1 **Explanation of Benefits (EOB) -** A claims statement that is sent whenever you use your health plan for services or products from a healthcare provider. It shows how your benefits cover the cost of a service from your provider and what you owe. The EOB is not a bill.

2 **Service/Product -** The type of services or products you received from your provider.

3 **Dates of Service -** The date(s) you received service.

4 **Amount Billed -** The full amount billed by your provider to your health plan.

5 **Your Plan Discounts & Payments -** This section details the amounts that you do not need to pay.

6 **Premera Network Discount -** The amount you save by using a provider that belongs to a Premera network. Premera negotiates lower rates with its in-network providers to help you save money. This amount may not be itemized and may only show in the Totals row of the Claim Detail.

7 **Amount Paid By Your Health Plan -** The portion of the charges eligible for benefits minus your copay, deductible, coinsurance, network discount and amount paid by another source up to the billed amount.

8 **Amount Paid By Another Source -** Examples of other sources include: a health funding account, other health insurance, automobile insurance, homeowners' insurance, disability insurance, etc. This amount may not be itemized and may only show in the Totals row of the Claim Detail.

9 **Copay -** A set amount you pay for certain covered services such as office visits or prescriptions. Copays are usually paid at the time of service.

10 **Deductible -** Your deductible is the amount you need to pay each year for covered services before your plan starts paying benefits.

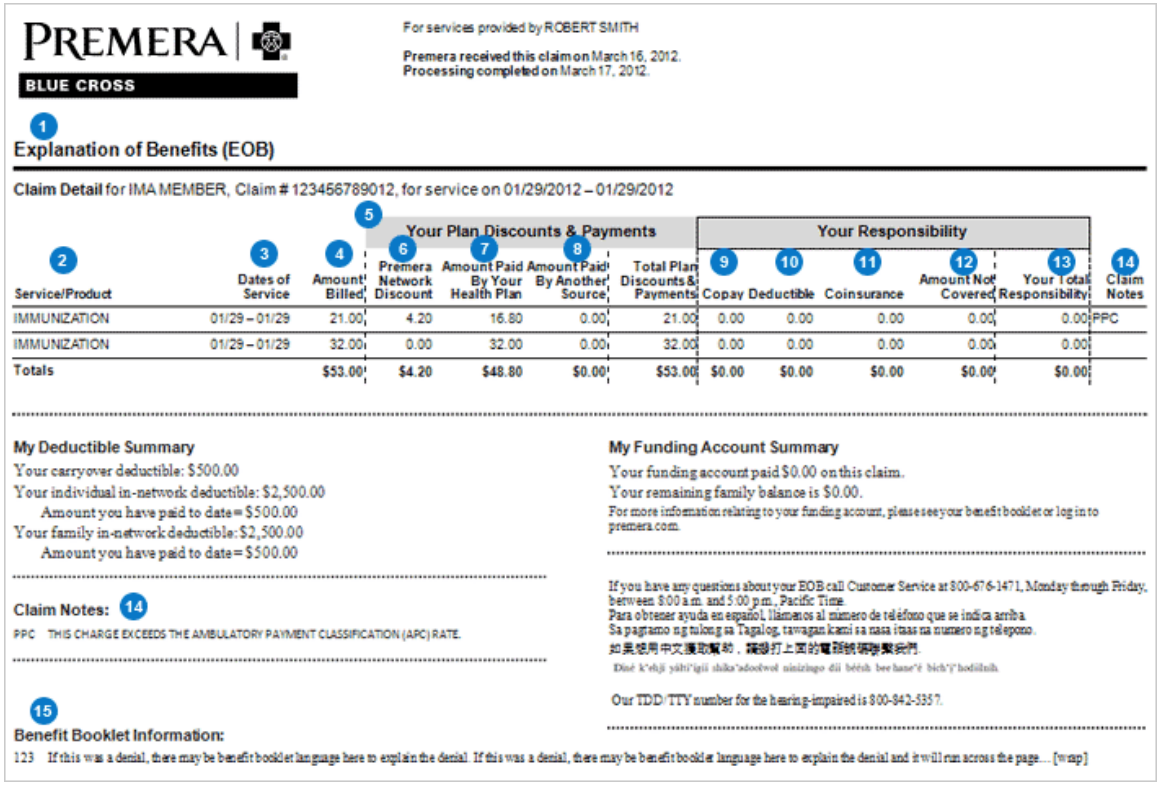
11 **Coinsurance -** A percentage of covered expenses that you pay after you meet your deductible.

