MEDICA®

Understanding an Explanation of Benefits (EOB)

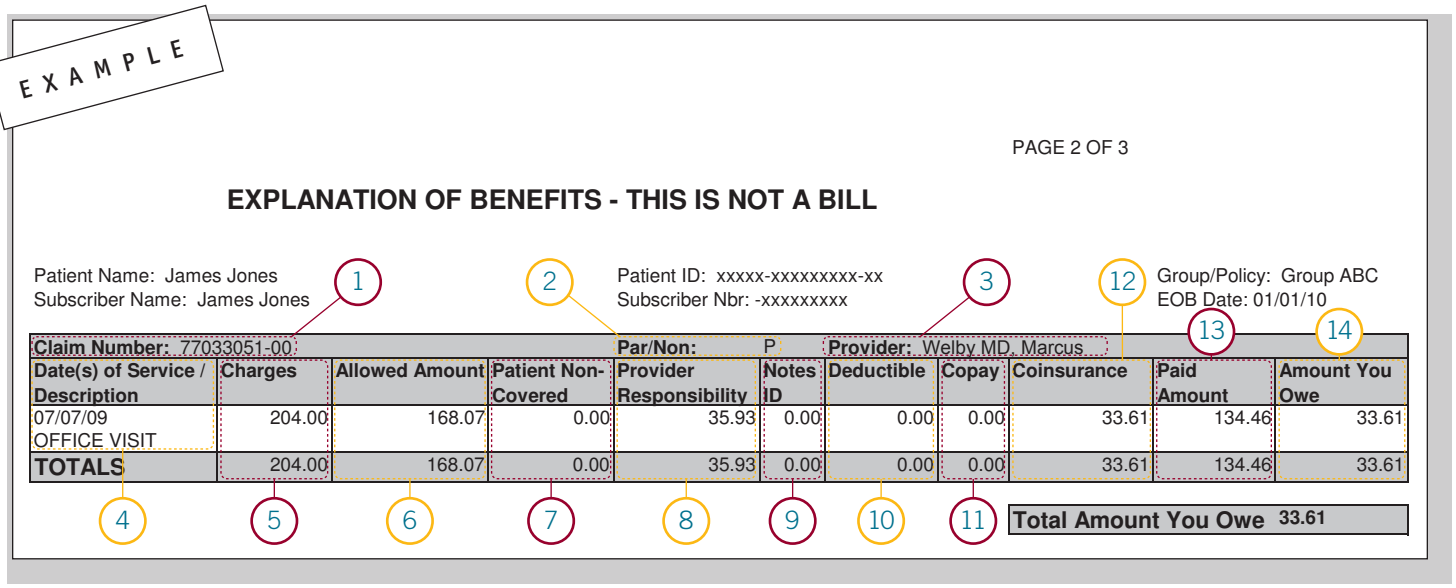
UNIVERSITY OF MINNESOTA

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

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EXPLANATION OF BENEFITS - THIS IS NOT A BILL

Patient Name: James Jones
Subscriber Name: James Jones

Patient ID: xxxxx-xxxxxxxxx-xx
Subscriber Nbr: -xxxxxxxxx

Group/Policy: Group ABC
EOB Date: 01/01/10

Claim Number: 77033051-00 **Par/Non:** P **Provider:** Welby MD, Marcus

Date(s) of Service / Description	Charges	Allowed Amount	Patient Non-Covered	Provider Responsibility	Notes ID	Deductible	Copay	Coinsurance	Paid Amount	Amount You Owe
07/07/09 OFFICE VISIT	204.00	168.07	0.00	35.93	0.00	0.00	0.00	33.61	134.46	33.61
TOTALS	204.00	168.07	0.00	35.93	0.00	0.00	0.00	33.61	134.46	33.61

Total Amount You Owe 33.61

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.

www.mymedica.com 952-992-1814 or toll free 1-877-252-5558. Hearing-impaired: 1-800-855-2880.