BlueCross BlueShield of Texas



Get to Know Your Explanation of Benefits

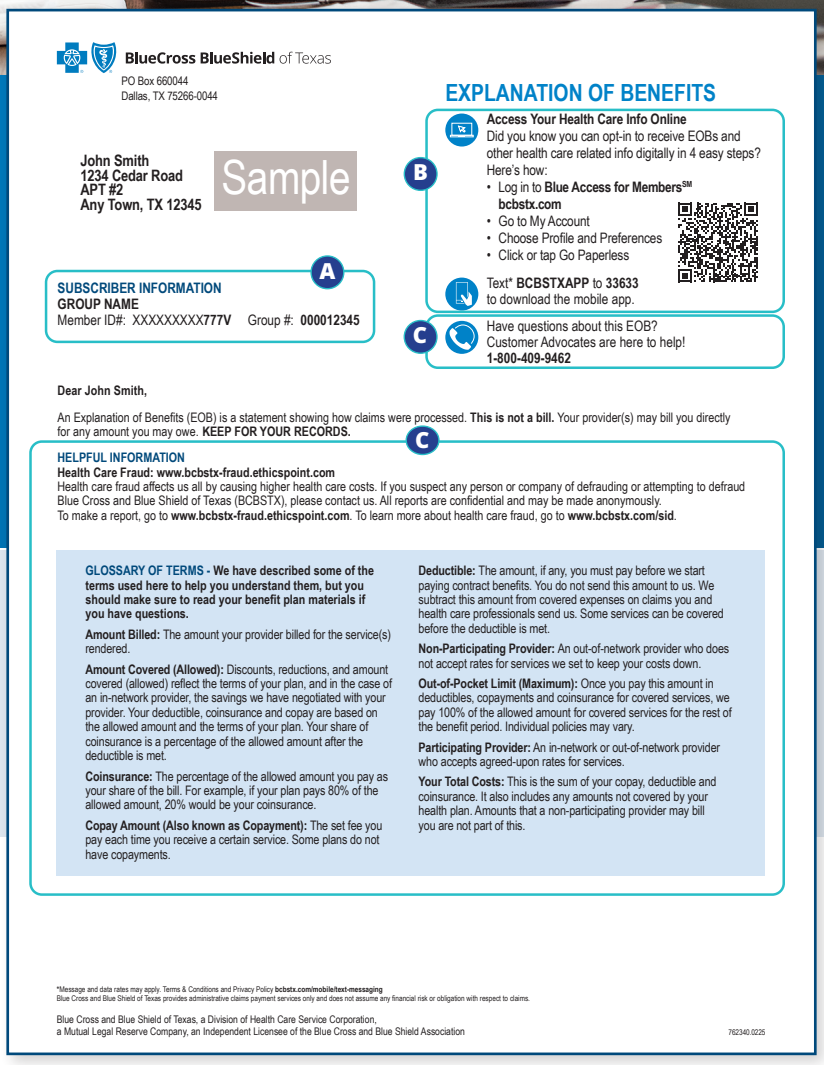
Your **Explanation of Benefits** helps you understand when and how we process your claims. It gives you a detailed look at the covered services and how much you may owe your provider after we apply your benefits.

Page One Covers the Basics

A. Find your policy ID.

B. Choose how you want to get your EOB.

C. Find resources if you need more help.



BlueCross BlueShield of Texas
PO Box 660044
Dallas, TX 75266-0044

EXPLANATION OF BENEFITS

John Smith
1234 Cedar Road
APT #2
Any Town, TX 12345

Sample

B

Access Your Health Care Info Online
Did you know you can opt-in to receive EOBs and other health care related info digitally in 4 easy steps? Here's how:
- Log in to **Blue Access for Members℠** **bcbstx.com**
- Go to My Account
- Choose Profile and Preferences
- Click or tap Go Paperless

Text* **BCBSTXAPP** to **33633** to download the mobile app.

A

SUBSCRIBER INFORMATION
GROUP NAME
Member ID#: XXXXXXXXX**777V** Group #: **000012345**

C

Have questions about this EOB?
Customer Advocates are here to help!
1-800-409-9462

Dear John Smith,

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

C

HELPFUL INFORMATION
Health Care Fraud: www.bcbstx-fraud.ethicspoint.com
Health care fraud affects us all by causing higher health care costs. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Texas (BCBSTX), please contact us. All reports are confidential and may be made anonymously.
To make a report, go to **www.bcbstx-fraud.ethicspoint.com**. To learn more about health care fraud, go to **www.bcbstx.com/sid**.

