How to Read Your Explanation of Benefits (EOBs)

Each time a claim is filed from your doctor, we send you an explanation of benefits (EOB) form, which provides important information about how your claim was processed.

Explanation of Health Care Benefits

Claim Information (2) (3) XXXXXXXX XX/XX/XXXX

(1) **THIS IS NOT A BILL.** This is an explanation of the claim processed based on your plan benefits in effect when the service was performed. Please keep this form for your tax records.

Subscriber Name FIRST NAME LAST NAME
Patient Name FIRST NAME LAST NAME

(4) Claim Number: XXXXXXXXXXX Patient ID: Patient Control Number: XXXX Group Number:XXXXXXXX
Group Name: COMPANY ABC
Provider: PROVIDER ABC

(5) (6) (7) (8) (9) (10) (11) (12)

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd by Other Ins	Deductible Amount	Co-pay Amount	Co-Insurance Amount	Paid Amount	Amount You Owe	Notes ID
XX/XX/XXXX - XX/XX/XXXX DESCRIPTION OF SERVICE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

(13) **Note:** Explanations or descriptions corresponding to the amount(s) noted in the breakdown of charges and benefits.

(14) **Patient Benefit Summary**

Patient: FIRST NAME LAST NAME
Benefit Period: 00/00/2018 - 00/00/2018
You have satisfied $0.00 of your $0.00 individual deductible.
$0.00 has been applied to your $0.00 individual out-of-pocket limit.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

Explanation of Benefits Guide

1. **This Is Not a Bill –** Please do not send payment for this service to BCBSND. Please keep this form for your records.
2. **Subscriber Name –** Member name. **Patient Name –** The name of the patient who received the service.
3. **Benefit Plan Number –** The member's BCBSND benefit plan number. **Date –** Date the EOB is printed.
4. **Claim Number –** The claim number designated for the purpose of identification. **Group Name –** Name of the health plan. **Provider –** The name of the individual or institution that was paid for the service.

   Patient Control Number – The number associated with the visit to the provider.

   Group Number – The number associated with the member's employer.
5. **Date of Service/Description –** The date and type of service performed.
6. **Charges –** The charge billed by your provider for each service.
7. **Provider Responsibility Amount –** The portion of your charge that may have been reduced by BCBSND for services provided by a participating provider.

   Allowed Amount – Maximum allowed amount for health care services.

8. **Patient Noncovered Amount –** The charges that are noncovered according to the terms in your benefit plan.

   Amount Paid by Other Insurance – Examples of other insurance include other health insurance, automobile insurance, homeowners insurance, etc.

9. **Deductible Amount –** Specified dollar amount for certain covered services received during the benefit period that is your responsibility to the provider.
10. **Co-pay Amount –** Specified dollar amount payable for certain covered services that is your responsibility to the provider.
11. **Co-insurance Amount –** Percentage of the allowed charge for certain covered services that is your responsibility to the provider.

    Paid Amount – The amount the member's coverage paid toward each service.

12. **Amount You Owe –** The total amount that you are responsible to pay to your provider.
13. **Notes –** Explanations or descriptions corresponding to the amount(s) noted in the breakdown of charges and benefits.
14. **Patient Benefit Summary –** The total deductible, co-insurance and/or co-payment that you have accumulated to date. These totals may reflect claims in process for which you have not yet received an EOB.

Members can visit www.BCBSND.com and login to Online Member Services to view and print EOB statements.

29300921 • 1-19