A guide to your new Explanation Of Benefits (EOB)

An EOB is an explanation of your benefits at the time a claim is processed. It is a description of the claim process. The new EOB contains claim detail for all claims submitted for you and your dependents under your plan.

SAMPLE EOB

1025UCDS01010000001

Horizon

Horizon Blue Cross Blue Shield of New Jersey

P. O. Box 420
Newark, New Jersey 07101-0420

CHECK NO 000055055 DATE 10/25/00

CUSTOMER SERVICE: 1-800-355-2583 NJ
MON-FRI, 8am-6 pm
P. O. Box 420
Newark, New Jersey 07102-0420
Visit our web site www.horizon-bcbsnj.com

SUBSCRIBER JAMES L. JONES
ADDRESS 2081 NILES CORTLAND RD, SE
ANY TOWN, NJ 07105-1234
SUBSCRIBER ID 111-11-1111
GROUP NUMBER 1234567890-1234

THIS IS YOUR CUSTOMER EXPLANATION OF BENEFITS (EOB). THE CLAIMS LISTED BELOW ARE INCLUDED ON THIS EOB. SEE CLAIM DETAILS BEGINNING ON REVERSE SIDE

CLAIM NUMBER	CLAIM AMOUNT	CLAIM NUMBER	CLAIM AMOUNT
12345678901222222	120.00	12345678903333333	100.00

TOTAL OF SUBMITTED CLAIMS: 220.00

You or your representative may ask for reconsideration of any claim or portion of a claim, for which you believe benefits have been erroneously denied based on the limitations and/or exclusions in your benefit booklet. If you wish to pursue legal action, you must do so within 12 months from the date you received notice of denial. Your request should be made in writing and include the following.

Names and addresses of Patient and Customer
Customer ID number used in the claim
Dates of Service and Claim numbers.
Provider name and address
Why you think the claim should be reconsidered.

| FOLD AT PERFORATION AND DETACH CHECK BEFORE DEPOSITING |

Horizon

Horizon Blue Cross Blue Shield of New Jersey

P. O. Box 420
Newark, New Jersey 07101-0420

PNC BANK N.A.
JEANNETTE PA 15644

DATE: 10/25/00
SUBSCRIBER ID: 111-11-1111

CHECK NUMBER
0000055055
0056-1509/0441

VOID 6 MONTHS AFTER DATE ISSUED

PAY EXACTLY:
TWO HUNDRED AND NO/100 DOLLARS

AMOUNT
$*******200.00

TO THE ORDER OF

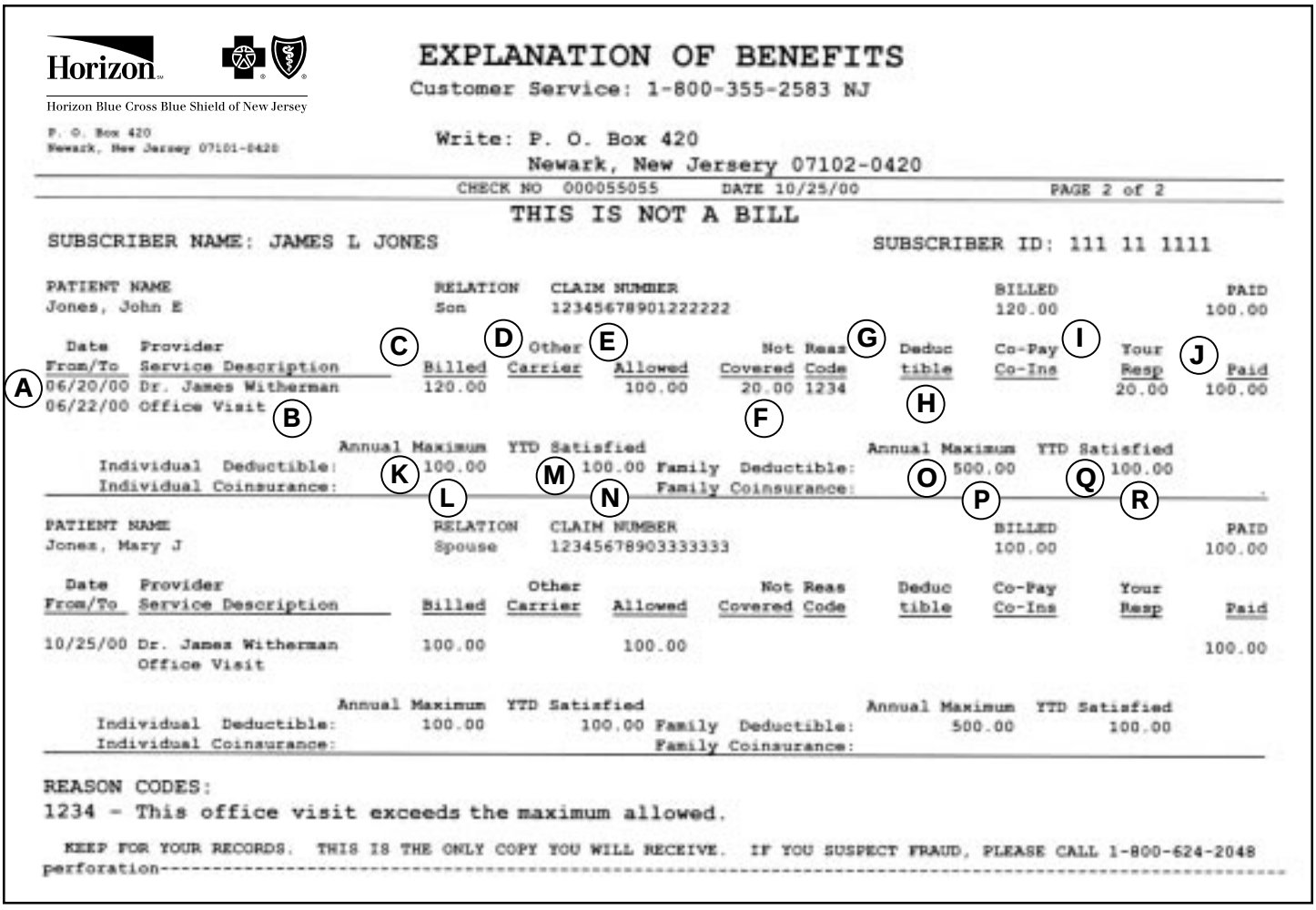
1 MC-PP-15D 0003
2
3 |IiIiIiIiIiIiIiIiIIIiIiIiIiIiI
4
5 JAMES L JONES
6 XXXX NILES CORTLAND RD SE
7 ANY TOWN, NJ 07105-9999

