

Frequently Asked Questions

Q: What should I do if I don't receive a provider bill?

A: You may not receive a provider bill if you already paid a copayment and BCBSNC covered the remainder of the bill. Check the "Your Balance" section of your EOB to confirm.

Q: What should I do if I do not receive an EOB?

A: You should always receive an EOB from BCBSNC if a claim has been received by BCBSNC. You should call the customer service number on the back of your member ID card.

Q: What should I do if I receive multiple EOBs and provider bills for the same procedure, visit or service?

A: This is a common situation if you received care from multiple providers. As you receive your provider bills compare the following with your EOB:

- Date of service
- Provider name
- Your balance

The total dollar amount you pay your provider, including copayments, should not exceed the amount listed in the "Your Balance" section of the EOB, unless you received a check directly from BCBSNC. Then you will owe the "Amount Paid by BCBSNC" plus "Your Balance."

Q: What should I pay if the amount on the provider bill is different than the amount listed in the "Your Balance" section of my EOB?

A: The total amount you pay your provider, including copayments, should never be more than the amount listed in the "Your Balance" section of the EOB, unless you received a check directly from BCBSNC.

If the provider bill is less, pay the amount listed on your provider bill. You may receive additional bills for the same visit or procedure if you received care from multiple providers.

If the provider bill is more than "Your Balance", and you did not receive a check directly from BCBSNC, call the Customer Service number listed on the back of your Member ID card.

Definitions

Copayment:

The fixed-dollar amount that is due and payable by the member at the time a covered service is provided.

Coinsurance:

The sharing of charges by BCBSNC and the member for covered services received by a member, usually stated as a percentage.

Deductible:

The specified dollar amount for certain covered services that the member must incur before benefits are payable for the remaining covered services. The deductible does not include copayment, member coinsurance, charges in excess of the allowed amount, amounts exceeding any maximum and expenses for non-covered services.

When you visit your doctor in an office setting, some services or supplies may be provided by hospital-owned or operated practices. Because these services and supplies are hospital-affiliated, your deductible and coinsurance may apply.

To avoid any unexpected charges, contact your provider to confirm whether:

- The practice is hospital-owned.
- Any services are hospital-based and, therefore, subject to deductible and coinsurance.

If you have questions about this brochure, please call the customer service number on the back of your ID card.

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Understanding What You Owe

A step-by-step guide to determining what you owe after visiting your provider.

Service
Joe Doctor Claim ID xxxxxxxxxxxx 03-06-2003
OFFICE VISIT
Joe Doctor Claim ID xxxxxxxxxxxx 03-06-2003
SUPPLIES
CLAIM TOTAL:

Please save this form for your tax records.
\$100.00 Applied to In-Network Deductible Benefit Period 08/17/2002



**BlueCross BlueShield
of North Carolina**

1 During your provider visit

In-Network

A participating or contracted provider by BCBSNC for the member's specific plan.

1. Present your BCBSNC ID card.
2. Pay a copayment, if indicated on your ID card. If no copayment is listed, depending on your provider, you may be asked to pay all or a portion of your balance at the time of your visit.
3. There are no claims to file.

Out-of-Network

A provider who has not been designated as a participating or contracted provider by BCBSNC for the member's specific plan.

1. Present your BCBSNC ID card.
2. Depending on your provider, you may be asked to pay a portion or all of the fees at the time of your visit.
3. Ask if your provider will file the claim. If not, you will have to file it.

Note: Some plans do not cover out-of-network visits. Check your benefits booklet.

2 After your provider visit

After you have visited a provider and a claim for health care services has been filed, BCBSNC will send you an Explanation of Benefits (EOB). The EOB provides important information about claims processed by BCBSNC.

Your EOB is not a bill. Do not send payment to your provider unless you receive a bill directly from your provider. Always compare your provider bill with your EOB to confirm that services you received and charges listed are correct. Keep all EOBs and provider bills on file for future reference.

3 Understanding your "Explanation of Benefits"


- 1 Amount of Bill:** Total amount billed by your health care provider.
- 2 Amount You Do Not Owe:** The amount saved by using a network provider. Reflects rates agreed upon between BCBSNC and provider.
- 3 Amount Paid By BCBSNC:** The amount of total bill that BCBSNC covered and paid to the provider or the member.

Note: If your EOB includes a check made out to you, you will owe the provider the "Amount Paid by BCBSNC" plus "Your Balance." Confirm the amount when you receive your provider bill, and do not pay more than the total.

- 4 Your Balance:** Amount you owe your provider. You may have already paid this at the doctor's office as a copayment or deductible or it may have been covered under additional insurance. Compare with your provider bill.

Note: Out-of-network providers may bill you the difference between what BCBSNC pays and the actual charge.

- 5 Deductible Status:** How much has been applied to your deductible for the benefit period.
- 6 Coinsurance Status:** How much has been applied to your coinsurance maximum for the benefit period.



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EXPLANATION OF BENEFITS

THIS IS NOT A BILL

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Date:

Subscriber's Name: **John Doe**

☎ If you have any questions call 1 (xxx) xxx-xxxx

Patient's Name: Jane (Member)	1	2	3	4	BLUE OPTIONS
Service	Amount of Bill	Amount You Do Not Owe	Amount Paid By BCBSNC	Your Balance	Explanation of Your Balance
Joe Doctor Claim ID xxxxxxxxxxxx 03-06-2003 OFFICE VISIT	100.00	35.00	52.00	13.00	13.00 Coinsurance
Joe Doctor Claim ID xxxxxxxxxxxx 03-06-2003 SUPPLIES	22.00	8.80	10.56	2.64	2.64 Coinsurance
CLAIM TOTAL:	122.00	43.80	62.56	15.64	
Please save this form for your tax records.			Your balance may not reflect any prior payments made by you or another insurance company.		
\$100.00 Applied to In-Network Deductible Benefit Period 08/17/2002			\$152.55 Applied to In-Network Coinsurance Benefit Period 08/17/2002		
5			6		

