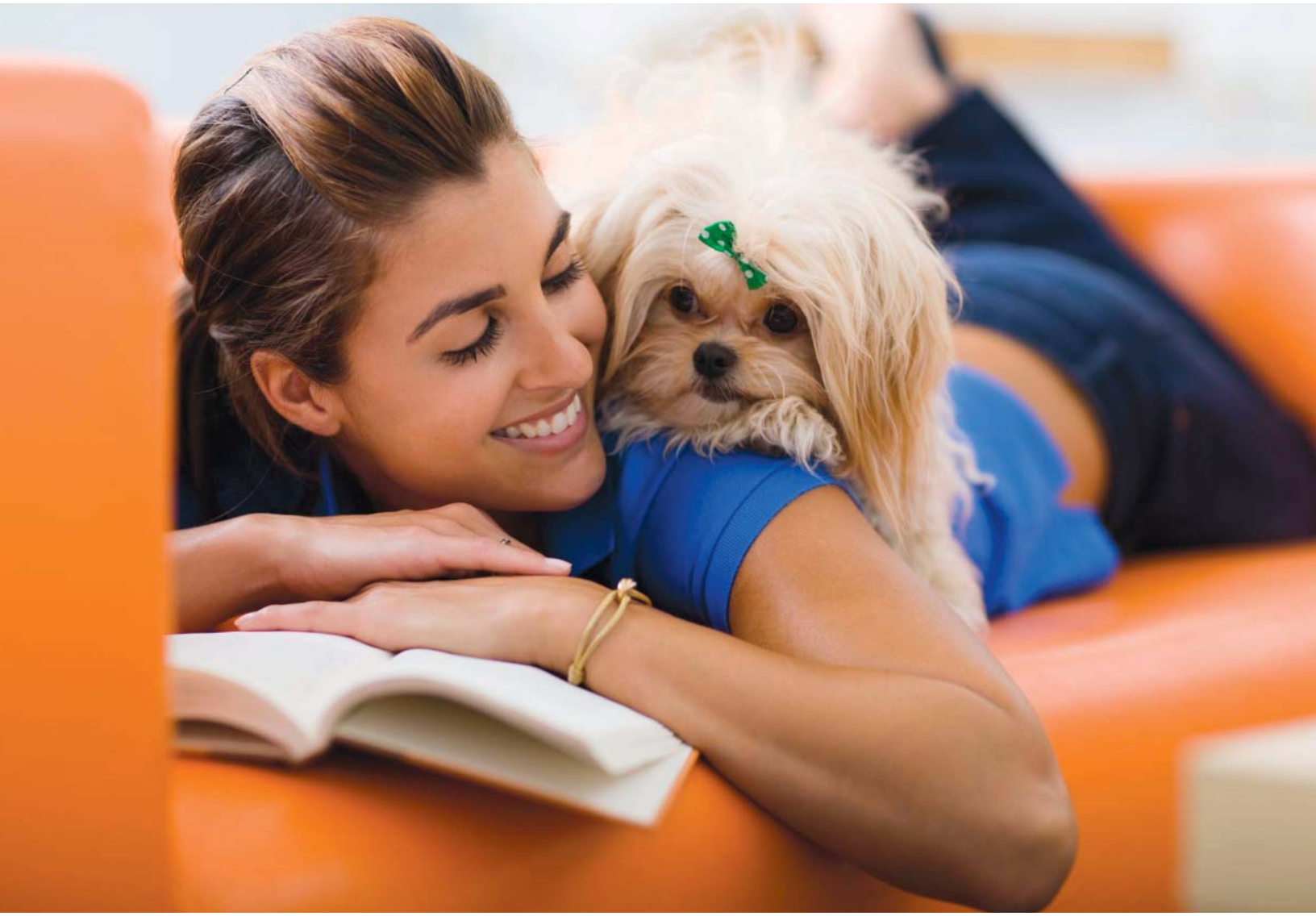
A Guide to Your Explanation of Benefits

BlueCross BlueShield Nebraska



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/subscriber*. Most states define an adult as a person 18 years of age and older.

You may also view your EOB in your *my*blue account. To sign up for your account, go to mynebraskablue.com, select "Sign Up," and complete the four easy steps.

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

1. **Addresses —** The mailing address and website for Blue Cross and Blue Shield of Nebraska (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 number shown on the back of your BCBSNE member ID card or on your EOB form.
4. **Date —** Date the EOB is printed.
   Contract Number — The member's BCBSNE contract (member ID) number.
   Page Number — Identifies the number of pages for this EOB.
5. **Member Services Phone Number —** The number 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 you are responsible to pay to your provider.
12. **Your Responsibility to the Provider —** The total amount you are responsible to pay to your provider.
13. **Cost Sharing Status —** The total out-of-pocket cost (deductible, coinsurance, and/or copayment) you have accumulated to date. These totals may reflect claims in process for which you have not yet received an EOB. Please see the Note on page 4 for more information.
14. **Important Message —** This space is reserved for general messages that may apply to you.
15. **Breakdown of Charges and Benefits —** The back page of your EOB shows a detailed breakdown of how your claims were processed.
16. **Date —** Date the EOB is printed.
    Name — Member's name.
    Contract Number — The member's BCBSNE contract (member ID) 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 designated claim number.
18. **Date of Service —** The date the service was performed.