GLOSSARY OF TERMS - We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.

Amount Billed: The amount your provider billed for the service(s) rendered.

Amount Covered (Allowed): Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

Coinsurance: The percentage of the allowed amount you pay as your share of the bill. For example, if your plan pays 80% of the allowed amount, 20% would be your coinsurance.

Copay Amount (Also known as Copayment): The set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit (Maximum): Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period. Individual policies may vary.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this.

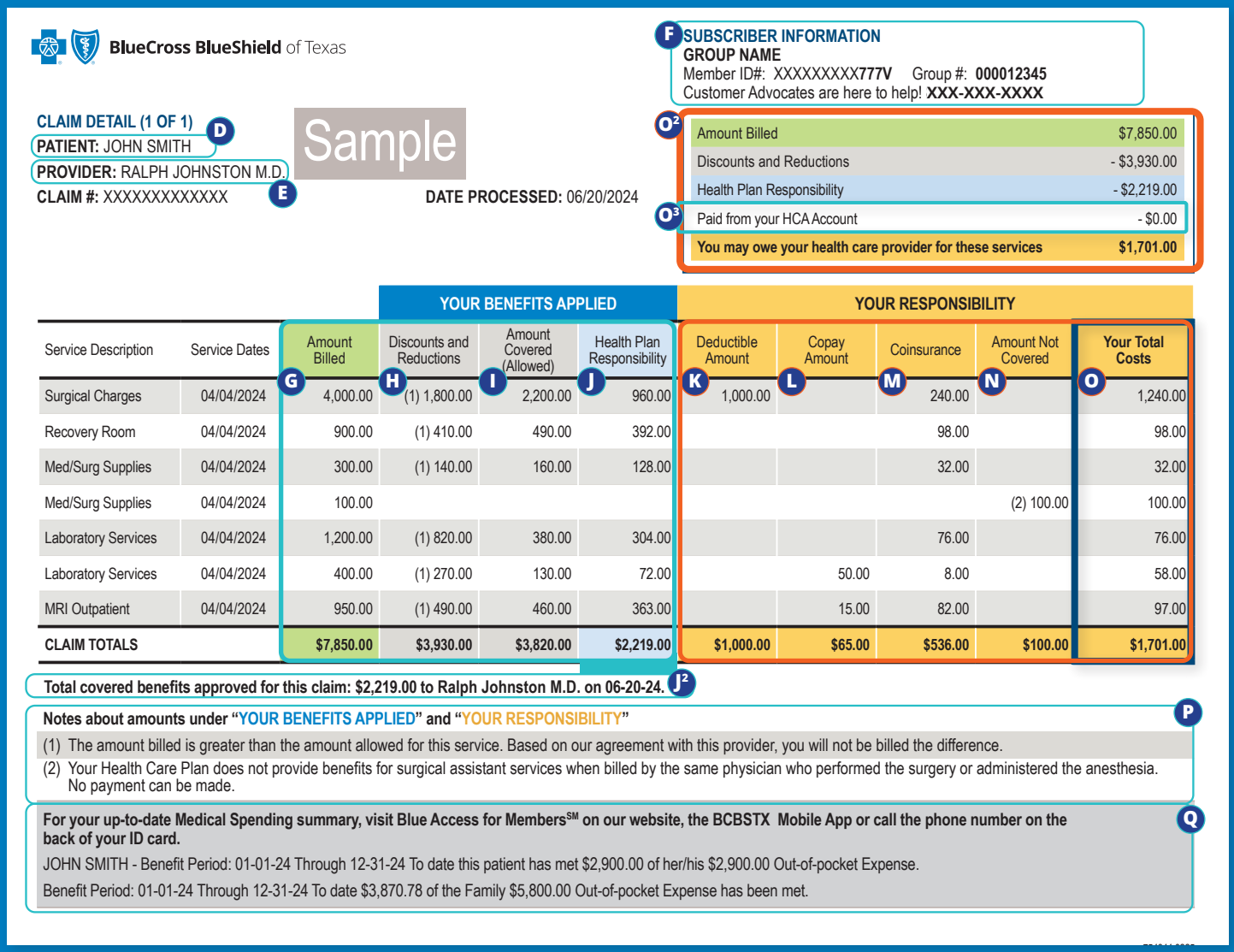
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BlueCross BlueShield of Texas

