




# How to Read Your Explanation of Benefits (EOB)

The explanation of benefits (EOB) explains the costs for services you received. This includes what the provider billed for, what Highmark paid for, and what you will need to pay. When you get a bill, you can compare it to the EOB to make sure everything looks correct. It's a summary of the charges and payments related to your medical care. It's not a bill. We provide this summary to help you understand how your plan covered the services you received, according to your benefits.

- You can see how much we have paid and how much you have paid or can expect to pay.
- If you owe anything, your doctors and other health care providers will send you a bill.

## Sample EOB Statement\*



**2** Member ID  
012345678910

Group Name  
Guidestone

Group ID  
ABC123

Print Date  
XX/XX/XX

Page  
1

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### About your explanation of benefits:

**1** Hello, John Doe.

Your **explanation of benefits** (EOB) is a summary of the charges and payments related to your medical care. It's not a bill. We provide this summary to help you understand how your health plan covered the services you received, according to your benefits.

- You can see how much we have paid your providers and how much you can expect to pay.
- If you owe anything, your doctors and other health care providers will send you a bill.

If you have no issues with your EOB, you can feel free to discard it. If something comes up in the future, you can always access it online.

We value you as a member and are always here to help. If you need us, contact us using one of the methods on the right. »

**3** Charges and payments processed from:  
02/01/23 to 02/28/23

**4** Easy ways to get answers to your questions

Visit [HighmarkAnswers.com](#) or scan the QR code to:

- Access helpful info.
- Sign up to go paperless.
- Live chat at [MyHighmark.com](#)
- Call Member Service at:  
1-800-329-2792 (TTY/TDD: 711)  
Monday – Friday, 8 a.m. – 8 p.m. EST

Free aids and services are available to people with difficulties communicating.

Free language interpreter services are available for non-english speakers.

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

## Title Page

- 1 MEMBER NAME**
- 2 MEMBER ID**  
Member identification number. (This is the identification number listed on your medical ID card.)
- 3 CLAIM DATE RANGE**  
Date range this EOB contains information for.
- 4 HELPFUL RESOURCES**  
QR code to EOB FAQs website and Member Service number to call with questions.

*\*Sample EOB images are for illustrative purposes only and your EOB may vary.*

## Claims Summary Page

### Explanation of benefits summary:

Date(s) of Service: 02/23/23  
Plan Holder: John Doe  
Charges and payments for: John Doe

\$	THIS IS NOT A BILL
<b>Your Health Plan's Price</b> The Total Provider Charges on your claims were: <b>\$140.00</b> . Your provider has agreed to accept our negotiated price, as shown in <b>Your Health Plan's Price</b> in the next column.	<b>Total Your Plan Paid</b> <b>Your Total Responsibility</b> <b>The remaining balance after paid claims were processed. Details on next page.</b>
<b>\$85.70</b> The total price your plan allows for a covered service.	<b>\$60.70</b> The amount your plan covered for health care services.
<b>\$25.00</b> The remaining balance after paid claims were processed. Details on next page.	

**What's next?** This is not a bill. The remaining balance is what we expect your provider will bill you. Contact your provider for questions about payment options. If you already paid, there's nothing to do. If you get a bill that is higher than the amount shown for **Your Total Responsibility**, contact Member Service.

**Review the information about your claims to see if it seems to be correct:**

If you have questions or think there might be a mistake, start by calling the doctor's office or other service provider. Ask them to explain the claim. If you still have questions, contact Member Service.

**You have the right to make an appeal or complaint:**

Making an appeal is a formal way of asking us to change our decision about your coverage. You can make an appeal if we deny a claim or if we approve a claim but you disagree with how much you are paying for the item or services.

- DATE(S) OF SERVICE**  
Date range of services this EOB contains information for.
- PLAN HOLDER**  
Individual who holds the contract.
- CHARGES AND PAYMENTS FOR**  
Name of the individual who received the services listed in this EOB.
- WHAT'S NEXT?**  
Explains what your next steps should be.

