


How to Read your Explanation of Benefits

You may receive an Explanation of Benefits (EOB) each time we process a medical claim. **The EOB is not a bill.** It is a document that explains health care services you received, how much is covered by your health insurance and any balance you may be responsible to pay your provider. Refer to your Benefit Summary or Plan Contract for information about your medical benefits.

- 1** Name of the main person (subscriber) for your health insurance policy.
- 2** Summary of patient information. We may ask for your claim number if you contact us by phone.
- 3** The **EOB is not a bill** or a request for payment. You will receive a separate bill from your provider for any amounts you may be responsible to pay.
- 4** **Provider Name:** The name of the provider or facility that provided health care services.
- 5** **Service Date:** The date(s) you received a health care service from this provider or facility.
- 6** **Type of Service:** A general description of the service(s) you received.
- 7** **Amount Charged:** The amount your provider has billed your health insurance for each service.
- 8** **Amount Allowed:** The amount that your health insurance allows for each service billed.
- 9** **Amount Not Covered:** The portion of the claim that is not covered by your health insurance.
- 10** **Remarks:** Additional messages that may explain how your claim was processed in a footnote below.
- 11** **Deductible:** Based on your claim and specific benefit coverage, this is the amount that has been applied to your deductible.
- 12** **Copay/Coinsurance:** This is the copay or coinsurance amount you must pay, after your deductible has been applied. Copay is a fixed dollar amount, coinsurance is a percentage of the allowed amount.
- 13** **Amount Paid:** The amount your health insurance will pay the provider for services you received.
- 14** **Member Responsibility:** The amount you owe the provider. Your provider will bill you separately. Do not send money to Providence Health Plan.
- 15** These boxes will display any **amounts applied to your deductible and/or out-of-pocket maximum.** This information varies by plan type and may not appear on all EOBs.

 P.O. Box 4327 Portland, Oregon 97208-4327							
Forwarding Service Requested 							
JOE PROVIDENCE 1234 ANYPLACE DRIVE PORTLAND, OR 97222							
<div><div>02/15/2012 Patient Name: JOE PROVIDENCE Group Number: 112345 Claim Number: 000100999100 Patient ID Number: 100100001-00</div></div>							
EXPLANATION OF BENEFITS							
Below is an explanation of your benefits with Providence Health Plan.							
THIS IS NOT A BILL							
Please do not send money to Providence Health Plan. Send an money owed to the provider of service.							
PROVIDER NAME: PROVIDENCE, JANE							
5	6	7	8	9	10	11	12
Service Date	Type of Service	Amount Charged	Amount Allowed	Amt Not Covered	Remark	Deduct	Copay / Coinsurance
2/5/2012	Consultation	\$135.00	\$87.75	\$47.25	XCO	\$0.00	\$20.00
2/5/2012	Surgery	\$680.00	\$395.85	\$284.15	XCO	\$395.85	\$0.00
<div><div>13 Amount Paid by Plan: \$67.75</div><div>14 Member Responsibility: \$415.85</div></div>							
Remark Explanation(s): XCO - Amount not covered is provider writeoff for eligible services							
\$395.85 applied to your individual annual Deductible \$2,000.00							
>>PLEASE KEEP A COPY OF THIS DOCUMENT FOR YOUR RECORDS<<							