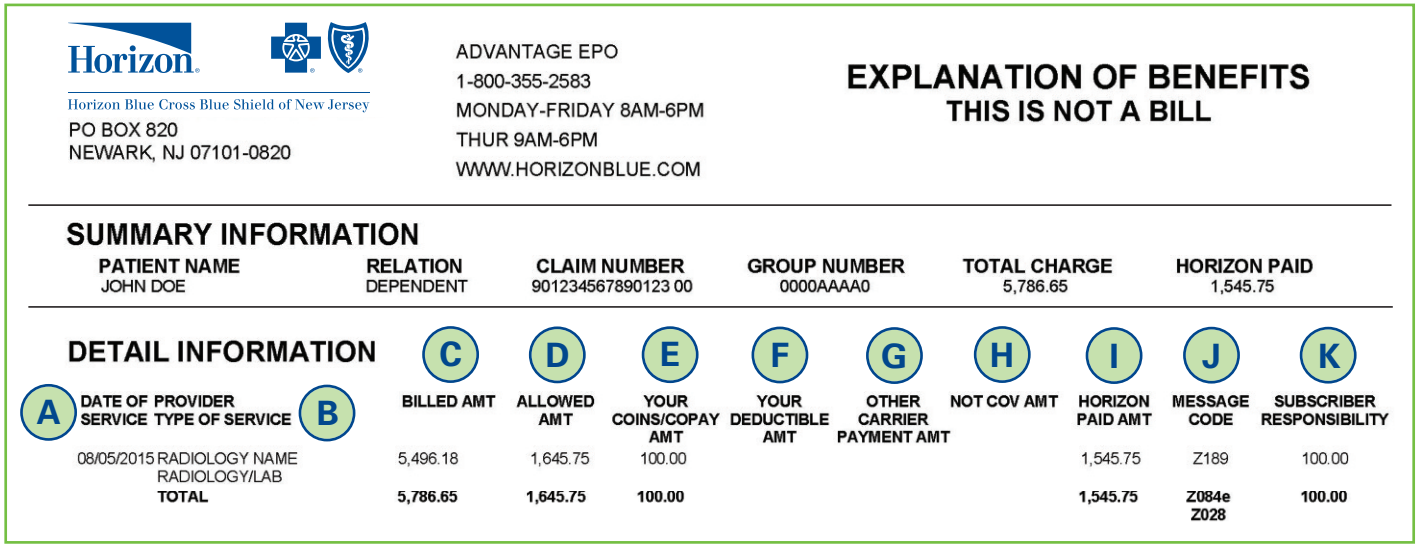
Horizon Blue Cross Blue Shield of New Jersey

Understanding Your Explanation of Benefits

Your Explanation of Benefits (EOB) from Horizon Blue Cross Blue Shield of New Jersey helps you understand how your plan pays claims. Register and sign in to Member Online Services at **HorizonBlue.com/members** to view, save and print your EOB.



Horizon Blue Cross Blue Shield of New Jersey
PO BOX 820
NEWARK, NJ 07101-0820

ADVANTAGE EPO
1-800-355-2583
MONDAY-FRIDAY 8AM-6PM
THUR 9AM-6PM
WWW.HORIZONBLUE.COM

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
JOHN DOE	DEPENDENT	901234567890123 00	0000AAAA0	5,786.65	1,545.75

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
08/05/2015	RADIOLOGY NAME RADIOLOGY/LAB	5,496.18	1,645.75	100.00				1,545.75	Z189	100.00
	TOTAL	**5,786.65**	**1,645.75**	**100.00**				**1,545.75**	**Z084e Z028**	**100.00**

A – Date of Service The date that services were provided to the patient.

B – Type of Service A brief explanation of each service.

C – Billed Amount Amount charged by the doctor, health care professional or facility 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.

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 doctor, health care professional or facility.

F – Your Deductible Amount The amount applied for this service under your benefits contract. You are responsible for paying this amount to the doctor, health care professional or facility.

G – Other Carrier Payment Amount The amount paid by another insurance carrier, 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. When using an out-of-network doctor, health care professional or facility, the costs above the negotiated rate of an in-network provider will appear here.

I – Horizon BCBSNJ Paid Amount The total amount paid to you, your doctor, health care professional or facility for the services performed.

J – Message Code These codes refer to specific messages below each claim that help explain how we calculated our payment.

K – Subscriber Responsibility The amount you owe the doctor, health care professional or facility. This includes any copayment, deductible or coinsurance, if applicable. For out-of-network services, the difference between billed and allowed amounts is included here.