Detailed Explanation of Benefits (EOB)

April 1 - April 30, 2010

Line No.	Patient/Provider/Service	Service Date	Billed Amount	PPO Discount	Allowed Amount	Employer Payment	Other Insurance	Your Financial Responsibility: Not Covered	Co-pay	Deductible	Co-insurance	% Paid	HealthEZ Paid	Paid from	You Owe Provider
	JANE SAMPLE														
	CARE CLINIC														
1	Apply Leg Cast	4/15/2010	248.00	24.07	223.93	.00	.00	.00	.00	223.93	.00		223.93	HSA	.00
	Reason: This amount is discounted from your claim because the provider is in the America's PPO Network.														
	Total:		**248.00**	**24.07**	**223.93**	**.00**	**.00**	**.00**	**.00**	**223.93**	**.00**		**223.93**		**.00**
	ALEX SAMPLE														
	COUNTY HOSPITAL														
1	CAT Scan	4/15/2010	911.00	391.60	519.40	441.49	.00	.00	.00	.00	77.91		77.91	Credit	.00
	Reason: This amount is discounted from your claim because the provider is in the America's PPO Network.														
	Total:		**911.00**	**391.60**	**519.40**	**441.49**	**.00**	**.00**	**.00**	**.00**	**77.91**		**77.91**		**.00**
	Charged to Account: M**3679														
	JANE SAMPLE														
	FAMILY DENTALCARE														
1	Exam, Flouride, Prophylaxis	4/12/2010	138.00	20.70	117.30	117.30	.00	.00	.00	.00	.00		.00		.00
	Reason: This amount is discounted from your claim because the provider is in the Metro DentalCare Network.														
	Total:		**138.00**	**20.70**	**117.30**	**117.30**	**.00**	**.00**	**.00**	**.00**	**.00**		**.00**		**.00**

Your Employer

Employer Logo

Member Name: JANE SAMPLE
Member ID Number: XXXXX4321
Group Name: Company XYZ
Group Number: 111

Your Health Plan Administrator

HEALTHEZ

For benefit, payment or billing questions, call **800-948-9450** or visit your custom benefits site at www.YourCompanyBenefits.com, where you can also your statement online, search for specific claims, and more.

Please refer to your employer's summary plan document for the details on your health plan benefits and plan administration