How Do I Read My Explanation of Benefits (EOB)??

What is an EOB? Why did I receive it? What do I have to pay?

An Explanation of Benefits (EOB) is a statement you receive from the insurance company each time a claim is submitted to them either by you or by your provider/doctor on your behalf. A copy is sent to you and one is sent to your provider/doctor. It explains how your claim was processed and/or paid. It will include some or all of the following information: what doctor you saw, the date, the amount the doctor billed, any discounts that may apply, the amount paid and to whom it was paid, any amount that went toward your deductible, the copay and/or coinsurance amount you are responsible for, and the reason for denial if your claim was denied.

What does an EOB tell me?

Date and Type of Service: The name of the provider/doctor, the date or span of dates in which you received the medical care, and the type of medical care you received (office visit, lab, emergency care, etc.).
Submitted Charges: The total charge the provider/doctor billed for services rendered.
Negotiated or Allowed: When the provider/doctor is preferred or in-network, the rate that has been negotiated for the service.
Pending or Not Payable: Explanation of how your claim was processed and/or paid, or why a service was not covered. Corresponds to "General Remarks" section at bottom of EOB.
Your Copay: $25 fee payable at time of service, in addition to what the insurance covers, when you visit a non-preferred or out-of-network provider. There is no copay ($-0-) when you visit preferred or in-network providers.
Your Deductible: The dollar amount you are responsible for paying before the insurance company will begin to pay. The student deductible is $100 annually. You only need to meet (pay) your deductible once per policy year. The first $100 in bills/claims the insurance company processes will be applied toward your deductible. You are required to pay your doctor/provider this amount.
Amount Remaining: The total covered amount minus the copay and/or deductible amount. This is the amount the insurance company will pay a portion of (90%, 60%, etc.).
Paid At: The level at which the covered service is paid at according to your plan brochure. For example: "Paid At 90%" means (after you meet your annual deductible) the insurance company pays 90% of that covered dollar amount and you are responsible for the remaining 10%.
Plan Pays: The amount that was paid to the provider/doctor by the insurance company. This amount is the percentage (90%, 60%, etc.) of the amount remaining.

What dollar amount am I responsible to pay my provider?

The deductible amount
And
A $25 office visit copay if visiting a non-preferred or out-of-network provider
(no [$-0-] office visit copay is required when visiting a preferred or in-network provider)
And
The difference between the amount remaining and what the plan pays
And
Any amount that is not covered (EXCEPT the Aetna PPO discount amount)

Sample EOB: Provided on the back of this document. To learn more about your benefits and to view your Plan Brochure, go to **www.aetnastudenthealth.com** (click on "Find Your School" and enter **812804** as your Policy Number).

Explanation of Benefits

THIS IS NOT A BILL

Please Retain for Future Reference
Date Printed: 10/16/07

Aetna
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014

STUDENT'S NAME

Jane Smith
25 First Street
Cambridge, MA 02141

QUESTIONS? *Contact us at* **aetnanavigator.com**

FOR CUSTOMER SERVICE, PLEASE CALL:
1-800-878-1927

Member ID: W12345678
Group Number: 0812804-13-123 BC 12
All Remarks Appear After Final Claim

Claim Activity for JANE SMITH (self)

Patient Responsibility (shaded columns)

Date and Type of Service	Submitted Charges	Negotiated or Allowed	Pending or Not Payable (See Remarks)	Your Copay	Your Deductible	Amount Remaining	Paid At	Plan Pays	Your Share of Amount Remaining	Total Patient Responsibility
	A	B	C	D	E	F		G	H	I
This is the claim detail for the bills **received on 10/06/07**										
Mary Jones, M.D. 9/25/07 *Office Visit*	300.00	200.00	1		100.00	100.00	90%	90.00	**10.00**	**110.00**
Column Totals	300.00	200.00			100.00	100.00		90.00	**10.00**	**110.00**

MARY JONES May Bill You: **$110.00**
E + H = I

General Remarks:
1 – Discount was applied. This amount represents the difference between your provider's charge and the negotiated discount amount. You are not responsible for this amount.

Payment Summary:
Sent To: Mary Jones, M.D.
Date Sent: 10/15/2007
Amount: $90.00