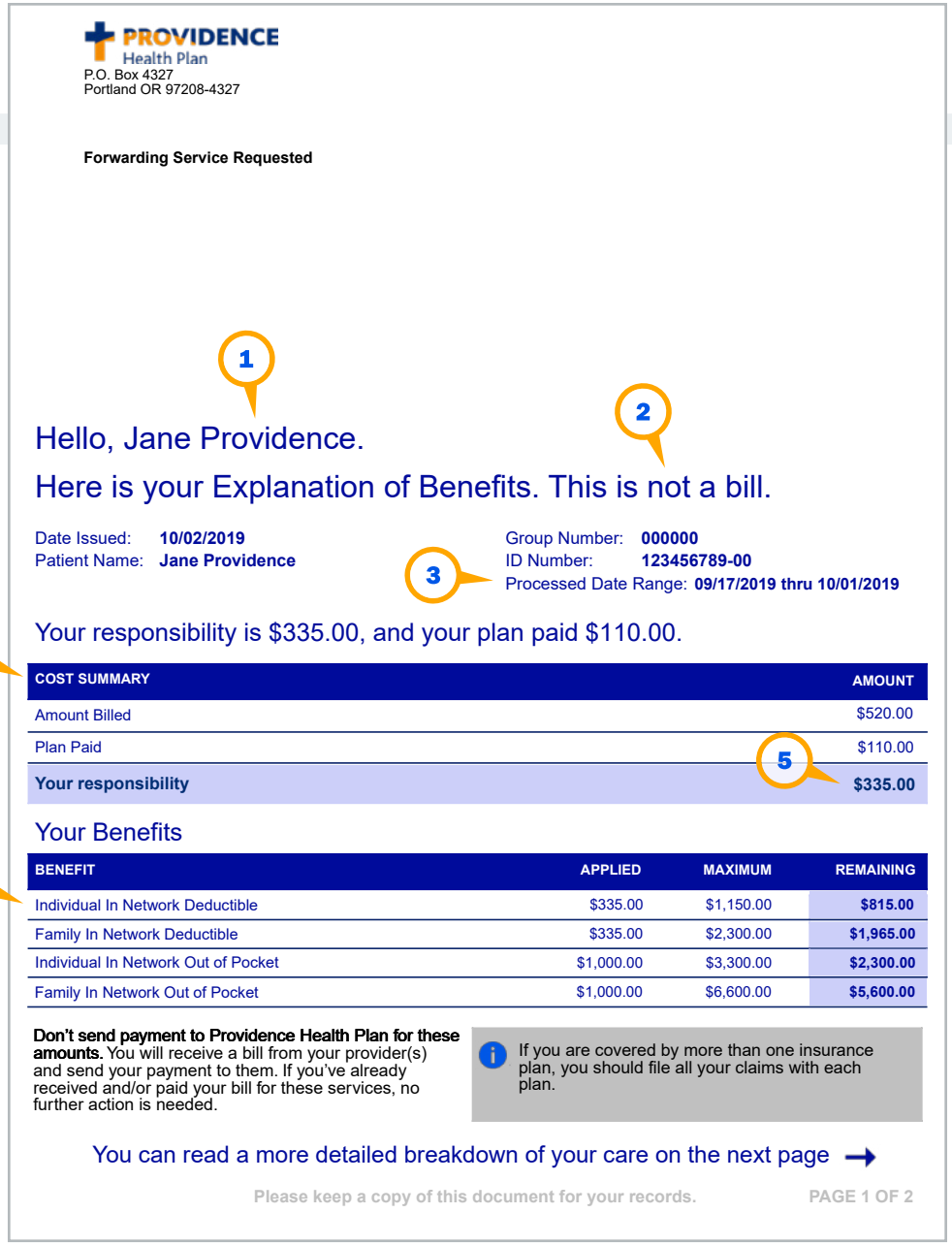
PROVIDENCE
Health Plan

How to Read your Explanation of Benefits

You will receive an Explanation of Benefits (EOB) each time we process a medical claim. The EOB is definitely *not* a bill— it's a document that lists the claims processed for health care services you've received, how much is covered by your health insurance and any balances you may be responsible for paying to your provider.

> Information about your medical benefits can be found in your benefit summary and member contract/handbook.

