Did You Know?

Reading and Understanding Your Explanation of Benefits

By Jim Trageser

Ensure that you pay close attention to the bill your insurance company sends so that you are only paying for the services you receive.

“This is not a bill” is often as far as we read when we receive a printout from our insurance carrier marked Explanation of Benefits (EOB).

But while there is an understandable relief in seeing that it’s not a bill, an EOB itself is an important document in managing our healthcare costs and lifetime benefit caps. Our EOBs from health insurance, dental insurance and prescription drug plans should be scrutinized as carefully as our credit card bills.

Verify

Mistakes happen; it’s human nature. But in a financial world that increasingly relies on lifetime health insurance caps to allow employers to manage their costs, making sure that you and your insurance carrier are billed only for the treatments and services you actually receive is more important than ever. This is particularly true for those with an ongoing medical condition, where repeat office visits create repeat opportunities for human error to arise, and where lifetime caps are more of a concern than they are for the general population.

Every time you visit the doctor, dentist or other medical facility that is covered by your insurance plan, you will receive an EOB for that visit from your insurance carrier within a few weeks. And while specific layouts of EOB forms vary from insurance company to insurance company, all of them contain the same basic information:

- date of the visit
- doctor or medical facility you visited
- type of service you received
- amount of the bill being submitted to the insurance company
- any network savings/adjustment
- amount paid by the insurance company
- any deductible paid or owed by the patient
- balance of the bill, owed by the patient

Whenever you get an EOB, it’s important to verify that the information is accurate — that you really did go to that doctor on that date and receive the treatment listed. For instance, when I recently went to see a physician specializing in vision care for a retinal scan, my EOB entry for that visit read “Office Vision Care,” along with the date of my visit, the name of the medical group the doctor belongs to, and the amount the
doctor charged for the visit. There may also be various codes or notes inserted into a claim on an EOB, offering further information on a specific claim. (My EOB, above, included a note that routine vision exams aren’t covered.)

**Compare**

While the EOB may list the portion of a bill that you’re responsible for (either as a deduction or a non-covered procedure), you don’t pay the doctor upon receiving the EOB. The care provider will also receive a version of the EOB, and will then send you a bill based on what the insurance company has paid or not paid.

When you receive the bill from the doctor or medical office, compare it with the EOB for that visit and make sure that what you’re being billed matches what the EOB says you owe. If you notice a discrepancy, contact your medical provider to get an explanation. If you’re not satisfied with the explanation, you need to follow up with the insurance company.

**Save**

Most experts advise saving your EOBs with your other important paperwork (i.e., utility bills, insurance policies, etc.) in case of disputes that may arise in the future.

Professor A. Thomas Golden at the Thomas Jefferson School of Law in San Diego, Calif., said that while most states don’t treat EOBs as an implied promise or contract, laws vary widely from state to state. Golden, who teaches contract law, said insurance policies are regulated by both state contract and insurance laws, but that hanging on to your EOBs is a good idea no matter where you live: “Should a dispute arise as to the appropriate interpretation of a vague or ambiguous term in the insurance contract, EOBs issued since the contract was entered could be used to assist in resolving the vagueness or ambiguity. This would be most helpful to the patient in situations where an insurer makes a decision in the patient’s case that is less beneficial than prior decisions made by the same insurer in previously issued EOBs under the same policy.”

**If There’s an Error**

If any of the information is wrong (if, say, my EOB had read “Fertility Treatment” instead of “Office Vision Care”), then it is important to contact the insurance company immediately to get the claim corrected. Every EOB contains a contact phone number for the insurer’s customer service department, and it’s usually a toll-free number. Whenever you find what you think may be an error on an EOB, you should immediately call that contact number and file an appeal.

When filing an appeal, begin your conversation by getting the first and last names of the customer service representative you’re dealing with and writing them down. Ask if they have a direct line you can use to call them back if you have any further questions later. Also ask to have a written confirmation of the appeal mailed to you so you have a record of it.

Many insurers have specific appeals processes that will be explained to you, and the appeals process is regulated by state law in many parts of the country.

**Understand Your Relationship**

According to Golden, it is important to recognize what your relationship to your health insurer is. If you purchase your health insurance through an agent on your own, then you have a contract with the insurer — meaning that if you feel the insurer is not living up to the terms of the policy you purchased, you have the right to seek legal recourse to enforce the terms of the contract. However, if you receive your health insurance through work, then it is your employer that has a contract relationship with the health insurance company. Even here, though, Golden said employees may have some ability to force the insurance company to honor a claim that you believe should have been covered by the policy.

“The fact that the employee contributes (usually through payroll
deductions) to the payment of premiums does not make the employee a party to the insurance contract,” explains Golden. “The patient/employee is in most cases an ‘intended third party beneficiary’ of the contract between his/her employer and the insurance company, meaning that the patient/employee may have standing to bring legal proceedings against the insurer for breach of its contract with the employer. But the employee has no control over the terms of that contract.”

Those who work for larger companies may find that their employer is self-insured — meaning that they pay all claims out of their own funds, often hiring a health insurance company to administer their employees’ claims. In such cases, employees’ ability to seek recourse over a disputed claim will depend on the nature of their employment (contract, union, at-will, salaried, etc.) and the laws of their state.

Those who get their health insurance through Medicare receive it as a benefit from the government, with federal law dictating appeals processes for disputed claims. appeals. Check with your insurer or employer for setting up an online account.

EOBs and Lifetime Caps
In an article on lifetime caps in the February-March 2009 issue of IG Living, it was explained that only what the insurance companies actually pay out on your behalf counts against your lifetime cap, which is the maximum amount of your medical bills that the insurer will pay over the course of your life. In reading an EOB, the amount in the field marked “paid by health plan” (or something similar) is the only amount that counts against your lifetime cap. This will almost always differ from what the medical provider charges, and this will be indicated on your EOB. In addition to the “amount charged” field, there will generally be a “network savings” field (or something similar) if you’re in a PPO-style health plan. This is the discount the health insurance company has negotiated with the medical (or dental) provider. (This can also lower the amount of your deductibles or co-pays.)

Those with chronic medical conditions know how quickly medical costs can add up, even with in-network discounts, and why it’s so important to verify the accuracy of your health insurance accounting each time you receive an EOB. Double-checking every charge made to your insurance plan is of particular importance following hospital stays, when multiple healthcare providers may be billing your insurance separately. When our youngest was born last summer, we received separate EOBs for mom from the attending physician, the anesthesiologist, the hospital’s on-site pharmacy and the surgeon who performed the Caesarean. Then there were the EOBs for the baby’s pediatrician, plus the baby’s share of the hospital room charge. Given the high dollar value on many of these charges, even a single error could have resulted in a significant dent in our lifetime caps. You can be sure we checked them all thoroughly!

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Editor’s Note: Many physician offices and clinics are investing in software that will estimate instantly what the expected out-of-pocket expenses are going to be for the patient. They then require 50 percent of that expense up front before they will treat the patient. This software is being provided by insurance companies, with Cigna being the latest to provide it. What used to take up to 90 days to figure out, can now be done in a matter of minutes. It’s possible that this kind of system will result in even more patients going without treatment because of out-of-pocket expenses. In addition, the increase in popularity of health savings account plans has prompted some physician offices to request payments up front. For more information, you can read a recent article published in the Washington Post, “Doctors Seek Fees at Time of Service,” at http://www.washingtonpost.com/wp-dyn/content/article/2009/03/02/AR2009030201786.html?hpid=sec-health.