

Here's how to find out!



BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

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How much did your health plan pay?  
How much do you owe?

# Understanding Your Explanation of Benefits (EOB)

**Y**our Explanation of Benefits, or EOB, is a form that gives you details about your claims' status. It features important information about services you received, how much we covered, how much you may owe your provider(s) and much, much more.

You'll notice we've gathered most of the quick details you're looking for in a convenient Summary Information box. Details about your claims are in column format, so you can easily track the information about each service you received. We've also included helpful definitions on each and every EOB, so you'll know more about what you're reading!

This convenient guide will walk you through a typical EOB. Thank you for allowing us to serve you!

# EXPLANATION OF BENEFITS (EOB)

12345

(ADDRESS)



## South Carolina EXPLANATION OF BENEFITS

### THIS IS NOT A BILL

- 1** If you have a question about your claim, please call customer service at (PHONE NUMBERS AND HOURS)

JOHN DOE  
PO BOX 0000  
ANYWHERE, SC 12345

### 2 SUMMARY INFORMATION

**3** (DATE)  
CHECK NO.: 123456789

<b>4</b> Patient's Name JONATHAN DOE	<b>5</b> Relationship to Policyholder CHILD	<b>6</b> ID No. ABC123456789012	<b>7</b> Claim No. 12345N789-99-99
<b>8</b> TOTAL CHARGE FOR YOUR CLAIM: 870.85	<b>9</b> TOTAL AMOUNT WE PAID: 522.51	<b>10</b> WHAT YOU OWE PROVIDER(S): 130.63	
<b>11</b> To date, you have satisfied 250.00 of the 250.00 deductible for the benefit period that began 07/24/2008. This claim contributed 130.63 toward your out-of-pocket maximum. You have satisfied 1,072.04 of the 2,000.00 out-of-pocket maximum for this benefit period. We have paid a total of 4,555.54 for this person this benefit period.			

### DETAIL INFORMATION

<b>12</b> Provider(s)	BC HOSPITAL	BC HOSPITAL	BC HOSPITAL
<b>13</b> Network Participation	YES	YES	YES
<b>14</b> Dates of Service	07/01/08	07/01/08	07/01/08
<b>15</b> Type of Service	OUTPT RADIOLOGY	OUTPT LAB/PATH	OUTPATIENT HOSPITAL
<b>16</b> Charge	89.00	123.87	657.98
<b>17</b> Amount Not Covered	22.24 01*	30.97 01*	164.50 01*
<b>18</b> Covered Expenses	66.76	92.90	493.48
<b>19</b> Deductible	.00	.00	.00
<b>20</b> Copayment	.00	.00	.00
<b>21</b> Allowed Amount	66.76	92.90	493.48
<b>22</b> Coinsurance	13.35	18.58	98.70
<b>23</b> Amount Paid	53.41	74.32	394.78

**24** \*Please refer to the remarks section.

Suspect claims fraud? Please help by calling our hotline at 1-800-763-0703.

THANK YOU FOR ALLOWING US TO SERVE YOU!

(Web Site Address)

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### 25 Helpful Definitions (Please check your schedule of benefits in your benefit booklet for details.)

**Amount Approved for Coordination** — the amount we will coordinate with your primary health or dental plan's payment.

**Benefit Period** — the period of time you must pay any deductibles and coinsurance payments that may apply. Benefits begin once you meet the deductible. If you reach the limit, we pay covered expenses in full for the rest of the benefit period. Deductibles and coinsurance start over with each new benefit period.

**Coinsurance** — the percentage of the allowed amount you pay as your share of the bill. If your plan pays 80 percent, then 20 percent would be your coinsurance.

**Copayment** — a set fee you pay each time you receive a certain service. Some plans do not have copayments.

**Deductible** — the amount, if any, that you are responsible for paying before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and health care professionals send to us.

**Less Benefit Limitation** — the amount that is more than your contract allows for this type of service. Your plan covers these services until you have reached the limit of your benefits.

**Network Participation** — this column shows whether or not the health care professional who provided the service participates in our network. If "YES," this is a network participant. If "NO," this is not a network participant. If "N/A," the issue doesn't apply to your coverage, or this particular claim.

**Out-of-Pocket Maximum** — the highest amount of covered expenses you will have to pay during a benefit period.

**Total Benefit Allowed** — the amount we would have paid if another insurance carrier was not involved.

### 26 APPEAL OR REVIEW (APPEALS INFORMATION)

#### Remarks Section

- 27** 01 THIS AMOUNT REPRESENTS THE DIFFERENCE BETWEEN THE ACTUAL CHARGE AND THE PRE-NEGOTIATED REIMBURSEMENT AMOUNT. YOU ARE NOT RESPONSIBLE FOR THESE NON-COVERED CHARGES.

Route Code: B2N  
Group Number: 123456789

- Customer Service Information** — If you have a question about your coverage or the information on your EOB, here's how to contact us.
- Summary Information** — This box gives you important information at a glance.
- Check Number** — This number helps our customer service representatives quickly track a check in case you have questions regarding payment. This field will only show if we are making a payment to the member.
- Patient's Name** — The name of the person who received a service. This could be you, your spouse or a dependent child who has coverage under your health plan.
- Relationship to Policyholder** — This is the patient's relationship to the member.
- ID Number** — The covered policyholder's number. Please have this number handy when you call customer service.
- Claim Number** — The number we assigned to your claim so we can track it.
- Total Charge for Your Claim** — The amount the provider(s) charged for this claim.
- Total Amount We Paid** — The amount we paid for the entire claim, based on your coverage.
- What You Owe Provider(s)** — The amount, if any, you need to pay the provider(s) for this claim. There may be times when you don't owe anything.
- Deductible and Out-of-Pocket Summary** — This area explains how much you have paid toward your deductible, if applicable. It shows how much of this claim went toward your out-of-pocket expenses and how much you've paid toward your out-of-pocket maximum so far this benefit period. It also shows how much we've paid in benefits for the patient during this benefit period.
- Provider(s)** — The health care professional or facility that provided services to the patient.
- Network Participation** — Whether or not the provider(s) the patient visited participates in our network.
- Dates of Service** — When the patient received services.
- Type of Service** — A description of the type of service for each claim.
- Charge** — The amount the provider(s) charged for the service.
- Amount Not Covered** — The amount, if any, for non-covered services or the amount that is above the allowed charge.
- Covered Expenses** — The amount considered for benefits after any non-covered charges have been subtracted.
- Deductible** — The amount, if any, you pay to providers for services each benefit period before we start paying our share. You do not send this amount to us. We subtract this amount from covered expenses on the claims you and providers send to us.
- Copayment** — The set fee you pay each time you receive a certain service. Some plans do not have copayments.
- Allowed Amount** — This is the amount from which your coinsurance, if applicable, will be determined.
- Coinsurance** — The percentage of covered expenses you pay as your share of the allowable amount. An allowable amount is the most a plan will pay for a covered service. For example, if your plan pays 80 percent, then 20 percent would be your coinsurance.
- Amount Paid** — The amount we paid, based on your coverage.
- Remarks Note** — Shows where to look for reasons.
- Helpful Definitions** — We've included some definitions to help you better understand your EOB.
- Appeal or Review Information** — How to file an appeal if you disagree with our decision.
- Remarks Section** — This section explains any Remarks in the Amount Not Covered field (17).