A step-by-step guide

Understanding what you owe after visiting your provider
Definitions

Your Provider Billed: The amount your health care provider submitted for the services you received.

Allowed Amount: The discounted rate we have negotiated with in-network providers or facilities for covered services, which saves you money when you receive in-network care.

Member Savings: The amount you saved by visiting an in-network provider or facility.

Your Plan Paid: The amount paid for the service based on the allowed amount.

Copayment: The fixed dollar amount you pay upfront to a health care provider for a covered service. Copayments can vary depending on the service, the type of health care provider, and whether the provider is in or out of network. Copayments do not count toward your deductible or out-of-pocket maximum.

Deductible: The amount you may pay for eligible services during a benefit period before your plan begins to pay. It does not include copayments, coinsurance, noncovered services, or any charges in excess of any maximum or allowed amount.

Coinsurance: The cost sharing of allowable charges by you and for covered services after you’ve met your deductible, if applicable. Usually shown as a percentage.

Other Liability: Out-of-network costs, costs for services that should have had prior review or authorization before they were performed, or any excluded services.

Explanation of Benefits
December 01, 2011
This is not a bill.

Subscriber information
First: John A
Last: Doe
ID: W123456789
Plan: Blue Options Plan

Benefit Year Summary - For benefit period starting 01/01/2011

<table>
<thead>
<tr>
<th>Blue Plans Plan</th>
<th>In-Network Deductible</th>
<th>Out-Of-Network Deductible</th>
<th>In-Network Out-of-Pocket</th>
<th>Out-Of-Network Out-of-Pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>John A</td>
<td>$700.00</td>
<td>$1,400.00</td>
<td>$3,210.00</td>
<td>$6,420.00</td>
</tr>
<tr>
<td>Jane B</td>
<td>$700.00</td>
<td>$0.00</td>
<td>$3,210.00</td>
<td>$6,420.00</td>
</tr>
<tr>
<td>Joe C</td>
<td>$700.00</td>
<td>$0.00</td>
<td>$3,210.00</td>
<td>$6,420.00</td>
</tr>
<tr>
<td>Family</td>
<td>$2,100.00</td>
<td>$4,200.00</td>
<td>$9,650.00</td>
<td>$19,260.00</td>
</tr>
</tbody>
</table>

These benefits require you and/or your family to reach payment maximums, labeled “Plan’s Maximum” before your plan pays a greater share of the cost. These maximums can be reached in two ways: when you’ve satisfied your individual maximums, or when your family has met its maximums. Payments made by members are credited both to their individual Amount Satisfied and to the family’s, up to the individual maximum amount. Individual maximum requirements are waived when your family maximum is reached. The amount satisfied column will read “Met” if an individual or family maximum is satisfied.

Patient: John A. Doe #: W123456789

Medical Services Detail

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>Reason Code</th>
<th>Amount Your Provider May Bill You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim #: 01-102510-046-40</td>
<td></td>
<td>TOTAL $600.00</td>
</tr>
<tr>
<td>Date(s):</td>
<td>Service: MEDICAL CARE</td>
<td>$900.00</td>
</tr>
<tr>
<td>Date(s):</td>
<td>Service: LABORATORY</td>
<td>$100.00</td>
</tr>
<tr>
<td>Date(s):</td>
<td>Service: SUPPLIES</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

Total for Claim #: 01-102510-046-40 $1,075.00

What our codes mean:
ENB: Claim denied. Service is not covered for either the primary diagnosis or service code listed. May resubmit if other covered diagnosis or service codes apply. Claim will be reopened upon receipt of requested information within one year of denial.
Easy steps
to make sure your claims are accurate

1 During your provider visit

In network
When you visit an in-network provider, a participating or contracted provider by Blue Cross and Blue Shield of North Carolina (BCBSNC) for your specific plan, please follow these steps:
1. Present your BCBSNC ID card.
2. Pay a copayment, if indicated on your ID card.
   If no copayment is listed, depending on your provider, you may be asked to pay a portion or all of your balance at the time of your visit.
There are no claims to file.

Out of network
When you visit an out-of-network provider, a provider who has not been designated as a participating or contracted provider by BCBSNC for your specific plan, please follow these steps:
1. Present your BCBSNC ID card.
2. Depending on your provider, you may be asked to pay a portion or all of the fees at the time of your visit.
3. Ask if your provider will file the claim. If not, you will have to file it.
   Note: Some plans do not cover out-of-network visits. Check your Benefit Booklet.

2 After your provider visit

After you have visited a provider and a claim for health care services is filed, BCBSNC will send you an Explanation of Benefits (EOB). The EOB provides important information about claims processed by BCBSNC.

Your EOB is not a bill. It’s a summary of your benefits applied to your claims. Do not send payment to your provider unless you receive a bill directly from your provider. Always compare your provider bill with your EOB to confirm that services you received and charges listed are correct. Keep all EOBs and provider bills on file for future reference.

3 Understanding your Explanation of Benefits (EOB)

See the sample EOB on page 2 and learn how to find the information you need.

1 Benefit Year Summary
How much of your deductible and/or coinsurance is applied for the current benefit period as of the date of the EOB. A “benefit period” is a period of time during which covered services must occur in order to be eligible for payment.

2 Plan’s Maximum
This is the specific deductible, coinsurance, or out-of-pocket amount for your plan, and what you may owe cannot exceed these amounts.

3 Amount Satisfied
The total amount of your deductible, coinsurance, and/or out-of-pocket expenses met for the benefit period as of the date of the EOB.

4 Claim Number
Identifies specific services received during a health care visit.

5 Service
A summary description of the type of medical service provided. If you need more information about a particular service, contact your health care provider or call the customer service number listed on your EOB or ID card.

6 Reason Code
Indicates an explanation follows in the “What Our Codes Mean” section at the end of the EOB.

7 Total
The amount you owe the provider.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What should I do if I don’t receive a provider bill?</td>
<td>You may not receive a provider bill if you already paid a copayment and BCBSNC covered the remainder of the bill. Check the “Amount Your Provider May Bill You” section of your EOB to confirm.</td>
</tr>
<tr>
<td>Why is an EOB important?</td>
<td>The EOB can help you track your health care spending or medical claims history. Your EOB also helps you verify that the services and charges listed are correct. Compare the EOB with the bills you get from your doctor or health care facility. If something doesn’t look right to you, contact the health care provider who filed the claim or customer service to discuss the claim in question. Also, if you disagree with a specific benefit decision, you have the right to appeal it by following the steps listed on the back of the EOB. You can request a copy of an EOB by calling the customer service number on the back of your BCBSNC ID card. Plus, you can log in to mybcbsnc.com to view your entire claims history and status.</td>
</tr>
</tbody>
</table>
| What should I do if I receive multiple EOBs and provider bills for the same procedure, visit or service? | This is a common situation if you received care from multiple providers. As you receive your provider bills, compare the following with your EOB:  
- Date of service  
- Provider name  
- Services and amounts  
The total dollar amount you pay your provider, including copayments, should not exceed the amount listed in the “Amount Your Provider May Bill You” section of the EOB, unless you received a check directly from BCBSNC. Then you will owe the “Your Plan Paid” plus “Amount Your Provider May Bill You.” |
| What should I pay if the amount on the provider bill is different than the amount listed in the “Amount Your Provider May Bill You” section of my EOB? | The total amount you pay your provider, including copayments, should never be more than the amount listed in the “Amount Your Provider May Bill You” section of the EOB, unless you received a check directly from BCBSNC. If the provider bill is less, pay the amount listed on your provider bill. You may receive additional bills for the same visit or procedure if you received care from multiple providers. If the provider bill is more than “Amount Your Provider May Bill You,” and you did not receive a check directly from BCBSNC, call the Customer Service number listed on the back of your BCBSNC ID card. |

If you have any additional questions about billing or your EOB, call the Customer Service number listed on the back of your BCBSNC ID card.

Scan this barcode with your mobile device to learn more about your EOB, or visit bcbncn.com/eob to access an interactive version of a sample EOB.