

Member: Test B Smith
123 INSURANCE AVENUE
CHICAGO, IL 60611

ID: TESTMEMB1



Statement Date
10/10/08

3 This is not a bill.

EXPLANATION OF BENEFITS

Servicing Provider: Smith, Kevin L.

Claim Number: TSTCLAIM0800

Description of Service	Dates of Service	Total Charges	Member Responsibility			Plan Disallow	Approved Amount	Adj Amount	Amount Paid	Remarks
			Copay /Ded	Co Insurance	Non Covered					
Laboratory Services	09/18/08-09/18/08	75.70	5.49	0.00	0.00	70.21	5.49	0.00	0.00	
Claim Totals:		75.70	5.49	0.00	0.00	70.21	5.49	0.00	0.00	

Grand Totals:

Reason Codes

The Medical Explanation of Benefits is designed to help you understand how your claims are processed. Here's some key information you'll find on this EOB:

- 1.Patient:** This is the name of the member who received services.
- 2.Insured ID:** This is the identification number of the member, the same ID number that is printed on your Anthem Blue Cross and Blue Shield member ID card.
- 3. Description of Service:** This is a general description of each service included on the claim.
- 4.Dates of Service:** These are the dates reported for each service performed for the member.
- 5.Total Charges:** This is the amount billed by the doctor, hospital or other provider.
- 6.Copay/Deductible:** A copay would be a set dollar amount that the member is responsible to pay, based on his/her plan benefits. The deductible would be a paid amount the member would first have to meet before benefits coverage begins.

- 7.Coinsurance:** This is a percentage of costs that a member pays for covered services, based on his/her benefit design.
- 8.Non-covered Services:** This represents any level of services the member receives that is not covered by the plan benefits. The member would be responsible for paying these charges.
- 9.Plan Disallow:** This is any amount the doctor, hospital or other provider bills above the amount that Anthem Blue Cross and Blue Shield agrees to pay for services rendered.
- 10.Approved Amount:** This is the amount that Anthem Blue Cross and Blue Shield agrees to pay for services rendered.
- 11.Adjusted Amount:** This is a field reserved for internal use.
- 12.Amount Paid:** This is the actual amount that Anthem Blue Cross and Blue Shield pays to the doctor, hospital or other provider for services rendered.
- 13: Remarks:** This area is for specific messages that clarifies a payment situation or explains why a member might be responsible for payment for a given service, for example if the member received a service that is not covered by his/her plan benefits.

SAMPLE

Member: Test B Smith
123 INSURANCE AVENUE
CHICAGO, IL 60611

ID: TESTMEMB1

WHITE STOCK



For Customer Service Call
1-888-445-8916
TTY for the hearing impaired
1-800-425-5705

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EXPLANATION OF BENEFITS

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*** Please send voluntary refunds to:

Central Region Lockbox
PO Box 73651
Cleveland, OH 44193-1177

*** If you do not agree with this decision please review the attachment.

If you need assistance in Spanish to understand this document, you may request it for free by calling customer service at the number on your identification card or in your enrollment booklet.

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

*** Anthem Insurance Companies, Inc (AICI) is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. AICI is the risk bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. AICI has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region. In Wisconsin, Blue Cross and Blue Shield of Wisconsin ("BCBWi") underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") underwrites or administers the HMO policies; and CompCare and BCBSWi collectively underwrite or administer the POS policies. BCBSWi and CompCare are

VOID

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

<p>What if I Don't Agree With This Decision?</p>	<p>What Do I Include With My Appeal?</p>
<p>You have the right to appeal. To exercise it, file your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.</p>	<p>You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should pay for the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.</p>
<p>Who May File An Appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others also already may be authorized under State law to act for you.</p>	<p>What Happens Next? If you appeal, we will review our decision. After we review our decision, if payment for any of your claims is still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medical Health Plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.</p>
<p>You can call us at: (888) 445-8916 to learn how to name your authorized representative. [If you have a hearing or speech impairment, please call us at TTY/TTD (800) 425-5705</p>	<p>Contact Information: If you need information or help, contact us at:</p>
<p>If you want someone to act for you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.</p>	<p>Toll Free: (888) 445-8916 or TTY/TTD: (800) 45-5705</p>
<p>How Do I File An Appeal? You or your authorized representative should mail or deliver your written appeal to the address(es) below:</p>	<p>Other Resources To Help You: Medicare Right Center Toll Free: 1-888-HMO-9050</p>
<p>Medicare Advantage Grievance and Appeals Unit PO Box 1975 Fond du Lac, WI 54936</p>	<p>Elder Care Locator Toll Free: 1-800-677-1116</p>
<p>We must give you a decision no later than 60 calendar days after we receive your appeal.</p>	<p>1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048</p>

Form No. CMS-10003

Exp. Date 8/31/2010

According to the Paperwork Reduction Act of 1995, no person are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0829. The time required to complete this information collection is estimated to average 6.3 to 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.