READING AN AMBETTER HEALTH EXPLANATION OF BENEFITS (EOB) 2.0

Disclaimer: All PHI and PII on the examples below is anonymized.

The number fields on this table correlate to the numbers on the images of the EOB.

#	Description
EOB Cover Page	
1	Health Plan Return Address
2	Member Address
3	Customer Service Phone Number
4	Run Date – When the EOB was printed
5	Member ID – Matches Amisys member number
6	Member Name
A	Paperless Disclosure and QR code (2.0 Enhancement)
EOB Amount Summary Page	
7	Health Plan Responsibility – Total amount the plan pays the providers for this EOB
8	Member Cost Share Responsibility – Total amount the member pays for this EOB
9	Denied Charges – Total amount denied for this EOB
Claim Header Information	
10	Provider Name
11	Network Status – In-Network denotes a participating provider and Out-of-Network denotes a nonparticipating provider
12	Claim Number
Service Line Information	
13	Service Detail - Claim Information – This section shows details for all service lines associated with the claim
14	Service Line Number – Service lines ending in 00 signify an original service line. Service lines ending in an odd number (01, 03, etc.) signify the money on the service line is being recouped. Service lines ending in an even number (02, 04, etc.) signify an adjusted service line.
15	Service Date From – The date the service began
16	Service Date Through – The date the service ended
17	Service Code – Procedure or diagnosis code
#	**Description**
Service Line Information (*continued*)	
18	Service Description
19	Billed Charges – Amount billed by the provider for the service
20	Allowed Amount – Amount Centene is contracted to pay for the service
21	Disallowed Charges – Amount of the contract discount for the service
22	Denied Charges – Amount denied for the service
23	Other Insurance Allowed – Amount the other insurance carrier is contracted to pay for the service
24	Other Insurance Paid – Amount the other insurance carrier paid for the service
25	Tax Paid – Amount of tax paid for the service
26	Interest Paid – Amount of interest paid on the service
27	Claim Line Status – Denotes if the service line was paid or not paid
28	Paid Date – The date the service line was paid. The claim was adjusted if there are multiple dates. Service lines with previous paid dates may have also been sent on a previous EOB.
29	Other Reductions to Allowed Amount – Discounts and Withholds and Capitated Risk Amounts reduce the amount that will be paid
30	Member Cost Share Responsibility Amounts – Copay, Coinsurance, and Applied to Deductible are amounts the member owes for the service
31	Discounts and Withholds – Sum of late submission fees, prompt payment discounts, and other discounts
32	Capitated Risk Amount

33	Copay for the service, owed by the member
#	**Description**
Service Line Information (*continued*)	
34	Coinsurance for the service, owed by the member
35	Applied to Deductible – Amount applied to deductible for the service, owed by the member
36	Explanation Codes – Codes assigned to each service line signifying how the claim was processed and why (Centene specific)
37	Net Payment Amount Per Claim Line - The net amount Centene paid for the service
Claim Subtotal Amounts	
38	Net Claim Summary – This section shows the subtotal amounts for the claim
39	Sum of Billed Charges for the claim
40	Sum of Allowed Charges for the claim
41	Sum of Denied Charges for the claim
42	Sum of Other Insurance Payments and Other Reductions to Allowed Amounts – Sum of #26 and #31 for the claim
43	Sum of Additional Allowances – Sum of #27 and #28
44	Sum of Member Cost Share Responsibility Amounts – Sum of #32 for the claim
45	Health Plan Payment – Sum of #39 for the claim
Explanation Codes Descriptions	
46	Payment, Denial, & Adjustment Explanation Codes for this Explanation of Benefits – This section lists all Explanation Codes from #38, their corresponding CARC and RARC codes (if applicable), and descriptions of all codes

#	Description
Explanation Codes Descriptions (*continued*)	
47	Explanation (EX) Code – Codes assigned to each service line signifying how the claim was processed and why (Centene specific)
48	CARC Code – Claim Adjustment Reason Codes, Industry standard codes Centene has mapped to their EX codes
49	RARC Code – Remittance Advice Remark Codes, Industry standard codes Centene has mapped to their EX codes
Accumulator Information	
50	Benefit Year – The EOB will display the current and previous benefit year if applicable
51	Deductible Applied Year to Date
52	Annual Deductible Limit
53	In-Network Deductible Remaining
54	Applied to Out of Pocket Max Year to Date
55	Annual Out of Pocket Limit
56	In-Network Out of Pocket Remaining
57	Copays Applied Year to Date
58	Coinsurance Applied Year to Date
Accumulator Information Note: Out-of-Network and Family Limits are not displayed but can be viewed on the Member Portal.	
Surprise Medical Bills	
2-Page Disclosure for Rights and Protections Against Surprise Medical Bills	

