

JI SPECIALTY SERVICES, INC.  
 P O BOX 26610  
 AUSTIN TX 78755-6610  
 CUSTOMER SERVICE: 1-800-808-6372



EXPLANATION OF BENEFITS

GROUP #  
 DATE  
 EMPLOYEE #  
 PATIENT ID #  
 EOB #  
 DOC#

3	4	5	6	7	8	9	10	11	12	13
PROVIDER/ DESCRIPTION	DATE OF SERVICE FROM TO	SUBMITTED	INELIGIBLE	CODE **	PPO SAVINGS	COPAY	DEDUCTIBLE	BALANCE	PLAN PAYS	TOTAL BENEFIT PAYABLE
ABC HOSPITAL ROOM BOARD HOSP ANCILLARY	050102 050102	3000.00					2500.00	500.00	80%	400.00
	050102 050102	500.00						500.00	80%	400.00
							2500.00	1000.00		
	TOTAL AMOUNTS	3500.00								800.00

14 → \*\* EXPLANATION OF CODES

15 SUMMARY OF SUBMITTED CHARGES

TOTAL SUBMITTED CHARGES	3500.00
TOTAL BENEFITS PAID BY THIS INSURANCE	800.00
TOTAL PPO SAVINGS	
OTHER INSURANCE CARRIER PAYMENT	

16 YEAR TO DATE ACCUMULATORS

PATIENT 2002 IN-NETWORK DEDUCTIBLE MET	\$2500.00
FAMILY 2002 IN-NETWORK DEDUCTIBLE MET	\$2500.00
PATIENT 2002 IN-NETWORK COINSURANCE MET	\$200.00
PATIENT 2002 OUT-OF-NETWORK DEDUCTIBLE MET	\$0.00
FAMILY 2002 OUT-OF-NETWORK DEDUCTIBLE MET	\$0.00
PATIENT 2002 OUT-OF-NETWORK COININSURANCE MET	\$0.00

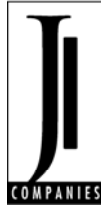
17 SHADED AREA BELOW SHOWS THE PATIENT'S RESPONSIBILITY

NON-COVERED CHARGES DEDUCTIBLE	2500.00
CO-PAY	
PATIENT'S CO-INSURANCE	200.00
TOTAL PATIENT'S RESPONSIBILITY	2700.00

18

A PAYMENT OF \$800.00 HAS BEEN MADE TO ABC HOSPITAL





## Explanation of Benefits

1. **Employee information**
2. **Group information, date, etc** – Employer information, date EOB was processed, internal numbers identifying this claim.
3. **Provider information/Description** – Name of medical provider who billed services/General description of services rendered.
4. **Date of Service** – Date of doctor or hospital visit
5. **Charges Submitted** – Amount billed for each procedure
6. **Ineligible Charges** – Amount of the billed charge that was not covered. Can include amounts over usual and customary if the doctor is not in the PPO Network.
7. **Code** – see explanation in block 14.
8. **PPO Savings** – Discount amount from Preferred Provider Network
9. **Co-pay** – flat dollar amount usually paid at time of service
10. **Deductible** – Amount of this charge that was applied to the calendar year deductible
11. **Balance** – Amount remaining after deductible and co-pay are applied
12. **Percentage Plan pays** – In-network plan pays 90%, Out-of-Network plan pays 70%, Out-of-Area plan pays 80%. Some charges are paid at 100% after co-pay.
13. **Total Benefit Payable** – Amount paid by plan for this charge.
14. **Explanation of codes** – Explanation for ineligible or PPO savings amounts.
15. **Summary of Submitted Charges** – Summary of charges and payments
16. **Year to Date Accumulators** – Deductibles and out-of-pocket amounts accumulated for the year.
17. **Patient Responsibility** – Amount owed to provider after plan payment. Patient may have already paid some amounts.
18. **Total amount paid to the provider** – Amount paid on this claim.