Understanding Your
Explanation of Benefits

Members receive easy-to-understand Explanation of Benefits (EOBs) with consolidated information on medical claims and payments made for each family member. In this guide, CoreSource provides definitions of EOB terms and a sample EOB. Each numbered definition below corresponds to one of the numbers on the sample EOB on the following pages.

1. **Group Number** – Number assigned to the employer by CoreSource
2. **Print Date** – Date the check was issued
3. **Patient Name** – Name of person who received the service
4. **Type of Service** – Description of the visit (i.e. physician visit)
5. **Claim Number** – This number identifies the claim in our system
6. **Description of Service** – A brief description of the services for which the provider billed
7. **Service Date** – The date the provider indicated the services billed for were received or rendered
8. **Billed Charges** – Services for the member that have been billed to the member's health plan
9. **Discount Amount** – The amount that has been reduced from the provider
10. **Other Adjustments** – Negotiated or ineligible amounts that are not a member's responsibility
11. **Other Plan Payment** – A payment made by another health plan due to coordination of benefits
12. **Ineligible** – Amount of submitted charges not covered by the plan
13. **Copay** – A predetermined charge that the provider can collect from you at the time of service
14. **Deductible** – The amount of the covered charge that the patient is responsible for before health plan payment begins
15. **Co-Insurance** – A percentage of the submitted charges not paid by the health plan for which the member is responsible
16. **Plan Benefit** – Total amount that will be paid by the plan for the submitted charge(s)
17. **Plan Paid At** – Percentage of the covered expense paid by the plan, after any applicable deductible
18. **Reason Codes** – Used to explain why a portion of submitted charges is not covered by the plan. A number, or reason code, shown on the EOB corresponds with an explanation.
19. **Patient Account Number** – Account number assigned by the facility or professional provider that rendered the service
20. **Provider** – Name of facility or professional provider that rendered the service
21. **Issued** – Date the claim was released and sent to processing to send payment or an EOB statement
22. **Patient Responsibility** – Portion of total submitted expenses for which the member is responsible
23. **Family** – Dollars applied toward the employee and covered dependents
24. **Current Year** – Benefit payments made during this year
25. **Prior Year** – Benefit payments made last year

* Depending on how the claim was paid, these columns may appear differently. The claim will be paid with in-network, out-of-network or PPO rates. These columns will include payments toward your deductible, out-of-pocket costs and lifetime medical maximum allowance.

Sample

Explanation of Benefits

The items appearing on the Explanation of Benefits (EOB) sample are for reference clarification only and correspond to further details, definitions and terminology.

CoreSource
PO Box 2920
Clinton, IA 52733-2920

CORESOURCE
A Trustmark Company
PERSONAL FLEXIBLE TRUSTED

Questions: Contact us:
Toll-Free: 1-800-624-7130
Website: myCoreSource.com

Sally Sample

123 Main Street
Anywhere USA 12345

ABC Company

1 Group Number 54321
2 Print Date Month DD, YYYY

Consolidated Family Explanation of Benefits

This is not a Bill

Sally Sample

3 Patient's Name / 4 Type of Service	7 Service Date(s)	Billed Charges	Discount Amount	Other Adjustments	Other Plan Payment	Patient Responsibility After Payment: Ineligible	Co-Pay	Deductible	Co-Ins	Plan Benefit	Plan Paid	Reason Codes
5 Patient # 1												
6 Claim #: E00015454389 Pat. Acct. #: 10188851 Provider: Mainstreet Medical Group Network: AETNA SIGNATURE ADMINISTRATORS												**11 Issued: 4/20/10**
DIAGNOSTIC PROF	03/11/2010	29.00	11.73	0.00	3.27	0.00	0.00	0.00	0.00	14.00	100%	901 509 676
Totals:		29.00	11.73	0.00	3.27	0.00	0.00	0.00	0.00	14.00		
										12 Patient Responsibility	**0.00**	
8 Patient # 2												
Claim #: EC03250111 Pat. Acct. #: 123 Provider: ABC Medical Center Network: Hospital Network												**Issued: 4/20/10**
ANCILLARY EXPENSE	01/18/2010	75.00	0.00	0.00	0.00	0.00	0.00	75.00	0.00	0.00	0%	
Totals:		75.00	0.00	0.00	0.00	0.00	0.00	75.00	0.00	0.00		
										Patient Responsibility	**75.00**	
Patient # 3												
Claim #: D00013658105 Pat. Acct. #: 13435593 Provider: ABC Hospital Network: AETNA SIGNATURE ADMINISTRATORS												**Issued: 4/20/10**
ANCILLARY EXPENSE	03/09/2010	2,392.00	1,967.00	0.00	0.00	0.00	0.00	300.00	25.00	100.00	80%	901
Totals:		2,392.00	1,967.00	0.00	0.00	0.00	0.00	300.00	25.00	100.00		
										Patient Responsibility	**325.00**	
Patient # 4												
Claim #: E00014955858 Pat. Acct. #: 10006855 Provider: Mainstreet Medical Group Network: AETNA SIGNATURE ADMINISTRATORS												**Issued: 4/20/10**
PHYSICIAN VISIT	01/23/2010	95.00	3.92	0.00	0.00	0.00	10.00	0.00	0.00	81.08	100%	901 676
MISC SUPPLY	01/23/2010	75.00	0.00	75.00	0.00	0.00	0.00	0.00	0.00	0.00	0%	816 676
Totals:		170.00	3.92	75.00	0.00	0.00	10.00	0.00	0.00	81.08		
										Patient Responsibility	**10.00**	
Patient # 5												
Claim #: EC03250115 Pat. Acct. #: 112233ABIR Provider: ABC Medical Center Network: Hospital Network												**Issued: 4/20/10**
ANCILLARY EXPENSE	04/15/2010	250.00	0.00	0.00	0.00	0.00	0.00	250.00	0.00	0.00	0%	
Totals:		250.00	0.00	0.00	0.00	0.00	0.00	250.00	0.00	0.00		
										Patient Responsibility	**250.00**	

