ABCs of EOBs

Everything you need to know about your Explanation of Benefits.

What is an EOB? An Explanation of Benefits (EOB) Summary explains how your claim was processed and how charges were allocated based on the criteria outlined in your health plan information. It is designed to make it easier for you to understand how your claim was handled.

Understanding your plan. Doctors or hospitals are "providers" because they provide health services to you, the "member." Your "group number" is your health plan identifier that is designated by your "group." You have an assigned member ID number that is associated with your group. All of this information can be found on your EOB.

What will your EOB tell you? Your EOB can be read from left to right and includes the service performed, which provider performed the service, and the charged amount. The far right column of the chart shows whether you have any out-of-pocket responsibility in the form of a copay, deductible, or coinsurance.

Why it is important to understand your EOB. Understanding your EOB can help you keep track of medical expenses, verify the accuracy of charges, and identify any discrepancies or issues with your claims. Regularly reviewing and understanding your EOBs empowers you to manage your healthcare and finances more effectively, ensuring that you are only paying what you owe and that your insurance benefits are being used appropriately.

View your EOB statements online. An EOB summary history is available to view and download through the member self-service website at **webtpa.com**.

Still have questions? **Call the phone number on the back of your ID card to speak with a customer service representative or visit your member portal at webtpa.com.**

WebTPA
A GuideWell Company

1

WEBTPA
P O BOX 1808
GRAPEVINE TX 76099

JOHN SMITH
123 SAMPLE DR
IRVING, TX 75063

2

WebTPA
A GuideWell Company

Explanation of Benefits

THIS IS NOT A BILL

KEEP FOR TAX PURPOSES

3

Customer Service: 800-000-0000

4

Group # 2024SMPL
Date 01/01/2024
Employee JOHN SMITH
Member JOHN SMITH
Member ID 00000000-00

5 Line #	6 Provider / Description of Service	7 Claim Number / Date of Service	8 Charges Submitted	9 Discount	10 Non Covered	11 Copay	12 Deduct Applied	13 Coins	14 Other Coverage	15 W/H*	16 Total Benefit Payable
1	SURGICAL CENTE R490-AMBULATORY SURGICAL CARE-	00000000E000000R0 01/01/2024 - 01/01/2024	44,343.00	38,409.50	0.00	0.00	2,996.15	587.47	0.00		2,349.88
		Total Amounts	44,343.00	38,409.50	0.00	0.00	2,996.15	587.47	0.00		2,349.88

* Withhold amounts are not the responsibility of the member

Shaded area below is the member summary for this Explanation of Benefits

18

Deductible	2,996.15
Co-Pay	0.00
Member's Co-Insurance	587.47
Total	3,583.62

17

Remarks

6061 LINE 1; 606 DEDUCTIBLE APPLIED.
6202 LINE 1; 620 FAMILY DEDUCTIBLE HAS BEEN MET. NETWORK FAMILY DEDUCTIBLE

19

Notice of Appeal Rights

Applicable law gives you the right to appeal our decision and receive a full and fair review. You may appeal our decision even if you do not have new information to send us. You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. If you do not agree with our denial, in whole or in part, and you wish to appeal our decision, you or your authorized representative must write to us within one hundred eighty (180) days from the date of this letter. Your appeal should be signed, dated and clearly state your position. Along with your appeal letter, you may submit written comments, documents, records and other information related to your claim. Send your request to the above return address. Once we receive your appeal, we will again review your entire claim, including any information previously submitted and any additional information received with your appeal. Upon completion of this review, we will advise you of our determination. If your plan is subject to Employee Retirement Security Act of 1974 ("ERISA"), and we deny your claim after you appeal, you then have the right to bring a civil action under Section 502(a) of ERISA. If you are uncertain whether your plan is subject to ERISA, contact your plan administrator.

Below is a breakdown of how to read your EOB. The corresponding numbers are on the previous page.

1. The administrators of your health plan, as organized by your employer
2. Employee name and address or alternate name and address
3. Dedicated 800 customer service phone line for all of your health plan questions as well as the WebTPA website address for 24-hour self service
4. Employer name, employer group number, today's date, employee name, member name, member ID number
5. Services rendered by the provider on that day
6. Brief description of the procedure or service your provider rendered and provider name
7. Number assigned to your claim and dates you went to the provider
8. Total amount the provider charged for the service you received before your benefits were considered
9. An out-of-network payment is made using a set percentage of Medicare rates, following the Maximum Allowable Charge rules (Consult the Definitions Section in the Plan Document for details)
10. Amounts not covered under your benefits plan provided by your employer, not including any related co-payments
11. Amount you paid on date of service; copayments may not accrue toward the 100% maximum out-of-pocket payment
12. Amount applied to your calendar year deductible, which must be satisfied before any money is paid by the plan for any covered services
13. Arrangement by which both member and plan share, in a specific ratio, costs
14. Amount, if any, to be withheld from the total paid to the provider according to the contract
15. Amount covered under other policies due to coordination of benefits for any covered services
16. Amount paid by the plan to the provider
17. Critical details or remarks necessary to explain charges for line items
18. Summary of the amounts represented in the above claim record, including deductible, copay, and coinsurance
19. Notice of appeal rights