Transforming the *Explanation of Benefits*

Forms, Applications and Statements – English

Anthem®

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Here's how Anthem, Inc. transformed a complex, black and white financial statement into a more engaging and informative member experience with our two key populations:

- Medicare Advantage health plan members
- Members of large and small employer group plans, as well as for individual members (those who do not have employer health coverage)
- This is a company-wide initiative to improve the experience and understanding for Anthem health plan members.

Both example documents that follow in this PDF are samples only. Actual *Explanation of Benefits (EOB)* examples include protected health information (PHI). The samples are just as the real documents appear, but include faux names and data.

Thank you for reviewing our entry!

Example 1: Medicare Advantage

The first sample for **Medicare Advantage** members features:

- A first "dashboard" page with important information at a glance
  - Financial highlights right up front
  - A callout if any claim was denied
  - A personalized care checklist
  - Personalized savings tips
- A second year-to-date summary page with updates on status against deductibles and out-of-pocket amounts
- Claims details with explanations
- Claims denials explained in plain language

ANTHEM BLUE CROSS AND BLUE SHIELD
PO BOX 105148
ATLANTA, GA 30348

Anthem BlueCross BlueShield

Don't worry, this is not a bill.

Jane Doe
123 Main Street, Apt #2
Anywhere, OH 63333

Medical and Hospital

Explanation of Benefits (EOB)
from 11/01/2017 through 11/30/2017

Hi, Jane!
Here's your Medicare Advantage Monthly Report.

For: **Jane Doe**
Member ID: **AN1234567**
Plan: **Anthem MediBlue Essential (HMO)**

Helpful resources

Call us!
We're here to help you. Just give us a call at **1-800-467-1199**, TTY: **711**, 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

Or go online
Visit **www.anthem.com/login** for even more information:

- See new claims and claims history.
- Search for doctors, hospitals and pharmacies.
- Choose to get plan documents by email.

Look for two savings tips inside!

Claims summary

Remaining deductible

Yearly plan deductible:	**$1,000.00**
You paid:	**$492.00**
Remaining:	**$508.00**

Year-to-date summary

You paid:	**$603.00**
Plan paid:	**$1,016.00**

This month's claims

Anthem paid:	**$231.00**
You paid:	**$160.00**

Your care checklist*

- ☐ **Time for your yearly doctor visit.**
- ☐ **You may be due for a mammogram.**
- ☐ **Get checked for osteoporosis.**
- ☐ **Time for an eye exam.**
- ☐ **Don't skip getting a flu shot.**

* Your checklist is as of 11/30/2017 and may not reflect your most recent claims.

Alert! A service or claim was denied. See details inside.

2017 year-to-date summary

Member ID: AN1234567 | **Plan:** Anthem MediBlue Essential (HMO)

Summary of totals for medical and hospital claims

	Amount the doctors or facilities have billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Monthly totals Claims processed from 11/01/2017 to 11/30/2017	$1,103.00	$291.00	$231.00	**$160.00**
Yearly totals All claims processed through 09/30/2017	$4,019.00	$2,875.00	$2,002.00	**$505.00**

2017 yearly deductible

Yearly plan deductible	Applied to date	Remaining deductible
$1,000.00	$492.00	**$508.00**

2017 out-of-pocket (OOP) maximums

For doctors or facilities in your plan	Applied to date	Remaining OOP maximum
$6,000.00	$2,000.00	**$4,000.00**

You may have more recent health care services that aren't showing up here. Visit **www.anthem.com/login** to see your up-to-date details.

Details for claims processed in November 2017

as of 11/30/2017

Your share of the cost may be a copay or coinsurance or the amount you need to pay to meet the deductible, if you have one. You may need to pay all of the cost if a service is not covered, is denied for medical reasons or you have not yet met the deductible.

This is how much your plan pays.

Medicare determines what it will cover and pay. All doctors and facilities that accept Medicare agree to these rates. Also, your plan has negotiated rates with doctors and facilities in your plan.

Doctors, hospitals and health care service providers choose what to charge. This is what you might pay if you did not have coverage.

