BREAKDOWN OF CHARGES AND BENEFITS

(15) Date: 04/01/08   DOE JOHN A
Benefit (16) n Number: YQA99999999   Group 999   2 of

Patient/Claim Number (17) Provider/Type of Service	(19) Processed Date	(20) Charges Submitted	(21) Covered Amounts: Provider Discount	(22) CHAND	(23) Previously Processed	(24) Noncovered and Cost Sharing Amounts: Noncovered Charges	(25) Deductible	(26) Coinsurance	(27) Copayment
JOHN / CLAIM 99201000000/00 Date of service : 03/03/08 / Inpatient Hospital	04/01/08	3419.53		3077.58				341.95 A	
(18) TOTALS:		3419.53		3077.58				341.95	

(28) * YOUR RESPONSIBILITY TO THE PROVIDER: 341.95

If you have any questions about this Explanation of Benefits, please call or write our Member Services department at the telephone number or address on this form. For additional information regarding the process for reconsideration of your claim, please refer to your Benefit Plan.

(29) o federal regulations and our continuing commitment to confidentiality, Explanation of Benefits will be addressed to the member who received es.

EXPLANATION OF NOTES:

A - This amount has been applied to your coinsurance. (00-086-00)

(15) **Date** - Date the EOB was printed.
Name - Subscriber's name.
Benefit Plan Number - The subscriber's CHAND benefit plan number.
Group Number - The subscriber's health insurance plan group number.

(16) **Patient/Claim Number** - The name of the patient who received the service and the claim number designated for the purpose of identification.

(17) **Provider/Type of Service** - The name of the individual or institution that performed the service and the type of service that was performed.

(18) **Date of Service** - The date the service was performed.

(19) **Processed Date** - The date the claim completed processing.

(20) **Charges Submitted** - The charge billed by your provider for each service.

(21) **Provider Discount** - The portion of the charge that may have been discounted by your provider.

(22) **CHAND** - The amount the subscriber's coverage paid toward each service.

(23) **Previously Processed** - Any amount previously processed by this plan, Medicare or another insurance company.

(24) **Noncovered Charges** - The charges that are noncovered according to the terms set forth in your benefit plan.

(25) **Deductible** - Specified dollar amount for certain covered services received during the benefit period that is your responsibility to the provider.

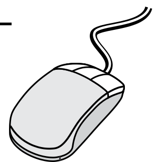
(26) **Coinsurance** - Percentage of the allowed charge for certain covered services that is your responsibility to the provider.

(27) **Copayment** - Specified dollar amount payable for certain covered services that is your responsibility to the provider.

(28) **Your Responsibility To The Provider** - The total amount that you are responsible to pay to your provider.

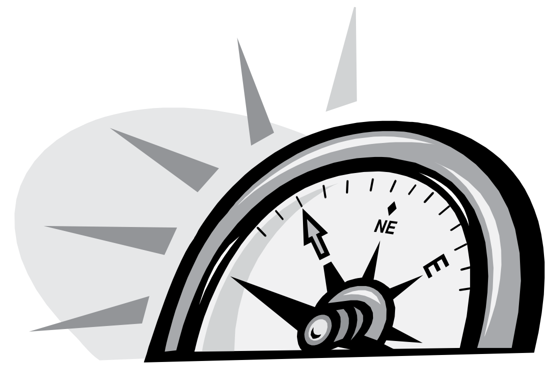
(29) **Explanation Of Notes** - Explanations or descriptions corresponding to the amount(s) noted in the breakdown of charges and benefits (sections 23, 25, 26, 27, 28 and 29 shown above).

Please call Member Services with any questions. The phone numbers are listed on the front of your EOB or on the back of your ID card.