Ambetter Health
123 Street Rd
City, State 12345

1

ELECTRONIC SERVICE REQUESTED

00 141 102519 538437107 85224 4092 92

JOHN DOE
1234 MEMBER RD APT B
CHANDLER, AZ 85224-4092

2

ambetter HEALTH

EXPLANATION OF BENEFITS (EOB)

An 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.**

1-888-555-5555
(TTY/TDD 1-888-111-1111)

3

EOB Date: 7/5/2020 4

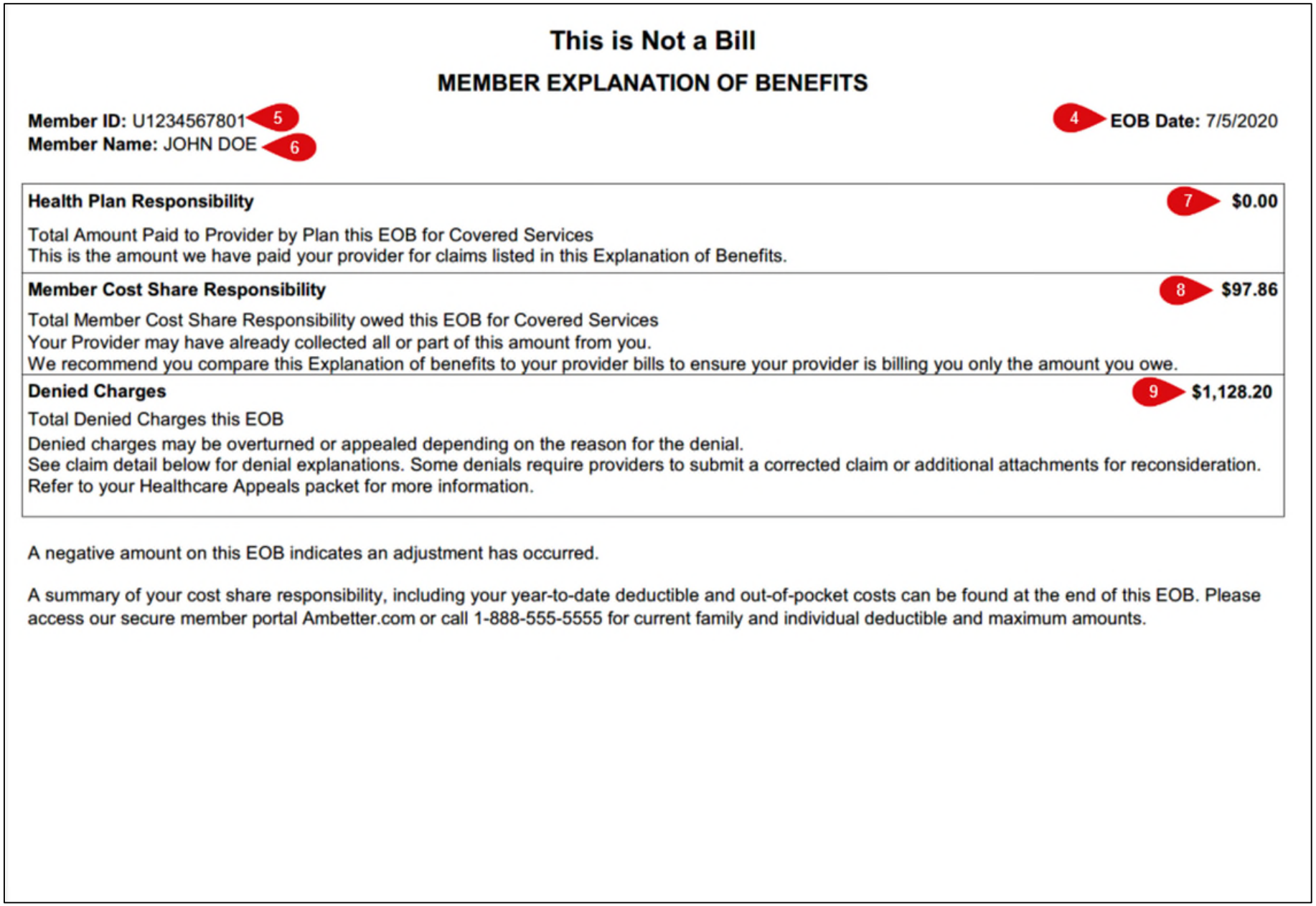
Member ID: U1234567801 5

Member Name: JOHN DOE 6

A

GO PAPERLESS. *It's fast, convenient, and timely. Simply update all your communication preferences on your portal at member.ambetterhealth.com, or scan the QR code below.*

Disclaimer: All addresses, phone numbers, and other contact information are fictitious and should not be used to contact the plan.



This is Not a Bill

MEMBER EXPLANATION OF BENEFITS

Member ID: U1234567801 (5)
Member Name: JOHN DOE (6)

(4) **EOB Date:** 7/5/2020

Health Plan Responsibility Total Amount Paid to Provider by Plan this EOB for Covered Services This is the amount we have paid your provider for claims listed in this Explanation of Benefits.	(7) **$0.00**
Member Cost Share Responsibility Total Member Cost Share Responsibility owed this EOB for Covered Services Your Provider may have already collected all or part of this amount from you. We recommend you compare this Explanation of benefits to your provider bills to ensure your provider is billing you only the amount you owe.	(8) **$97.86**
Denied Charges Total Denied Charges this EOB Denied charges may be overturned or appealed depending on the reason for the denial. See claim detail below for denial explanations. Some denials require providers to submit a corrected claim or additional attachments for reconsideration. Refer to your Healthcare Appeals packet for more information.	(9) **$1,128.20**

A negative amount on this EOB indicates an adjustment has occurred.

A summary of your cost share responsibility, including your year-to-date deductible and out-of-pocket costs can be found at the end of this EOB. Please access our secure member portal Ambetter.com or call 1-888-555-5555 for current family and individual deductible and maximum amounts.

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Understanding Your Explanation of Benefits (EOB)

Member Cost Share Responsibility Explanation

Member Cost Share Responsibility Explanation

This page explains member cost share for first time claims and adjustments for network and non-network providers. This information is required by the state and is standard for all EOBs in a given market. This information varies slightly from market to market.

This includes disclosures regarding the No Surprise Billing Act.

