



## How to Read an Explanation of Benefits (EOB)

Below is a description of your Explanation of Benefits (EOB). The numbers correspond with the numbers on the sample copy of the EOB (see the last page for an example of an EOB).



- (1) Claim processing office: This is the location of the claims processing office. You can write to customer service at this location.
- (2) Address: The name and address where the EOB is being mailed.
- (3) Customer Service: Number to call with questions regarding your claim and the hours for calling.
- (4) Claim Number: The unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.
- (5) Group Number: The identification number for your Group. Please refer to this number if you call or write about your claim.
- (6) Group Name: The name of your Group. (In most cases, this is your employer.)
- (7) Location: The number assigned to your location within the Group.
- (8) Location Name: The name or description of the location.
- (9) Enrollee: Name of the employee.
- (10) Enrollee ID: Employee's social security number (last 4 digits only) or identification number. Refer to this ID if you call or write about your claim.
- (11) Plan Number: The identification number for your plan of benefits.
- (12) Patient: Name of the individual for whom services were rendered or supplies were furnished.
- (13) Relationship: Relationship of the patient to the employee.
- (14) Patient Acct: Number assigned by the service provider, i.e. doctor's chart number, hospital number.



- (15) Paid Date: If a check was issued, the date it was issued.
- (16) Plan Sponsor: Name of the plan sponsor. (In most cases, this is your employer.)
- (17) Provider: The name of the person or organization who rendered the service or provided the supply.
- (18) Dates Of Service: The date(s) (Month, Day, Year) on which services were rendered.
- (19) Proc Code: The Current Procedural Terminology (CPT) codes listed on the provider's bill.
- (20) Charge Amount: The charge for each service as indicated on the bills submitted.
- (21) Charges Not Covered: Amount that is not eligible for benefits under the plan, or more information is needed to process the claim.
- (22) Reason Code: Code relating to the "Charges Not Covered" amount. Also used to request additional information or provide further explanations of the claim payment.
- (23) Provider Discount: Identifies the savings received from a Preferred Provider Organization (PPO). The corresponding reason code will appear in this field. The explanation will appear in the "Checks Issued" box (see #41).
- (24) Maximum Benefit: Allowable charges to be considered by your plan after subtracting Charges Not Covered and the Provider Discount from the Charge Amount.
- (25) Copay: The amount of charges specified by your plan that you must pay before benefits are paid.
- (26) Deductible Amount: The amount of charges that apply to your deductible specified by your plan that you must pay before benefits are payable.
- (27) Covered Expenses: Amount of eligible charges to be considered by your plan after subtracting Charges Not Covered, Provider Discounts, Copays and Deductible amounts from the Charge Amount.
- (28) Paid At: The percentage that the Covered Expenses will be considered as determined by your plan.
- (29) Total Payable Amount: Benefits payable for services provided.
- (30) Column Totals: The sum of each column.
- (31) Benefit Deductible: The amount that is not eligible for benefits as determined by your plan, such as precertification penalties.
- (32) Adjusted Payment / Other Insurance: Represents adjustments based upon the benefits of other health plans or insurance carriers, including Medicare.
- (33) Total Paid: The sum of the "Total Amount Payable" column.



- (34) You are entitled to a review: Statement explaining your entitlement of a review of the benefit determination on the Explanation of Benefits (EOB).
- (35) Reason code: Description for the Reason code (s box 22) will appear in this section.
- (36) Satisfied Amounts After This Claim: Dollar amount satisfied for the current year. (Note: If dates of service are in two calendar years, (2007 and 2008) the current year's (2008) amounts is shown.
- (37) Payee Name: Individual or organization to whom benefits are paid.
- (38) Check Number: The unique number assigned to the check.
- (39) Check Amount: Total benefit amount paid on this claim.
- (40) Enrollee Responsibility: After all benefits have been calculated, this is the amount of the enrollee's responsibility.
- (41) Provider Discount Code: The reason for negotiated savings.

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#### Check Section (Items 42-52)

This section contains the check portion of the EOB. If benefits are assigned, a provider will receive an EOB and check, if applicable. The employee will receive an EOB showing all providers for the claim on one EOB with a non-negotiable check. Much of the information here is a repeat of the descriptions for the EOB.

- (42) Group Name: The name of your Group. (In most cases this is your employer.)
- (43) Enrollee: Name of the Employee.
- (44) Patient: Name of the individual for whom services were rendered or supplies were furnished.
- (45) Patient Acct: Number assigned by patient's provider of services.
- (46) Group Number: The identification number for your Group. Please refer to this number if you call or write about your claim.
- (47) Date: The date the check was issued.
- (48) Claim Number: The unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.
- (49) Check Number: The unique number assigned to this check.
- (50) Check Amount: Total benefit amount paid on this claim.
- (51) Pay Exactly: The amount of this check in words.
- (52) Pay To The Order Of: Name and address of the person or organization to whom benefits were paid.

