TRICOR INSURANCE

Benefits Advocacy for School Staff and Faculty

A Review and Understanding of Explanation of Benefits (EOB)

School district leadership and administration often play a significant role in the support of their faculty and staff that fulfill the mission of providing quality education.

At TRICOR Insurance, we work with many of our public and private employer-based clients in helping them to provide good support and advocacy as it relates to their employee benefits programs. This piece is focusing on the Explanation of Benefits (EOB) that health plan members receive. They can be confusing and overwhelming at times to employees, especially if they are managing a lot of medical conditions and treatments. The School administration office, often led by Human Resources along with support from your Benefits Consultant, can help bring support and clarity to employees as questions and concerns arise.

A Review and Understanding of "Explanation of Benefits (EOB)"

The EOB is a form required from insurance companies to their members to explain what part of a claim was paid by the insurance coverage and what part was not paid, and includes a detailed description of why it was not paid. Once a claim has been submitted from a health care provider for a medical service or treatment, the health plan member should receive an Explanation of Benefits (EOB) from their insurance company. This will come to the plan member in a paper copy to the member's home or is made available online through the member online portal with their health insurance company. It may take a few weeks for the plan member to receive the EOB as it does take

some time for the claim to work through the process. It is important to understand the components of an EOB to be sure a plan member is being provided all the benefits that the health plan is designed to cover.

In our employee benefits practice, we work with our employer-base benefits clients to assist them in this area as many people have a difficult time understanding their EOBs. Employees often connect with HR or their administration offices first if bills or EOBs are not clear, and it is good for those school advocates to have a good understanding of how the process works to bring that initial support to the employee.

These forms, many times, will differ from one insurance company to another. It is common for insurance companies to combine many dates of service or several providers within a single site clinic in one EOB form. We also work with insurance companies that generate separate forms for each single date of service and providers that were utilized.

Most EOBs contain the following detailed information:

- Name and address of the health plan member
- Name of the patient
- The group number
- The member ID number
- Claim number
- Date the claim was processed
- Date of service
- Name of the health care facility and the specific provider name
- Name of the procedure or service and the billing code
- Amount that was billed to the insurance company by the provider
- The portion of the bill that is eligible for insurance coverage
- The reason why the non-covered portion was not covered
- The amount of the charges that are subject to the patient's deductible
- The amount paid by insurance company

The important elements of an EOB are to clearly understand the breakdown of a health care claim. This is done by reviewing on the EOB form how much has been paid by your insurance company and how much is the plan member's responsibility. It is good to then match up that same information on the EOB to the invoice/bill from the health care provider that is received by the plan member.

The school district's human resource staff often plays a big role in the initial supportive connection of an employee if something isn't matching up and needs more explanation. Providers and insurance companies do make mistakes from time to time and those can be corrected. With private health information (PHI) on EOBs, many times it is best for those school advocates to guide those employees

directly with the insurance company's customer service team or ask for the Benefits Consultant's support team for assistance.

In today's world of health insurance, it is not common for an insurance company to pay 100% of a medical service or treatment. When deductibles, coinsurance, and copayments come into play, it is key to understand the breakdown and cross reference EOBs and provider bills to be sure coverage has been properly applied.

Below are some common reasons for partial payment of a claim by your insurance company:

- Part or all of the claim was charged to the plan member to satisfy the deductible
- Part of the claim was charged to the member in the form of a copayment
- Part or all of the claim was charged to the member to satisfy the coinsurance requirement
- The charges for the services exceeded the maximum benefit available for the service
- The claim was a duplicate and had been previously paid
- The charges exceeded the insurance company's reasonable and customary limitation (this happens more frequently when using out-of-network providers)
- The charges are for a non-covered service (example is an elective cosmetic surgery procedure)

We hope this provides school leadership, the administrative office, and human resources some background and review on the topic of EOBs. Health insurance is one of the strongest key benefits for employees and it also brings a great deal of complexities and at times high emotion when both someone's health and finances are connected. Supporting individuals we work with on these health plans with compassion, empathy, and advocacy is always a good path to take.

Important Disclaimer: We strongly recommend connecting with a licensed professional for an assessment of any employee benefit coverages and offerings.

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