*Subscriber means the person who is the primary insured.

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BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

PO Box 3248
Omaha, NE 68180-0001
www.mynebraskablue.com

THIS IS NOT A BILL

2 (Please Keep This Form For Your Records)

EXPLANATION OF BENEFITS

4 Date: 12/31/14
Contract Number: YED123456789
Member Number: 01
Page Number: 1 of 3

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

Member Services

5 (TOLL FREE) 877-258-3888

Payment Summary

6 Patient/Claim Number	7 Paid to :	8 Total Charge	9 Covered Amount	10 Previously Processed	11 Your Responsibility
DOE 0918353054/00	SMITH COUNTY HOSPITAL	269.00	215.99	0.00	53.01

12 * YOUR RESPONSIBILITY TO THE PROVIDER: 53.01

* 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 COST SHARING STATUS AS OF 12/31/14

	Individual	Family
In-Network Deductible Maximums:	$750	$1500
Amount Applied:	$750.00	$750.00

	Individual	Family
In-Network Out-of-Pocket Limit:	$1500	$3000
Amount Applied:	$803.01	$803.01

	Individual	Family
Out-of-Network Deductible Maximums:	$5000	$10000
Amount Applied:	$0.00	$0.00

	Individual	Family
Out-of-Network Out-of-Pocket Limit:	$12700	$25400
Amount Applied:	$0.00	$0.00

14 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.

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

NOTICE: For additional details regarding your claim, including specific policy provisions and the provider's diagnosis and procedure codes, please contact Member Services at the telephone number shown above.

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

Para obtener asistencia en español llame al número que se encuentra en la parte de atrás de su tarjeta de identificación.
Kung kailangan ninyo ang tulong sa Tagalog, pakitawagan ang numero sa liod ng iyong I.D. card.
如果需要中文的帮助，请拨打您的保险卡背面的电话号码。
T'áá Dinék'ehjí shiká' 'a'doolwoł ninizingo, t'áá shǫǫdí Naaltsoos Bee Ééhozíní bine'dęę' béésh bee hane'í biká'ígíí bich'į' hólne' dooleeł.

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

BREAKDOWN OF CHARGES AND BENEFITS

16 Date: 12/31/14 JANE E DOE
Contract Number: YED123456789 Group 400008

Page 2 of 3

Patient/Claim Number Provider/Type of Service	20 Processed Date	21 Charges Submitted	22 Covered Amounts: Provider Discount	23 Amount Paid	24 Previously Processed	25 Noncovered Cost Sharing Amounts: Noncovered Charges	26 Deductible	27 Coinsurance	28 Copayment
17 DOE / Claim 0918353054/00	12/30/14								
18 Date of service : 12/01/14									
19 THAYER COUNTY MEMO / Outpatient Hospital		269.00	4.00 A	211.99				53.01 B	
TOTALS:		269.00	4.00	211.99				53.01	

29 * YOUR RESPONSIBILITY TO THE PROVIDER: 53.01

30 APPEAL PROCEDURE: If you disagree with the decision reflected on this claim, you may request an appeal. Consult your Certificate of Coverage or Contract for information regarding your specific appeal process.

EXPLANATION OF NOTES:

31 A - Your responsibility has been reduced by this amount as a result of a provider agreement with Blue Cross Blue Shield of Nebraska. (06-001-03)
B - This amount has been applied to your coinsurance. (09-220-20)

19. **Provider/Type of Service —** The name of the individual or facility that performed the service and the type of service that 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 you are responsible to pay to your provider.
30. **Appeal Procedure –** Guidance on how to request an appeal if you disagree with the decision made on a claim.
31. **Explanation of Notes —** Explanations or descriptions corresponding to the amount(s) noted in the breakdown of charges and benefits (sections 22, 24, 25, 26, 27, 28 and 29 shown above).

Note: Copay amounts for medical services and prescription drugs do not apply toward the calendar year deductible.

Members with single coverage only need to satisfy the individual deductible and out-of-pocket limits. For members with family coverage, there are two types of deductible and out-of-pocket limits – aggregate and embedded. Here's how they work:

Aggregate family deductible means if the subscriber has family coverage, the entire family deductible must be met prior to any benefits becoming available. Family members may combine their covered expenses to satisfy the required family deductible. After the required deductible has been satisfied, the subscriber is responsible for paying a certain percentage of covered charges, called "coinsurance," until the out-of-pocket limit has been reached. Under family membership, the entire **aggregate family out-of-pocket limit** must be met before covered services are paid at 100%. Family members may combine their covered expenses to satisfy the required out-of-pocket limit.

Embedded family deductible means if the subscriber has family coverage, family members may combine their covered expenses to satisfy the required calendar year family deductible.

However, no one family member contributes more than the individual deductible amount to satisfy the family's deductible.

After the required deductible has been satisfied, the subscriber is responsible for paying a certain percentage of covered charges, called "coinsurance," until the out-of-pocket limit has been reached. Under family coverage, the family may combine their covered expenses to satisfy the required **embedded family out-of-pocket limit**. No one family member contributes more than the individual out-of-pocket limit to satisfy the family's out-of-pocket limit.

Under HSA-eligible plans, all covered services apply toward satisfaction of the deductible before any coinsurance and/or copayments will apply.

Please call Member Services with any questions. The phone number is listed on the front of your EOB and on the back of your BCBSNE member ID card.