How To Read Your EOB

A brand new look, same excellent service…

As we continuously focus on ways to enhance the service we provide to you, we are pleased to announce some changes to the Explanation of Benefits (EOB). The EOB is the form which you receive after using your healthcare benefits. We have redesigned the EOB with a new layout which makes the document much easier to read and understand.

Below you will see an example of the newly redesigned EOB along with very helpful information on "How to Read Your EOB". Please review the information contained in the "How to Read Your EOB" and make note of where important information is now located.

As always, we aim to provide the highest level of customer service and hope that the redesigned EOB offers a benefit to you and your family. Remember, do not hesitate to contact the Fund Office with any questions regarding your benefits.

1. **Customer Inquiries:** If you have questions, please give us a call at the number(s) located at the top of your Explanation of Benefits Statement. Our friendly and knowledgeable staff are available to assist you Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Standard Time.
2. **Service Dates:** Represents the patient's date(s) of treatment.
3. **Description:** Briefly describes the nature of the services rendered.
4. **Total Charged:** Billed charges before negotiated adjustments, network discounts, copays, deductibles or any denied charges.
5. **Provider Responsibility:** Amount of discount per the network contract.
6. **Ineligible:** Amount not covered under plan.
7. **Remark Code:** Reason for Ineligible amount; See #21 Comments for additional description.
8. **Allowed Amount:** Final provider expense eligible to be applied against the health plan's benefits.
9. **Deductible:** Amount member is responsible for prior to any payment by the health plan. Amounts will vary between in-network and out-of-network charges. The deductible may not apply to all services.
10. **Co-Pay:** The amount for which the patient is responsible to pay based on the plan coverage.
11. **Co-Insurance:** Your share of the allowed amount that you are responsible to pay.
12. **Claim Summary - Total Charge:** Summary of billed charges before negotiated adjustments, network discounts, copays, deductibles or any denied charges.
13. **Claim Summary - Pd By Other Ins:** Summary of another carrier's coverage for this claim.
14. **Claim Summary - Adjustment:** Any changes to the original amount paid due to new or additional information.
15. **Claim Summary - Total You Owe:** The amount for which the patient is responsible for including any coinsurance, copays, deductibles and non-covered services.
16. **Claim Summary - Provider Resp:** Provider's share of expenses.
17. **Claim Summary - Other Adjustment:** Any changes to the original amount paid due to a correction of a previous claim.
18. **Claim Summary - Total Payment:** Actual health plan payment amount made to provider or insured.
19. **Deductible Calculation:** The amount of allowed expense applied toward the plan deductible and out-of-pocket maximums which have accumulated during the health plan benefit period.
20. **Comment:** A descriptive field that explains any non-covered service or payment reduction from the Remark Code (item #7). May also contain notes regarding a payment that was made to a provider.
21. **Appeal Information:** Information and procedures instructing on how to file a formal review for any denied claim. Please note this tab typically prints on the back side of your EOB. Please see your EOB for the full verbiage for this section.

St. Paul Electrical Workers Fringe Funds
1330 Conway Street, Suite 130
St. Paul, MN 55106

Forwarding Service Requested

********************************SNGLP
7 1 SP 1
JANE SAMPLE
123 MAIN STREET
ANYTOWN MN 55425

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

1 Customer Inquiries

Claim Administration Services Provided by:
Painters and Allied Trades District Council #82

Local: (952)-851-5949
Toll Free: 1-(800)-535-6373
Fax: (952)-851-3521

Date:	11/02/20
Insured:	JANE SAMPLE
Patient:	JOHN SAMPLE
Patient ID:	AA123456789
Patient Control #:	987654321XYZ
Group/Policy:	5WM00630-000ABC
Loc/Dept:	ACTIV

Please Note
IMPORTANT INFORMATION MAY PRINT ON BACK

Claim #: **99999999**

Provider #: 121212121212 **Participating Provider: YES**
Provider: SAMPLE PROVIDER UNIVERSTIY

2 Service Dates	3 Description	4 Total Charge	5 Provider Resp	6 Ineligible Amount	7 Remark Code	8 Allowed Amount	9 Deductible	10 Co-Pay	11 Co-Ins
09/10-09/10/2020	LAB	$328.00	$6.56	$0.00	PDA	$328.00	$0.00	$0.00	$0.00
	Column Totals:	**$328.00**	**$6.56**	**$0.00**		**$328.00**	**$0.00**	**$0.00**	**$0.00**

Claim Summary

12 Total Charge	13 Pd By Other Ins	14 Adjustment	15 Total You Owe	16 Provider Resp	17 Other Adjustment	18 Total Payment
$328.00	**$249.28**	**$0.00**	**$0.00**	**$6.56**	**$0.00**	**$72.16**

19 Deductible Calculation

Claim Year	Description	Individual	Family
2015	IN NET DED APPLIED	$200.00	$200.00
2015	OUT NET DED APPLIED	$200.00	$200.00
2015	IN NET OOP APPLIED	$174.60	$174.60
2015	OUT NET OOP APPLIED	$174.60	$174.60

20 Comments

PDA PROVIDER IS RESPONSIBLE FOR THE OTHER HEALTH PLAN'S DISALLOW AMOUNT.
*** PAYMENT SENT TO PROVIDER ***

21 Important Information Regarding your Explanation of Health Care Benefits

A	Refer to the benefit chart A in the Plan document	J	Refer to the general provisions/claim procedures section in the Plan document
B	Refer to the general exclusions section in the Plan document	K	Refer to the termination of coverage section in the Plan document
C	Refer to the definitions section in the Plan document	L	Refer to the prescription drug section in the Plan document
D	Refer to the coordination of benefits section in the Plan document	M	Refer to the Organ/Bone Marrow transplant section in the Plan document
E	Refer to the plan payment provisions section in the Plan document	N	Refer to the alternative care/benefit substitution section in the Plan document
F	Refer to the notification requirements section in the Plan document	O	Refer to the pre-existing exclusions section in the Plan document
G	Refer to the prior authorization section in the Plan document	P	This information requested from you under separate cover
H	Refer to the eligibility section in the Plan document	Q	This information requested from the provider under separate cover
I	Refer to the COBRA section in the Plan document		

Please see your actual EOB for complete information regarding your Explanation of HealthCare Benefits. Please note this tab typically prints on the back of your EOB.