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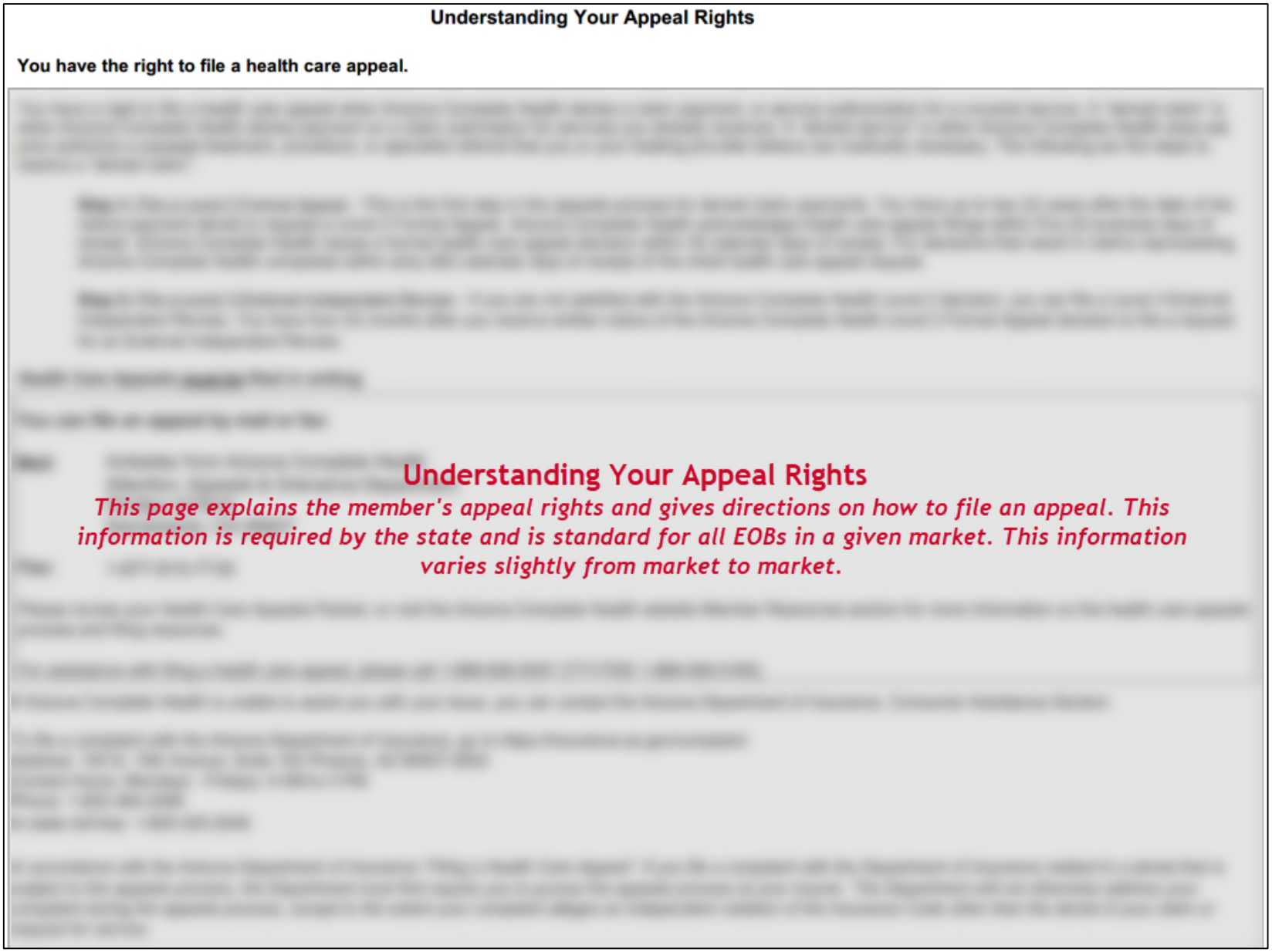

Understanding Your Appeal Rights

You have the right to file a health care appeal.

[redacted]

Understanding Your Appeal Rights

This page explains the member's appeal rights and gives directions on how to file an appeal. This information is required by the state and is standard for all EOBs in a given market. This information varies slightly from market to market.

[redacted]

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Member ID: U1234567801 5
Member Name: JOHN DOE 6

4 **EOB Date:** 7/5/2020

Provider Name: STATE IMAGING CO 10 Network Status: In-Network 11 12 Claim Number: T153CC874265

Service Detail - Claim Information (T153CC874265) 13

Line Number 14	Service Date From 15	Service Date Through 16	Service Code 17	Service Description 18
0100	4/3/2019	4/3/2019	73221	MRI ANY JT UPPER EXTREM
0101	4/3/2019	4/3/2019	73221	MRI ANY JT UPPER EXTREM
0102	4/3/2019	4/3/2019	73221	MRI ANY JT UPPER EXTREM
0103	4/3/2019	4/3/2019	73221	MRI ANY JT UPPER EXTREM
0104	4/3/2019	4/3/2019	73221	MRI ANY JT UPPER EXTREM

Line Number 14	Billed Charges 19	Allowed Charges 20	Disallowed Charges (Contract Discount) 21	Denied Charges 22	Other Insurance Allowed 23	Other Insurance Paid 24	Tax Paid 25	Interest Paid 26	Claim Line Status 27	Paid Date (Claim has Been Adjusted if Dates are Different) 28
0100	$1,128.20	$203.13	$925.07	$1,128.20	$0.00	$0.00	$0.00	$0.00	Not Paid	6/9/2020
0101	-$1,128.20	-$203.13	-$925.07	-$1,128.20	$0.00	$0.00	$0.00	$0.00	Not Paid	6/22/2020
0102	$1,128.20	$203.13	$925.07	$1,128.20	$0.00	$0.00	$0.00	$0.00	Not Paid	6/22/2020
0103	-$1,128.20	-$203.13	-$925.07	-$1,128.20	$0.00	$0.00	$0.00	$0.00	Not Paid	7/2/2020
0104	$1,128.20	$203.13	$925.07	$1,128.20	$0.00	$0.00	$0.00	$0.00	Not Paid	7/2/2020

