The ABC's of an EOB

Understanding your Explanation of Benefits (EOB) Statement for your **Dignity Health Ventura Medical Plan**

Part of making the most of your health care coverage is understanding how your plan pays your claims and what your role is in that process. BRMS provides you with an important resource called an Explanation of Benefits (EOB) to do this.

The EOB is a document that you will receive after you see a physician or other health care professional, at the time your claim is processed. Here is an overview of that information and what it means.

brms
Forwarding Service Requested

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

J11D 4

JOE SMITH
123 ADDRESS AVE
CITY ST 12345

Customer Service
Questions? Please call our Customer Support Department at 1-866-750-0576
7:00am - 6:00pm PT or visit us on the web
www.brmsclaims.com

Date: 3/28/2018
Group: Dignity Health Ventura
Plan: DHMP Ventura

Please Note
ADDITIONAL INFORMATION MAY PRINT ON BACK

Claim #: 6833904
Patient: JANE SMITH
Provider: RICK MAMMATH
Reference: 005983821
Insured: JOE SMITH

Dates of Service (A)	Procedure Code (B)	Charge (C)	Discount Amount (D)	Not Allowed (E)	Allowed (F)	Deductible (G)	Co-pay (H)	Coinsurance (I)	Paid (J)	Comment (K)
01/09-01/09/2018	99213	$163.00	$55.38	$0.00	$107.62	$107.62	$0.00	$0.00	$0.00	
	Column Totals	$163.00	$55.38	$0.00	$107.62	$107.62	$0.00	$0.00	$0.00	

(L) **Patient's Responsibility:** $107.62

Other Credits or Adjustments $0.00
Total Net Payment $0.00

(M) **Benefit Status for 2018**
$107.62 of the $300.00 Tier 2 Individual Medical Deductible has been accumulated
$107.62 of the $900.00 Tier 2 Family Medical Deductible has been accumulated
$107.62 of the $2,000.00 Tier 1/Tier 2 Individual Medical Out of Pocket Maximum has been accumulated
$107.62 of the $6,000.00 Tier 1/Tier 2 Family Medical Out of Pocket Maximum has been accumulated

(N) **Appeal Information**
Your claims were processed under the specific terms of your coverage and based on all the information submitted with your claims. After first reviewing your coverage provisions, if you have a question or objection to the amount paid, you should call or write us within 180 days after receiving this explanation.

A – Date of Service	The date that services were provided to the patient.
B – Procedure	Procedure code for the type of service.
C – Charge	Amount charged by the physician or health care professional for each service on the claim.
D – Discount Amount	The discounted amount your network applied to your claim.
E – Not Allowed	Non eligible charges under the plan.
F – Allowed	The amount the insurance provider approved for payment based on your plan benefits prior to the deductible, coinsurance, copayment or other member cost-sharing (if applicable).
G – Deductible	The amount applied for the service under your benefits contract. The patient is responsible for paying this amount to the physician or health care professional.
H – Co-pay	The co-pay is a fixed amount and is the patients responsibility. The patient pays this amount to the physician or health care professional.
I – Coinsurance	Coinsurance is the percentage of the service the patient is responsible for paying to the physician or health care professional, after satisfying the deductible.
J – Paid	Total amount paid to the patient, the physician or health care professional for services performed.
K – Comment	Any medical plan comments or notes.
L – Patient Responsibility	The total amount of the claim the patient is responsible for.
M – Benefit Status	Summary of your plan year out of pocket expenses.
N – Appeal	Brief explanation on how to file an appeal.

If you have questions about how to read your EOB, please contact (866) 750-0576.