Understanding Explanation of Benefit Terms

A Date

The date service was received.

B Description of Service

Shows the health services that were received, like a medical visit, lab test, screening, etc.

C Coverage Notes

Coverage Notes offer specific information about the coverage decisions made by IMG regarding a particular service. These notes may include reasons for the approval or denial of services, any limitation or exclusions that apply, and additional instructions or

D Amount Billed

The amount billed refers to the total charge submitted by your provider for the services rendered to a patient. This figure represents the initial cost before any insurance adjustments, discounts, or payments are applied.

E Cost Reduction

Cost reduction refers to the amount subtracted from the total charges billed by a healthcare provider, resulting from negotiated discounts adjustments, or contractual agreements between the provider and the insurance company. This reduction lowers the overall cost of services before the insurance payment and patient responsibility are calculated.

F Covered Amount

The covered amount is the portion of the total billed charges for healthcare services that an insurance company agrees to pay according to the terms of the policy. This amount is determined after applying any cost reductions, such as negotiated discounts or adjustments. The covered amount represents the insurer's financial responsibility and is used to calculate the remaining balance that the policyholder may need to pay, including deductibles, copayments, and coinsurance.

G Not Covered

Not Covered refers to the portion of healthcare services or charges that an insurance policy does not pay for. These are expenses that fall outside the scope of the policy's coverage, meaning the policyholder is fully responsible for paying these costs out-of-pocket. Reasons for services being Not Covered can include exclusions specified in the policy, services deemed medically unnecessary, or treatments received from out-of-network providers. The Not Covered amount is clearly indicated in the EOB to help policyholders understand which costs they need to manage independently.

H Deductible

The dollar amount as selected on the Application and specified in the Declaration, that the Insured Person must pay eligible medical expenses per Period of Coverage prior to receiving benefits or coverage under this insurance and not including any applicable Coinsurance.

I Copay

The amount the Insured Person is responsible to pay for each urgent care or walk-in clinic visit.

J Coinsurance

A shared cost between you and your health plan. This is the percentage of eligible medical expenses that the company will pay (up to the maximum limit) after your deductible has been met.

K Your Responsibility

The total amount you owe to your provider after discounts, coinsurance and deductibles. Your provider may bill you directly if any amount is still owed.

View our complete Glossary of Terms >