Understanding your Explanation of Benefits

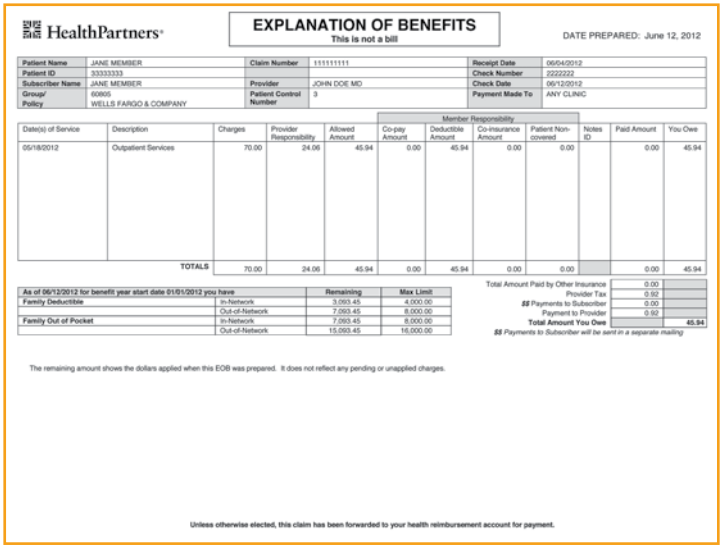
After you visit the doctor's office, you'll get an Explanation of Benefits (EOB) Statement. This statement details your medical claims and shows if you need to pay anything to a provider. An EOB is not a bill. EOBs are sent to you when you or one of your covered dependents use your benefit plan. You can see all claims processed for that period, plus remaining balances for your in-network and out-of-network balance information and deductibles.

VIEWING YOUR EXPLANATION OF BENEFITS

Your EOBs are sent to you online at **healthpartners.com/wf**. We'll send you an email whenever a new statement is posted. You can view your current and past EOB statements or current claims activity at any time of the day or night at **healthpartners.com/wf**. Staying informed and up to date with your EOB statement can help you get the most out of your health care plan.

UNDERSTANDING YOUR STATEMENT

To help you better understand your Explanation of Benefits, please see the following page for a numbered diagram. Each number is associated with the field description.



HealthPartners

EXPLANATION OF BENEFITS
This is not a bill

DATE PREPARED: June 12, 2012

Patient Name	JANE MEMBER	Claim Number	111111111	Receipt Date	06/04/2012
Patient ID	33333333			Check Number	2222222
Subscriber Name	JANE MEMBER	Provider	JOHN DOE MD	Check Date	06/12/2012
Group/ Policy	60805 WELLS FARGO & COMPANY	Patient Control Number	3	Payment Made To	ANY CLINIC

					Member Responsibility						
Date(s) of Service	Description	Charges	Provider Responsibility	Allowed Amount	Co-pay Amount	Deductible Amount	Co-insurance Amount	Patient Non-covered	Notes ID	Paid Amount	You Owe
05/18/2012	Outpatient Services	70.00	24.06	45.94	0.00	45.94	0.00	0.00		0.00	45.94
TOTALS		70.00	24.06	45.94	0.00	45.94	0.00	0.00		0.00	45.94

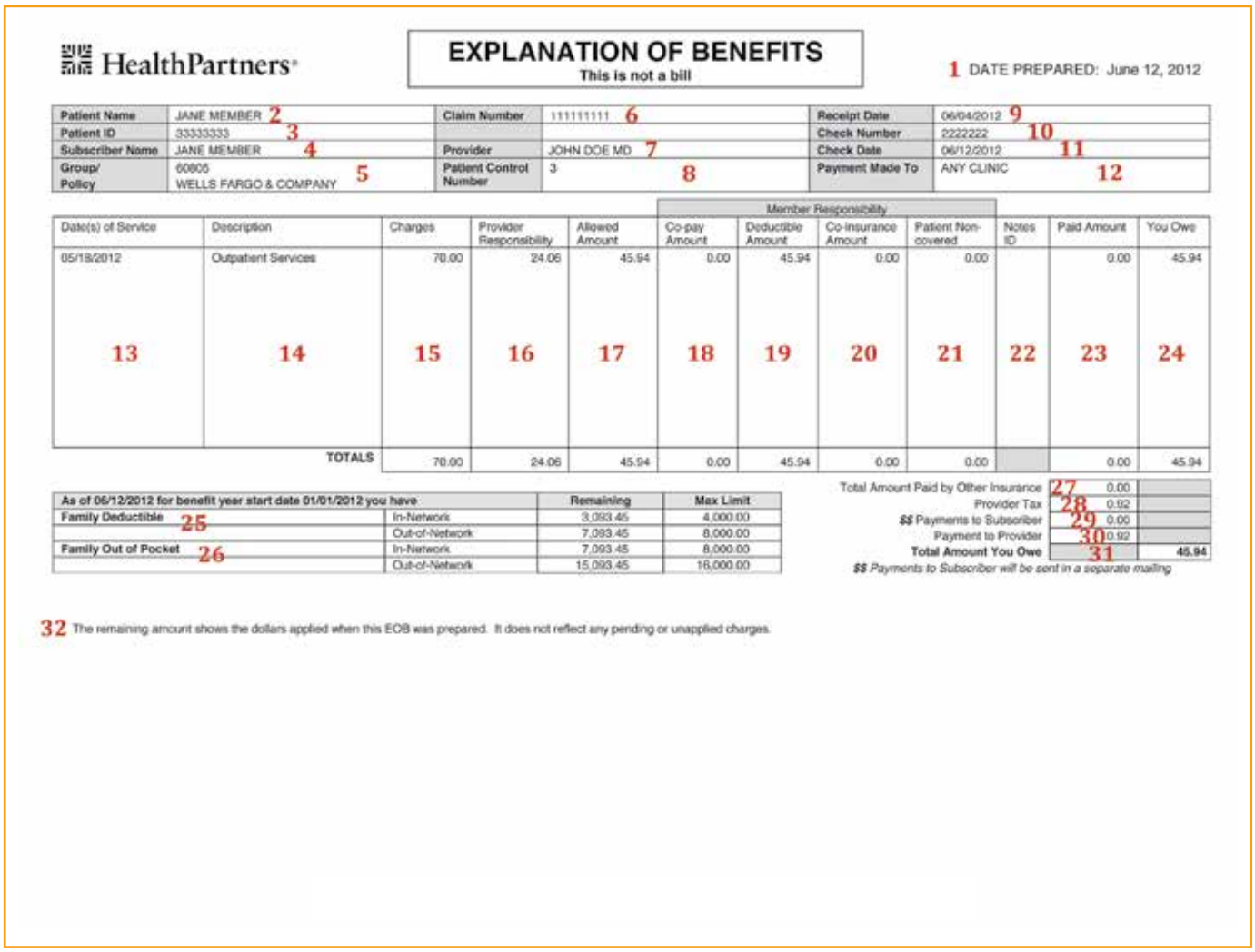
As of 06/12/2012 for benefit year start date 01/01/2012 you have		Remaining	Max Limit
Family Deductible	In-Network	3,093.45	4,000.00
	Out-of-Network	7,093.45	8,000.00
Family Out of Pocket	In-Network	7,093.45	8,000.00
	Out-of-Network	15,093.45	16,000.00