A Guide to Your

EXPLANATION OF BENEFITS

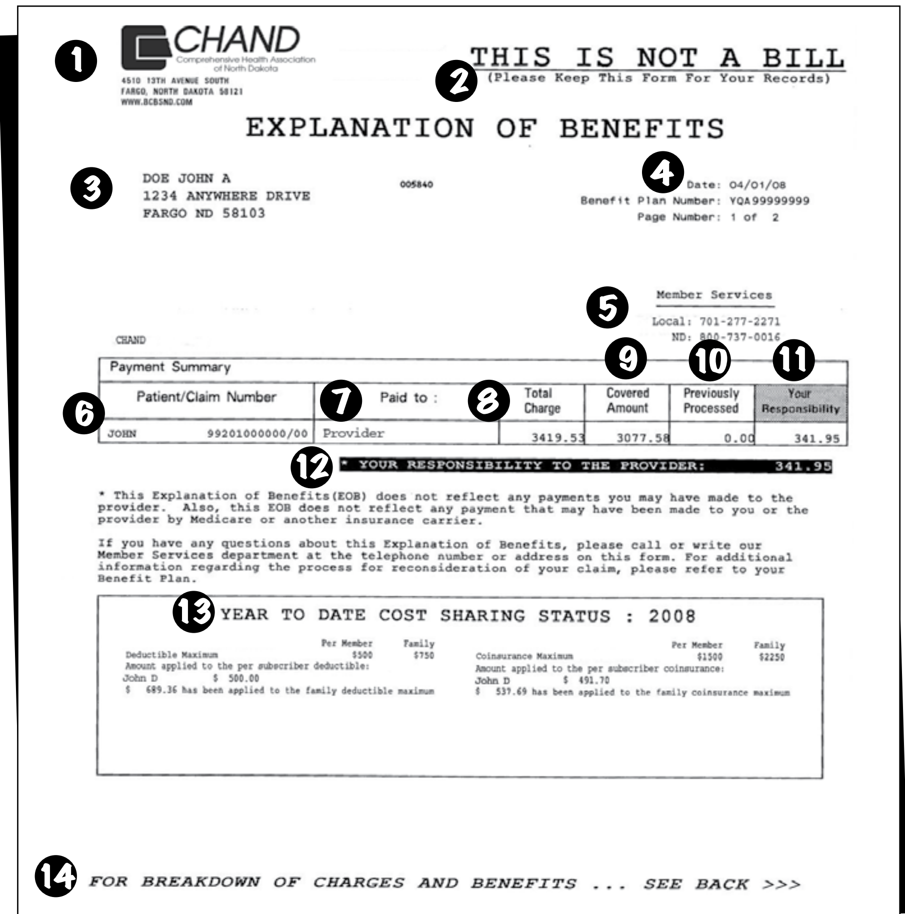


29311848 (5051) 12-08

EXPLANATION OF BENEFITS

This form has been designed to explain how your health care claims were processed. The major features of the EOB include:

1. **Addresses** - The mailing address for CHAND.
2. **This Is Not A Bill** - Please do not send payment for this service to CHAND. Please keep this form for your records.
3. **Subscriber's Name and Address** - The name and address of the subscriber as shown on our records. If not correct, please call Member Services at the numbers shown on the back of your ID card or on your EOB form.
4. **Date** - Date the EOB is printed.
   Benefit Plan Number - The subscriber's CHAND benefit plan number.
   Page Number - Identifies the number of pages for this EOB.
5. **Member Services Phone Numbers** - The numbers you should call with questions on this EOB.
6. **Patient/Claim Number** - The name of the patient who received the service and the claim number designated for the purpose of identification.
7. **Paid To** - The name of the individual or institution that was paid for the service.
8. **Total Charge** - The total charge associated with the claim.
9. **Covered Amount** - The portion of the claim that has been discounted or paid by this plan.
10. **Previously Processed** - Any amount previously processed by this plan, Medicare or another insurance company.
11. **Your Responsibility** - The portion of the claim that you are responsible to pay to your provider.
12. **Your Responsibility To The Provider** - The total amount that you are responsible to pay to your provider.



CHAND
Comprehensive Health Association of North Dakota
4510 13TH AVENUE SOUTH
FARGO, NORTH DAKOTA 58121
WWW.BCBSND.COM

THIS IS NOT A BILL
(Please Keep This Form For Your Records)

EXPLANATION OF BENEFITS

DOE JOHN A
1234 ANYWHERE DRIVE
FARGO ND 58103

005840

Date: 04/01/08
Benefit Plan Number: YQA99999999
Page Number: 1 of 2

Member Services
Local: 701-277-2271
ND: 800-737-0016

CHAND

Payment Summary

Patient/Claim Number		Paid to :	Total Charge	Covered Amount	Previously Processed	Your Responsibility
JOHN	99201000000/00	Provider	3419.53	3077.58	0.00	341.95

* YOUR RESPONSIBILITY TO THE PROVIDER: 341.95

* This Explanation of Benefits(EOB) does not reflect any payments you may have made to the provider. Also, this EOB does not reflect any payment that may have been made to you or the provider by Medicare or another insurance carrier.

If you have any questions about this Explanation of Benefits, please call or write our Member Services department at the telephone number or address on this form. For additional information regarding the process for reconsideration of your claim, please refer to your Benefit Plan.

YEAR TO DATE COST SHARING STATUS : 2008

	Per Member	Family
Deductible Maximum	$500	$750

Amount applied to the per subscriber deductible:
John D $ 500.00
$ 689.36 has been applied to the family deductible maximum

	Per Member	Family
Coinsurance Maximum	$1500	$2250

Amount applied to the per subscriber coinsurance:
John D $ 491.70
$ 537.69 has been applied to the family coinsurance maximum

FOR BREAKDOWN OF CHARGES AND BENEFITS ... SEE BACK >>>

13. **Year To Date Cost Sharing Status** - The total deductible, coinsurance, and/or copayment that you have accumulated to date. These totals may reflect claims in process for which you have not yet received an EOB.
14. **For Breakdown Of Charges And Benefits** - A detailed breakdown of how your claims were processed is included on the reverse side of your EOB.