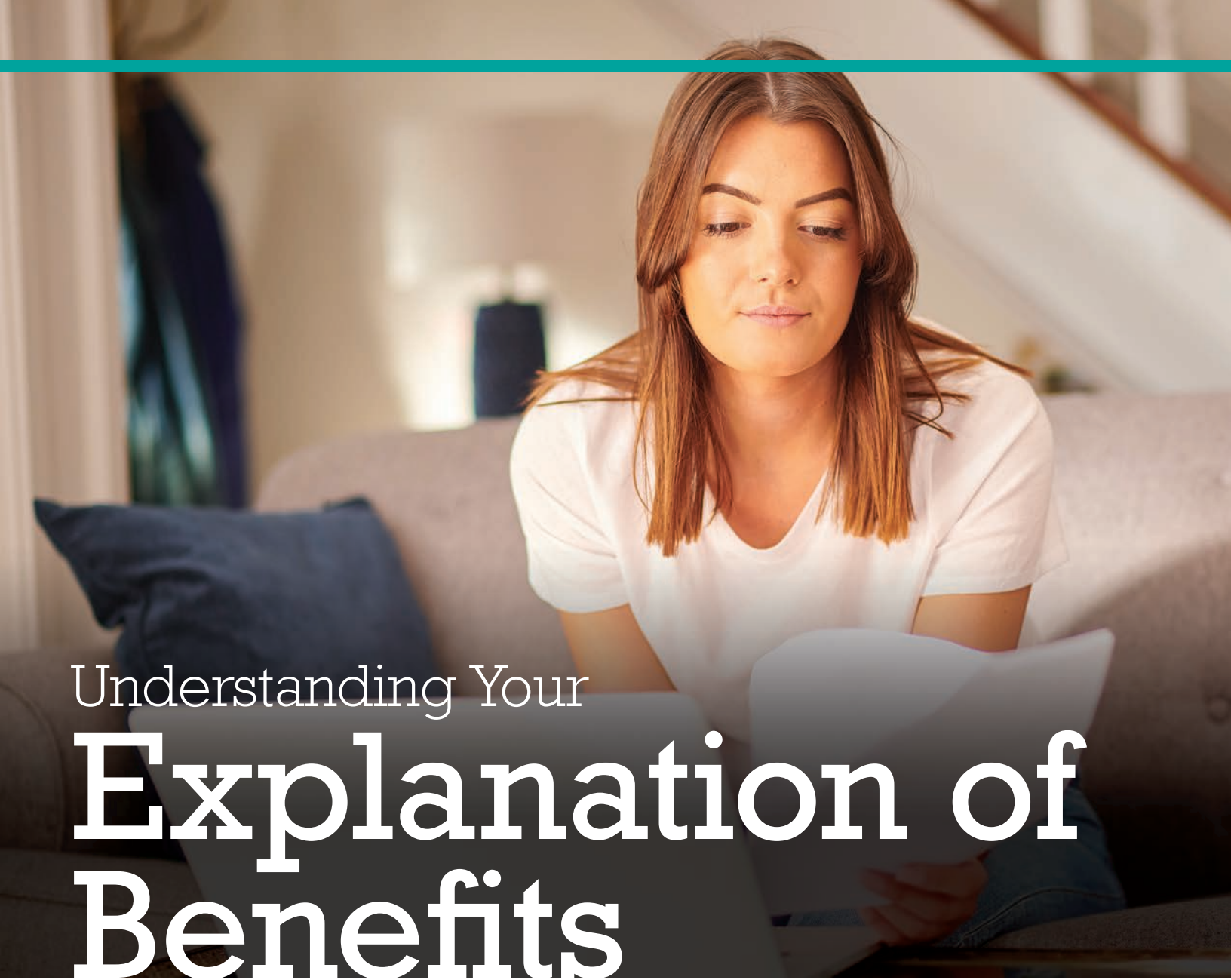


# Explanation of Benefits

A Guide for Members



MEDICAL MUTUAL®



Understanding Your

# Explanation of Benefits

**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.**

# Understanding an EOB

An EOB provides a complete picture of the cost for healthcare services you receive. The EOB is not a bill, and if you owe money for services, your provider will send you a bill directly. These pages show an example of what an EOB looks like.

**Date statement was produced** — November 24, 2025

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

**Policyholder name and address** — JOHN DOE, 123 MAIN STREET, ANYTOWN OH 44000

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

**Your benefits provider** — ABC COMPANY

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

**The network status of your healthcare provider** — In network

**Name of patient** — John Doe

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

Type of service	Amount billed(\$)	Allowed amount(\$)	Benefits paid(\$)	Amount you are responsible for(\$)
<b>Date of Service:</b> October 31, 2025				
X-Ray Exam of Neck/Spine - see note E23	151.01	56.74	0.00	56.74
Office Visit, Mod Complx, 25 Min - see note E23	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>

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

**Amount billed** — The dollar amount billed by your healthcare provider for the service(s) rendered.

**Allowed amount** — The maximum benefit allowable under your health plan.

**Benefits paid** — Amounts paid under your health plan to your healthcare provider.

**Amount you are responsible for** — The amount you owe for the indicated service(s) rendered.

**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.



**YOUR EXPLANATION OF BENEFITS**

November 24, 2025 ID number 987654321097 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 31, 2025 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
<b>Total amount billed</b>	<b>\$2,452.50</b>

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

Check number 6999997 dated November 19, 2025 was sent to Community Hospital.

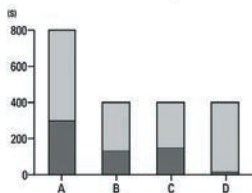
**Note: E69** - For covered charges, your healthcare professional has agreed to accept the allowed amount as payment in full.

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

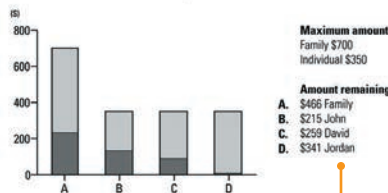
**UPDATE ON YOUR DEDUCTIBLE AND COINSURANCE BALANCES**

Your plan benefit year: January 1, 2025–December 31, 2025

**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 24, 2025.
- 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**



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