www.HorizonBlue.com

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 members 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**>.

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Horizon Blue Cross Blue Shield of New Jersey

Horizon Blue Cross Blue Shield of New Jersey
PO BOX 420
NEWARK, NJ 07101-0420

CUSTOMER SERVICE
1-800-355-2583

DATE: 01/25/2010 PAGE 2 OF 2

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	123456789000 00	111111	105.00	105.00

DETAIL INFORMATION

A DATE OF SERVICE	PROVIDER TYPE OF SERVICE	B	C BILLED AMT	D ALLOWED AMT	E YOUR COINS/COPAY AMT	F YOUR DEDUCTIBLE AMT	G OTHER CARRIER PAYMENT AMT	H NOT COV AMT	I HORIZON PAID AMT	J MESSAGE CODE	K SUBSCRIBER 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.

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Horizon Blue Cross Blue Shield of New Jersey

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