F SUBSCRIBER INFORMATION
GROUP NAME
Member ID#: XXXXXXXXX777V Group #: 000012345
Customer Advocates are here to help! XXX-XXX-XXXX

CLAIM DETAIL (1 OF 1) D
PATIENT: JOHN SMITH
PROVIDER: RALPH JOHNSTON M.D.
CLAIM #: XXXXXXXXXXXX E

Sample

DATE PROCESSED: 06/20/2024

O² O³

Amount Billed	$7,850.00
Discounts and Reductions	- $3,930.00
Health Plan Responsibility	- $2,219.00
Paid from your HCA Account	- $0.00
You may owe your health care provider for these services	$1,701.00

		YOUR BENEFITS APPLIED				YOUR RESPONSIBILITY				
Service Description	Service Dates	Amount Billed G	Discounts and Reductions H	Amount Covered (Allowed) I	Health Plan Responsibility J	Deductible Amount K	Copay Amount L	Coinsurance M	Amount Not Covered N	Your Total Costs O
Surgical Charges	04/04/2024	4,000.00	(1) 1,800.00	2,200.00	960.00	1,000.00		240.00		1,240.00
Recovery Room	04/04/2024	900.00	(1) 410.00	490.00	392.00			98.00		98.00
Med/Surg Supplies	04/04/2024	300.00	(1) 140.00	160.00	128.00			32.00		32.00
Med/Surg Supplies	04/04/2024	100.00							(2) 100.00	100.00
Laboratory Services	04/04/2024	1,200.00	(1) 820.00	380.00	304.00			76.00		76.00
Laboratory Services	04/04/2024	400.00	(1) 270.00	130.00	72.00		50.00	8.00		58.00
MRI Outpatient	04/04/2024	950.00	(1) 490.00	460.00	363.00		15.00	82.00		97.00
CLAIM TOTALS		$7,850.00	$3,930.00	$3,820.00	$2,219.00	$1,000.00	$65.00	$536.00	$100.00	$1,701.00

Total covered benefits approved for this claim: $2,219.00 to Ralph Johnston M.D. on 06-20-24. J²

Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY" P

(1) The amount billed is greater than the amount allowed for this service. Based on our agreement with this provider, you will not be billed the difference.
(2) Your Health Care Plan does not provide benefits for surgical assistant services when billed by the same physician who performed the surgery or administered the anesthesia. No payment can be made.

For your up-to-date Medical Spending summary, visit Blue Access for Members℠ on our website, the BCBSTX Mobile App or call the phone number on the back of your ID card. Q

JOHN SMITH - Benefit Period: 01-01-24 Through 12-31-24 To date this patient has met $2,900.00 of her/his $2,900.00 Out-of-pocket Expense.

Benefit Period: 01-01-24 Through 12-31-24 To date $3,870.78 of the Family $5,800.00 Out-of-pocket Expense has been met.

On Page Two You Can:

At a glance, confirm the:

D. Patient **E.** Provider **F.** Policy Information

Get the Details

YOUR BENEFITS APPLIED – This section shows the care you received and how it's covered.

G. Amount Billed - this is the total amount your provider billed us for your care.

I. Amount Covered (Allowed) is the amount billed (G) minus any discounts or reductions (H).

J. Health Plan Responsibility is the portion we paid to your provider.

Confirm Your Cost Share

YOUR RESPONSIBILITY – This section shows your member cost-share amounts, including:

K. Deductible **L.** Copays **M.** Coinsurance

O. Your Total Costs details the amounts shown in O², and is the sum of your copay, deductible and coinsurance. You may owe less if your provider collected any of these payments up front. It also includes amounts not covered by your health plan (N). It does not include charges that an out-of-network provider may bill you. If your benefits feature a Health Care Account, or other Health Savings Account, payments from those accounts will be reflected in this line (O³). HCAs and HSAs do not apply to all benefit plans.

Get More Information

Your EOB may detail:

J². Total covered benefits approved – This is the amount and the date we paid your provider. The total matches the total in the Health Plan Responsibility column (J).

P. Any discounts and reductions (H) or amounts that aren't covered (N).

Q. Your yearly out-of-pocket totals so you'll know when your patient cost-shares are met.

* Message and data rates may apply. See terms and conditions and our privacy policy at bcbstx.com/member/account-access/mobile/text-messaging.

EOB samples are for illustrative purposes only. Not all EOBs are the same. The format and content of an EOB depends on your benefit plan and the services provided.