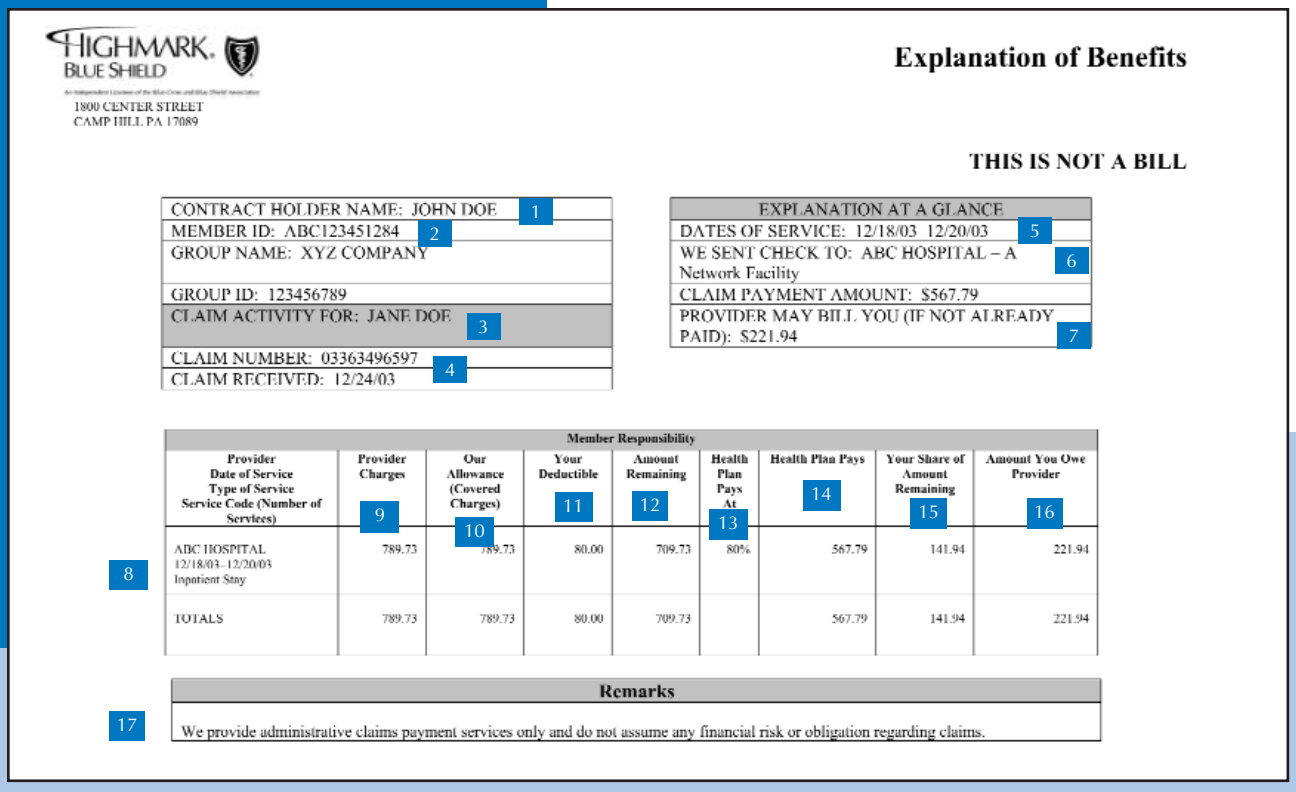
HOW TO READ YOUR Explanation of Benefits Statement

Below is a sample Explanation of Benefits (EOB) Statement. This is the information you will receive after your benefits claim has been processed. In order to understand this example, match the field number on the EOB to the corresponding number shown in the following narrative.



HIGHMARK. BLUE SHIELD
1800 CENTER STREET
CAMP HILL PA 17089

Explanation of Benefits

THIS IS NOT A BILL

CONTRACT HOLDER NAME: JOHN DOE 1
MEMBER ID: ABC123451284 2
GROUP NAME: XYZ COMPANY
GROUP ID: 123456789
CLAIM ACTIVITY FOR: JANE DOE 3
CLAIM NUMBER: 03363496597
CLAIM RECEIVED: 12/24/03 4

EXPLANATION AT A GLANCE
DATES OF SERVICE: 12/18/03 12/20/03 5
WE SENT CHECK TO: ABC HOSPITAL – A Network Facility 6
CLAIM PAYMENT AMOUNT: $567.79
PROVIDER MAY BILL YOU (IF NOT ALREADY PAID): $221.94 7

Member Responsibility

Provider Date of Service Type of Service Service Code (Number of Services)	Provider Charges 9	Our Allowance (Covered Charges) 10	Your Deductible 11	Amount Remaining 12	Health Plan Pays At 13	Health Plan Pays 14	Your Share of Amount Remaining 15	Amount You Owe Provider 16
8 ABC HOSPITAL 12/18/03–12/20/03 Inpatient Stay	789.73	789.73	80.00	709.73	80%	567.79	141.94	221.94
TOTALS	789.73	789.73	80.00	709.73		567.79	141.94	221.94

Remarks
17 We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

1 **Contract Holder Name** – individual who holds the contract. (Usually the employee, for company sponsored benefit plans.)

2 **Member ID** – employee's member identification number. (This is the identification number listed on your medical identification card.)

3 **Claim Activity For** – name of the individual who received the services. (If claims for multiple family members are processed during the same period, each patient will have a separate page.)

4 **Claim Number** – number assigned by the computer for identification purposes.

5 **Dates of Service** – date range this EOB contains information for.

6 **We Sent Check to** – individual/facility who reimbursement was sent to. (If you receive services from a participating provider, reimbursement will be sent directly to the provider. If you receive services from a non-participating provider, your reimbursement check will be sent to you.)

7 **Provider May Bill You** – summary of what you owe the provider. The individual breakdown is shown in the Member Responsibility chart.

8 **Provider** – provider's name. (A provider is a facility or professional performing or supplying the services.)
Date of Service – date of service(s) performed or supplied.
Type of Service – e.g. surgery, office visit, etc.
Service Code – code to identify what services were performed.

9 **Provider Charges** – the amount the provider actually charged for the services.

10 **Our Allowance** – amount covered under your program. (If you use a provider that participates with Highmark, they must accept "Our Allowance" as payment in full and cannot bill you for the difference between the "Provider Charges" and "Our Allowance.")

11 **Your Deductible** – the amount that was applied to your program's deductible.

12 **Amount Remaining** – amount remaining after your deductible has been subtracted from the Allowance.

13 **Health Plan Pays At** – percentage that your program pays after any deductible, coinsurance or copayment amounts have been met. For example, if you have an 80/20 program, your program pays 80% and you are responsible for the other 20%.

14 **Health Plan Pays** – the actual dollar calculation of the amount the health plan pays. (ie. "Health Plan Pays at" percentage multiplied by "Amount Remaining" or, 80% x $709.73)

15 **Your Share of Amount Remaining** – the amount remaining after your program's payment has been subtracted. (ie. "Amount Remaining" minus "Health Plan Pays at," or $709.73 – $567.79)

16 **Amount You Owe Provider** – the total of all of your responsibilities. This includes any deductible, coinsurance or copayment amounts plus your share of the remaining amount.

17 **Remarks** – explains why certain charges were not covered.

If you suspect fraud or abuse involving your health insurance, please call the toll-free fraud or abuse hotline at 1-800-438-2478.