The Cincinnati Life Insurance Company  
 Affl. w/ Cincinnati Financial Corp.  
 P.O Box 145496  
 Cincinnati, OH 45250-5496



EXPLANATION OF BENEFITS - EOB  
 THIS IS NOT A BILL

For Customer Service, please call (513) 603-5850  
 (3) between the hours of 8:00 am and 4:30 pm, eastern time  
 or contact us at HIPAA\_LHADMIN@cinfin.com

(1) P.O. BOX: 145496  
 Cincinnati, OH 45250-5496

RETURN SERVICE REQUESTED

(2) DR. ROBERT JONES  
 PO BOX 125  
 SLATON, TX 79364-0125

(4)	Claim #: 90117390-01
(5)	Group #: 9890100
(6)	Group Name: CINCINNATI FINANCIAL CORPORATION
(7)	Location: 001
(8)	Location Name: CIC
(9)	Enrollee: JOE SMITH
(10)	Enrollee ID: *****4987
(11)	Plan #: TCK
(12)	Patient: JOE SMITH
(13)	Relationship: SELF
(14)	Patient Acct:
(15)	Paid Date: 01/26/2008
(16)	Plan Sponsor: CINCINNATI FINANCIAL CORPORATION

(17) Provider: DR. ROBERT JONES

DATES OF SERVICE FROM THRU	PROC CODE	CHARGE AMOUNT	MINUS CHARGES NOT COVERED	REASON CODE	MINUS PROVIDER DISCOUNT	MAXIMUM BENEFIT	MINUS COPAY	MINUS DEDUCTIBLE AMOUNT	EQUALS COVERED EXPENSES	PAID AT	TOTAL PAYABLE AMOUNT
(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)
04/16-04/16/2007	73620	66.00	0.00		J3 29.94	36.06	0.00	0.00	36.06	80%	28.85
COLUMN TOTALS		(30) 66.00	0.00		29.94	36.06	0.00	0.00	36.06		28.85

Your cooperation is needed to stop fraud! If these services were not rendered, please contact The Cincinnati Life Insurance Company immediately at the number shown above.	BENEFIT DEDUCTIBLE (31)	.00
	ADJUSTED PAYMENT/ OTHER INSURANCE (32)	.00
	TOTAL PAID (33)	28.85

DESCRIPTION OF REMARKS/MESSAGES

(34) \* You are entitled to a review of this benefit determination if you have questions or do not agree. To obtain a review, submit your request in writing to the office to which you submitted your initial request for benefits. Your request should include your name, Enrollee ID and other identifying information shown above, the issues, and any data, documents and comments you would like to have considered. Written requests for review must be mailed or delivered within the time limit required by your Plan. Please consult your Plan Document for more information about claim review procedures. If a claim is denied, or partially denied, because of lack of medical necessity or an experimental treatment exclusion, internal rules, guidelines, protocol or an explanation of the clinical judgment for determination will be provided without charge, upon request.

(35) When applicable, description of Reason Code appears here.

(36) SATISFIED AMOUNTS AFTER THIS CLAIM

YOU HAVE MET ALL YOUR INDIVIDUAL IN NETWORK DEDUCTIBLE FOR 2007.  
 YOU HAVE MET \$92.96 OF YOUR \$1,000.00 INDIVIDUAL IN NETWORK OUT OF POCKET FOR 2007.  
 YOU HAVE MET ALL OF YOUR FAMILY IN NETWORK DEDUCTIBLE FOR 2007.  
 YOU HAVE MET \$1,092.96 OF YOUR \$2,000.00 FAMILY IN NETWORK OUT OF POCKET FOR 2007.

CHECK(S) ISSUED			ENROLLEE
(37) PAYEE NAME	(38) CHECK NUMBER	(39) CHECK AMOUNT	RESPONSIBILITY (40)
DR. ROBERT JONES	00000008	\$28.85	0.00
(41) J3 PATIENT NOT LIABLE PPO DISCOUNT			



The Cincinnati Life Insurance Company  
 Affl. w/ Cincinnati Financial Corp.  
 P.O Box 145496  
 Cincinnati, OH 45250-5496

FIFTH THIRD BANK NORTHERN KY

NO. 00000008 (49)  
 73-27/421

(42) GROUP NAME: CINCINNATI FINANCIAL CORPORATION	(46) GROUP #:	9890100
(43) ENROLLEE: JOE SMITH	(47) DATE:	01/26/2008 (50)
(44) PATIENT: JOE SMITH	(48) CLAIM #:	90117390-01
(45) PATIENT ACCT:		

(51) PAY EXACTLY \*\*\* TWENTY-EIGHT DOLLARS AND EIGHT-FIVE CENTS

(52) PAY TO THE ORDER OF  
 DR. ROBERT JONES  
 PO BOX 125  
 SLATON TX 79364

*Steve J. Johnston*

Authorized Signature  
 VOID AFTER 180 DAYS

⑈00000008⑈ ⑆04 2 100 27 2⑆ 7480 795330⑈