rights text below).

Service Code/Description

POV PHYSICIAN VISIT - OUT PATIENT

Reason Code/Description (7) (cont.)

IH BC PRUDENT BUYER DISCOUNT
11 CO-PAY

(2) (cont.)

Payment Details

Paid To	Check No.	Amount
NEW BEGINNINGS OB GYN	294753	$142.71

Your Benefit Accumulators

$0 of $0 of the Individual Network Deductible has been met for 2018
$0 of $6600.00 of the Individual Network Out of Pocket has been met for 2018
$22719.41 Lifetime maximum paid to date
$0 of $0 of the Family Network Deductible has been met for 2018
$0 of $13200.00 of the Family Network Out of Pocket has been met for 2018

Appeal Rights

How to appeal a claim decision You may be able to resolve most questions about your claim payment decision by contacting the benefit office. Upon request and at no charge, you can receive more details when decisions are based on coverage limits, internal guidelines and protocols, medical necessity or experimental treatment criteria. At your request, we will provide the names of medical experts, if applicable to our decision. If you still disagree, you have a right to appeal, in writing, to the Board of Trustees within 180 days. You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. A decision by the Trustees will be made at the next regularly scheduled Trustees' meeting following the request for review, except that a request for review received within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If circumstances require a further extension of time, a benefit determination will be made no later than the third meeting following the receipt of the petition for review. You will be notified of the decision of the Trustees in writing within five (5) days after the benefit determination is made.*