

# Understanding Your Explanation of Benefits (EOB)



PO Box 9232, Des Moines, Iowa 50306-9232

This is your Explanation of Health Care Benefits. This statement shows how we applied your coverage to claim(s) submitted to us. If you have a question, call the customer service number shown at the bottom of this page. This is **NOT** a bill.

PATIENT NAME: YOUR NAME HERE  
ISSUE DATE: 06/10/14

WELL MARK ID #: 123AD4567

Date of Service	Patient Account Number Health Care Provider	Claim Number Type of Service	Amount Charged	Network Savings	Amount Paid by Health Plan	Deductible	Copayment	Coinsurance	Amount Not Covered	Notes
05/19/2014	11223-11223344 Physician Name	000000000000000								
		Office Medical Care	\$102.00	\$5.00	\$82.00	\$0.00	\$15.00	\$0.00	\$0.00	
		Office Laboratory	\$36.00	\$15.00	\$21.00	\$0.00	\$0.00	\$0.00	\$0.00	
		Office Laboratory	\$30.00	\$20.00	\$10.00	\$0.00	\$0.00	\$0.00	\$0.00	
		<b>Claim Total:</b>	<b>\$168.00</b>	<b>\$40.00</b>	<b>\$113.00</b>	<b>\$0.00</b>	<b>\$15.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	1,2
		<b>Other Insurance Paid:</b>	<b>\$8.62</b>							<b>You are responsible for \$15.00</b>

Notes regarding the claim(s) submitted to us:

- 1 - Wellmark provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. (Z110)
- 2 - We have settled this claim directly with your provider. (Z195)

1. **Patient account number** - Your account number with your health care provider.
2. **Amount charged** - The total amount charged by a health care provider for services you received, whether or not the services are covered under your health plan.
3. **Network savings** - The amount you saved by receiving services from a health care provider within your health plan's network.
4. **Amount paid by health plan** - The amount paid to you or your health care provider.
5. **Deductible** - The fixed dollar amount you pay for certain covered services before benefits are available. Your health care provider may bill you for these charges.
6. **Copayment** - The fixed dollar amount you pay for certain covered services. Your health care provider may require this payment when you receive services.
7. **Coinsurance** - The amount, calculated using a fixed percentage, you pay for certain covered services. Your health care provider may bill you for these charges.
8. **Amount not covered** - The portion of the charges not covered under your health plan.
9. **Other insurance paid** - If you have coverage with another health plan, this is the amount that the other plan has agreed to pay.
10. **Amount you are responsible for** - Your share of the cost of the services shown on the EOB. You should use this information to coordinate your payment(s) with your providers.