of Tennessee

Information on Explanations of Benefits (EOBs)

Each time we process a claim you or your health care provider submit, we explain how we processed it on an EOB. An EOB, or claim summary, is a statement we send to you explaining:

- How much a provider charged for your care or service
- How much of that charge we paid
- How much of that charge you're responsible for paying
- Why we denied a claim, in some cases

Each time you receive an EOB, please review it closely and compare it to the receipt or statement from the provider. You can find your EOBs/claim summaries in your bcbst.com account or by calling us at the Member Service number on the back of your Member ID card.

of Tennessee

LINDA SMITH
123 MAIN STREET
CHATTANOOGA, TN 37402-0000

April 27, 2022

Claim for:
LINDA SMITH
Claim ID:
000000000
Member ID:
000000000
Group ID:
000000000000

YOUR CLAIM SUMMARY

You recently received care from: **Chris Hall, MD**

The date of your care was: **March 11, 2022**

Here's your share of the cost: **$335.58**

Keep this summary, your Explanation of Benefits, for your records. Your provider will send a bill from their office. You might have even paid them already. If they bill you for more than we say you owe, call us. We can help you resolve the issue.

Amount Provider Billed	$473.00
BlueCross Member Discount	$137.42
Paid	$0.00
Other Insurance Paid	$0.00

Your Share of the Cost **$335.58**

For a breakdown of services and costs billed with this claim, check out the detailed summary on the next page.

YOUR ACCOUNT ESTIMATE AS OF 04/27/2022

In-network	You have paid	$509.18	toward your	$1,000.00	individual deductible.
Deductible	You have paid	$509.18	toward your	$2,500.00	family deductible.
Out-of-pocket	You have paid	$553.53	toward your	$4,000.00	individual maximum.
Maximum	You have paid	$689.19	toward your	$10,000.00	family maximum.

You can confirm your most up-to-date claims and balances information online at **bcbst.com**. You will need to login first or create an account, if you haven't already.

If you have questions about this summary, chat with us online or give us a call at 1-800-558-6213. For TDD/TTY help call 1-800-848-0299.

of Tennessee

Claim for:
LINDA SMITH
Claim ID:
000000000

YOUR CLAIM DETAILS

Service Date	Service Provided	Provider Billed	BlueCross Discount	Paid	Your Share of the Costs		Notes
03/11/22	Medical Services	$297.00	$95.18	$0.00	Deductible	$201.82	Z3S
					Copay	$0.00	
					Coinsurance	$0.00	
					Non-Covered	$0.00	
03/11/22	Pathology	$176.00	$42.24	$0.00	Deductible	$133.76	
					Copay	$0.00	
					Coinsurance	$0.00	
					Non-Covered	$0.00	
TOTAL		$473.00	$137.42	$0.00	Deductible	$335.58	
					Copay	$0.00	
					Coinsurance	$0.00	
					Non-Covered	$0.00	

$335.58
Your Share of the Costs

Notes
Z3S You have used a network "S" provider.

of Tennessee

HOW TO GET MORE DETAILS ABOUT THIS CLAIM

Not sure what this claim summary means? We're here to help.

- Find out why we made the decision to pay or not pay a certain amount.
- Get details about the benefits your health plan covers.
- Ask for the diagnosis and treatment codes your provider used to bill us, and what they mean. We'll provide these at no cost to you.

Visit **bcbst.com** to chat with us or call us.

DECISIONS YOU CAN APPEAL

We do everything we can to make sure we've paid your claim the right way, based on your benefits. If you don't agree with the decision we made, you have a right to tell us why and ask us to reconsider. This is called filing an appeal (sometimes we call it filing a grievance). Give us a call and we'll walk you through the process.

Here are some important things to keep in mind:

- You must ask for an appeal within 180 days of getting this statement (unless your Evidence of Coverage says you have more time.)
- We'll give you an answer within 15 to 60 days of getting your appeal – depending on your health plan rules.
- If waiting will stop you from getting urgent care you need, tell us and we'll give you an answer within 72 hours.
- You can file an appeal yourself, and we're here to help if you have questions. But if you need extra support, you can choose to work with a representative – like a lawyer – to help you file your appeal or a civil lawsuit.
- You may begin an external appeal with an outside agency at the same time we're reviewing your appeal if you need care urgently or you are getting ongoing care.

Find out about all your rights and responsibilities at **bcbst.com/memberrights**.
We follow all federal and state laws.

HOW WE KEEP YOUR INFORMATION PRIVATE

To learn more about how we protect your privacy or get a copy of our Notice of Privacy Practices online, visit **bcbst.com/yourrights**.

DO YOU NEED EXTRA HELP?

If you think you need help from an outside agency, there are Consumer Assistance Programs available to help you. Visit **bcbst.com/yourrights** to find the agency that works with your type of plan or to find out about your rights and responsibilities.

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of Tennessee

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

The No Surprises Act, a new federal law, protects you from getting surprise medical bills when you get out-of-network care:

- During a medical emergency
- At an in-network facility (a hospital or ambulatory surgical center)
- Via air ambulance transports from the scene of an accident or when prior approval is received

WHAT IS "BALANCE BILLING" OR "SURPRISE BILLING?"

When you see a health care provider, you may owe a share of the cost. This is for things like your deductible, copays and/or coinsurance. Your share of the costs is often much higher when you see a provider or go to a facility that isn't in your health plan's network.

Out-of-network providers and facilities haven't signed a contract with your health plan. So, these providers can send you a bill for the difference between what your health plan paid and the full amount the provider charged for the service. This is called balance billing. This amount is likely more than in-network costs for the same service and may not count toward your annual out-of-pocket maximum.

"Surprise billing" is a balance bill you don't expect. A surprise bill can happen when you can't control who's involved in your care, like:

- When you have an emergency
- When you schedule services at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU'RE PROTECTED FROM BALANCE BILLING FOR:

Emergency services – You're protected if you have an emergency medical condition and get emergency services from an out-of-network provider. In these cases, the most the provider may bill you is your plan's in-network cost-sharing amount (this includes your in-network deductible, copay and/or coinsurance). You can't be balance billed for emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these services.

Certain services at an in-network hospital or outpatient surgical center – When you get services from an in-network hospital or outpatient surgical center, some providers there may be out of network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't balance bill you and aren't allowed to ask you to give up your protections against balance billing.

If you get other services at these in-network facilities, out-of-network providers may balance bill you if you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out of network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You're only responsible for paying your share of the cost (like the copays, coinsurance, and deductibles that you'd pay if the provider or facility was in network). Your health plan will pay the out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services from out-of-network providers.
  - Base your share of the cost on what you would pay an in-network provider and show that amount in your claim summary (also known as an explanation of benefits).
  - Count your share of the costs for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you can call us using the number on the back of your ID card. You may also contact the federal No Surprises Help Desk (NSHD) by calling **1-800-985-3059**. Visit **cms.gov/nosurprises** for more information about your rights under federal law.