Other Reductions to Allowed Amount 29			Member Cost Share Responsibility Amounts 30			Explanation Codes (See Descriptions Below Net Claim Summary) 36	Net Payment Amount Per Claim Line (After Member Responsibility Withheld) 37
Line Number 14	Discounts and Withholds 31	Capitated Risk Amount 32	Copay 33	Coinsurance 34	Applied To Deductible 35		
0100	$0.00	$0.00	$0.00	$0.00	$0.00	A1	$0.00
0101	$0.00	$0.00	$0.00	$0.00	$0.00	JU	$0.00
0102	$0.00	$0.00	$0.00	$0.00	$0.00	A1	$0.00
0103	$0.00	$0.00	$0.00	$0.00	$0.00	JU	$0.00
0104	$0.00	$0.00	$0.00	$0.00	$0.00	A1,QM	$0.00

Net Claim Summary (T153CC874265) 38					Amounts Owed By Member 44	Health Plan Payment 45
	Sum of Billed Charges 39	Sum of Allowed Charges 40	Sum of Denied Charges 41	Sum of Other Insurance Payments and Other Reductions to Allowed Amounts 42	Sum of Additional Allowances (Tax Paid and Interest Paid) 43	Sum of Member Cost Share Responsibility Amounts	Net Paid or Recouped This Claim (A Negative Amount Indicates a Recoupment)
All Lines	$1,128.20	$203.13	$1,128.20	$0.00	$0.00	$0.00	$0.00

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Member ID: U1234567801 5

Member Name: JOHN DOE 6

4 **EOB Date:** 7/5/2020

Payment, Denial, & Adjustment Explanation Codes for this Explanation of Benefits 46

Payment/Denial/Adjustment Explanation codes used on one or more of the claims above	
EX Code 59 47 CARC Code 59 48	PAY: SERVICES REIMBURSED ACCORDING TO MULTIPLE PROCEDURE GUIDELINES Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
EX Code 01 47 CARC Code 1 48	DEDUCTIBLE APPLIED Deductible Amount
EX Code 91 47 CARC Code 45 48	REIMBURSEMENT OF FEE SCHEDULE AND/OR CONTRACTED RATES Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
EX Code A1 47 CARC Code 197 48	DENIED: NO RECORD OF PRIOR AUTHORIZATION FOR SERVICE BILLED Precertification/authorization/notification/pre-treatment absent.
EX Code JU 47	ADJUSTMENT MADE TO PREVIOUSLY SUBMITTED CLAIM
EX Code QM 47 CARC Code 246 48 RARC Code N572 49	DENIED: NO RECORD OF PRIOR AUTHORIZATION FOR SERVICE BILLED Precertification/authorization/notification/pre-treatment absent. This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.

EX codes are specific to your plan. CARC and RARC codes and descriptions are industry standard and used by all payers.

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Member ID: U1234567801 (5)

Member Name: JOHN DOE (6)

(4) **EOB Date:** 7/5/2020

Understanding your Annual Deductible and Out-of-Pocket Limits

For the best and most current information, please access our secure member portal at Ambetter.com or call 1-888-555-5555 for current family and individual deductible and maximum amounts.

HMO & PPO Plans - Member Cost Share Responsibility Applied to Annual In-Network Deductible and Out of Pocket Maximum for Covered Services

(50) Benefit Year	(51) Deductible Applied Year to Date	(52) Annual Deductible Limit	(53) In-Network Deductible Remaining	(54) Applied to Out of Pocket Max Year to Date	(55) Annual Out of Pocket Limit	(56) In-Network Out of Pocket Remaining
2020	$570.58	$1,050.00	$479.42	$978.36	$2,700.00	$1,721.64
2019	$925.00	$925.00	$0.00	$2,580.00	$2,550.00	-$30.00

Member Cost Share Responsibility Applied to In-Network Out of Pocket Maximum

(50) Benefit Year	(57) Copays Applied Year to Date	(58) Coinsurance Applied Year to Date	(51) Deductible Applied Year to Date	(54) Applied to Out of Pocket Max Year to Date
2020	$120.00	$287.78	$570.58	$978.36
2019	$930.00	$725.00	$925.00	$2,580.00

This is the end of your EOB. The Non-Discrimination Notice and National Other Language Assistance Page documents that follow are required on all member mailings by regulation.