HORIZON BCBSNJ

"0000055055" #042000013# +810073711

Statement Of Open Items

A separate page will be enclosed with your EOB if we have reprocessed a claim resulting in a dollar amount due back to Horizon BCBSNJ, this is known as an *account receivable*. The separate page will list the amount that was originally due and any amounts subtracted from claim payments to satisfy the *account receivable*. When this occurs, a summary will appear on the first page of the EOB.



Horizon

Horizon Blue Cross Blue Shield of New Jersey

P. O. Box 420
Newark, New Jersey 07101-0420

EXPLANATION OF BENEFITS

Customer Service: 1-800-355-2583 NJ

Write: P. O. Box 420
Newark, New Jersey 07102-0420

CHECK NO 000055055 DATE 10/25/00 PAGE 2 of 2

THIS IS NOT A BILL

SUBSCRIBER NAME: JAMES L JONES SUBSCRIBER ID: 111 11 1111

PATIENT NAME	RELATION	CLAIM NUMBER	BILLED	PAID
Jones, John E	Son	12345678901222222	120.00	100.00

Date From/To	Provider Service Description	Billed (C)	Other Carrier (D)	Allowed (E)	Not Covered (F)	Reas Code (G)	Deductible (H)	Co-Pay Co-Ins (I)	Your Resp	Paid (J)
06/20/00	Dr. James Witherman	120.00		100.00	20.00	1234			20.00	100.00
06/22/00	Office Visit									

	Annual Maximum	YTD Satisfied		Annual Maximum	YTD Satisfied
Individual Deductible:	(K) 100.00	(M) 100.00	Family Deductible:	(O) 500.00	(Q) 100.00
Individual Coinsurance:	(L)	(N)	Family Coinsurance:	(P)	(R)

PATIENT NAME	RELATION	CLAIM NUMBER	BILLED	PAID
Jones, Mary J	Spouse	12345678903333333	100.00	100.00

Date From/To	Provider Service Description	Billed	Other Carrier	Allowed	Not Covered	Reas Code	Deductible	Co-Pay Co-Ins	Your Resp	Paid
10/25/00	Dr. James Witherman Office Visit	100.00		100.00						100.00

	Annual Maximum	YTD Satisfied		Annual Maximum	YTD Satisfied
Individual Deductible:	100.00	100.00	Family Deductible:	500.00	100.00
Individual Coinsurance:			Family Coinsurance:		

REASON CODES:
1234 - This office visit exceeds the maximum allowed.

KEEP FOR YOUR RECORDS. THIS IS THE ONLY COPY YOU WILL RECEIVE. IF YOU SUSPECT FRAUD, PLEASE CALL 1-800-624-2048
perforation----------

A - Date From/To	The dates services were provided to the patient.
B - Service Description	A brief explanation of each service.
C - Billed	Amount charged by provider for each service on the claim.
D - Other Carrier	The amount paid by another insurance carrier, including Medicare.
E - Allowed	The amount we approved for payment prior to the deductible, coinsurance or other member expenses (if any).
F - Not Covered	Any amount of the fee charged for the service that is not covered by Horizon BCBSNJ; expenses not covered or in excess of your benefits. You may be responsible for this amount in addition to any deductible and coinsurance amounts
G - Reas (Reason) Code	These codes refer to specific messages below each claim which help explain how we calculated our payment.
H - Deductible	The amount applied to this service under your benefits contract. You are responsible for this amount. You pay this amount to the provider
I - Co-Pay Co-Ins	The copayment or coinsurance amount which is your responsibility after you have met your deductible, if applicable. You pay this amount to the provider.
J - Paid	The total amount paid to you or your provider for the service performed.
K - Annual Maximum** - Individual Deductible	The total deductible amount that each covered person must satisfy in each benefit period.
L - Annual Maximum** - Individual Coinsurance	The total coinsurance amount that each covered person must satisfy in each benefit period.
M -YTD* Satisfied** - Individual Deductible	The actual deductible amount that each covered person has satisfied during the benefit period.
N -YTD* Satisfied** - Individual Coinsurance	The actual coinsurance amount that each covered person has satisfied during the benefit period.
O - Annual Maximum** - Family Deductible	The total deductible amount that the entire family must satisfy in each benefit period.
P - Annual Maximum** - Family Coinsurance	The total coinsurance amount that the entire family must satisfy in each benefit period.
Q -YTD* Satisfied** - Family Deductible	The actual deductible amount that the entire family has satisfied during the benefit period.
R -YTD* Satisfied** - Family Coinsurance	The actual coinsurance amount that the entire family has satisfied during the benefit period.

*YTD = Year to Date **Not applicable to all plans