1. **Member:** The name of the person the claims were processed under.
2. **This is not a bill** or a request for payment. You may receive a separate bill from your provider for any amount you may be responsible to pay.
3. **Processed Date Range:** Includes all claims processed within this timeframe.
4. **Cost Summary:** A high-level view of all claims processed within this timeframe, including what was charged, what's been paid by your health insurance and the balance you may be responsible for paying.
5. **Your responsibility:** The amount you may be billed by your provider(s) for the claims listed in your EOB. Remember, this is not a bill. The EOB shows you a breakdown of what has and has not been covered by your plan.
6. **Maximums:** Any amounts applied to your deductible and/or out-of-pocket maximum (the amount you pay after meeting your deductible), and the amount remaining for the year.



PROVIDENCE Health Plan
P.O. Box 4327
Portland OR 97208-4327

Forwarding Service Requested

1

Hello, Jane Providence.

2

Here is your Explanation of Benefits. This is not a bill.

Date Issued: **10/02/2019**
Patient Name: **Jane Providence**

3

Group Number: **000000**
ID Number: **123456789-00**
Processed Date Range: **09/17/2019 thru 10/01/2019**

Your responsibility is $335.00, and your plan paid $110.00.

4

COST SUMMARY	AMOUNT
Amount Billed	$520.00
Plan Paid	$110.00
Your responsibility	**$335.00**

5

Your Benefits

6

BENEFIT	APPLIED	MAXIMUM	REMAINING
Individual In Network Deductible	$335.00	$1,150.00	**$815.00**
Family In Network Deductible	$335.00	$2,300.00	**$1,965.00**
Individual In Network Out of Pocket	$1,000.00	$3,300.00	**$2,300.00**
Family In Network Out of Pocket	$1,000.00	$6,600.00	**$5,600.00**

Don't send payment to Providence Health Plan for these amounts. You will receive a bill from your provider(s) and send your payment to them. If you've already received and/or paid your bill for these services, no further action is needed.

If you are covered by more than one insurance plan, you should file all your claims with each plan.

You can read a more detailed breakdown of your care on the next page →

Please keep a copy of this document for your records. PAGE 1 OF 2

7. **Claim #:** If you contact us by phone, we may ask for your claim number, which can be found here above each claim table.

8. **Provider Name:** The name of the provider or facility listed on the claim.

9. **Service Date:** The date(s) you received health care service(s) from this provider or facility.

10. **Type of Service:** A brief description of the health care service(s) you received.

11. **Amount Charged:** The amount your health insurance was billed by the provider or facility for the health service(s) you received.

12. **Allowed:** The pricing that is allowed for this service.

13. **Disallowed:** The portion of the claim that is not covered by your health insurance.

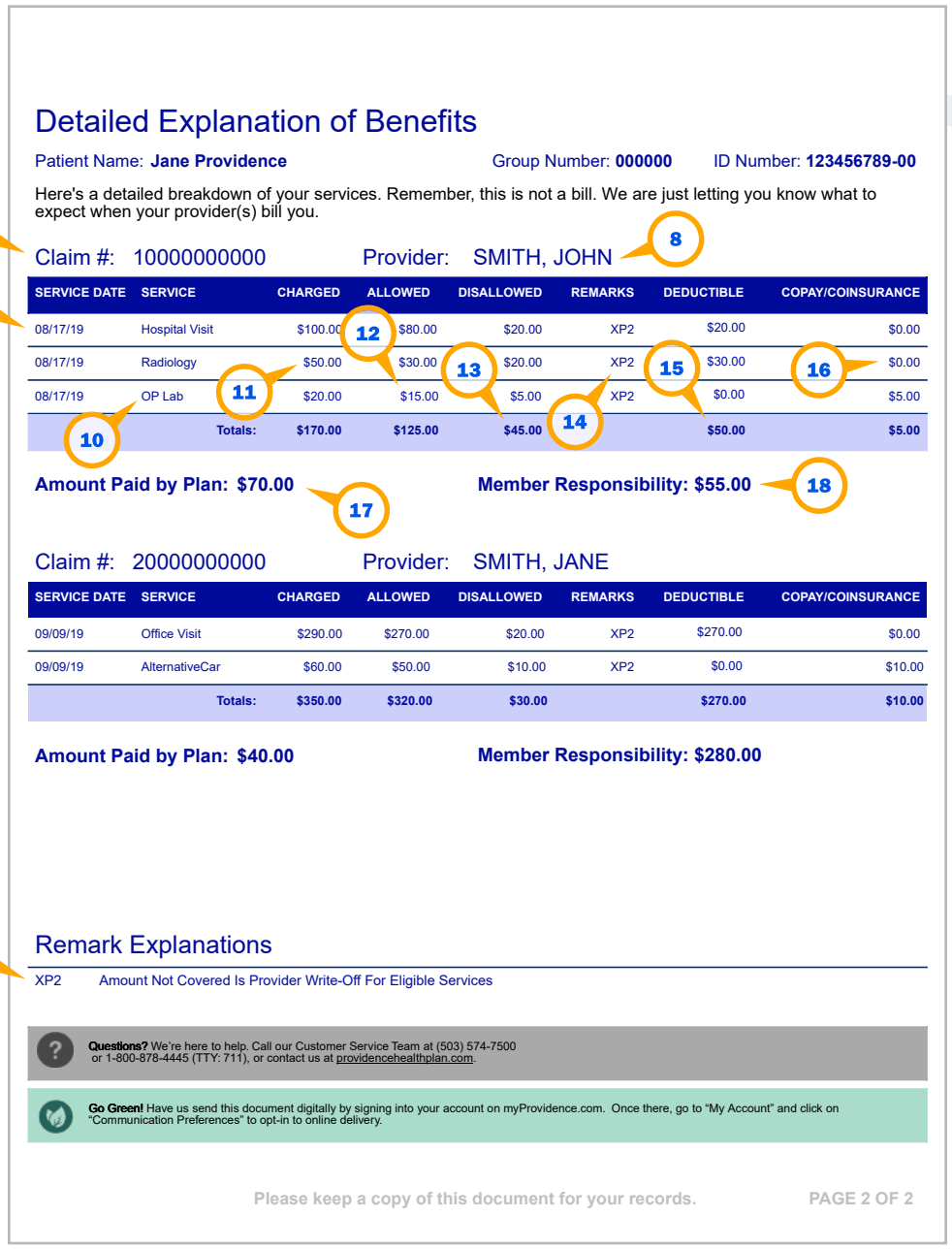
14. **Remarks and Explanations:** Remarks are the codes attached to the claim. See the "Remark Explanations" section below for a full description.

