

Insurance Name

Claim Processed Date:

Explanation of Benefits - EOB
(Claim Detail)

Subscriber Name: (Your Name)

<u>Service Date</u>	<u>Service Code</u>	<u>Billed</u>	<u>Allowed</u>	<u>Not Covered</u>	<u>Copay</u>	<u>Deductible</u>	<u>Coinsurance</u>	<u>Plan Payment</u>
01/01/2019	Drug name/Code	\$1,600	\$1,000	\$0	\$600	\$0	\$0	\$400
01/01/2019	Other Services	\$200	\$100	\$0	\$50	\$0	\$0	\$50

Reason Codes:

Above: Example of an itemized EOB detailing patient's responsibility, after primary commercial insurance coverage, for the drug

- If your administering office is billing you directly for the medication, you must submit an itemized "EOB" and bill statement from the office for reimbursement to be applied. The reimbursement will be less your \$25 portion with a maximum benefit of \$1,500 per calendar year.
- We only cover the copay, deductible or coinsurance applied to the drug code. All "Other Services" are not covered under this program.
- If drug name/code is not listed on your EOB, please obtain a bill statement from your office that lists the drug name and billed amount.
- Services must be itemized so we can identify your responsibility specific to the medication only.
- If drug is "not covered" or denied by your plan, our program will not assist.
- Program does not reimburse payments made by Health Savings or Flexible Spending accounts.