## Claims Details Page

Includes a more detailed breakdown of the claim charges and payment details:

### Charge and payment details:

MEMBER: Amy Richmond

Date(s) of Service: XX/XX/XX - XX/XX/XX

Provider: Billing Provider

Network: Network Type

Claim # 21165324399

Provider Specialty (XXX) XXX-XXXX

11

	12 Provider Charges	Your Health Plan's Price	Your Plan Paid	Other Insurance Pays	Your Responsibility	Notes
SERVICE:	\$10,002.00	\$3,670.86	\$0.00	\$3,670.86	\$0.00	
Emergency Room	\$2,238.00	\$881.78	\$0.00	\$881.78	\$0.00	1
Procedure code XXXXX						2
Pharmacy	\$16.00	\$0.00	\$0.00	\$0.00	\$0.00	2
Procedure code XXXXX						1
CAT Scan	\$3,536.00	\$1,272.87	\$0.00	\$1,272.87	\$0.00	3
Procedure code XXXXX						1
Laboratory	\$4,212.00	\$1,516.21	\$0.00	\$1,516.21	\$0.00	1
Procedure code XXXXX						2

- PROVIDER**  
Provider name and information.  
(A provider is a facility or professional performing or supplying services.)
- SERVICE**  
Includes information on type of service.
- CLAIM #**  
Number assigned to claim for identification purposes.  
(A claim is the request for payment that's sent to your insurance company after you receive care.)
- PROVIDER CHARGES**  
The amount your provider charged for a service to your health plan. This is the total price for the service or procedure before insurance is applied.

## Charge and payment details:

MEMBER:		Amy Richmond							
Date(s) of Service:	XX/XX/XX - XX/XX/XX			Claim # 21165324399					
Provider:	Billing Provider			Provider Specialty					
Network:	Network Type			XX-XX					
				13	14	15	16	17	18
		Provider Charged	Your Health Plan's Price	Your Plan Paid	Your Coinsurance	Not Covered	Your Responsibility	Notes	
SERVICE:		\$339.57	\$94.36	\$0.13	\$18.99	\$260.30	\$279.29	1	
Laboratory		\$81.75	\$21.60	\$0.13	\$4.32	\$17.15	\$21.47	1	
Procedure code XXXXX				=80%	=20%				
Medical Equipment		\$257.82	\$73.36	\$0.00	\$14.67	\$243.15	\$257.82	1	
Procedure code XXXXX				=80%	=20%				
Notes:								Reason Code	
1	You pay 20% of the total amount for services from an in-network provider.						XXXXX		

## Claims Details Page

13

### YOUR HEALTH PLAN'S PRICE

The price for the service after your insurance was applied. Your plan negotiated with your provider to give you a discounted rate.

14

### YOUR PLAN PAID

The amount your plan covered for health care services received.

15

### YOUR COINSURANCE

The percentage you may owe for certain covered services.

16

### NOT COVERED

The amount for health care services that are not covered by your health plan.

17

### YOUR RESPONSIBILITY

The provider will bill you for this amount.

18

### NOTES

Explains why certain charges were not covered.

## 19 Individual plan progress:

Benefit Period: 08/03/22 – 08/04/22

Member(s): John Doe  
 \$146.71 has been applied to your \$1,400.00 individual in-network out-of-pocket limit.  
**Placeholder Dependent 1**  
 \$0.00 has been applied to your \$1,400.00 individual in-network out-of-pocket limit.  
**Placeholder Dependent 2**  
 \$0.00 has been applied to your \$0,000.00 individual in-network out-of-pocket limit.

## Family plan progress:

Benefit Period: 08/03/22 – 08/04/22  
 \$863.48 has been applied to your \$2,800.00 family in-network out-of-pocket limit.

19

## PLAN PROGRESS PAGE

Includes a breakdown to help you track plan progress such as your deductible.



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