Doctor or facility	Date of service	Service	Amount the doctor or facility billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Dr. Maxine Medicare (in your plan) A Claim number: 99-99999	11/06/17	Office visit - 99991	$125.00	$72.00	$62.00	$10.00 Copay for services from a doctor or facility in your plan
Subtotal:			**$125.00**	**$72.00**	**$62.00**	**$10.00**

Continues on next page

Details for claims processed in November 2017

as of 11/30/2017

Doctor or facility	Date of service	Service	Amount the doctor or facility billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Dr. Sam Specialist (not in your plan) Claim number: 99-100000	11/17/17	Neurobehavioral exam - 99203	$110.00	$0.00 **Denied: Reason code YAN***	$0.00	**$110.00** **You pay this cost because coverage was denied. See explanation.**
Subtotal:			**$110.00**	**$0.00**	**$0.00**	**$110.00**

Doctor or facility	Date of service	Service	Amount the doctor or facility billed the plan	Total cost (amount the plan approved)	Plan's share	Your share
Dr. E.R. Care (in your plan) Claim number: 99-100001	11/25/17	Emergency Room visit - 99214 B	$492.00	$219.00	$169.00	**$50.00** **Copay for services from a doctor or facility in your plan**
Pantelis, Diane P. (in your plan) Claim number: 99-100001	11/25/17	Routine EKG using at least 12 leads including interpretation and report - 93000	$376.00	$0.00	$0.00	**$0.00** **The amounts are $0.00 because the cost is covered under another part of this claim.**
Subtotal:			**$868.00**	**$219.00**	**$169.00**	**$50.00**

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Details for claims processed in November 2017

as of 11/30/2017

Savings tips

A Good job! You saved money by using a doctor or facility in your plan.

B You should always go to the ER or call 911 if you think you're in danger. For less serious needs, try urgent care. It could save you time and money.

Denials explained

* **Denial reason code YAN:** This claim was not paid because the service was performed by a doctor or health care professional who is not in the plan and did not get prior approval.

Continues on next page

Have a complaint?

You have the right to make a complaint or appeal

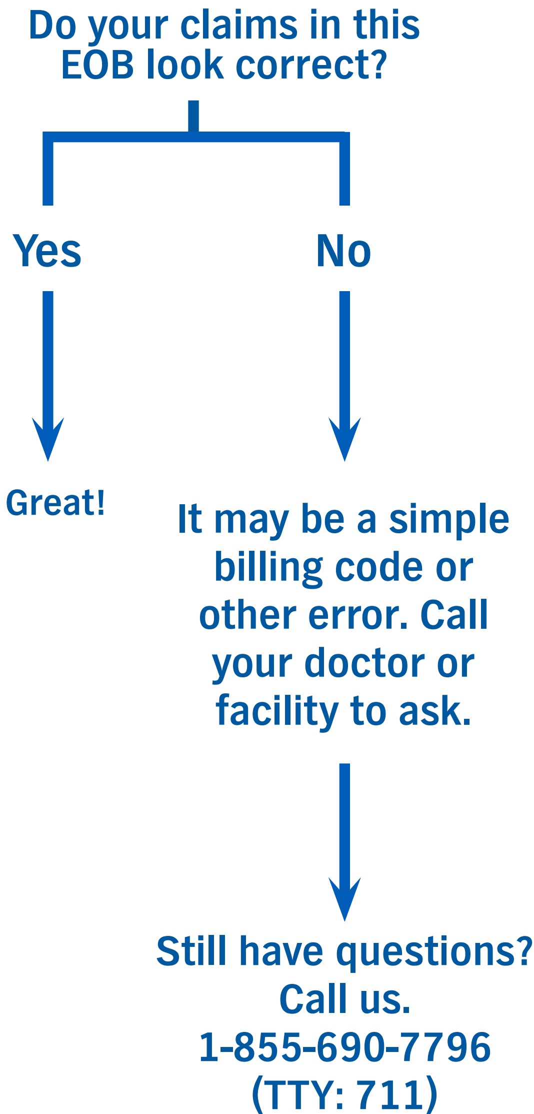
Making an appeal is a formal way of asking us to change our decision about your coverage. You can appeal if we deny a claim. You can also appeal if we approve a claim but you disagree with how much you are paying for the item or service. To learn more, call us.

Things to know about your denied claim

We have denied all or part of one or more claims listed in this report. You have the right to appeal. Making an appeal is a formal way of asking us to change the decision we made to deny your claim. If we agree to change our decision, it means we will approve the claim rather than deny it, and we will pay our share.

The doctor or facility can also make an appeal, and if this happens, you may not have to pay. You may wish to contact them to find out if they will ask us for an appeal. If they properly ask for an appeal, you will not need to pay, except for the normal cost-sharing amount. And you don't need to make an appeal yourself.

When we deny part or all of a claim, we send you a letter ("Notice of Denial of Payment"). It tells why the service or item is not covered. It also tells what to do if you want to appeal and have us reconsider. If you do not have this letter, call Customer Service.



Remember, this report is not a bill.

