How to Read an Explanation of Benefits (EOB) and Understand Your Responsibility

What is an Explanation of Benefits?

An EOB is a statement from CareSource giving you details on payment for a health care service you received. It's not a bill, but it shows the costs covered by CareSource and what you may owe to the provider.

By comparing EOBs with bills from your provider, you can make sure amounts are accurate and avoid overpaying. If you see differences or have questions, call your provider or CareSource Member Services for clarification.

CareSource®

Example of a CareSource EOB Claim Table

Here's the information shown on your EOB and what it means. Numbered explanations for each field follow the table.

Medical Claim Details

Below you will find detail for each claim processed in this Statement Period. Note – *Helpful* Terms are defined following Claim Details. Also below is a list of Remark Codes to explain each claim denial reason.

1 [redacted] **Medical Claim Details**

Provider: [redacted] 2

4 **Provider Type:** In-Network

6 **Patient Account number:** [redacted]

3 **Date of Service:** 10/27/2022 - 10/27/2022

Claim number: [redacted] 5

Claim Paid On: 11/26/22

Type of Service	Billed Charges	Plan Allowable	Discount Savings	CareSource Paid	Remark code(s)	Your Itemized Responsibility to Provider				The amount you owe
						Deduct	Coinsur-ance	CoPay	Exclusion Not Covered	
	9	10	11	12	13	8				
7 PHYSICIAN VISIT/EXAM	$150.00	$120.96	$29.04	$45.96	PXN	$0.00	$0.00	$75.00	$0.00	$75.00 14
Totals:	$150.00	$120.96	$29.04	$45.96		$0.00	$0.00	$75.00	$0.00	$75.00

What the Remark Codes Mean:

Code	
PXN	The charge exceeds reimbursement amount for this service

1. **Patient's Name:** This is the name of the member who received the service.
2. **Provider Information:** Details of the provider who performed the service.
3. **Service Date:** When the service was provided.
4. **Provider Type:** This will advise if the provider was in-network or out-of-network.
5. **Claim Number:** A unique number for the specific claim.
6. **Patient's Account number:** Numbers assigned by providers to patients who have received services.
7. **Type of Service:** The type of care you received. Different services can share the same label, like "Medical" or "Facility." This helps protect your privacy.
8. **Itemized Responsibility:** This includes your responsibility broken down into deductible, coinsurance, copayment, and amounts not covered by your plan.
9. **Billed Charges:** The amount your provider billed CareSource for the services you received.
10. **Plan Allowable:** The maximum amount your plan will pay for a service.
11. **Discount Savings:** The amount a provider discounts the original charge because you are a CareSource member.
12. **CareSource Paid:** The amount CareSource paid to your provider for services you received. Please note that this amount may be $0 if your plan has a deductible that has not been met or if your copay or co-insurance is equal to the allowed amount.
13. **Remark Code(s):** A note that explains more about the costs, charges, and paid amounts for your visit, or why certain services were not covered. An explanation of remark codes is listed below each claim table.
14. **The amount you owe:** The amount you may pay the provider after any in-network discount and plan payments are applied. This does not reflect payments you have already made to the provider. For example, it could show a $25 copay that you paid at the time of the visit. By comparing EOBs with bills from your provider, you can make sure amounts are accurate and avoid overpaying.

Other Features on Your EOB

Summary of Deductible and Out of Pocket

The summary highlights your progress toward your deductible and out-of-pocket limit for the year to date.

Payment overview for Marie:

Deductible		Out-of-Pocket Limit	
10%met		5% met	
10% In-Network	0% Out-of-Network	5% In-Network	0% Out-of-Network
$4,000 left to meet this deductible		$9,500 left to meet this limit	
Applied To-Date: $500		Applied To-Date: $500	
Plan's Limit $4,500		Plan's Limit $10,000	

Annual Family Summary of Medical Expenses

This shows you or your family's out of pocket expenses for the year to date, along with any non-covered services and the total amount you owe for all services received for the year to date.

Plan Year: 2024

Statement Summary of Family Medical Out-of-Pocket/Your Share Expenses, includes non-covered servvices.

Individual	Deductible	Copay	Coinsurance	Non-Covered Services	The Total Amount You Owe
David	$80.00	$100.00	$0.00	$536.88	$716.88
Marie	$4.00	$20.00	$0.00	$0.00	$24.00

Non-Covered Services represent the items or partial amounts that are not covered by your plan, including amounts from an out-of-network provider, which you may be responsible for paying.

Your claim totals may differ from the detail above because the claim totals reported are for this statement period only.

What counts toward my out-of-pocket maximum?

Plan Features	Applies to the Annual Out-of-Pocket Maximum?
Copayments	Yes
Payments toward Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for Non-Covered Services	No
Optional Dental, Vision, and Fitness Benefits	No

Definitions (EOB Terminology)

Knowing health insurance terms will help you navigate your costs. We added this section to define terms on the EOB that are not on the claims table shown above, or that you need to know to understand your costs. You can also visit our web page on Understanding Your Costs to learn more.

Allowed Amount or Plan Allowable: The reduced rate CareSource negotiated with in-network providers for covered services. This is one of the reasons in-network care saves you money. For example, a doctor may charge $150 for a visit — but CareSource negotiated an allowed amount of $100. Thus, you save $50 as a plan member.

Appeal: A request that your health insurance carrier review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing: A bill from your provider for the difference between the amount billed to CareSource and what CareSource or the provider's contract allows.

Co-insurance: A percentage of the allowed amount that you pay your provider for services covered by your plan. CareSource pays the remaining amount, up to the allowable. Co-insurance is normally paid after your deductible has been met.

Copayment: A fixed dollar amount that you pay for certain covered services. This amount, also called a copay, is a portion of the full billed amount.

Covered Services: Refer to your Evidence of Coverage for details about which health care services are covered by your plan.

Deductible: You pay 100% of the allowed amount for services covered by your plan until your deductible has been met, after which CareSource begins to pay. The deductible does not need to be met for some services to be paid for by CareSource, such preventive services or services that have a copay. You may still owe a percentage of the allowed amount after you meet your deductible (see "co-insurance"), but CareSource will pay the remainder.

Exclusion / Not Covered: This can include non-covered services or out-of-network costs above the allowed amount and services that did not have prior authorization (approval), if required.

Family Deductible: Once the sum of all family member payments meets the family deductible, each member begins to pay the copay or coinsurance amount.

In-Network: Doctors, hospitals, clinics and other providers that contract with your plan to provide services at a lower rate.

Out-of-Network: These expenses are covered only in the case of emergency care from an out-of-network provider, or urgent care services outside the service area, or other special circumstances.

Out-of-Pocket Maximum: The amount that you will pay each benefit year for covered services. For a complete definition, please refer to your Evidence of Coverage. When you have met your Annual Out of Pocket Maximum for a benefit year, your plan will pay 100% of eligible expenses for covered serviced through the end of that benefit year.

Plan's Limit: This is the specific deductible, co-insurance, or out-of-pocket limit for your plan.

Surprise Billing: An unexpected bill for the difference between what CareSource allows and the full price that providers charge, before plan discounts. This is also called balance billing. This can happen when you can't control who is involved in your care, such as when you seek emergency care and the only providers available do not contract with your insurance. Surprise (or balance) billing is not allowed by our network providers, in certain hospital or emergency situations. See your Evidence of Coverage for more details.