Sample

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Reason Code Descriptions:

509 THIS BENEFIT PAYMENT HAS BEEN COORDINATED WITH THE BENEFITS PAYABLE UNDER OTHER MEDICAL OR DENTAL PLANS. PLEASE SEE THE COORDINATION OF BENEFITS LANGUAGE IN YOUR PLAN BOOKLET FOR AN EXPLANATION OF THIS PROCESS.

676 THE AMOUNT INDICATED AS "PLAN BENEFIT" WILL BE CREDITED TO YOUR ACCOUNT BY THE PROVIDER OF SERVICE.

816 CLAIMCHECK REVIEW HAS DETERMINED THAT THIS PROCEDURE WAS BILLED WITH ANOTHER PROCEDURE THAT, BY CLINICAL PRACTICE STANDARDS SHOULD NOT CO-EXIST DURING THE SAME SESSION.

901 THE DISCOUNT AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE PROVIDER'S NORMAL CHARGE AND A REDUCED AMOUNT DUE TO A PREFERRED PROVIDER ARRANGEMENT. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT. REFER TO THE PREFERRED PROVIDER SECTION OF THE PLAN BOOKLET.

		MEDICAL ② Current Year	③ Prior Year
④ Patient 1	PPO Network Medical Deductible Met	$150.00	$250.00
	Out of Network Medical Deductible Met	$150.00	$250.00
⑤ Patient 2	Hospital Network Medical Lifetime Maximum Met	$350.00	$350.00
⑥ Patient 3	PPO Network Medical Deductible Met	$200.00	$300.00
	PPO Network Medical Stoploss/Out of Pocket Met	$15.00	$25.00
	PPO Network Medical Lifetime Maximum Met	$1,165.50	$1,165.50
	Out of Network Medical Deductible Met	$200.00	$300.00
	Out of Network Stoploss/Out of Pocket Met	$15.00	$25.00
	Out of Network Medical Lifetime Maximum Met	$1,165.50	$1,165.50
⑦ Patient 4	PPO Network Medical Deductible Met	$50.00	$75.00
	Out of Network Medical Deductible Met	$50.00	$75.00
⑧ Patient 5	Hospital Network Medical Lifetime Maximum Met	$1500.00	$1500.00
⑨ Family	PPO Network Medical Deductible Met	$400.00	$625.00
	PPO Network Medical Stoploss/Out of Pocket Met	$15.00	$25.00
	Out of Network Medical Deductible Met	$400.00	$625.00
	Out of Network Stoploss/Out of Pocket Met	$15.00	$25.00

Please see your Summary Plan Description for a more detailed explanation of your plan benefits, exclusions, and maximums. The dollars displayed on this statement are as of the Print Date and are subject to change. Your next Consolidated Explanation of Benefits, if any claims are processed, will be issued no later than the week of: MM/DD/YYYY

Right of Appeal

If your Plan is not subject to ERISA, the following may not apply. You may request a review of a denied claim by making a written request to the Named Fiduciary within 180 calendar days from receipt of a notice of denial, include the reasons you feel the claim should not have been denied along with any additional information and comments relevant to the claim You are entitled to receive, upon request and free of charge, copies of all documents relevant to the denial including: any internal guideline or similar criterion that was relied on in making the determination; and an explanation of any scientific or clinical judgment on which any medical necessity conducted by individuals who made the original determination or their subordinates. You will be notified of the decision within a reasonable period of time but not later than 60 days after the plan receives your request for review. If your claim is denied on appeal, you have the right to bring a civil action for benefits under Section 502(a) of ERISA. Please see your Plan Document/Summary Plan Description for further details.

Employment Retirement Income Security Act (ERISA)

If you are enrolled through an employer-sponsored or other group health benefit plan that is subject to ERISA, and receive an adverse benefit determination on your appeal (s), you may bring a civil action under Section 502(a) of ERISA. In general, ERISA does not cover group health plans established or maintained by governmental entities (Federal, state, and municipal) for their employees or by churches for their employees. To determine whether ERISA applies to your group health benefit plan, please contact your Employer, Group Administrator, or Plan Sponsor.

Stop Health Care Fraud: If you suspect fraud. Call our Fraud Hotline 877-45-FRAUD