

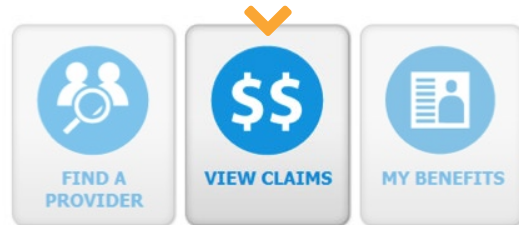
HOW TO FIND YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT

An Explanation of Benefits (EOB) is not a bill. Instead, it explains how your benefits have been applied. It shows what you may owe after your health insurance claim has been processed. You should review it to make sure you received the services for which you are billed.

You may need to use your EOB to get reimbursement from a spending account. You can also use your EOB as a document to confirm that spending account payments are for eligible medical services. To download a copy of your EOB from your member website, log on to highmarkblueshield.com and follow the instructions below.

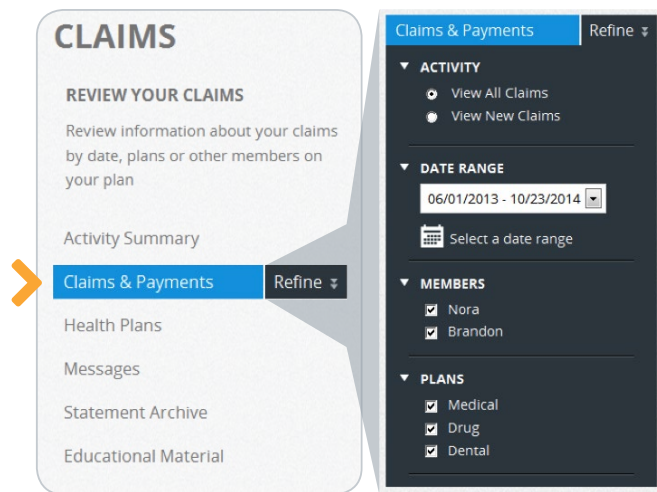
FIND THE EOB ON YOUR MEMBER WEBSITE

- 1 Open the **Claims tab** or the **View Claims** link.

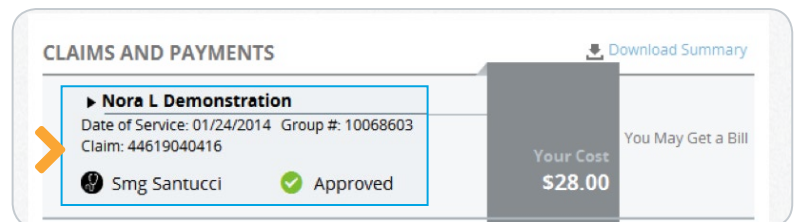


- 2 **Claims Summary Page:** You will see your most recent claims and payments. If you have no claims for the last 60 days, click on the **Claims and Payments** link on the left.

The **Refine** option will let you search for older claims. You can expand the date range to search previous months or years.



- 3 From the list of claims, click on the claim you need. It will expand to provide more details.



- 4 In the expanded claim, use the **EOB download link** at the bottom of the panel to view or save the EOB Statement

CLAIMS AND PAYMENTS [Download Summary](#)

▼ **Nora L Demonstration**
 Date of Service: 01/24/2014 Group #: 10068603
 Claim: 44619040416

Smg Santucci Approved

Your Cost \$28.00 You May Get a Bill

This claim, 44619040416, has 1 service(s)

1

Office/Outpatient Visit	Approved	Provider Charge	\$34.00
Santucci Francesco Md		Member Discounted Rate	\$28.00
01/24/2014		Your Amount Owed for	\$28.00
Procedure Code: 99211		Deductible	
Quantity: 1		Your Total Cost	\$28.00

[Download Claim Details](#) [EOB 05/06/2014](#)

- 5 You can **open or save** the file. If you **save** the file to your computer, you can later submit it to your spending account administrator, print, fax or mail it, or send as an attachment to an email.

File Download

Do you want to open or save this file?

Name: statementDoc.pdf
 Type: Adobe Acrobat Document
 From: www.highmarkblueshield.com

While files from the Internet can be useful, some files can potentially harm your computer. If you do not trust the source, do not open or save this file. [What's the risk?](#)

- 6 **View the EOB.** If you **open** the file, you will see a multi-page PDF. Review it to make sure the information is correct before you submit it. If you have any question about your EOB, call the member service number on the back of your ID card.

HIGHMARK BLUE SHIELD **DUPLICATE** MAY 06, 2014 Page 1 of 2
Explanation of Benefits
 Need Help? Call 1-800-241-5704
THIS IS NOT A BILL

Contract Holder Name: NORA L DEMONSTRATION		EXPLANATION AT A GLANCE	
Member ID: 119724249001		Date of Service: 01/24/14	
Group Name: ABC DEMONSTRATION CO PA GROUP 7		Provider:	
Group ID: 100686-003		SMG SANTUCCI	
Claim Activity PDF: NORA L DEMONSTRATION		An Out-of-Network Provider	
Claim Number: 44619040416		Provider May Bill You	
		(If Not Already Paid):	\$ 28.00

Provider Date of Service Type of Service Service Code (Number of Services)	Provider's Charge	Non-Billable To Member	Member Responsibility		Amount You Owe Provider (Total of Shaded Columns)	See Remarks
			Plan Allowance (Covered Charges)	Your Deductible		
SMG SANTUCCI 01/24/14 OFFICE/OUTPATIENT VISIT 99211 (1)	34.00	6.00 24068	28.00	28.00 X5018	28.00	Q0213
NOVINE	34.00	6.00	28.00	28.00	28.00	

Explanation of Remark Codes:

J0068 - This is the difference between the provider's charge and our allowance. These services were not performed by a network provider, but the provider has agreed to accept the allowance as payment in full for covered services.

Q0213 - These services were not performed by a network provider. This provider has agreed to accept the allowance as payment in full because of a special agreement.

X5018 - The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.

PROGRAM BENEFIT SUMMARY

Benefit Period: 01/01/14 - 12/31/14 Group Number: 100686-003
 You have satisfied \$28.00 of your \$10,000.00 program out of network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

HOW TO READ YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT

An EOB is not a bill. Instead, it explains how your benefits have been applied. It shows what you may owe after your health insurance claim has been processed. You should review it to make sure you received the services that are being billed.



Explanation of Benefits THIS IS NOT A BILL

1	Contract Holder Name: SAMUEL SAMPLE
2	Member ID: 012345678910
	Group Name: ABC CORP.
	Group ID: 123456 789
3	Claim Activity For: SAMUEL SAMPLE
4	Claim Number: 12345678910

EXPLANATION AT A GLANCE	
5	Date of Service: 01/28/14
6	We Sent Payment To: PATHOLOGY PRACTICE A Network Provider
	Claim Payment Amount: \$ 90.00
7	Provider May Bill You (If Not Already Paid) : \$ 7.00

Member Responsibility						
Provider Date of Service Type of Service Service Code (Number of Services)	Provider's Charge	Non-Billable To Member	Plan Allowance (Covered Charges)	Your Deductible	Health Plan Pays	Amount You Owe Provider
8 PATHOLOGY PRACTICE 01/28/14 SURGICAL PATHOLOGY TEST 88305 (2)	284.00	187.00 J4047	97.00	7.00	90.00	7.00
TOTALS	9 284.00	10 187.00	11 97.00	12 7.00	90.00	13 7.00

14	Explanation of Remark Codes
J4047	- This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount.
X5018	- The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.