12 **Amount Not Covered -** The portion of the amount billed that was not covered or eligible for payment under your plan. Examples include charges for services or products that are not covered by your plan, duplicate claims that are not your responsibility, amount related to not getting a prior authorization for service, and any charges submitted that are above the maximum amount your plan pays for out-of-network care.

13 **Your Total Responsibility -** This section details the portion of the bill that is your responsibility to pay. This amount might include your copay, deductible, coinsurance, any amount over the maximum reimbursable charge, or products/services not covered by your plan. If you received payment intended for a provider, it is your responsibility to pay the provider.

14 **Claim Notes -** When present, these notes provide general information about the claim and may also provide specific explanation of activity that occurred in the Amount Not Covered, Amount Paid by Another Source, and What Your Plan Paid fields. For example, if the claim was denied because your provider submitted the same claim twice, a note would tell you that we denied the claim as a duplicate.

Benefit Booklet Information - If applicable, contains information about why portions of a claim were denied.



PREMERA BLUE CROSS

For services provided by ROBERT SMITH

Premera received this claim on March 16, 2012.
Processing completed on March 17, 2012.

1 **Explanation of Benefits (EOB)**

Claim Detail for IMA MEMBER, Claim # 123456789012, for service on 01/29/2012 – 01/29/2012

			5 Your Plan Discounts & Payments				Your Responsibility					
2 Service/Product	3 Dates of Service	4 Amount Billed	6 Premera Network Discount	7 Amount Paid By Your Health Plan	8 Amount Paid By Another Source	Total Plan Discounts & Payments	9 Copay	10 Deductible	11 Coinsurance	12 Amount Not Covered	13 Your Total Responsibility	14 Claim Notes
IMMUNIZATION	01/29 – 01/29	21.00	4.20	16.80	0.00	21.00	0.00	0.00	0.00	0.00	0.00	PPC
IMMUNIZATION	01/29 – 01/29	32.00	0.00	32.00	0.00	32.00	0.00	0.00	0.00	0.00	0.00	
Totals		**$53.00**	**$4.20**	**$48.80**	**$0.00**	**$53.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

My Deductible Summary

Your carryover deductible: $500.00
Your individual in-network deductible: $2,500.00
Amount you have paid to date = $500.00
Your family in-network deductible: $2,500.00
Amount you have paid to date = $500.00

Claim Notes: 14

PPC THIS CHARGE EXCEEDS THE AMBULATORY PAYMENT CLASSIFICATION (APC) RATE.

My Funding Account Summary

Your funding account paid $0.00 on this claim.
Your remaining family balance is $0.00.
For more information relating to your funding account, please see your benefit booklet or log in to premera.com.

If you have any questions about your EOB call Customer Service at 800-676-1471, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Pacific Time.
Para obtener ayuda en español, llámenos al número de teléfono que se indica arriba.
Sa pagtamo ng tulong sa Tagalog, tawagan kami sa nasa itaas na numero ng telepono.
如果您用中文獲取幫助，請撥打上面的電話號碼聯繫我們.
Díné k'ehjí yáhí'ígíí shika'adoołwol nínízingo díí béésh bee hane'é bich'į' hodíilnih.

Our TDD/TTY number for the hearing-impaired is 800-842-5357.

15 **Benefit Booklet Information:**

123 If this was a denial, there may be benefit booklet language here to explain the denial. If this was a denial, there may be benefit booklet language here to explain the denial and it will run across the page.... [wrap]