HealthComp

Understanding your **Explanation of Benefits (EOB):** Summary Page

Amanda Forester
621 Santa Fe Avenue
Fresno, CA 93720

Monthly Benefits Summary
Here is a summary of the healthcare claims processed for the period of **01/01/2018 through 01/31/2018.** You can view individual claims by visiting **HCOnline** (hconline.healthcomp.com).

A Statement Date: January 2018
B Group: ABC1 / Group A
C **Enrollee:** Amanda Forester
D **Member ID:** 461611

E **Your Plan Paid** $200.23

Your Responsibility F **$103.00**

January 2018 Summary			Covered By Your Plan			Your Responsibility
G Claim #	H Patient Name	I Total Charge(s)	J Plan Rate	K Plan Paid	L Paid by Other Insurance	M You Owe
36670368-01	Amanda Forester	$617.00	$303.23	$200.23	$0.00	$103.00

N **Other Credits or Adjustments:** **$0.00**

F **Your Total Responsibility:** **$103.00**

A. **Statement Date**: The calendar month that is covered by the EOB.

B. **Group:** The Group ID number that was assigned by HealthComp and the name of your Group (i.e. employer).

C. **Enrollee:** The name of the employee (or COBRA participant) who is enrolled in the health plan.

D. **Member ID:** The member ID number that was assigned by HealthComp.

E. **Your Plan Paid:** The total amount that was covered by your health benefits for all health services listed in the EOB.

F. **Your Responsibility:** The total amount that you owe for all health services listed in the EOB. This may include copays that you already paid.

G. **Claim #:** The claim number that was assigned by HealthComp.

H. **Patient Name:** The plan member who received the service(s).

I. **Total Charge(s):** The total amount that the provider charged for all health services listed in the claim.

J. **Plan Rate:** This is the Total Charge amount minus any network discounts (if available).

K. **Plan Paid:** The amount that was covered by your health benefits for all health services listed in the claim.

L. **Paid by Other Insurance:** A portion of the Total Charge may have been covered by another source (e.g. other health insurance, automobile insurance)

M. **You Owe:** This is the total amount that you owe for all health services listed in the claim. This may include copays that you already paid**.**

N. **Other Credits or Adjustments:** This section shows any final adjustments that were made to the amount that you owe.

HealthComp

Understanding your
Explanation of Benefits (EOB):
Claim Details

A **Claim #:** 36670368-01
B **Patient:** Amanda Forester
C **Member ID:** 461611

	Covered by Your Plan				Your Responsibility					
D Service Details	E Total Charge	F Plan Rate	G Plan Paid	H Paid by Other Insurance	I Not Covered	J For Your Deductible	K Co-pay/ Coinsurance	L Total	M Reason Codes	N Service Codes
Date: 1/10/2018 A) Physician - Office Visit	$280.00	$151.73	$131.73	$0.00	$0.00	$0.00	$20.00 $0.00	$20.00	JA, 02	410
Date: 1/10/2018 A) Surgical Services	$337.00	$151.50	$68.50	$0.00	$0.00	$83.00	$0.00 $0.00	$83.00	JA	412
Totals	$617.00	$303.23	$200.23	$0.00	$0.00	$83.00	$20.00	**$103.00**		

Q **Provider:** Dr. Joseph Forbes
ABC Medical Group
260 Main Street, Suite 300
Cityville, CA 10000

O **Other Credits or Adjustments:** **$0.00**
P **Your Total Responsibility:** **$103.00**

R **Reason Code Description**

JA - Discount. Patient not liable.
02 - Copayment was taken on this service

S **Payment Distribution**

Code:	Claim #	Paid To:	Check No.	Amount
A)	36670368-01	ABC Medical Group	01053445	$200.23

T **Messages**

Claim #	Message:
36670368-01	Payment will be remitted by local carrier.

A. **Claim #:** The claim number that was assigned by HealthComp.

B. **Patient:** The plan member who received the services.

C. **Member ID:** The member ID number that was assigned by HealthComp.

D. **Service Details:** A description of the health service that was received and the date that it was received.

E. **Total Charge:** The amount that the provider charged for the service received.

F. **Plan Rate:** The Total Charge amount minus any network discounts (if available).

G. **Plan Paid:** The amount that was covered by your health benefits.

H. **Paid by Other Insurance:** A portion of the Total Charge may have been covered by another source (e.g. other health insurance, automobile insurance)

I. **Not Covered:** The amount that was not covered by your health plan.

J. **For Your Deductible:** This is the portion of the amount that you owe that will count towards your deductible. Your deductible is the amount that you must pay each year for covered services before your plan starts paying benefits.

K. **Co-pay / Co-insurance**

- **Co-pay** – This is a set amount that you must pay for certain covered services (such as office visits or prescriptions). You may have already paid for your co-pay at the provider's office.
- **Co-insurance** – This is a percentage of covered expenses that you must pay after you meet your deductible.

L. **Total:** This is the total amount that you owe for the service received.

M. **Reason Codes:** Identifies HealthComp's reason code for charges that were not covered or require further explanation.

N. **Service Codes:** Identifies HealthComp's code for the health service that was received.

O. **Other Credits or Adjustments:** This section shows any final adjustments that were made to the amount that you owe.

P. **Your Total Responsibility:** This is the total amount that you owe for all health services listed in the claim. This may include copays that you already paid.

Q. **Provider:** The provider and facility that rendered the health service(s).

R. **Reason Code Description**: This section contains a description of the Reason Codes in section M.

S. **Payment Distribution:** Identifies the name of the payee, payment amount and check number of each payment that HealthComp issues for health services listed in the EOB.

T. **Messages:** Shows additional information related to this EOB.