


Understanding Your EOB (Explanation of Benefits)



EXPLANATION OF BENEFITS
THIS IS NOT A BILL. Important information. Retain for your records.

Claim Information

Patient/Member Name: [Redacted]
Member ID: [Redacted]
Claim Number: [Redacted]
Provider: [Redacted]
Provider Account: [Redacted]
Process Date: 2020-09-02 04:41:45.579

Procedure Code

| Service Date(s) | Billed | Adjustment | Allowed Deductible | Coinsurance | Copay | Paid |
|--|-------------------|--------------------------------|--------------------|---------------|----------------|-----------------|
| 99309-NURSING FAC CARE SUBSEQ 01-08-2020 | \$1,250.00 | \$625.00 ^{27 210 274} | \$625.00 | \$0.00 | \$62.50 | \$562.50 |
| TOTAL | \$1,250.00 | \$625.00 | \$625.00 | \$0.00 | \$62.50 | \$562.50 |

Notes

Billed amount: The amount the provider charges for the services provided.
Allowed amount: The maximum amount paid for covered services provided. In-network providers have agreed to accept this amount as payment in full.
Payments:
\$4.40 Was Applied
Total Accumulation
\$4.40 Was Applied
Expenses
Total Accumulation
Limit is \$44.91
\$40.00 Was Applied
Expenses
Total Accumulation
Limit is \$86.91
Thank You For Using
27%-Coinsurance Amount
210-Denial message
274-Supplier does not

Payment

Billed Amount: \$1,250.00
Allowed Amount: \$625.00
Plan Payment: \$562.50
Your Responsibility*: \$62.50

* For out-of-network claims, this does not include amounts above PEHP's in-network rate, for which you may be balance billed by a provider.

Prior authorization is required for services like genetic tests, hospital-based sleep studies, and general anesthesia (instead of conscious sedation) for colonoscopies.

We send an EOB each time we process a claim for you or someone on your plan. Go paperless and view EOBs in your PEHP account at www.pehp.org.

BILLED AMOUNT

The medical provider's (e.g., doctor, hospital, or clinic) bill for your service.

ALLOWED AMOUNT

The maximum fee allowable for a given procedure, test, device, or medication established by PEHP and accepted by In-Network Providers. Also referred to as "In-Network Rate."

AMOUNT ELIGIBLE

This is PEHP's In-Network Rate. This is the most we allow in-network providers to charge for this service. However, out-of-network providers may charge more than the In-Network Rate. Avoid paying more by using only providers in your network (go to www.pehp.org).

DEDUCTIBLE

The set amount you pay for eligible charges in a plan year before cost sharing takes place.

COINSURANCE

The percentage of the cost you must pay under your plan. You may already have paid this amount when you received services. If so, the provider's bill may be lower than what's shown on the EOB.

COPAY

The fixed dollar amount you must pay under your plan. You may already have paid this amount when you received services. If so, the provider's bill may be lower than what's shown on the EOB.

PLAN PAYMENT

The part of the bill PEHP paid.

CLAIM NUMBER

Keep this number as reference if you call PEHP about your claim.

YOUR RESPONSIBILITY

The amount of the bill the provider expects you to pay. This is between you and the provider.