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 based on a preventive care visit with an in-network provider.

#### EXPLANATION OF BENEFITS - THIS IS NOT A BILL

<table>
<thead>
<tr>
<th>Claim Number: 77033051-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date(s) of Service / Description</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>OFFICE VISIT</td>
</tr>
<tr>
<td>TOTALS</td>
</tr>
</tbody>
</table>

Notes: 32 - Charge exceed fee schedule/max allowable/contracted/legislated fee arrangement

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.

7. **Patient Non-Covered** – The amount the member is responsible for paying because the service is not covered by the member’s health plan. This amount is included in the “Amount You Owe.”

8. **Provider Responsibility** – Any portion of the billed charges the provider is responsible for absorbing. You are not responsible for these charges.

   Charges - Allowed Amount = Provider Responsibility

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. This amount is included in the “Amount You Owe.” 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. Based on your plan’s copay amount for certain services. This amount is included in the “Amount You Owe.”

12. **Coinsurance** – A percentage of the “Allowed Amount” the member or patient is responsible for paying. Based on your plan’s coinsurance amount for certain services. This amount is included in the “Amount You Owe.”

13. **Paid Amount** – The amount paid by Medica for the service.

14. **Amount You Owe** – The amount the member is responsible for paying. When you receive a bill from your provider, compare the amount on the bill to the “Amount You Owe” shown in the EOB. If you had a copay for your visit, you may have already paid the copay at the time of your visit.
Understanding an Explanation of Benefits (EOB) When You Have an Adjusted Claim

Sometimes a claim is corrected, or adjusted, after it is processed. This can happen for many reasons like when the provider submits additional changes, or an error was found on how the claim was processed.

If you receive an EOB showing an adjusted claim, your adjusted claim may look similar to the following example:

Example of an adjusted claim showing correction to original claim

Your claim has been adjusted if you see one or more of the following items on your EOB:

1. Adjustment Original Paid Date (shows an adjustment was made to the original claim that was originally paid on the date indicated)
2. Minus (-) sign behind a dollar amount
3. The letters “CR” following a dollar amount in the “Amount You Owe” column*

*Note: The letters “CR” on an adjusted EOB do not indicate that a credit or money is owed. It simply indicates that the claim has been adjusted.

What to Do if You Receive an Adjusted EOB

Log on to mymedica.com or call Customer Service to find out the current amount you may owe for a claim. To view your claim on mymedica.com:

1. Log on to mymedica.com
2. Choose the “Claims & Account” tab and select “Claims Summary” or choose the large “View My Claims” button located on the center of the page
3. Select the patient’s name and date of service and click “Search”
4. When you find your claim, click on “More Details”
5. The amount you may be responsible for is shown under “Amount You May Owe”