UNDERSTANDING YOUR
EXPLANATION OF BENEFITS (EOB)

Your EOB provides a summary of charges for the care you receive, along with a breakdown of plan payment amounts and amounts due. Remember to save your EOB and compare it to the bill you receive from your provider. This will show you how your claim was paid and whether any amounts are still due to the provider according to the terms of your plan.

Claim#: 0000000
Patient: JOHN DOE
Pat Acct#: 00000000

Provider: MEMORIAL HOSPITAL
Insured: John Doe 000000000
Division: 100

Dates of Services	Procedure Code	(2) Total Charge	(3) Less Reduction	Ineligible Amount	Other Patient Responsibility	Remark Code	(4) Deductible Amount	(5) Copay Amount	(6) Coinsurance Amount	Paid At	Payment Amount
4/27/2020	80053	$281.00	$259.44	$0.00	$0.00	MAA	$0.00	$0.00	$3.23	85%	$18.33
4/27/2020	81003	$96.00	$91.41	$0.00	$0.00	MAA	$0.00	$0.00	$0.69	85%	$3.90
4/27/2020	85025	$166.00	$150.13	$0.00	$0.00	MAA	$0.00	$0.00	$2.38	85%	$13.49
	Column Totals	$543.00	$500.98	$0.00	$0.00		$0.00	$0.00	$6.30		$35.72

(1) **Patient Responsibility.....$6.30**

Other Insurance Credits **$0.00**
Adjusted Payment (7) **$35.72**

Claim Summary

Dates of Services	Patient Name	Amount Billed	Not Covered	Less Reduction	Other Patient Responsibility	(8) Allowed Amount	Deductible Amount	Copay Amount	Payment Amount
4/27/2020	John Doe	$200.00	$160.22	$0.00	$0.00	$39.78	$0.00	$0.00	$35.72

Remark Code Description

(9) MAA — MAXIMUM ALLOWABLE AMOUNT BASED ON PLANS FEE SCHEDULE. PATIENT SHOULD NOT BE RESPONSIBLE FOR AMOUNTS OTHER THAN DEDUCTIBLE, COPAYS AND COINSURANCE.

COMMON REMARK CODE DESCRIPTIONS

DUP = Denied for a Duplicate Claim

NC = Charges not allowed; no coverage under the plan for this service

DVISM = Exceeds policy maximum number of visits under your plan

COB = Coordination of benefits required

ACC = Denied for accident details letter; accident details letter needs to be submitted

1. **Patient Responsibility:** The out-of-pocket amount you owe your provider for this claim.
2. **Total Charges:** The amount your provider bills for the services received.
3. **Less Reduction:** The amounts discounted from this claim based on provider agreements.
4. **Deductible Amount:** The amount of charges paid that apply toward your deductible.
5. **Copay Amount:** The amount charged as a copayment (for applicable services).
6. **Coinsurance Amount:** The percentage-based amount you pay for covered services after your deductible is met.
7. **Adjusted Payment:** The amount your health plan paid on this claim.
8. **Allowed Amount:** The amount your provider will be reimbursed after agreed-upon carrier/network arrangements.
9. **Remark Code Description:** Additional information on claim adjustments.