BlueCross BlueShield of Texas
PO Box 660044
Dallas, TX 75266-0044

EXPLANATION OF BENEFITS

Log into **www.healthselectoftexas.com**
- View plan and claim details
- Contact us through our secure Message Center
- Sign up for digital health plan info
- Search for health care providers

Text* **GOBCBSTX** to **33633** to download the mobile app.

Have questions about this EOB?
Personal Health Assistants are here to help!
1-800-252-8039

Participant Name
Address
City, State Zipcode

1

2

SUBSCRIBER INFORMATION

HEALTHSELECT OF TEXAS
Member ID#: 000 Group #: 000

Dear Participant Name,

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

HELPFUL INFORMATION

Glossary of Terms: We have described below some of the terms in this EOB. If you have questions, contact a Personal Health Assistant at 1-800-252-8039 or you may also find additional information on these terms in your Master Benefit Plan Document at healthselectoftexas.com.

Deductible: a set amount you must pay out-of-pocket each calendar year for covered services before the Plan begins to pay for anything except preventive care services.

Coinsurance: the percentage of allowable amounts you are required to pay for certain covered health services.

Out-of-Pocket Coinsurance Maximum: the most you are required to pay each calendar year for coinsurance.

3

Copay: the set dollar amount you are required to pay for certain covered health services.

Inpatient Copay Maximum: the most you are required to pay each calendar year in copays for inpatient stays in a hospital or for inpatient care for mental health services, serious mental illness services, or substance use disorder services. There are separate network and non-network inpatient copay maximums for this plan.

Total Network Out-of-Pocket Maximum: the most you are required to pay each calendar year for applicable network deductibles, coinsurance, and copays. The total network out-of-pocket maximum includes both medical and prescription drug services.

Patient: the person who received medical or mental health services.

Subscriber: the participant who is the employee, retiree, or other person enrolled in the Plan as provided for under the Act, and who is not a dependent.

Health Care Fraud Hotline: 800-543-0867
Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Texas, please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to **bcbstx.com.**

BlueCross BlueShield of Texas

CLAIM DETAIL (1 of 1)

PATIENT: Participant Name

PROVIDER: Provider Name

CLAIM #: 000000000

DATE PROCESSED: 05/12/2021

SUBSCRIBER INFORMATION

HEALTHSELECT OF TEXAS

Member ID#:**000000000** Group#:**000000000**

Personal Health Assistants are here to help! **1-800-252-8039**

Amount Billed	$261.97
Discounts and Reductions	- $138.65
Health Plan Responsibility	- $98.32
You may owe your health care provider for these services	**$25.00**

			YOUR BENEFITS APPLIED			YOUR RESPONSIBILITY				
Service Description	**Service Dates**	Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	**Your Total Costs**
Medical Visits	05/04/2021	230.00	(1) 115.31	114.69	89.69		25.00			25.00
Laboratory Services	05/04/2021	9.00	(2) 9.00							0.00
Laboratory Services	05/04/2021	22.97	(1) 14.34	8.63	8.63					0.00
CLAIM TOTALS		**$261.97**	**$138.65**	**$123.32**	**$98.32**	**$0.00**	**$25.00**	**$0.00**	**$0.00**	**$25.00**

Total covered benefits approved for this claim: $98.32 to Provider Name on 05-12-21. Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"

(1) The amount billed is more than what is allowed for this service. Your provider should not bill you for any balance over what is allowed.

(2) This service should not be billed as a separate charge. It is part of another service performed on this date. Your provider should not bill you for this.

For your up-to-date Medical Spending summary, visit Blue Access for Members℠ on our website, the BCBSTX Mobile App or call the phone number on the back of your ID card.

Participant Name - Benefit Period: 01-01-21 Through 12-31-21 To date this patient has met $26.10 of her/his $6,750.00 in-network out-of-pocket maximum.

Benefit Period: 01-01-21 Through 12-31-21 To date $1,006.72 of the family $13,500.00 in-network out-of-pocket maximum has been met.