Understanding an Explanation of Benefits (EOB)

After you've seen a provider for care, you will likely receive a document from Medica called an “Explanation of Benefits” (EOB). The EOB is a record of the services you or another covered family member received on a certain date.

It includes:
- A general description of services (for example, “Office Visit” or “Lab”)
- The provider’s charge for the services
- Medica’s share of the costs
- The payment amount the network provider has agreed to accept from Medica, or the full amount charged by an out-of-network provider
- An estimate of your share of costs, if any

The EOB is not a bill. If you owe money for your share of costs, the provider will bill you separately. The EOB is Medica’s way of helping you understand and budget for your out-of-pocket expenses.

Example: EXPLANATION OF BENEFITS - THIS IS NOT A BILL

<table>
<thead>
<tr>
<th>Claim Number: 77033051-99</th>
<th>Par/Non: P</th>
<th>Provider: Welby MD, Marcus</th>
<th>Paid Amount: 134.46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date(s) of Service / Description</td>
<td>Charges</td>
<td>Allowed Amount</td>
<td>Patient Non-Covered</td>
</tr>
<tr>
<td>OFFICE VISIT</td>
<td>204.00</td>
<td>168.07</td>
<td>0.00</td>
</tr>
<tr>
<td>TOTALS</td>
<td>204.00</td>
<td>168.07</td>
<td>0.00</td>
</tr>
</tbody>
</table>

1. **Claim Number** – Provides a reference number that can be used when addressing questions to Customer Service about a claim or when reconciling amounts listed on the EOB with invoices received from the provider.
2. **Par/Non** – “P” means participating (or network) provider; “N” means non-participating (or out-of-network) provider.
3. **Provider** – Lists the provider’s name.
4. **Date(s) of Service / Description** – The month, day and year the service was provided, along with the type of service.
5. **Charges** – The amount the provider or facility billed for the service. Note: This amount does not reflect discounts Medica has negotiated with the provider or facility.
6. **Allowed Amount** – The contracted rate Medica has negotiated with the provider or facility for the service.
7. **Patient Non-Covered** – The amount the member is responsible for paying because the service is not covered by the member’s health plan.
8. **Provider Responsibility** – Any portion of the billed charges the provider is responsible for absorbing.
9. **Notes ID** – Notes or comments that apply to a particular charge.
10. **Deductible** – A fixed dollar amount the member is responsible for paying each plan year before the plan begins to pay for covered services. Note: “Patient Non-Covered” amounts do not count toward meeting the yearly deductible.
11. **Copay** – Short for “copayment,” a fixed amount the member or patient pays up front when receiving a health care service.
12. **Coinsurance** – A percentage of the “Allowed Amount” the member or patient is responsible for paying.
13. **Paid Amount** – The amount paid by Medica for the service.
14. **Amount You Owe** – The amount the member is responsible for paying.