Total Amount Paid by Other Insurance	0.00	
Provider Tax	0.92	
$$ Payments to Subscriber	0.00	
Payment to Provider	0.92	
Total Amount You Owe		**45.94**

$$ Payments to Subscriber will be sent in a separate mailing

The remaining amount shows the dollars applied when this EOB was prepared. It does not reflect any pending or unapplied charges.

Unless otherwise elected, this claim has been forwarded to your health reimbursement account for payment.



HealthPartners®

EXPLANATION OF BENEFITS
This is not a bill

1 DATE PREPARED: June 12, 2012

Patient Name	JANE MEMBER 2	Claim Number	111111111 6	Receipt Date	06/04/2012 9
Patient ID	33333333 3			Check Number	2222222 10
Subscriber Name	JANE MEMBER 4	Provider	JOHN DOE MD 7	Check Date	06/12/2012 11
Group/ Policy	60805 WELLS FARGO & COMPANY 5	Patient Control Number	3 8	Payment Made To	ANY CLINIC 12

						Member Responsibility					
Date(s) of Service	Description	Charges	Provider Responsibility	Allowed Amount	Co-pay Amount	Deductible Amount	Co-insurance Amount	Patient Non-covered	Notes ID	Paid Amount	You Owe
05/18/2012	Outpatient Services	70.00	24.06	45.94	0.00	45.94	0.00	0.00		0.00	45.94
13	14	15	16	17	18	19	20	21	22	23	24
	TOTALS	70.00	24.06	45.94	0.00	45.94	0.00	0.00		0.00	45.94

As of 06/12/2012 for benefit year start date 01/01/2012 you have		Remaining	Max Limit
Family Deductible 25	In-Network	3,093.45	4,000.00
	Out-of-Network	7,093.45	8,000.00
Family Out of Pocket 26	In-Network	7,093.45	8,000.00
	Out-of-Network	15,093.45	16,000.00

Total Amount Paid by Other Insurance 27	0.00	
Provider Tax 28	0.92	
$$ Payments to Subscriber 29	0.00	
Payment to Provider 30	0.92	
Total Amount You Owe 31		**45.94**

$$ Payments to Subscriber will be sent in a separate mailing

32 The remaining amount shows the dollars applied when this EOB was prepared. It does not reflect any pending or unapplied charges.

1. Date EOB was generated
2. Patient's name
3. Patient's member number
4. Subscriber/owner of policy (not necessarily patient)
5. Employer's group number and policy name
6. Claim reference number
7. Provider of care
8. Patient control number
9. Date claim was received
10. Check number
11. Date of check
12. Check issued to
13. Dates of patient care
14. Description of care
15. Total charges
16. Provider's responsibility
17. Amount member owes + amount paid by HealthPartners
18. Member's cost based on co-pay
19. Member's cost based on deductible
20. Member's cost based on co-insurance
21. Amount of services not covered by insurance
22. Reference to notes (#32) on non-covered amounts
23. Amount paid by HealthPartners
24. Amount member owes
25. Family deductible balances
26. Family in-network out-of-pocket balances
27. Amount paid by patient's other benefit plan
28. Tax paid by provider
29. Total plan covered amount payable to policyholder
30. Total plan covered amount payable to provider
31. Total member liability – what you owe
32. Explanation of any non-covered amounts