Group Health Cooperative
of South Central Wisconsin

GHC-SCW Administration Office
1265 John Q Hammons Dr., PO BOX 44971
Madison, WI 53744-4971

BETTER TOGETHER℠
EXPLANATION OF BENEFITS

Epic Generated: 08/24/21

Patient Name: John Doe
Member #: 000000
Policy Holder Name: John Doe "Johnny"
Group: 7363000, EPIC

HOW TO READ YOUR EXPLANATION OF HEALTH CARE BENEFITS (EOB) STATEMENT

JOHN DOE
1234 MAIN STREET
MADISON, WI 53717

Accredited by the National Committee for Quality Assurance (NCQA)

1. Claim Information

Claim Number: 01010101

Date: 6/7/21
Provider: Adam Burns
Paid to: GROUP HEALTH COOPERATIVE

Total cost of services	340.00
In-plan savings	-243.00
Covered by this plan	0.00
Total expected cost	97.00

3.

THIS IS NOT A BILL.

There is no payment due for these services at this time.

2. Service Details

a. Date	b. Procedure/ DRG	c. Service	d. Billed	e. Allowed	f. Ex Ben Amount	g. Not Covered	h. Copay	h. Deductible	h. Co-Insurance	i. Reason Code	j. Patient Total
6/7/21	92014 CPT(R)	Medical Care	225.00	146.25	0.00	0.00	0.00	50.00	0.00	45	50.00
6/7/21	92015 CPT(R)	Medical Care	68.00	44.20	0.00	0.00	0.00	0.00	0.00	45	0.00
6/7/21	92499 CPT(R)	Other Medical Items or Services	47.00	0.00	0.00	47.00	0.00	0.00	0.00	96, P	47.00
		Claim Totals:	**340.00**	**190.45**	**0.00**	**47.00**	**0.00**	**50.00**	**0.00**		**97.00**

Code Summary

45 - Charges exceed the fee schedule or maximum allowable
96 - Non-covered charges.
P - Procedure Denied

4. Maximum Out-of-Pocket Expenses and Deductibles

How this applies to your benefits through GHC-SCW:

The Chart below is the Maximum Out-Of-Pocket Expenses and Deductibles sections, in here you can see how much you've accumulated toward your deductible and out-of-pocket-maximum up until this claim date benefits.

Tier Name	Group	Used
ALL ENCOUNTERS MOOP CNTR		
ROLL	Individual	$26.61 of $1,000.00 paid 04/01/2021-03/31/2022 ($973.39 remaining)
	Family	$93.33 of $2,000.00 paid 04/01/2021-03/31/2022 ($1,906.67 Remaining)

Explanation of Benefits (EOB) Terms Explained

The explanation of benefits is not a bill. It should be used to verify the accuracy and validity of any bill you may receive regarding your claim(s).

1. ACCOUNT SUMMARY

Lists your account information with details like the patient's name, date(s), and claim number.

2. CLAIM DETAILS

a. Date: Day(s) you received the service.
b. Procedure/DRG: Procedure code(s) for the service(s) billed.
c. Service: The service(s) you received during this visit.
d. Billed: Cost of the services provided.
e. Allowed: The amount allowed for services after any discounts have been deducted by your plan. It may also be the maximum allowed amount for a Reasonable and Customary charge.
f. Ex Ben Amount: The amount that is over your benefit maximum limit and therefore is excluded or not covered.
g. Not Covered: The costs not covered under your benefit plan.
h. Copayment/Deductible/Coinsurance: What you are responsible to pay toward these services, according to your plan benefits.
i. Reason Code: Describes the type of payment made or a reason for a denial.
j. Patient Total: The amount you may be responsible to pay.

3. AMOUNT OF RESPONSIBILITY

You may be responsible to pay a portion of the charges/service costs to the provider or facility.

This may include copay, coinsurance, deductible, or non-covered charges.

4. ACCUMULATION INFORMATION

This section shows the amount that you have accumulated toward your benefit maximums, coinsurance, deductible or stop loss limits.