



MEDICAL MUTUAL®

# Explanation of Benefits Guide

Medical Mutual® is dedicated to providing comprehensive healthcare coverage. To help you get the most from your benefit coverage while keeping costs affordable, it is important that you understand your coverage and use your benefits according to your benefit plan or certificate of coverage. Reviewing your Explanation of Benefits (EOB) will help you better understand your benefits.

**YOUR EXPLANATION OF BENEFITS**

**SUMMARY OF YOUR CLAIMS**

Total benefits we paid	\$204.00
Total you are responsible for	\$204.00

**DETAILS OF YOUR CLAIM**

Date of Service	Amount Billed	Amount Paid	Amount Responsible for
11/20/14	100.00	50.00	50.00
11/20/14	100.00	50.00	50.00
11/20/14	200.00	100.00	100.00

## Understanding Your Explanation of Benefits

Your EOB details recent claims and how they were paid or provides clarification as to why claims were denied. Please note that the EOB is not a bill.

The main sections of the EOB include:

- The top section, which includes Customer Care information and your member identification number.
- The Summary of Claims, which shows the total benefits we paid and the total amount you are responsible for paying.
- The Details of Your Claims, which covers every processed physician and hospital claim during a payment cycle. The claims in this section will be presented by family member and may be several pages. In this section, you may also see notes, which are used like footnotes to indicate that some aspect of the benefits administered needs to be explained further.
- The Update on Your Deductible and Coinsurance Balances, which graphically show the amounts you and your dependents have accumulated toward the patient and family annual maximums as applicable.

You will find a sample EOB form outlined for your convenience on the next two pages. General explanations are provided for each section. If you need more information or have questions, contact Customer Care using the number provided on your EOB.

# Explanation of Benefits Guide

**Date statement was produced** → November 26, 2014

**Customer Care information**  
Website, address and phone numbers where you can send inquiries and have specific questions answered.

**Your ID number**  
Your member identification number located on your identification card. Same as contract/certificate number. Important for all claim inquiries.

**Policyholder name and address**

**Your benefits provider**

**Summary of your claims**  
The amount paid by your health plan and the amount you owe.

**The network status of your healthcare provider**

**Name of patient**  
The person who received service(s).

**List of service(s) billed and any notes**

**Explanation of your final responsibility for covered services**

**YOUR EXPLANATION OF BENEFITS**

This is not a bill - it's a statement listing the details of your recent health benefit claims. You'll receive a bill from your service provider for any amount you owe. Please check the details below carefully and let us know if you have any questions.

**SUMMARY OF YOUR CLAIMS**

Total benefits we paid	\$1,006.00
▶ Total you are responsible for	<b>\$244.48</b>

**Keep Your Costs Down!**

You can minimize your out-of-pocket expenses by going to doctors and hospitals that are part of your health plan network. You can verify whether the doctors you used are in-network by checking the Details section below.

To find a list of doctors in your network, please visit our website or call a Customer Service representative at (800) 111-1111.

Remember, you can view your plan information and claims statements anytime, day or night, by signing on to My Health Plan on our website.

**DETAILS OF YOUR CLAIM**

**John Doe**  
*Claim Number:* 0322612345-000  
*Services provided by:* John M. Jones MD (In network)

Type of service	Amount billed(\$)	Allowed amount(\$)	Benefits paid(\$)	Amount you are responsible for(\$)
<b>Date of Service:</b> October 27, 2014				
X-Ray Exam of Neck/Spine - <i>see note E23</i>	151.01	56.74	0.00	56.74
Office Visit, Mod Complx, 25 Min - <i>see note E23</i>	107.00	75.96	0.00	75.96
<b>Total for this claim</b>	<b>\$258.01</b>	<b>\$132.70</b>	<b>\$0.00</b>	<b>\$132.70</b>

A benefit year deductible of \$132.70 was applied to this claim.

**Note: E23** - Your in network healthcare professional has agreed to accept the allowed amount (our payment plus any deductible and coinsurance) as payment in full.

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<p><b>Amount billed</b> The dollar amount billed by your healthcare provider for the service(s) rendered.</p>	<p><b>Allowed amount</b> The maximum benefit allowable under your health plan.</p>	<p><b>Benefits paid</b> Amounts paid under your health plan to your healthcare provider.</p>	<p><b>Amount you are responsible for</b> The amount you owe for the indicated service(s) rendered.</p>
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**YOUR EXPLANATION OF BENEFITS**  
 November 26, 2014 ID number 987654321987 John Doe

Claim Number: 0324598765-000  
 Services provided by: Community Hospital (In network)

Type of service	Covered charges(\$)	Allowed amount (\$)	Benefits paid (\$)	Amount you are responsible for (\$)
Date of service: October 29, 2014				
Outpatient services - see note E69	2,452.50	1,117.78	1,006.00	111.78
<b>Total for this claim</b>	<b>\$2,452.50</b>	<b>\$1,117.78</b>	<b>\$1,006.00</b>	<b>\$111.78</b>

**Details of amounts billed for hospital outpatient services:**

Magnetic Resonance Imaging 2,452.50  
**Total amount billed \$2,452.50**

An in-network coinsurance of \$111.78 was applied to this claim.

Check number 6999997 dated November 21, 2014 was sent to Community Hospital.

**Note: E69** - For covered charges, your healthcare professional has agreed to accept the allowed amount as payment in full.

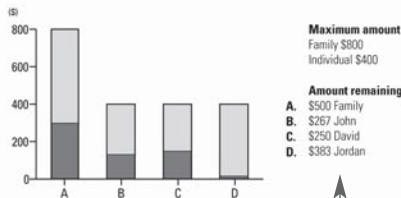
	Covered charges(\$)	Allowed amount (\$)	Benefits paid (\$)	Amount you are responsible for (\$)
<b>Total for John Doe</b>	<b>\$2,710.51</b>	<b>\$1,250.48</b>	<b>\$1,006.00</b>	<b>\$244.48</b>

(Amount billed)

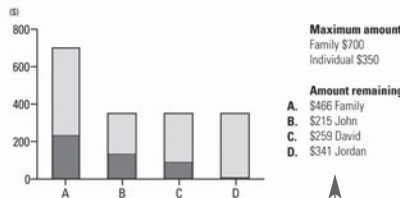
**UPDATE ON YOUR DEDUCTIBLE AND COINSURANCE BALANCES**

Your plan benefit year: January 1, 2014 – December 31, 2014

**Deductible for services provided**



**Coinsurance for services provided**



**In the chart(s) above:**

- The top of each bar shows your maximum contribution for the plan year.
- The dark shaded areas show how much you've contributed to November 26, 2014.
- The light shaded areas show the amounts remaining to be met. The letters below the bars refer to the family and individuals. See the tables to the right of the charts.

**Covered charges**

Based on the *Total amount billed* (by the hospital), this section shows the service(s) and amount(s) that are covered under your health plan.

**Total amount billed**

This section itemizes the service(s) billed by the hospital and provides the dollar amount billed by the hospital for the service(s).

**Check number**

This line verifies payment was made under your benefits for this service.

**Note**

Additional information about the benefit administration.

**Total for all EOB claims**

If there are multiple patients on an EOB, individual patient totals will be included in the statement.

**Amount remaining**

The deductible and coinsurance amounts left before you meet your family and/or individual annual maximum.

**Information on how to read your graphs.**



**MEDICAL MUTUAL®**  
2060 East Ninth Street  
Cleveland, OH 44115-1355

