

Be an empowered health care consumer.

Understand your **Explanation of Benefits** statement.

The ABCs of an EOB



Part of making the most of your health care coverage is understanding how your plan pays your claims and what your role is in that process. Horizon Blue Cross Blue Shield of New Jersey provides you with an important resource called an Explanation of Benefits (EOB) to do this.

The EOB is a document you will receive after you see a physician or other health care professional, at the time your claim is processed. On the EOB you will find claims and patient payment information for you and your covered family member on a single statement. The sample EOB to the right provides an overview of the information and what it means to you.

If you have questions about how to read your EOB, call Member Services at **1-800-355-BLUE (2583)**.

You can also view your EOBs through Member Online Services. You can easily download and print EOBs at your convenience.

To register for Member Online Services, please visit www.HorizonBlue.com.

 		CUSTOMER SERVICE 1-800-355-2583		DATE: 01/25/2010		PAGE 2 OF 2				
Horizon Blue Cross Blue Shield of New Jersey PO BOX 420 NEWARK, NJ 07101-0420				EXPLANATION OF BENEFITS THIS IS NOT A BILL						
SUBSCRIBER NAME: JOHN DOE				SUBSCRIBER ID: 999999999						
SUMMARY INFORMATION										
PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID					
JOHN DOE	SELF	12345678900000	111111	105.00	105.00					
DETAIL INFORMATION										
A	B	C	D	E	F	G	H	I	J	K
DATE OF PROVIDER SERVICE TYPE	DATE OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	YOUR COINSURANCE/CO-PAY DEDUCTIBLE AMOUNT	YOUR DEDUCTIBLE CARRIER AMOUNT	OTHER CARRIER PAYMENT AMOUNT	NOT COV AMT	HORIZON MESSAGE AMT	SUBSCRIBER CODE	PAID RESPONSIBILITY
1/15/10	ANYTOWN COMMUNITY HEALTH	105.00						105.00		0.00
TOTAL:		105.00						105.00		0.00

A - Date of Service	The date that services were provided to the patient.
B - Type of Service	A brief description of each service.
C - Billed Amount	Amount charged by the physician or health care professional for each service on the claim.
D - Allowed Amount	The amount we approved for payment based on your plan benefits prior to the deductible, coinsurance, copayment or other member cost sharing (if applicable). For services obtained out of network, the difference between billed and allowed amounts will be included in the amount shown as subscriber responsibility (K).
E - Your Coinsurance/ Copayment Amount	The coinsurance or copayment amount which is your responsibility after you have met your deductible, if applicable. You pay this amount to the physician or health care professional.
F - Your Deductible Amount	The amount applied for this service under your benefits contract. You are responsible for paying this amount to the physician or health care professional.
G - Other Carrier Payment Amount	The amount paid by another insurance carrier, including Medicare, if applicable.
H - Not Covered Amount	Any amount of the fee charged for the service that is not covered by your plan; expenses not covered or in excess of your benefits. You may be responsible for this amount in addition to any deductible, coinsurance or copayment. Examples of expenses that may appear in this column are costs above the negotiated rate when using an out-of-network physician or amounts for duplicate services.
I - Horizon BCBSNJ Paid Amount	The total amount paid to you, your physician or health care professional for the services performed.
J - Message Code	These codes refer to specific messages that print below each claim to help explain how we calculated our payment.
K - Subscriber Responsibility	The balance due to the physician or health care professional after the copayment, deductible, coinsurance and benefits have been applied.