If you owe anything, your doctors and other health care providers will send you a bill.

See something odd?

If you notice something that might be dishonest billing, report it. Call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. (TTY: **1-877-486-2048)**.

Also good to know

The benefit information provided is a brief summary, not a complete description, of benefits. For more information, contact the plan. Benefits, formulary, pharmacy network, provider network, premium, copayments and coinsurance may change each year.

Anthem Blue Cross and Blue Shield is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Example 2: Group health plan

The next sample is for **Group** and **Individual** health plan members. You'll notice it mirrors the Medicare version. This is intentional to keep our looks similar and with the same features when possible so there's less confusion and greater readability when our group and individual plan members age in to Medicare plans. It becomes seamless. This EOB also features:

- A first "dashboard" page with important information at a glance
  - Claims summary and what the family and each member may need to pay
  - Preventive care checklist for all covered members in the family
  - Tips and tools
- A second year-to-date summary page with updates on status against deductibles and out-of-pocket amounts, as well as definitions of key terms
- Claims details with explanations of the member's cost
- Savings opportunities, including the name and address of the nearest urgent care centers

RETURN ADDRESS

Anthem BlueCross BlueShield

Don't worry, this is not a bill.

Jane Q. Member
123 Main Street, Apt #2
Indianapolis, IN 46268

Hi Jane — Here's your

Health Care Summary

as of March 24, 2017.

Also called an Explanation of Benefits (EOB), it shows the care you and your family got, and who pays what. Plus ways to save money and stay healthy.

Need help in a different language? Call us.
¿Necesita ayuda en español? Llámenos.
1-800-123-4567

Helpful resources

Message us
Log in to **anthem.com** and select this icon

Call
1-800-123-4567 Mon-Fri, 8 a.m.- 6 p.m.
TTY/TDD: #711

Go online
At **anthem.com** or use the Anthem Anywhere mobile app.

Claims summary

Doctor/facility charges:	**$983.00**
Your discounts:	**— 584.03**
Due to your doctor/facility:	**$398.97**
Anthem paid:	**— 0.00**

What you pay: $398.97

Preventive care checklist*

For Jane

- ☐ Breast cancer screening
- ☐ Colon cancer screening
- ☐ Diabetes check

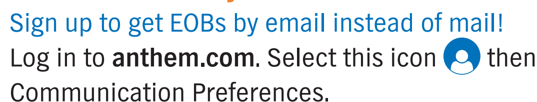
For Tom

- ☐ Child well-care visit
- ☐ Flu shot

*Your checklist is based on age and gender guidelines from the Centers for Disease Control and Prevention. Been to the doctor recently? It may not reflect your most recent services.

Tips and tools

Want us to email you instead?



Urgent care without the urgent cost
If it's not an emergency, try an urgent care instead of the ER. It could save you an average of $500. **UrgentCare Indy** is close by at 7911 N Michigan Rd, Indianapolis, IN 46268, 1-317-960-3278.

Medical necessity reviews are done by Anthem UM Services Inc, a separate company.
Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

2017 year-to-date summary

Jane Q. Member **Member ID:** WWW900W90909 **Coverage:** Individual + Child(ren)

Group ID: 000123 - ABCDEFG Corporation

Plan deductible	In-network deductible	Applied to date	Remaining deductible	Out-of-network deductible	Applied to date	Remaining deductible
Individual						
Jane Q. Member	$1,500.00	-$500.00	$1,000.00	$2,500.00	-$750.00	$1,750.00
Tom F. Dependent	$1,500.00	-$500.00	$1,000.00	$2,500.00	-$100.00	$2,400.00
Family	$4,000.00	-$1,000.00	$3,000.00	$6,000.00	-$1,000.00	$5,000.00

Out-of-pocket (OOP) maximum	In-network OOP max	Applied to date	Remaining OOP max	Out-of-network OOP max	Applied to date	Remaining OOP max
Individual						
Jane Q. Member	$4,000.00	-$1,000.00	$3,000.00	$8,000.00	-$1,060.00	$6,940.00
Tom F. Dependent	$4,000.00	-$750.00	$3,250.00	$8,000.00	-$1,000.00	$7,000.00
Family	$6,000.00	-$2,000.00	$4,000.000	$10,000.00	-$3,000.00	$7,000.00

Copay is the flat-dollar amount you may pay for health care, such as doctor visits.

Deductible is the amount you pay for health care before we start sharing the cost.

Out-of-pocket maximum is the most you'll pay for covered health care in your plan year. After that, we'll pay for all your covered health care.

Need more info? Go to **anthem.com/glossary**.