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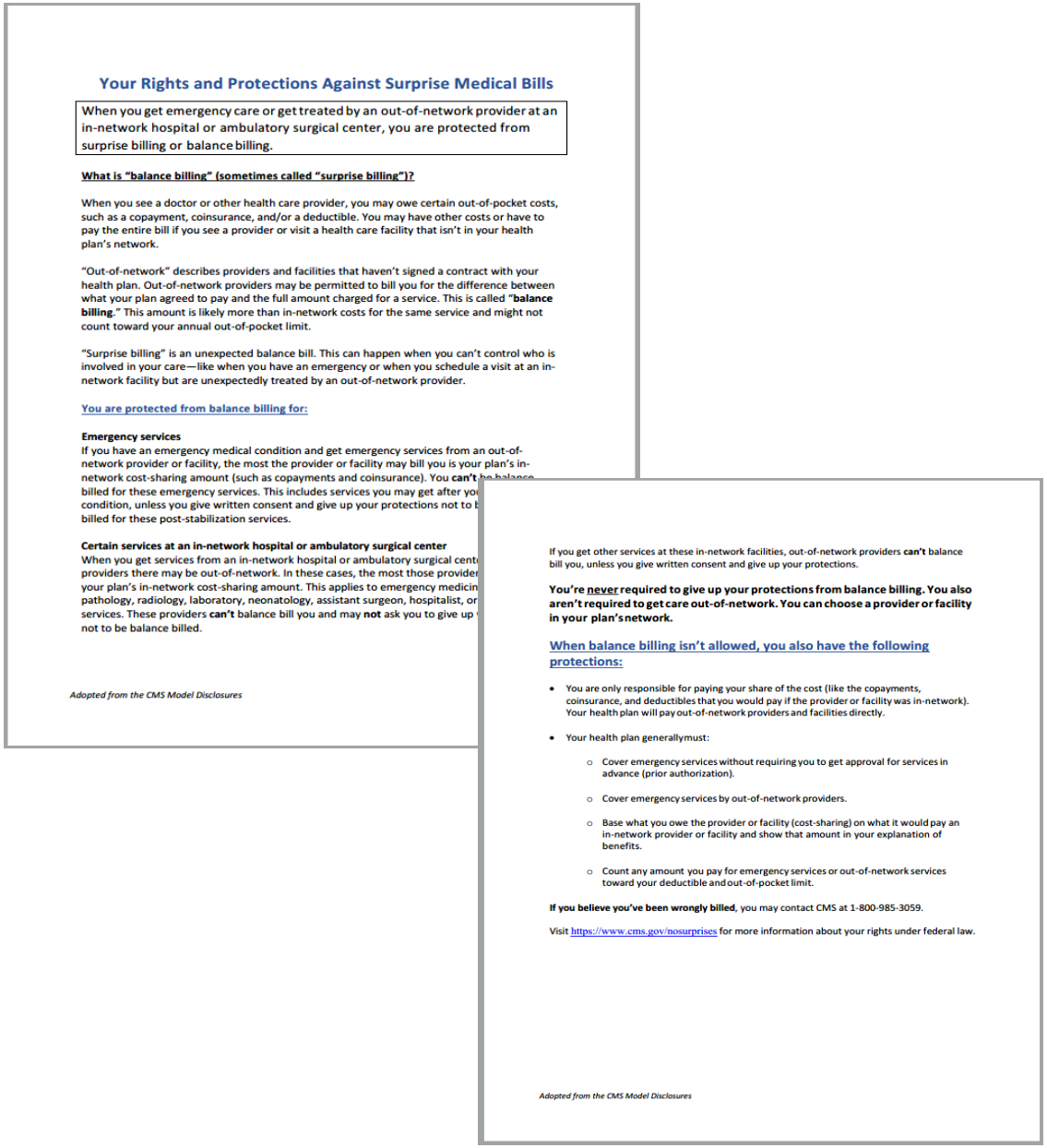
Your Rights and Protections Against Surprise Medical Bills.

This 2-page disclosure is required to advise members on their protections against surprise medical bills, it may vary by state.



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you
condition, unless you give written consent and give up your protections not to b
billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical cent
providers there may be out-of-network. In these cases, the most those provider
your plan's in-network cost-sharing amount. This applies to emergency medicin
pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or
services. These providers **can't** balance bill you and may **not** ask you to give up
not to be balance billed.

Adopted from the CMS Model Disclosures

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless 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 are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generallymust:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact CMS at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Adopted from the CMS Model Disclosures