Anthem

1351 William Howard Taft Rd
Cincinnati, OH 45206-1775

EXAMPLE

Your Claim Recap

JOHN Q. LUMENOS
2300 AVANT STREET
CLEVELAND, OH 44122

Account Holder:
John Q. Lumenos

Health Program ID:
9998817749004

Group Name:
Lumenos Client

Claim Number:
199943200001

Date Prepared:
05/20/2009

1. Summary of this Claim (See next page for details)

How Much was the Expense?

The total charge was:	**$ 150.00**
Amount allowed by your benefit:	$ 125.00
[Your Other Insurance Covered}	$ 0.00

How Much was Paid Under Your Program?

Amount paid by Traditional Health Coverage:	$ 0.00
Total paid under your Program:	**$ 0.00**

What is Your Out-of-Pocket Responsibility?[1]

Other out-of-pocket responsibility:	$ 125.00
Coinsurance responsibility:	$ 0.00
You are Responsible for This Amount:	**$ 125.00**

Your Provider should bill your directly for this amount.

2. Status of Your Program (After this Claim)[2]

Your Traditional Health Coverage

Begins after spending (on covered services):	$2,000.00
Amount spent to date:	$ 125.00

Your Annual Out-of-Pocket Maximum

Maximum for Network Providers:	$3,000.00
Amount accumulated towards Maximum to date:	$ 125.00
Maximum for Out-of-Network Providers:	$5,000.00
Amount accumulated towards Maximum to date:	$ 125.00

Claim Highlights

Date of Service:
05/03/2009

Consumer:
Mary Lumenos

Provider:
Dr. James J. Smith
Vienna Family Medicine
123 Maple Avenue
Cleveland, OH 44117

Thank you for choosing a provider participating in our network — helping you get the most for your health care dollar.

Have a question?
Go online to **www.anthem.com** or call **1-800-000-0000.**

Save trees by opting not to receive paper statements. You can simply check your account online at **<http://www.anthem.com>.**

[1] Your out-of-pocket responsibility may increase if you do not use a participating network provider. Your out-of-pocket responsibility may increase if you receive a service that is not a covered benefit and may not apply to your out-of-pocket maximum.

[2] The information above is accurate as of this claim for the benefit year in which it occurred. It may not reflect your most recent account balance and claims activity. Your actual balance depends upon claims that are in process and on services you have received that are not yet processed.

Si necesita ayuda en español para entender este documento, la puede solicitar sin ningún costo adicional llamando sin cargo al 1(800) 000-0000.

[Form Number Here]

EXAMPLE

Claim Number: 199943200001

Your Claim Recap

3. Claim Payment Details

	Health Care Provider Information Date of Service From: 05/03/2009 to 05/03/2009				Your Program Traditional Health Coverage		Your Responsibility	Explanation**
	Service (Units)	Provider Charged	Provider Responsibility	Amount Allowed by Benefit*	Amount Paid	Benefit Level	You Are Responsible for	
1	Medical Service - 1	$150.00	$25.00	$125.00	$0.00		$125.00	OPM
	TOTAL	**$150.00**	**$25.00**	**$125.00**	**$0.00**		**$125.00**	

*The "Amount Allowed by Benefit" is amount of the provider's charge covered by your benefits, minus the provider discount; the sum of the amounts paid from your Account, your Traditional Health Coverage and Your Responsibility will equal this amount.

Check Paid to: James J. Smith, M.D.

**Explanations

OPM: Deductible and/or coinsurance amounts have been applied to this claim. You are responsible for this amount.

The Appeals Process:

A. If payment for any service(s), or part of a service has been denied and you do not agree with the denial, you can call Anthem Blue Cross and Blue Shield at the number shown on the front of this form. Your request for review will be evaluated and we will notify you of the decision.

B. You have the right to initiate a formal appeal concerning any denied or partially denied claim by calling or writing to us. To file a verbal appeal, call the Customer Service number on the back of your identification card. To file a written appeal, write to Anthem Blue Cross and Blue Shield, P.O. Box 33200, Louisville, KY 40233-3320. If you write a letter, please state plainly the reason(s) why you think payment of the service should not have been denied. Include any documents not originally submitted with your claim and any information that you feel may have a bearing on our decision. Grievances/Appeals can be filed electronically using Anthem.com. If you have questions, please contact the customer service number on the back of your ID card.

   Anthem determines first level appeals (referred to as Level 1 appeals) of claim payment denials within a reasonable period of time appropriate to the medical circumstances but not later than 30 business days (20 business days if you are covered under an HMO product) when sufficient information is received to make a decision. Anthem may take an additional 10 business days (no extension is permitted for HMO members) to review your appeal if an extension is appropriate given the medical circumstances and if necessary information has not been received.

   Level 1 appeals must be filed within the end of the calendar year plus 12 months from the date you were notified of a denial or partial denial. You will receive written notice of Anthem's decision on your appeal. This notice will cite specific reasons for our decision.

   If you are not satisfied with Anthem's response to your Level 1 appeal, additional levels of appeal are available unless your Certificate of Coverage states otherwise. Additional appeal rights must be requested within 60 days (7 business days if you are an HMO member) after you receive Anthem's adverse determination from the prior level of review. Please refer to your Certificate of Coverage or call Customer Service for detailed information on the entire appeals process.

   You have the right to designate a representative (e.g. your Physician) to file any level of appeal review with us on your behalf and to represent you in that appeal level.

   If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your Level 1 appeal results in an adverse determination, you have the right to bring a civil action under section 502(a) of ERISA. You must file a Level 1 appeal concerning an adverse determination prior to exercising this right. All other available appeal levels will be considered voluntary for ERISA members.

C. If your benefits summary includes charges you don't recognize, it could be the result of a mishandled or inaccurate claim. Please contact Customer Service.

This payment is not a guarantee of payment of future claims. Every payment is subject to review to determine eligibility under your contract.

If you have any questions regarding this explanation of benefits, please contact your customer service representative at the number provided on the top of this Explanation of Benefits.

For additional detailed information regarding your health benefits, please refer to your Benefit Booklet/Certificate of Coverage or Summary Plan Description.

Health Insurance fraud hurts us all. You can assist Anthem Blue Cross and Blue Shield in fighting health fraud by carefully examining the information presented on the other side of this form.

Health Insurance fraud often involves the collection of fees for services never received, the payment of claims led on ineligible patients, and multiple claims submitted for the same services. If you suspect that the information on the Explanation of Benefits is incorrect and that medical fraud has occurred, please call Special Investigations at 1-800-848-9276 using our toll free HOTLINE. Callers will remain anonymous if they so choose. For anything other than fraud, contact your Customer Service unit directly using the phone number on the front of this form.