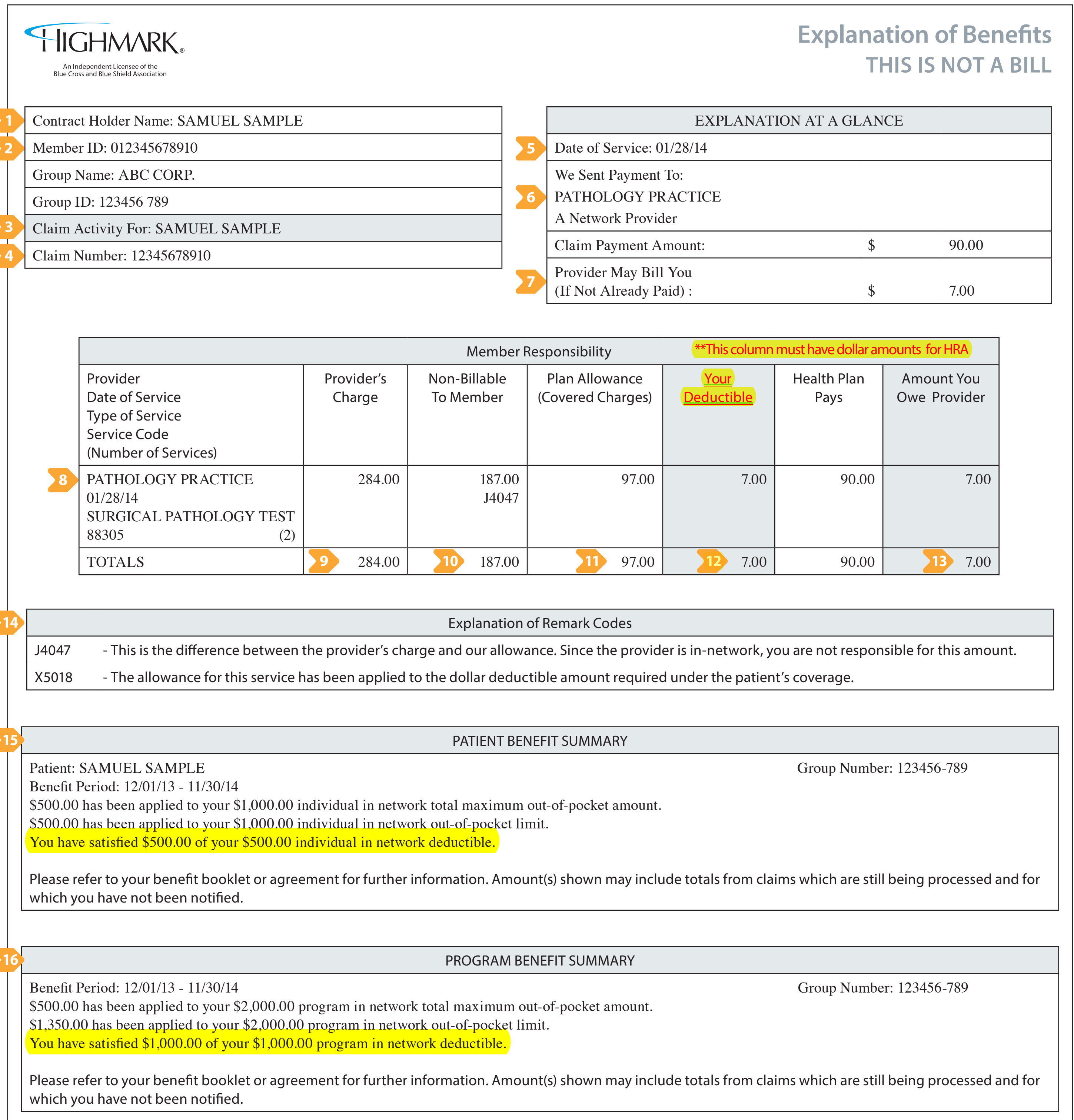
HOW TO READ YOUR

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.



HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

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	**This column must have dollar amounts for HRA		
	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 — Group Number: 123456-789
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 — Group Number: 123456-789
$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.

Highmark is a registered mark of Highmark Inc. 4/14

CS 105943

HIGHMARK®

HIGHMARK.COM