15	PATIENT BENEFIT SUMMARY
	Patient: SAMUEL SAMPLE Benefit Period: 12/01/13 - 11/30/14 \$500.00 has been applied to your \$1,000.00 individual in network total maximum out-of-pocket amount. \$500.00 has been applied to your \$1,000.00 individual in network out-of-pocket limit. You have satisfied \$500.00 of your \$500.00 individual in network deductible. Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

16	PROGRAM BENEFIT SUMMARY
	Benefit Period: 12/01/13 - 11/30/14 \$500.00 has been applied to your \$2,000.00 program in network total maximum out-of-pocket amount. \$1,350.00 has been applied to your \$2,000.00 program in network out-of-pocket limit. You have satisfied \$1,000.00 of your \$1,000.00 program in network deductible. Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

Please turn this page over for definitions of health insurance terms.

To better understand your EOB and how charges are calculated, here are definitions for terminology used in the statement.

- 1 CONTRACT HOLDER NAME** – the health care coverage is listed under this person's name.
- 2 MEMBER ID** – contract holder's member identification number.
- 3 CLAIM ACTIVITY FOR** – the person who received the services, either the contract holder, a spouse or dependent.
- 4 CLAIM NUMBER** – the system assigns each claim a number for identification purposes.
- 5 DATES OF SERVICE** – the day or days when services were performed.
- 6 WE SENT PAYMENT TO** – health care provider that received payment for services.
- 7 PROVIDER MAY BILL YOU** – what you may owe the provider.
- 8 PROVIDER** – facility or professional providing medical service, such as a hospital or a doctor.
 - A. DATE OF SERVICE** – the day or days when services were performed.
 - B. TYPE OF SERVICE** – surgery, office visit or test, for example.
 - C. SERVICE CODE** – medical billing code to identify what services were performed.
 - D. NUMBER OF SERVICES** – total number of services performed.
- 9 PROVIDER CHARGES** – the amount the provider charged for the services.
- 10 NON-BILLABLE TO MEMBER** – amount that the provider discounts for being in-network and does not charge you.
- 11 PLAN ALLOWANCE (COVERED CHARGES)** – the amount your plan allows as payment. This is the discounted rate you receive.
- 12 DEDUCTIBLE** – the amount that has been applied towards meeting your deductible.
- 13 AMOUNT YOU OWE PROVIDER (TOTAL OF SHADED COLUMNS)** – the total amount you owe, including any deductible, coinsurance or copayment amounts.
- 14 EXPLANATION OF REMARK CODES** – these codes explain why payments are approved or denied.
- 15 PATIENT BENEFIT SUMMARY** – summarizes a single patient's coverage within a benefit period.
 - A. INDIVIDUAL IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET AMOUNT** – the most you pay during a benefit period **including** deductibles, copayments and coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services.
 - B. INDIVIDUAL IN-NETWORK OUT-OF-POCKET LIMIT** – the most you pay during a benefit period, **excluding** copayments and deductibles. This amount generally includes only coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services. You may still be responsible for copayments or to fulfill the deductible.
 - C. INDIVIDUAL IN-NETWORK DEDUCTIBLE** – the amount you pay during a benefit period before your health plan begins to pay anything.
- 16 PROGRAM BENEFIT SUMMARY** – similar to the Patient Benefit Summary (#15), these amounts are added together to summarize all family members' coverage within a benefit period.
 - A. INDIVIDUAL IN-NETWORK TOTAL MAXIMUM OUT-OF-POCKET AMOUNT** – the most you pay during a benefit period **including** deductibles, copayments and coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services.
 - B. INDIVIDUAL IN-NETWORK OUT-OF-POCKET LIMIT** – the most you pay during a benefit period, **excluding** copayments and deductibles. This amount generally includes only coinsurance. Once this amount is reached, the health plan pays 100% of the allowed amount for covered services. You may still be responsible for copayments or to fulfill the deductible.
 - C. INDIVIDUAL IN-NETWORK DEDUCTIBLE** – the amount you pay during a benefit period before your health plan begins to pay anything.



If you suspect fraud or abuse involving your health insurance, please call the toll-free fraud or abuse hotline at 1-800-438-2478.