Understanding your explanation of benefits (EOB)

After Children's Healthcare of Atlanta has cared for your child, we send a bill (also called a claim) to your health insurance provider. Once your health insurance pays its part, the hospital or doctor's office sends you a bill for the portion you owe. **Your health insurance provider sends you an explanation of benefits (EOB)* outlining what they paid and why. Your EOB will never come from Children's.**

How to read your explanation of benefits (EOB):

1 Amount billed
The total amount charged for services received

2 Allowed amount
The total amount owed to the doctor or hospital; the sum of any insurance payment, co-insurance, deductible and copay

3 Plan discount
The amount you save by using an in-network healthcare provider

4 Insurance payment
The amount paid by your insurance company to your healthcare provider

5 Copayment
A fixed amount you pay for visits or supplies, which may vary by service

6 Deductible
A set amount you pay each year toward medical bills before the insurance company pays for anything

7 Co-insurance
The percentage of costs of a covered healthcare service that you pay

8 Amount not covered
Services that are not covered by your health insurance plan

9 Amount you owe
Your total cost for a healthcare service after insurance benefits are used

10 Notes
Explanations of the costs, charges and paid amounts for your visit

11 Your total responsibility
The total amount that you must pay; the sum of any deductible, copay or co-insurance

12 Benefit year summary
A summary of your health insurance plan payments to date

Visit choa.org/billing for more information.

**Children's Healthcare of Atlanta Inc. created this generic EOB for educational purposes only. It may not look like the actual EOB from your health insurer and is intended merely to assist patients in understanding what is included on EOBs generally. For specific information about benefits offered by your insurer, contact them directly.*

YOUR HEALTH INSURANCE PROVIDER

Your mailing address
Your name
Street address
City, State, ZIP

EXPLANATION OF BENEFITS

Account Summary	
Member name	Your name
Group #	987654321
Identification #	XYZ4321
Statement Date	MM/DD/YYYY
Amount you owe to provider	**$XXX.XX**

THIS IS NOT A BILL

Your healthcare professional may bill you directly for any amount that you owe.

			MEMBER BENEFIT			AMOUNT YOUR PROVIDER MAY BILL YOU					
Date of service	Medical service details	1 Amount billed	2 Allowed amount	3 Plan discount	4 Insurance payment	5 Copayment	6 Deductible	7 Co-insurance	8 Amount not covered	9 Amount you owe	10 Notes
MM/DD/YY	Office visit	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	A
MM/DD/YY	X-ray	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	B
											C
11 Your total responsibility											**$XXX.XX**

12 Individual benefit year summary	Amount remaining	Amount you paid
In-network deductible	$XXX.XX	$XXX.XX
In-network co-insurance	$XXX.XX	$XXX.XX
Out-of-network deductible	$XXX.XX	$XXX.XX
Out-of-network co-insurance	$XXX.XX	$XXX.XX

10 Notes

A. The contracted fee is applied for using a network physician. The patient is responsible for any copay, deductible and co-insurance amounts.
B. This service includes a copayment amount.
C. This service is not deemed a medical need and is not covered by your plan.

Questions?

For more information about your health plan and its benefits, contact your insurance provider.

Children's℠ Healthcare of Atlanta