How to read an Explanation of Benefits (EOB)

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

This is not a bill

1 Explanation of Benefits (EOB)

Claim summary for Terry Smith
Claim # 1234567890

For services on 6/20/2023 – 7/30/2023

For services provided by
Jones, Jo

Premera received this claim on
August 3, 2023

Processing completed on
August 10, 2023

Your total responsibility
$100.00

Pay your provider directly at the time of care or when you receive a bill.

2 Service/Product	3 Dates of service	4 Amount billed	5 YOUR PLAN DISCOUNTS & PAYMENTS: Premera network discount	Amount paid by your health plan	Amount from another source	Total plan discounts and payments	13 YOUR TOTAL RESPONSIBILITY: Copay	Deductible	Coinsurance	Amount not covered	Your total responsibility	14 Claim notes
Office visit	6/20/21	$20.00	$0.00 (6)	$0.00 (7)	$0.00 (8)	$20.00	$0.00 (9)	$0.00 (10)	$0.00 (11)	$0.00 (12)	$0.00	S9*
Hand surgery	7/15/21	$400.00	$200.00	$100.00	$0.00	$300.00	$0.00	$0.00	$100.00	$0.00	$100.00	S9*
Office visit	7/30/21	$20.00	$20.00	$0.00	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	
Totals		**$440.00**	$240.00	$100.00	**$0.00**	**$340.00**	$0.00	$0.00	$100.00	$0.00	**$100.00**	

14 Claim notes

S9* The member's coverage wasn't in effect on the date services were provided.

Please keep in mind

- **Go paperless.** To receive your EOBs by email, visit **premera.com**.
- Use the "Find a Doctor" tool to find an in-network provider.
- You should always ask your provider to check with Premera before scheduling a medical procedure.
- We welcome your feedback at **premeralistens.com**.

15 Benefit booklet information

If this was a denial, there may be benefit booklet language here to explain the denial.

Safeguarding your personal information is very important to Premera. If you believe you have been deceived to provide personal information to an unknown party or would like resources on how you can protect yourself from fraud and email scams such as "phishing," see our Fraud and Abuse page on **premera.com**.

1 **Explanation of Benefits** – This is 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** – This relates to the types of services or products you received from your provider.

3 **Dates of service** – This is the date(s) you received the service.

4 **Amount billed** – This is the full amount billed by your provider to your health plan.

5 **Your plan discounts and payments** – This section details the amounts that you do not need to pay.

6 **Premera network discount** – This is 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 save you 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** – This outlines 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 from another source** – Examples of other sources include a health funding account, other health insurance, automobile insurance, homeowner's insurance, disability insurance, etc. This amount may not be itemized and may only show in the totals row of the claim detail.

9 **Copay** – Your copay is the 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** – This is the percentage of covered expenses that you pay after you meet your deductible.

12 **Amount not covered** – This outlines any portion of the amount billed that was not covered or eligible for payment under your plan. Examples include charges for services or products that aren't covered by your plan; duplicate claims that aren't your responsibility; amount related to not getting a pre-approval 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.

15 **Benefit booklet information** – If applicable, this contains information about why portions of a claim were denied.

16 **Provider responsibility** – If applicable, this is an amount that the provider can't bill you for, per the WA Balance Billing Protection Act.

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