

**BREAKDOWN OF CHARGES AND BENEFITS**

16 Date: 02/17/09 Jane E Doe Page 2 of 2  
 Contract Number: YED123456789 Group 400008

17 Patient/Claim Number 18 Provider/Type of Service	19 Processed Date	20 Charges Submitted	22 Covered Amount		24 Previously Processed	25 Noncovered and Cost Sharing Amounts			
			23 Provider Discount	23 Amount Paid		25 Noncovered Charges	26 Deductible	27 Coinsurance	28 Copayment
Jane E / Claim 0918353054/00 Date of service : 01/12/09 WEST BROADWAYC / Independent Laboratory Collecti	02/10/09	12.00	8.00 A				4.00 B		
Jane E / Claim 0918353050/00 Date of service : 01/12/09 WEST BROADWAYC / Office Medical Care	02/10/09	161.00	39.00 A	102.00					20.00 C
Jane E / Claim 0918353056/00 Date of service : 01/12/09 WEST BROADWAYC / Independent Laboratory	02/10/09	13.00					13.00 B		
<b>TOTALS:</b>		<b>186.00</b>	<b>47.00</b>	<b>102.00</b>			<b>17.00</b>		<b>20.00</b>

29 \* YOUR RESPONSIBILITY TO THE PROVIDER: 37.00

FIRST-LEVEL APPEAL: A request for a first-level appeal must be submitted in writing within one year of the date the claim was processed, or as otherwise required by your plan. Please include any additional information which may resolve the dispute. This letter may be submitted by you or a representative on your behalf to: Blue Cross and Blue Shield of Nebraska, P.O. Box 3248, Omaha NE 68180-0001.

This letter must state that this is a request for an appeal and, if possible, include a copy of your Explanation of Benefits (EOB). If the EOB is not available, be sure your appeal includes (1) a general description of the appeal; (2) the name of the covered person; (3) Blue Cross and Blue Shield of Nebraska ID number; and (4) date of the service or claim number. All letters must include the name and relationship of the person submitting the appeal.

**EXPLANATION OF NOTES: 30**

A - Your responsibility has been reduced by this amount as a result of a provider agreement. (06-001-05)

- 16 **Date** - Date the EOB was printed.  
**Name** - Member's name.  
**Contract Number** - The member's BCBSNE contract number.  
**Group Number** - The member's health insurance plan group number.
- 17 **Patient/Claim Number** - The name of the patient who received the service and the claim number designated for the purpose of identification.
- 18 **Provider/Type of Service** - The name of the individual or institution that performed the service and the type of service that was performed.
- 19 **Date of Service** - The date the service was performed.
- 20 **Processed Date** - The date the claim completed processing.
- 21 **Charges Submitted** - The charge billed by your provider for each service.
- 22 **Provider Discount** - The portion of the charge that may have been discounted by your provider.
- 23 **Amount Paid** - The amount the member's coverage paid toward each service.
- 24 **Previously Processed** - Any amount previously processed by this plan, Medicare or another insurance company.
- 25 **Noncovered Charges** - The charges that are noncovered according to the terms set forth in your benefit plan.
- 26 **Deductible** - Specified dollar amount for certain covered services received during the benefit period that is your responsibility to the provider.
- 27 **Coinsurance** - Percentage of the allowed charge for certain covered services that is your responsibility to the provider.
- 28 **Copayment** - Specified dollar amount payable for certain covered services that is your responsibility to the provider.
- 29 **Your Responsibility to the Provider** - The total amount that you are responsible to pay to your provider.
- 30 **Explanation of Notes** - Explanations or descriptions corresponding to the amount(s) noted in the breakdown of charges and benefits (sections 23, 25, 26, 27, 28 and 29 shown above).

A Guide to Your

# Explanation of Benefits



Please call Member Services with any questions. The phone numbers are listed on the front of your EOB and on the back of your NETWORK BLUE ID card.


# How to Read Your Explanation of Benefits

Each time a claim is processed, we send an Explanation of Benefits (EOB) form. The EOB shows how we processed available benefits according to the terms of your coverage.

If the claims filed were for a spouse or other adult member, the EOB is sent to that person. The EOBs for minor dependents are generally sent to the parent/employee. Most states define an adult as a person 18 years of age and older.

