Blue Shield of California
PO Box 272560
Chico, CA 95627-2560

Blue Shield of California
An Independent Member of the Blue Shield Association

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EXPLANATION OF BENEFITS

This is NOT a Bill

Retain for your records along with any provider bills.

ROBIN SMITH
12345 1ST STREET
SACRAMENTO, CA 95819

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of **www.mylifepath.com**. If you have any questions about this document or your benefits, please call us at **(800) 200-3242**.

CLAIM SUMMARY AT A GLANCE

Patient Name: TAYLOR SMITH		Subscriber ID: J23456789-0000 Claim Number: 12345678900000
Patient responsibility: (Amount you paid or owe to provider.)	**$38.25**	**Your claim was received 05/27/04 and processed in 8 days.** We paid LABORATORY CORP OF AMERICA HOL
Amount we paid:	$74.00	
Network savings: (Amount saved by using a network provider.)	**$15.75**	**Deductible Status** As of 06/06/04, TAYLOR SMITH has met $38.25 of the $500.00 annual deductible for 2004.
Amount billed by Provider:	$128.00	

DETAIL **Provider:** LABORATORY CORP OF AMERICA HOL
Preferred Provider: YES

Service Date	Type of Service and Procedure Number	Amount Billed (Provider billed for services)	Amount Allowed (Preferred providers accept as payment)	Amount We Paid	Patient Responsibility: Non Covered	Patient Responsibility: Deductible (You pay provider before we begin payments)	Patient Responsibility: Copayment/ Coinsurance	Notes
05/08/04	OUTPT LABORATORY 80053	35.00	35.00	35.00	0.00	0.00	0.00	
05/10/04	OFFICE MEDICAL 84436	14.00	9.50	0.00	0.00	9.50	0.00	1
05/10/04-05/13/04	HOME MED EQUIP A4595RR	32.00	32.00	32.00	0.00	0.00	0.00	
05/10/04-05/13/04	HOME MED EQUIP L3800RR	10.00	3.75	0.00	0.00	3.75	0.00	1
05/14/04	PHYSIOTHERAPY 97110	23.00	23.00	7.00	0.00	16.00	0.00	
05/14/04	PHYSIOTHERAPY 97140	14.00	9.00	0.00	0.00	9.00	0.00	1
	Claim Totals:	**128.00**	**112.25**	**74.00**	**0.00**	**38.25**	**0.00**	

Notes

1 The provider of service has agreed to accept the allowed amount as payment in full. The subscriber is responsible only for deductibles, copayment amounts and non covered items.

Messages

If your plan requires hospital pre-admission review, you or your physician must contact our pre-admission review department or the designated third party review organization prior to your next planned stay to avoid additional out-of-pocket costs. For Shield Select, preferred savings, and preferred plans call 1-800-343-1691. For HMO plans call 1-800-444-0402. For third party review organizations, refer to your Evidence of Coverage booklet, certificate of insurance or ID card for the telephone number.

Thank you for choosing Blue Shield.

To see the extra services and support available to you, go to **www.mylifepath.com**.

Helpful Definitions

Amount Billed
This is the amount your provider billed for the services you received.

Amount Allowed
This is the amount the provider and Blue Shield have agreed will be accepted for payment for the services rendered.

Amount We Paid
This is the amount we paid to you or your provider.

Copayment/Coinsurance
This represents the copayment or the coinsurance amount you are responsible to pay for certain services. the coinsurance is the amunt you pay for services after your deductible is met. Providers may require payment when you receive services.

Date(s) of Service
The day or dates the patient received services.

Deductible
This is the amount you pay to providers each year before we start paying benefits under your plan. Your provider may bill you for these charges.

Non Covered
This is the portion of charges not covered by this benefit plan. Your provider may bill you for these charges.

Patient Responsibility
This is the amount you are responsible to pay the provider. It consists of not covered amounts, deductibles and copayment/coinsurance.

Negotiated Savings
The amount you saved by belonging to this health insurance plan. These savings are calculated as the Amount Billed minus the Patient Responsibility and minus the Amount We Paid.

Dear Subscriber:
Your claim has been processed in accordance with the services reported and the benefits, exclusions and limitations of your health plan. In some instances there may be one or more reasons why benefits cannot be provided. If your claim has been denied and you believe that additional information will affect the processing of the claim, or you have a question about service, a provider, your benefits or how to use your plan, call or write to Blue Shield's Customer/Member Services Department. Customer/Member Services can answer many questions over the telephone and will provide a complete response within thirty (30) days.

You are entitled to, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

GRIEVANCE PROCEDURE / REQUEST FOR APPEAL
If you are not satisfied with the Customer/Member Services Department response to your inquiry, you (or provider or a representative on your behalf) may request an appeal by 1) calling the Customer/Member Services Department toll-free telephone number, 2) writing to the Customer/Member Services Department, or 3) by submitting a completed Grievance Form. a Grievance Form can be obtained either by contacting Customer/Member Services or by logging on to **www.mylifepath.com**. The completed Grievance Form should be submitted to the Customer/Member Services Department. Appeals are resolved within 30 days.

The grievance system allows you to file grievances for at least 180 days following an incident or action that is subject to your dissatisfaction.

Customer/Member Service
PO Box 272560, Chico, CA 95627-2560
(800) 123-4567

The Department of Managed Health Care Notification

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR) through Department of Managed Health Care / Voluntary Appeal Procedure

Effective January 1, 2001, members have the right to request an Independent Medical Review through the Department of Managed Health Care (DMHC), as indicated in the above paragraph. The Independent Medical Review applies to services that are denied, modified or delayed by a decision off the plan that a service is not medically necessary or is considered experimental and/or investigational. members must a) have a provider recommending the treatment that is being sought, b) have received medically necessary urgent or emergency care from a provider, even though the provider may not be recommending the treatment. Members can contact the Department of Managed Health Care (DMHC) directly.

Employee Retirement Income Security Act (ERISA) Notification

If your employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA") you may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved. Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation.