

# WHEN AN EXPLANATION OF BENEFITS COMES, HERE'S WHAT TO DO WITH IT

Whenever you use your health insurance, we send you an Explanation of Benefits (EOB). It shows you a breakdown of the services you received, the cost of those services and what you might have to pay your provider. **An EOB is not a bill.**

## Your EOB shows you:

- 1 How much the doctor charged.
- 2 How much you saved through your health plan.
- 3 How much your health plan paid.
- 4 How much you may still owe.
- 5 How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your in-network benefits.

## On page 1, you'll find:

- A Helpful definitions.
- B How to reach us if you have questions.
- C Your member ID number.

**THIS IS NOT A BILL**

**PAYMENTS SUMMARY for PAUL MEMBER**

Your health care providers' charges  
Amount **you saved**  
Total amount **your plan paid**

|                 |   |
|-----------------|---|
| 07/31/2023      | 1 |
| \$262.00        | 2 |
| \$26.96         | 3 |
| \$55.91         | 4 |
| <b>\$179.13</b> |   |

**AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)**

**IN-NETWORK BENEFITS AT-A-GLANCE**

| Family                                                                                     |                                                                                                      | Member(s)                                                                                  |                                                                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Deductible                                                                                 | Out-of-Pocket                                                                                        | Deductible                                                                                 | Out-of-Pocket                                                                                        |
| <b>\$4,200.00 Maximum</b><br><div><div>Satisfied</div></div> <div>\$4,200.00 Applied</div> | <b>\$9,500.00 Maximum</b><br><div><div>\$5,163.31 Remaining</div><div>\$4,336.69 Applied</div></div> | <b>\$3,000.00 Maximum</b><br><div><div>Satisfied</div></div> <div>\$1,697.73 Applied</div> | <b>\$4,750.00 Maximum</b><br><div><div>\$2,957.85 Remaining</div><div>\$1,792.15 Applied</div></div> |

**A** **Deductible**  
Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.

**Out-of-Pocket**  
The most you could pay during a benefit plan year for your share of the cost of covered services.

**B** **WE'RE HERE!**  
**Write:** Your Health Plan  
P.O. Box 123456  
Anytown, USA 12345

**Web:** Log on to [www.MyHealthToolkit.com](http://www.MyHealthToolkit.com)  
**Toll-free:** 000-000-000 (Monday - Friday, 8:30 a.m. - 4:30 p.m.)  
**Local:** 000-000-0000

## Individual Claim Report

### EXPLANATION OF BENEFITS

**Plan Holder: PAUL MEMBER**

(ID # XYZ999999999999)

Benefit Plan Year: 01/01/2023 - 01/01/2024

Notice Date: 08/07/2023

**A** How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your out-of-network benefits.

- D** Additional details about your claim, including why a claim may have been denied.

A

Individual Claim Report: **EXPLANATION OF BENEFITS** Plan Holder: **PAUL MEMBER** (ID # XYZ9999999)




+

**MEDICAL CLAIMS** for patient: **PAUL MEMBER**

C

THIS IS NOT A BILL

| Provider and Service Information    |                                             |          | Charges and Insurance Payments |               |              | Breakdown of Member Responsibility |               |                          |                      |               |
|-------------------------------------|---------------------------------------------|----------|--------------------------------|---------------|--------------|------------------------------------|---------------|--------------------------|----------------------|---------------|
| Claim Number                        | Service Type                                | Provider | Covered                        | Your Plan     | Copay        | Deductible                         | Coinsurance   | Not Covered              | Amount You           |               |
| Provider Group                      | Date of Service(s)                          | Charges  | Expense                        | Paid          |              |                                    |               | see Comments below table | May Owe or Have Paid |               |
| 00000000000000<br>DERMATOLOGY AND S | OFFICE VISIT(S)<br>07/31/2023<br>In-Network | 240.00   | 217.91                         | 42.20         | 0.00         | 165.17                             | 10.54         | 0.00                     | 175.71               |               |
|                                     | OFFICE LAB/PATH<br>07/31/2023<br>In-Network | 22.00    | 17.13                          | 13.71         | 0.00         | 0.00                               | 3.42          | 0.00                     | 3.42                 |               |
|                                     | <b>Statement Period Total</b>               |          | <b>262.00</b>                  | <b>235.04</b> | <b>55.91</b> | <b>0.00</b>                        | <b>165.17</b> | <b>13.96</b>             | <b>0.00</b>          | <b>179.13</b> |

D

**Comments**

1 HERE'S WHERE YOU'LL FIND COMMENTS ABOUT YOUR CLAIM, IF APPLICABLE.

EE-1510-1-2024