You may have other health care services that aren't showing here. Visit anthem.com to see the latest info.

Claims details

Don't recognize these services?
Call the Fraud Hotline at 1-877-283-1524

Jane Q. Member | **Claim number:** 1234567891255 | **Received:** 3/6/17 | **Doctor**: Jennifer Jones, MD (Not in your plan)

Going to this doctor uses out-of-network benefits — if your plan has them.

You pay $175.00.
Here's how it breaks down.

Service date	Service	Reason code	Doctor charges	Your discounts	Due to your doctor	Anthem paid	Copay	Deductible	Your percentage of the costs	Services not covered	Your total cost
				−	=	−	+	+	+	+	
1/26/17	Special services		175.00	0.00	175.00	0.00	0.00	175.00	0.00	0.00	= 175.00
Totals:			**175.00**	**0.00**	**175.00**	**0.00**	**0.00**	**175.00**	**0.00**	**0.00**	**= $175.00**

You can learn more about these services, including diagnosis and treatment codes and what they mean. Just call Member Services at 1-800-123-4567.

Not happy? Here are your appeal rights.

Any time you pay for a portion of your care, you have the right to question whether we calculated it right. We call that your appeal rights.

Call us at 1-800-123-4567

- **Get help understanding this notice.**
- **Talk through your portion and our portion of these service costs, including any denials.**

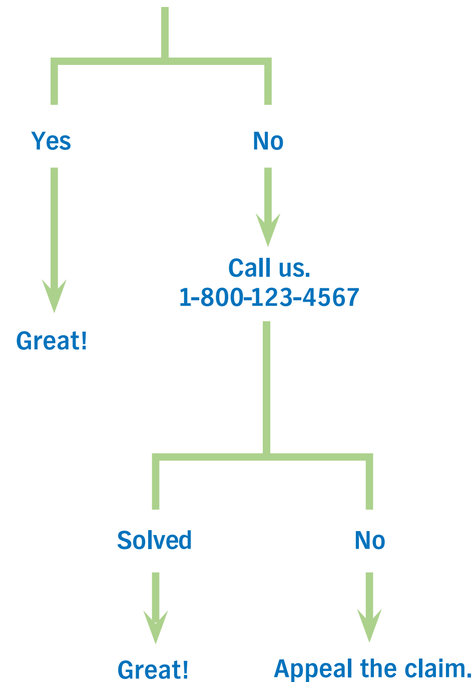
If you think something should have been covered (in whole or in part), but it wasn't, or it wasn't covered in the way you think it should be — you can appeal it and we'll take another look.

Here's how you appeal a claim. Check your plan benefits for how long you have to file an appeal. Usually it's within 180 days of when we told you our decision. You or someone acting for you can send us a note saying you want to appeal. You can do this by secure message on **anthem.com**. Make sure to select Grievances/Appeals as the subject of your message.

Or send us a note in the mail to:
Grievances and Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Be sure your appeal includes:

- Patient info: name, member ID, address, phone number, date of birth
- Claim info: date(s) of the service you're appealing, your doctor's name/address/phone number
- Any other info about your claim that you think is important



Do it online or in writing if you can. Or check your benefits booklet or plan documents to see if you can appeal by phone.

If you need a decision fast, call us. You can ask for an "expedited appeal," and get an answer in about 48 hours. Use this option if:

- Your life or health is in danger.
- In your doctor's opinion, your pain can't be adequately controlled while you wait.
- You're waiting to see if you should stay at the hospital or ER.

To ask for an expedited appeal or expedited review by someone outside our company — you, your doctor or someone acting for you can call the Member Services number on your ID Card.

Get more info on your claim — it's free. Give us a call. You can get billing/diagnosis codes and their meanings, or any other info we used to decide your claim, any time.

If you appeal, we'll review and give you a written decision within 20 business or 30 calendar days from the date we get your appeal request, whichever is sooner. Check your benefits booklet to see if it gives a different time limit. If you still don't feel our response is right, or if you don't hear back from us in time, you may be able to ask for a review from someone outside our company, an independent third party. Their decision is final.

Your health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Once you've used all your mandatory appeal rights, you have one year from our appeal decision to bring an action in federal court under section 502(a)(1)(B) of ERISA.

For questions about your rights or for help, call Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

State Regulator Contact:
Consumer Services Division,
Indiana Department of Insurance,
311 West Washington Street, Suite 300,
Indianapolis, IN 46204-2787
1-317-232-2395 or 1-800-622-4461

You can learn more about our grievance and appeal process at the Indiana Department of Insurance: in.gov/idoi/3008.htm