How to read your Explanation of Benefits (EOB)

Helpful definitions – see your *Evidence of Coverage* for additional information

1. Patient responsibility
The amount you are responsible to pay the provider. It consists of deductible, copayment/coinsurance, and non-covered amounts

2. Network savings
The amount you saved by using a Blue Shield network provider.

3. Service date
The day or dates the patient received services.

4. Amount billed
The amount your provider billed for the services you received.

5. Amount allowed
The amount used to calculate your benefits for the services provided.

6. Amount we paid
The amount we paid to your provider or you.

7. Non-covered
The portion of the amount billed not covered by your plan. You are responsible for this amount.

8. Deductible
The dollar amount that you must pay for covered services each year before we start paying benefits under your plan. You are responsible for this amount.

9. Copayment/coinsurance
The predetermined amount (copayment) for which you are responsible or a percentage of the cost (coinsurance) for which you are responsible, based on your plan benefits. You are responsible for this amount.

Sample EOB

Blue Shield of California
PO Box 272560
Chico, CA 95627-2560

Blue Shield of California
An Independent Member of the Blue Shield Association

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90 FP 1 B 1 1 A 10061 10061 **5 DGT

ROBIN SMITH
12345 1ST STREET
SACRAMENTO, CA 95819

EXPLANATION OF BENEFITS

This is NOT a Bill
Retain for your records along with any provider bills.

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of **www.mylifepath.com**. If you have any questions about this document or your benefits, please call us at **(800) 200-3242**.

CLAIM SUMMARY AT A GLANCE

Patient Name: TAYLOR SMITH | Subscriber ID: J23456789-0000 | Claim Number: 12345678900000

1 **Patient responsibility:** **$38.25**
(Amount you paid or owe to provider.)
Amount we paid: $74.00

2 **Network savings:** **$15.75**
(Amount saved by using a network provider.)
Amount billed by Provider: $128.00

Your claim was received 05/27/04 and processed in 8 days.
We paid LABORATORY CORP OF AMERICA HOL

Deductible Status
As of 06/06/04, TAYLOR SMITH has met $38.25 of the $500.00 annual deductible for 2004.

3 4 5 6 7 8 9

Provider: LABORATORY CORP OF AMERICA HO
Preferred Provider: YES

Service Date	Type of Service and Procedure Number	Amount Billed (Provider billed for services)	Amount Allowed (Preferred providers accept as payment)	Amount We Paid	Patient Responsibility: Non Covered	Patient Responsibility: Deductible (You pay provider before we begin payments)	Patient Responsibility: Copayment/ Coinsurance	Notes
05/08/04	OUTPT LABORATORY 80053	35.00	35.00	35.00	0.00	0.00	0.00	
05/10/04	OFFICE MEDICAL 84436	14.00	9.50	0.00	0.00	9.50	0.00	1

A35372 (11/08)

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