



How to read your Explanation of Benefits (EOB)

Number to call with questions

For Questions call 319-752-3200 or 800-373-1327 Or fax us @ 319-758-6271

Employee Benefit Systems
214 N. Main
Burlington, IA 52601

Explanation of Benefits Enhancements

You asked for it----you got it!!! Employee Benefit Systems is very excited about the Enhancements on our Explanation of Benefits (EOB). All the same information you are comfortable seeing is on the EOB PLUS new enhancements.

Our new EOB has 5 new enhancements:

- **Claim Summary Box** – This box includes “Employee Responsibility” This is the amount you owe the provider for this service.
- **“Discount” column** – This column shows your savings for using a network provider.
- **“Not Covered” column** – This column shows plan exclusions (see “remark” code).
- **Breakdown** of each charge now includes the co-payment amount (if applicable) or Deductible/Co-Insurance and the “paid at %” for each charge.
- **Accumulators** – This will show the dollar amount needed to meet your deductible and out of pocket for the year (January through December).

Forward Service Requested

Employer Name: []
 Social Security or ID Number of Employee: []
 Provider/Member's Name, Street Address, City, State, Zip Code: []
 Place patient was seen: []
 Date claim was processed: []

Group Information:
 Group #: 11
 Group: Demo PSF Company
 Insured: []
 SSN: []
 Claimant: []
 Employee #: []
 Patient Acct: []
 Provider Name: []
 Provider TIN: []
 Claim #: []
 Processed on: []

Claim Summary

Total Amount Covered:	100.00	Dollar Amount you owe
Paid by Other Insurance Co:	0.00	
Total Paid by Plan:	56.02	
Employee's Responsibility:	26.98	

Explanation of Benefits- This is NOT a Bill

Type of Service	Dates of Service	Total Charge	Not Covered	Discount	Eligible Expense	Remark Code	Co-Pay	Co-Ins	Deductible Applied	Paid at %	Plan Payment
Lab	1/1/06	\$100	\$0	\$17	\$83	3	\$0	\$14	\$12.98	80	\$56.02
Total		\$100	0	\$17	\$83		0	\$14	\$12.98		\$56.02

Accumulators

Deductible Remaining-Plan	0.00
Out of Pocket Remaining-Plan	150.00

Remarks

3 Applied to Deduct & Co-Insurance

Payment To

Amount	Check#	Date
56.02	00001	6/6/06

Remarks

3 Applied to Deduct & Co-Insurance

Member's dollar responsibility left to meet

Member is responsible for fixed dollar amount for services rendered

Amount Covered after discount and not covered

Explanation Code Messages explained below

Amount Applied to Deductible

Amount you owe calculated using a fixed %

Amount paid by the Self-Funded Plan

Please see reverse for example.

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P3456031001

ENV 2
 1 OF 2

WHITE STOCK
200607050150

TEST

Forwarding Service Requested

SINGLE PIECE

2 0.5176 SP 0.390

Joe Employee
 1111 STREET
 BURLINGTON, IA 52601

1

Group #: 11
 Group: Demo Partially Self Funded Compa
 Insured: Joe Employee
 SSN: 111-11-1112
 Claimant: INSURED
 Employee #: 1
 Patient Acct: gao80002
 Provider Name: .
 Provider TIN: 99-9999999
 Claim #: 2006-164000022-0000
 Processed on: 06/22/2006

Claim Summary

Total Amount Covered:	572.70
Paid by Other Insurance Co:	0.00
Total Paid by Plan:	119.76
Employee's Responsibility:	452.94

Explanation of Benefits - This is NOT a Bill

Type of Service	Dates of Service	Total Charge	Not Covered	Discount	Eligible Expense	Remark Code	Co-Pay	Co-Ins	Deductible Applied	Paid at %	Plan Payment
Hospital Misc.	05/04/2006-05/04/2006	106.00	0.00	18.02	87.98	1	0.00	0.00	87.98	80	0.00
Hospital Misc.	05/08/2006-05/08/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/10/2006-05/10/2006	100.00	0.00	17.00	83.00	1	0.00	0.00	83.00	80	0.00
Hospital Misc.	05/12/2006-05/12/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/15/2006-05/15/2006	96.00	0.00	16.32	79.68	1	0.00	0.00	79.68	80	0.00
Hospital Misc.	05/17/2006-05/17/2006	100.00	0.00	17.00	83.00	3	0.00	14.00	12.98	80	56.02
Hospital Misc.	05/19/2006-05/19/2006	96.00	0.00	16.32	79.68	2	0.00	15.94	0.00	80	63.74
TOTALS		690.00	0.00	117.30	572.70		0.00	29.94	423.00		119.76

Accumulators

DEDUCTIBLE REMAINING - PLAN
 OUT OF POCKET REMAINING - PLAN

0.00
 970.06

Payment To

Amount **Check #** **Date**
 119.76 0000001 06/23/2006

Remarks

- 1 Applied to Deductible
- 3 Applied to Deduct & Co-Insurance
- 2 Co-insurance Applied

VOID