

HOW TO READ YOUR EXPLANATION OF BENEFITS (EOB)

What is an Explanation of Benefits (EOB)?

An EOB is a notification from the Plan explaining how your medical claims are processed (including a payment or denial).

Is an EOB a bill from the insurance company?

No, the Plan does not bill members for medical services. We process and pay the claims submitted from your provider or hospital.

- 1 **The address to which the EOB was mailed.**
- 2 **Group Name**—the payor of your medical claim.
- 3 **Insured**—the subscriber.
- 4 **Patient**—the person who received medical services. This may be a subscriber or a dependent.
- 5 **ID Number**—the identification for the person receiving medical services.
- 6 **Claim Number**—document control number generated by the Plan. If you need to call a Health Benefits Officer to discuss the claim, this is an important number to give them.
- 7 **Provider**—the provider of your medical service. This could be an individual practice or facility.

Patient Account Number—the provider's patient account number. This number can help you match your EOB to the bill from your provider.

- 8 **Member Responsibility**—the amount the member may be responsible to pay the provider.
- 9 **Service Date**—the date your medical services were incurred.
- 10 **Procedure Code/Description**—the coverage category for which the code is classified.
- 11 **Billed Amount**—the total amount billed to the Plan by your provider.
- 12 **Contractual Adjustment**—reductions in payment due to network savings, coordination of benefits, or non-covered services. For more information, see number 19, Cont. Rmk/Other Rmk.
- 13 **Approved Amount**—the amount the Plan agrees to pay the provider for services rendered minus copays, deductibles or coinsurance, if applicable.

- 14 **Less Copay**
- 15 **Less Deductible**
- 16 **Less Coinsurance**
- 17 **Less Other Amounts**
- 18 **Plan Paid**—the amount paid by the Plan, who is being paid (provider, member, or other) and the check number.

- 19 **Cont. Rmk/Other Rmk**—a Plan code that explains why certain amounts were not covered.



FOREIGN SERVICE BENEFIT PLAN
1620 L STREET, NW, SUITE 800
WASHINGTON, DC 20036-5629



THIS IS NOT A BILL

EXPLANATION OF BENEFITS

You have received this Explanation of Benefits (EOB) as our notification to you explaining how your medical claims, including payments or denials, are being processed.

Payments made on behalf of:

2 FOREIGN SERVICE BENEFIT PLAN

3 Insured: Member, Mrs.
4 Patient: Member, Mrs.
5 ID Number: 85XXXXXXXX01
Date: 06/03/2010

1 Member, Mrs.
630000 M RD
ANYWHERE PA 15555

6 Claim Number: 2XXXXX879
7 M GENTS
710 ELM STREET
ALLENTOWN, PA 18109-2732

18 Check Number: 285373

8 Member Responsibility: \$0.00
7 Patient Account #: BAKE000004

Provider billing address may differ from physical office location

Service Date From - To Proc Code / Description	Billed Amount	Contractual Adjustment	Approved Amount	Member's Responsibility to Provider			Plan Paid	Cont./ Rmk	Other Rmk
				Copay	Deductible	Coinsurance			
9 04/21/10-04/21/10 99244 /MEDICINE 10	11 \$118.00	12 \$30.73	13 \$87.27	14 \$0.00	15 \$0.00	16 \$8.73	17 \$0.00	18 \$78.54	19
12 TOTALS:	\$118.00	\$30.73	\$87.27	\$0.00	\$0.00	\$8.73	\$0.00	\$78.54	
12 Coordination of Benefits:	Other Carrier Allowed: \$0.00		Other Carrier Paid: \$0.00						

6 Claim Number: 9XXXXXX2
7 WEST SLEEP MEDICINE
1260 MADISON STREET
ALLENTOWN, PA 18109-2729

18 Check Number: 285380

8 Member Responsibility: \$0.00
7 Patient Account #: BAKE000004

Provider billing address may differ from physical office location

Service Date From - To Proc Code / Description	Billed Amount	Contractual Adjustment	Approved Amount	Member's Responsibility to Provider			Plan Paid	Cont./ Rmk	Other Rmk
				Copay	Deductible	Coinsurance			
9 04/30/10-04/30/10 95810 /MEDICINE 10	11 \$1,200.00	12 \$449.00	13 \$751.00	14 \$0.00	15 \$0.00	16 \$0.00	17 \$0.00	18 \$751.00	19
12 TOTALS:	\$1,200.00	\$449.00	\$751.00	\$0.00	\$0.00	\$0.00	\$0.00	\$751.00	
12 Coordination of Benefits:	Other Carrier Allowed: \$0.00		Other Carrier Paid: \$0.00						

This determination is based upon the information we have received. Please contact a Customer Service Representative at 1-202-833-4910 with any questions or concerns. If there are any additional facts or circumstances, which you feel would affect our handling, you have the right to an appeal. For complete directions on submitting an appeal, please see the section of your Plan Brochure titled "Disputed Claims Process."

To ensure that your health plan was properly billed, please review the services listed on your explanation of benefits. If you believe any of the services were incorrectly billed, contact a customer service representative using the toll free number listed below.

12 Member responsibility includes the copayment, deductible, coinsurance, and other non-covered amounts. Member responsibility may also be reduced if/when Coordination of Benefits with a Primary Carrier occurs.

HOW TO READ YOUR MEMBER BENEFIT USAGE

A Benefits Header

- This introductory language precedes the Benefits Accumulation Summary.
- This date reflects when your claims were processed.

B Benefit Period Header

- This identifies the period (in date form) in which benefits are calculated.
- This could be by calendar year or contract benefit year.

C Benefit Accumulation Summary

- The information displayed in the columns below is based upon your benefit plan.

A The amounts below include claims processed as of 03/05/10. The information does not reflect any claims received or adjusted after the above mentioned date.

B Member Benefit Usage for Dates of Service **January 1, 2009 – December 31, 2009.**

If you have Medicare as your primary carrier, the deductible and out-of-pocket information referenced below do not apply.

Type	Deductible Dollars			Out-of-Pocket Dollars		
	Year-to-Date Satisfied	Maximum \$	Remaining \$	Year-to-Date Satisfied	Maximum \$	Remaining \$
In-Network Indiv.	\$10.00	\$200.00	\$190.00	\$0.00	\$1,000.00	\$1,000.00
Out of Network Indiv.	\$0.00	\$400.00	\$400.00	\$0.00	\$2,000.00	\$2,000.00
1	2	3	4	5	6	7

1 Type—displays the benefit coverage level where dollars have been used or are tracked. If you have different spending limits for different types of benefits, such as in-network or out-of-network, they will be listed as different types. For example, they may be listed as individual or family.

2 Year-to-Date Satisfied—total amount spent or credited towards the maximum amount you are required to pay before additional benefits are available.

3 Maximum \$—total amount you must spend in the benefit year before your additional insurance benefits are available.

4 Remaining \$—total amount you have left to pay on your deductible before the maximum limit is met and your other insurance benefits apply (Maximum minus Year-to-Date Satisfied).

5 Year-to-Date Satisfied—total amount spent or credited towards the maximum amount you are required to pay in the benefit year.

6 Maximum \$—total amount you may be responsible for in a benefit year based on your benefit plan design.

7 Remaining \$—total amount you have left to pay before the maximum limit is met (Maximum minus Year-to-Date Satisfied).

If you have questions, call your Health Benefits Officer at **202-833-4910**.