15. **Deductible:** In general, your "deductible" is the total amount of money you need to pay annually before your health insurance starts paying for most (or all) of your healthcare. The amount shown here in the "Deductible" column is what has been applied to your deductible, which will vary depending on your unique plan benefits.

16. **Copay/Coinsurance:** A copay is a fixed dollar amount while coinsurance is a percentage of the allowed amount.

17. **Amount Paid by Plan:** The total amount your health insurance paid to the provider for this claim.

18. **Member Responsibility:** The amount you may owe for this claim.



Detailed Explanation of Benefits

Patient Name: **Jane Providence** Group Number: **000000** ID Number: **123456789-00**

Here's a detailed breakdown of your services. Remember, this is not a bill. We are just letting you know what to expect when your provider(s) bill you.

Claim #: 10000000000 Provider: SMITH, JOHN

SERVICE DATE	SERVICE	CHARGED	ALLOWED	DISALLOWED	REMARKS	DEDUCTIBLE	COPAY/COINSURANCE
08/17/19	Hospital Visit	$100.00	$80.00	$20.00	XP2	$20.00	$0.00
08/17/19	Radiology	$50.00	$30.00	$20.00	XP2	$30.00	$0.00
08/17/19	OP Lab	$20.00	$15.00	$5.00	XP2	$0.00	$5.00
	Totals:	$170.00	$125.00	$45.00		$50.00	$5.00

Amount Paid by Plan: $70.00 **Member Responsibility: $55.00**

Claim #: 20000000000 Provider: SMITH, JANE

SERVICE DATE	SERVICE	CHARGED	ALLOWED	DISALLOWED	REMARKS	DEDUCTIBLE	COPAY/COINSURANCE
09/09/19	Office Visit	$290.00	$270.00	$20.00	XP2	$270.00	$0.00
09/09/19	AlternativeCar	$60.00	$50.00	$10.00	XP2	$0.00	$10.00
	Totals:	$350.00	$320.00	$30.00		$270.00	$10.00

Amount Paid by Plan: $40.00 **Member Responsibility: $280.00**

Remark Explanations

XP2 Amount Not Covered Is Provider Write-Off For Eligible Services

Questions? We're here to help. Call our Customer Service Team at (503) 574-7500 or 1-800-878-4445 (TTY: 711), or contact us at providencehealthplan.com.

Go Green! Have us send this document digitally by signing into your account on myProvidence.com. Once there, go to "My Account" and click on "Communication Preferences" to opt-in to online delivery.

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