# Understanding Your
## Explanation of Benefits

See back page for Sample EOB

For each claim submitted on your behalf, you will receive an Explanation of Benefits (EOB). At CoreSource, we realize that this information may be confusing, so we have provided this brochure to help make it clearer.

Each of the numbered explanations listed below corresponds to one of the numbers shown on the sample form on the reverse side.

1. **Employee Name** - Name of covered employee
2. **Patient Name** - Name of person who received the service
3. **Group Number** - Number assigned to the employer by CoreSource
4. **Group Name** - Name of employer
5. **Patient Account Number** - Account number assigned by the provider that rendered service
6. **Provider of Service** - Name of facility or professional provider that rendered the service
7. **Provider TIN** - Tax identification number assigned by the state
8. **Claim #** - This number identifies the claim in our system
9. **Check # -** Check number of check that was issued
10. **Issued Date** - Date the check was issued
11. **PPO** - Identifies the PPO Network that the provider belongs to
12. **Payment Made To** - To whom the check was issued
13. **Explanation of Benefits (EOB)** - An overview of how the charges were considered in processing this claim
14. **Service Date** - The date the provider indicated the services billed for were received or rendered
15. **Description of Service** - A brief description of the services for which the provider billed
16. **Submitted Amount** - Amount of charges submitted for payment
17. **Ineligible Amount/Remark 1**- Amount of submitted charges not covered by the plan (if any) and remark code (see #26)
18. **Ineligible Amount/Remark 2** - Amount of submitted charges not covered by the plan (if any) and remark code (see #26)
19. **Covered Amount** - Amount of submitted charges covered by the plan
20. **Deductible** - The amount of the covered charge that the patient is responsible for before benefits can be provided
21. **CoPay** - A set amount that the provider can collect from you at the time of service
22. **% Paid** - Percentage of covered expense paid by the plan, after any applicable deductible
23. **Plan Benefit** - Total amount of benefits payable by the plan for the submitted charge
24. **Employee Responsibility** - Amount of covered expense that is the employee's responsibility to pay
25. **Total** - Total amount in each column for this EOB
26. **Remark Code** - Remark code used for the amount of submitted charges not covered by the plan (if any) and corresponding description for code
27. **Deductible In Network** - Dollars met, if any, for in network services
28. **Deductible Out of Network** - Dollars met, if any, for out of network services
29. **Out of Pocket/Stoploss In Network** - Dollars met, if any, for in network services
30. **Out of Pocket/Stoploss Out of Network** - Dollars met, if any, for out of network services
31. **Lifetime Max In Network** - In network dollars met toward your lifetime major medical maximum
32. **Lifetime Max Out of Network** - Out of network dollars met toward your lifetime major medical maximum
33. **Individual** - The dependent the claim is for
34. **Current Year** - Current benefit year dollars met that have been applied
35. **Prior Year** - Prior benefit year dollars met
36. **Family** - Dollars applied toward the employee and covered dependents
37. **Current Year** - Current benefit year dollars met that have been applied toward the family
38. **Prior Year** - Prior benefit year dollars met that have been applied toward the family

CORESOURCE
*A Trustmark Company*

# Understanding Your
## Explanation of Benefits

The items appearing on the Explanation of Benefits (EOB) sample are for reference clarification only and correspond to further details, definitions and terminology.

**CORESOURCE**
*A Trustmark Company*
PO Box 2920
Clinton, IA 52733-2920

**Forwarding Service Requested**

SINGLE PIECE
1 0.3516 SP 0.420
CLAY BROWN 1
4940 CAMPBELL BLVD STE 200
BALTIMORE, MD 21236-5911

**WHITE STOCK**
200806133333
TEST

**This is an explanation of benefits payable under the patient's plan. Please refer to the remark section for any ineligible information. For questions regarding this claim, contact us at:**

| | | |
|---|---|---|
| 1 | EMPLOYEE NAME: | CLAY BROWN |
| 2 | PATIENT: | CLAY BROWN |
| 3 | GROUP #: | 9913 |
| 4 | GROUP NAME: | ABC COMPANY |
| 5 | PATIENT ACCOUNT NO: | 302COZ |
| 6 | PROVIDER OF SERVICE: | JAMES W. SMITH, DO |
| 7 | PROVIDER TIN: | 59-2584835-00000 |
| 8 | CLAIM #: | E90007912997 |
| 9 | CHECK #: | 1 |
| 10 | ISSUED DATE: | 06/12/2008 |
| 11 | PPO: | PHCS-PPO PRODUCT |
| 12 | PAYMENT MADE TO: | JAMES W SMITH JR DO PA |

13 **Explanation of Benefits**

| SERVICE DATE / DESCRIPTION OF SERVICE | SUBMITTED AMOUNT | INELIGIBLE AMOUNT 1 / RMK CODE | INELIGIBLE AMOUNT 2 / RMK CODE | COVERED AMOUNT | DEDUCTIBLE | COPAY | % PAID | PLAN BENEFIT | EMPLOYEE RESPONSIBILITY |
|---|---|---|---|---|---|---|---|---|---|
| 14 02/15/08 | 280.00 16 | 30.00 17 | 18 | 250.00 19 | 20 | 25.00 21 | 100% 22 | 225.00 23 | 25.00 24 |
| 15 PHYSICIAN VISIT | | 901 | | | | | | | |
| 25 **Total** | 280.00 | 30.00 | 0.00 | 250.00 | 0.00 | 25.00 | | 225.00 | 25.00 |

26 901 THIS AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE PROVIDER'S NORMAL CHARGE AND A REDUCED AMOUNT DUE TO A PREFERRED PROVIDER ARRANGEMENT. THE PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT. REFER TO THE PREFERRED PROVIDER SECTION OF THE PLAN BOOKLET.

| 33 **INDIVIDUAL** | DEDUCTIBLE IN NETWORK MET | DEDUCTIBLE OUT OF NETWORK MET | OUT OF POCKET/STOPLOSS IN NETWORK MET | OUT OF POCKET/STOPLOSS OUT OF NETWORK MET | LIFETIME MAX IN NETWORK MET | LIFETIME MAX OUT OF NETWORK MET |
|---|---|---|---|---|---|---|
| 34 CURRENT YEAR | 400.00 27 | 400.00 28 | 2022.86 29 | 2022.86 30 | 5035.00 31 | 5035.00 32 |
| 35 PRIOR YEAR | | | | | | |
| 36 **FAMILY** | | | | | | |
| 37 CURRENT YEAR | 400.00 | 400.00 | 2022.86 | 2022.86 | | |
| 38 PRIOR YEAR | | | | | | |

Dollars displayed are as of the issued date and are subject to change.