How to read your Explanation of Benefits (EOB)

Once your claim has been processed, both you and your provider will receive an Explanation of Benefits.

MyChart: View claims and EOBs

- To view your claims, click on **Your Menu** in the upper left corner of the page.
- Scroll to the **Insurance** section click on **Claims**.
- You will be able to see EOBs for any claims that have completed by, those that have not completed will display a **Processing** message.

Hometown Health

EXPLANATION OF BENEFITS

Member Name Member ID: C00077777 • Group: SCP RENOWN PREFERRED PBP 023 Sent 11/09/21

Claim Information

Reference Number: CLM-1129254

Date: 3/30/21

Provider: Provider Name

Location: 20/20 VISION

Paid to: 20/20 VISION

Total cost of services	110.00
In-plan savings	-1.30
Covered by this plan	-63.70
Total expected cost (7)	45.00

(1) This is not a bill. There is no payment due for these services at this time.

Service Details

Date	Service (2)	(3) Billed	(4) Allowed	(5) Not Covered	(6) Copay	Deductible	Co-Insurance	(8) Reason Code	Patient Total
3/30/21	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30-39 MIN	110.00	110.00	0.00	45.00	0.00	0.00	3	45.00
(9)	**Claim Totals:**	**110.00**	**110.00**	**0.00**	**45.00**	**0.00**	**0.00**		**45.00**

Code Summary

3 - 3-Co-payment Amount

The numbers on the diagram to the left correspond to the numbered explanations below.

1. **An EOB is not a bill.** It is an overview of the total amount the provider charged, paid, and the amount you are responsible for. You may get a bill separately from the provider.

2. **Service** description is an overview of the healthcare services you received, like a medical visit, lab tests, or screenings.

3. **Billed** charges is the amount your provider billed for your visit. Those that have not completed will display a processing message.

4. **Allowed** charges is the amount your provider will be reimbursed based on your plan's benefits and the amount the in-network provider is contracted to be paid. If the provider is not contracted, we allow the same amount Medicare would pay for the same service. This may not be the same as the billed charges.

5. **Not covered** amount is the difference between the billed charges and the allowed charges.

6. **Copay** and **deductible** is the amount you are responsible for according to your plan's benefits. You will see this broken-down service-by-service (line-by-line) in this section.

7. **Total expected cost** is the sum of the deductible, copay, coinsurance and any non covered amounts you are responsible for.

8. **Reason code** is a code that explains more about the costs, charges and paid amounts for your visit.

9. **Code summary** is a note that corresponds with the reason code that explains more about the costs, charges and paid amounts for your visit.

What if I have questions about a bill I received from a medical provider?

We encourage you to first reach out to the provider's office to discuss any denials or charges for which you are responsible. Voicing your questions and concerns directly with your provider may be the most effective way to resolve any issues. You can also ask your provider's office to review the claim to ensure it was appropriately submitted based on the services you received.

If you feel that your concerns were not adequately addressed, or if you would like us to know about your experience, reach out to our customer service team at **775-982-3232** They can help you file a grievance. Our grievance team will investigate all of your concerns by contacting the entity or individual provider directly, and work to develop a solution to ensure your needs are met.