Understanding your

Explanation of Benefits

Your Explanation of Benefits (EOB) is new and includes information to help you better understand how your claims were processed.

What is an EOB?

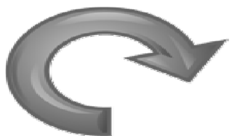
After you visit your doctor, a hospital, or any health care provider, we receive a claim for the services you received. The EOB provides you with important information about your visit.

The claims on your EOB are the claims we have already processed and there may be a time lapse between your service date and when we receive the claim. You will receive an EOB for months in which you have claims processed.

There will be a box for monthly and yearly total dollar amounts and a separate section for each month.

Remember, the EOB is **NOT** a bill. It's a summary of how your benefits are applied to your claims.

Please turn page over for additional information



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Here's a helpful list of words you may see on your EOB and what they mean.

- **Provider**: Any licensed, certified, or accredited health care professional or facility where you are seen.
- **Plan**: Your specific health insurance policy and related benefits.
- **Totals**: Your coinsurance and/or copayments that have been applied for the current benefit period as of the date of the EOB.
- **In-Network:** Doctors, hospitals, clinics, and other health care providers who have a contract with us to provide services to you at a discount.
- **Out-of-Network:** Services from health care providers who don't have a contract with us that will usually cost you more than those received from an in-network provider.
- **Plan's Share:** The amount the plan has paid for your claim.
- **Your Share:** The amount you **MAY** owe for your claim. This will be either a Copay and/or Coinsurance. Remember this is not a bill. Wait until you receive a bill from your provider.
- **Coinsurance:** The amount you may be required to pay as "*Your Share*" of the cost for services. Coinsurance is usually a percentage.
- **Copay:** The amount paid to the provider at the time you were seen.
- **Out-of-Pocket Limit:** The maximum annual coinsurance and copayments you pay for your plan and what you may owe cannot exceed these amounts for covered services.
- **Denied:** This is the amount that is not covered by the plan. You **MAY** be responsible for this amount. You have appeal rights, if you disagree.

Your name and member ID will appear in this location.

MONTHLY REPORT

Medical and Hospital Claims Processed in January 2014

For First Name Last Name
Member ID: Jxxxxxxxx01

This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid out-of-pocket (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. We send a separate report on Part D prescription drugs.
- If you notice something suspicious that might be dishonest billing, you can report it by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

This box will provide you with numbers to contact Customer Service if you have questions.

An independent licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of North Carolina is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.

PO Box 17509, Winston-Salem, NC 27116-7509

http://www.bcbsnc.com

Your Plan name will appear here.

If you have questions, call us: Plan's Phone Number

We are here 7 days a week from 8:00 am to 8:00 pm Eastern Time.

TTY / TDD only: **1-888-451-9957**

Magellan Health Services – 1-800-266-6167

Please contact Customer Service at the number above. Customer Service also has free language interpreter services available for non-English speakers.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Benefits, formulary, pharmacy network, provider network, copayments, and coinsurance may change on each year.

Below is an example of a claim that was processed and here is what you will find on each row

- Top row will include provider information and headings for each column.
- Each service will appear on a separate line and give a description of the service received that includes the (billing code), the date of service, amount the plan was billed by the provider, amount the plan approved, amount paid by the plan and your share.
- Totals line will be a summary of all lines within that specific claim.

Provider or Facility Name Claim Number: 130830E99999 (Out-of-network provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIEN (billing code 99284)	1/1/14	$333.00	$200.00	$200.00	$0.00
INSERTION OF TEMPORARY INDWELLING BLADDER CATHETER; SIMPLE (EG, FOLEY) (billing code 51702)	1/1/14	$267.00	$250.00	$250.00	$0.00
	TOTALS:	**$600.00**	**$450.00**	**$450.00**	**$0.00**

EXAMPLE

Below is an example of a Denied claim

Provider or Facility Name Claim Number: 130830E99997 (Out-of-network provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
SERVICE(S) PROVIDED BETWEEN 10:00PM AND 8:00 AM AT 24-HOUR FACILITY, IN (billing code 99053)	1/5/14	$50.00	$50.00 **DENIED** **$50.00** (See below for information about your appeal rights.)	$0.00	$50.00

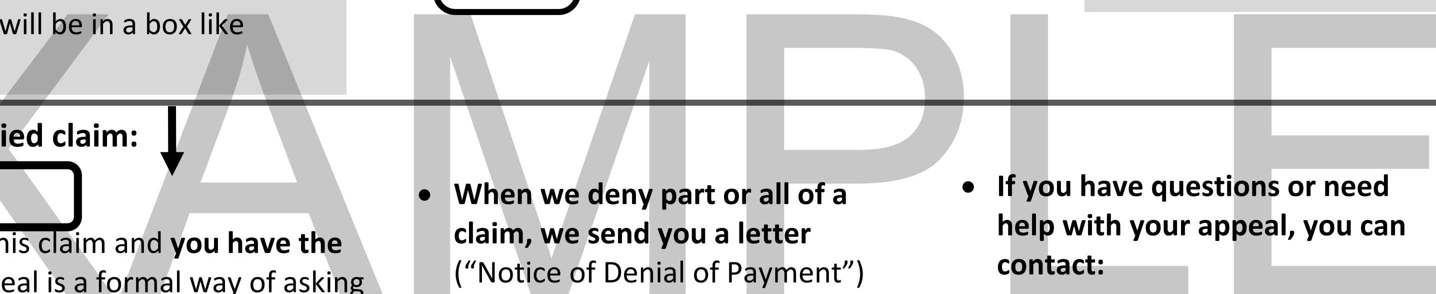
Denied dollar amounts will appear **BELOW** the word **DENIED**. You may be responsible for denied amounts. Your appeal rights and reason for denial will appear in a separate box.

TOTALS for medical and hospital claims	Amount providers have billed the plan	Total cost (amount the plan has approved)	Plan's share	Your share
Totals for this month (for claims processed from January 1 to January 31, 2014)	$600.00	$50.00 **DENIED** **$50.00**	$450.00	$50.00
Totals for 2014 (all claims processed through January 31, 2014)	$600.00	$50.00 **DENIED** **$50.00**	$450.00	$50.00

This row will be the totals of all claims processed for the month.

This row will be the totals of all claims processed since January 1 of the current year.

Denied dollar amounts will appear **BELOW** the word **DENIED**. You may be responsible for denied amounts. Your appeal rights and reason for denial will be in a box like below.



Things to know about your denied claim:

- Denied service not covered.

We have denied all or part of this claim and **you have the right to appeal.** Making an appeal is a formal way of asking us to *change the decision* we made to deny your claim. If we agree to change our decision, it means we will approve the claim rather than deny it, and we will pay our share.

The provider can also make an appeal, and if this happens, you may not have to pay. You may wish to contact the provider to find out if they will ask us for an appeal. If the provider properly asks for an appeal, you will not be responsible for payment, except for the normal cost-sharing amount, and you don't need to make an appeal yourself.

- **When we deny part or all of a claim, we send you a letter** ("Notice of Denial of Payment") explaining why the service or item is not covered. This letter also tells what to do if you want to appeal our decision and have us reconsider.
- **IMPORTANT**: If you do not have this letter, call us at Customer Service (phone numbers are in a box on page 1).

- **If you have questions or need help with your appeal, you can contact:**
  - Our Customer Service (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

The reason your claim denied will be above.