A sample EOB is provided on the following pages. The major features of the EOB include:

- 1 **Addresses** - The mailing address and website for BCBSNE.
- 2 **This is Not a Bill** - Please do not send payment for this service to BCBSNE. Please keep this form for your records.
- 3 **Member's Name and Address** - The name and address of the member as shown on our records. If not correct, please call Member Services at the numbers shown on the back of your ID card or on your EOB form.
- 4 **Date** - Date the EOB is printed.  
**Contract Number** - The member's BCBSNE contract number.  
**Page Number** - Identifies the number of pages for this EOB.
- 5 **Member Services Phone Numbers** - The numbers you should call with questions about this EOB.
- 6 **Patient/Claim Number** - The name of the patient who received the service and the claim number designated for the purpose of identification.
- 7 **Paid To** - The name of the individual or institution that was paid for the service.
- 8 **Total Charge** - The total charge associated with the claim.
- 9 **Covered Amount** - The portion of the claim that has been discounted or paid by this plan.
- 10 **Previously Processed** - Any amount previously processed by this plan, Medicare or another insurance company.
- 11 **Your Responsibility** - The portion of the claim that you are responsible to pay to your provider.
- 12 **Your Responsibility to the Provider** - The total amount that you are responsible to pay to your provider.
- 13 **Year-to-Date Cost Sharing Status** - The total deductible, coinsurance, and/or copayment that you have accumulated to date. These totals may reflect claims in process for which you have not yet received an EOB.
- 14 **Important Message** - This space has been reserved for general messages that may apply to you.
- 15 **For Breakdown of Charges and Benefits** - A detailed breakdown of how your claims were processed is included on the reverse side of your EOB.



7261 Mercy Road  
PO Box 3248  
Omaha, NE 68180-0001  
members.bcbsne.com

**BlueCross BlueShield of Nebraska**  
An Independent Licensee of the Blue Cross and Blue Shield Association.

**THIS IS NOT A BILL**  
(Please Keep This Form For Your Records)

## EXPLANATION OF BENEFITS

3 **JANE E DOE** \*      000183  
12345 DEER RIDGE LANE  
ELK CITY, NE 68117-1245

4 Date: 02/17/09  
Contract Number: YED123456789  
Page Number: 1 of 2

5 **Member Services**  
(TOLL FREE) 877-258-3888

6 Patient/Claim Number		7 Paid to :	8 Total Charge	9 Covered Amount	10 Previously Processed	11 Your Responsibility
JANE E	0918353054/00	WEST BROADWAYC	12.00	8.00	0.00	4.00
JANE E	0918353050/00	WEST BROADWAYC	161.00	141.00	0.00	20.00
JANE E	0918353056/00	WEST BROADWAYC	13.00	0.00	0.00	13.00

12 \* **YOUR RESPONSIBILITY TO THE PROVIDER: 37.00**

\* This Explanation of Benefits (EOB) does not reflect any payments you may have made to the provider. Also, this EOB does not reflect any payment that may have been made to you or the provider by Medicare or another insurance carrier.

13 **YEAR TO DATE COST SHARING STATUS : 2009**

Applied to \$250 per member deductible: JANE E \$ 17.00 \$ 17.00 has accumulated toward family deductible maximum.	Applied to \$750 per member coinsurance: JANE E \$ .00 \$ 0.00 has accumulated toward family coinsurance maximum.
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**IMPORTANT MESSAGE:**

For a brochure with step-by-step instructions on how to read BCBSNE's Explanation of Benefits (EOB) form, please contact Member Services at the phone numbers listed above.

This Benefit Plan is that of your employer. Blue Cross Blue Shield of Nebraska is serving only as the Claims Administrator and does not assume any financial risk.

If you have prescription drug coverage, avoid year-end delays; file your drug claims early.

This claim has been processed in accordance with the BlueCard Program. The provider in the state where services were performed has been notified by the local Blue Cross and Blue Shield Plan of the final benefit determination.

15 **FOR BREAKDOWN OF CHARGES AND BENEFITS ... SEE BACK >>>**

HELP STOP FRAUD!! - If you suspect Fraud, call (TOLL FREE) 877-632-Blue (2583) or write to: Special Investigations, Blue Cross Blue Shield of Nebraska, PO Box 3248, Omaha, NE 68180-0001

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