Return address

Barcode location - option 1

Jane Q. Member
Address line 1
Address line 2
City, State ZIP code

Anthem BlueCross BlueShield

THIS IS NOT A BILL.

So what is it?

It's Your Health Plan Statement, sometimes called an **Explanation of Benefits (EOB)**. It summarizes your health care services, how much they cost, and how your benefits apply to those costs.

To get help in a different language

Call 800-421-1880
Si desea ayuda en espanol, llame 800-421-1880
To get help in Chinese, Vietnamese, Korean, Tagalog, call 800-421-1880

Suspect fraud?

Call our Fraud Hotline at: **866-123-4567**

Jane,

Shop around for the best price. Costs for lab tests, scans and procedures vary widely. Comparing costs from different providers can save you money.

You can get your EOBs online anytime. It's easy.

- Log in at anthem.com and pick Profile
- Choose Email Preferences
- Select Primary Email Address
- Click Save/Update

Barcode location - option 1

Here's what's been paid for all family members with claims on this EOB.

Your claim summary — Look inside for a detailed claims explanation		
Amount charged by your provider	$298.00	Total amount the doctor or provider billed.
Less discounts	–167.00	Anthem gets discounted pricing with our network of providers. You have lower out-of-pocket costs when you use in-network providers.
Amount due to your provider	**$131.00**	This is what you and Anthem pay your provider.
Anthem paid	–79.40	This is the amount paid by Anthem.
Total you pay (or may have paid)	**$51.60**	

You saved $246.40 (or 83%) off the total amount billed. (Discount + what Anthem paid).

What should you do with this EOB?

1. Compare it to bills you get. Check that the date, provider, services and amount owed are the same.
2. Keep it for your records.

How to get help if you need it

Questions about benefits, claims, finding a doctor or ways to save on care?

Web: anthem.com
Message: Log in to anthem.com. Choose Customer Support > Message Center > Compose Message.
Call: 800–421–1880 (M-F, 8 a.m. – 6 p.m.) **TTY/TDD**: #711
Mobile: Download Anthem mobile app
Have your member ID or user ID/password ready.

Health Plan Statement

as of 2/01/2014

Healthy tip: You can clobber germs with a song. Wash your hands often using soap. Sing the "Happy Birthday" song when you do. By the end of the song, germs are gone.

Your member information

Account holder name	Member ID	Group ID	Group name	Coverage type
Jane Q. Member	1234567	000123	ABCDEFG Corporation	Individual + Child(ren)

2014 Year-to-date Information — *To learn more about what's covered, see your benefits booklet.*

It's important to know how close you are to meeting your plan's yearly deductible and out-of-pocket maximum.

2014 plan deductible

Individual	In-network maximum	Applied to date	Remaining deductible	Out-of-network maximum	Applied to date	Remaining deductible
Jane Q. Member	$500.00	-$500.00	$0.00	$750.00	-$750.00	$0.00
An individual deductible may be different than your deductible for all covered family members combined.						
Family	$2,000.00	-$1,000.00	$1,000.00	$2,500.00	-$850.00	$1,650.00

2014 out-of-pocket (OOP) maximum

Individual	In-network maximum	Applied to date	Remaining OOP	Out-of-network maximum	Applied to date	Remaining OOP
Jane Q. Member	$1,000.00	-$510.00	$490.00	$2,000.00	-$1,060.00	$940.00
An individual out-of-pocket maximum may be different than your out-of-pocket maximum for all covered family members combined.						
Family	$3,000.00	-$555.00	$2,445.00	$5,000.00	-$1,060.00	$3,940.00

Helpful definitions

Coinsurance — It's the fixed percentage you may pay for certain benefit plan services (like 30%). Some plans may require you to pay a deductible first.

Copay — It's the flat dollar amount you may pay for certain benefit plan services, such as doctor visits.

Deductible — It's the flat dollar amount you may pay for certain benefit plan services before your health plan begins to pay. Some plans may have more than one deductible.

Out-of-pocket maximum — This is the most you have to pay each benefit period for covered services. Once you reach this maximum amount, you don't pay anything for most services. It may include your copay, deductible and coinsurance payments. Some plans have separate out-of-pocket maximums for in-network and out-of-network services.

Services not covered — Charges you must pay because they aren't covered under your plan. The provider may bill you for these charges.

Note: You may have more recent claims that haven't been processed yet or included in the statement totals shown here.

Medical services payment detail

as of 2/01/2014

Services provided for:	Claim number	Provider	Network status	Patient account
Jane Q. Member (Self)	1234567891234	Deaconess Hospital	In-network	98765432198765

						Your health benefits paid	You pay				
Day you got care	Services received	Reason code	Amount charged by your provider	Your discounts −	Amount due to your provider =	Anthem paid −	Copay +	Deductible +	Coinsurance +	Services not covered +	Total you pay (or may have paid) =
1/6/14	Office Visit	135	175.00	-77.00	98.00	-73.00	25.00	0.00	0.00	0.00	25.00
1/6/14	Lab Service	038	68.00	-50.50	17.50	0.00	0.00	17.50	0.00	0.00	17.50
1/6/14	Lab Service	038 067	55.00	-39.50	15.50	-6.40	0.00	7.50	1.60	0.00	9.10
Subtotal			**298.00**	**-167.00**	**131.00**	**-79.40**	**25.00**	**25.00**	**1.60**	**0.00**	**51.60**

038: This amount has been applied to the member's medical deductible.
067: This balance is the member's coinsurance responsibility.
135: This amount is the member's copayment amount.

Total for Jane	**298.00**	**-167.00**	**131.00**	**-79.40**	**25.00**	**25.00**	**1.60**	**0.00**	**51.60**

You can learn more about services shown here, including diagnosis and treatment codes and what they mean. Just call Member Services at 800-421-1880.

What if I need help understanding this denial?
Contact us at **800-421-1880**.

What if I don't agree with this decision?
You may appeal any decision not to provide or pay for an item or service (in whole or in part). You must ask for an appeal within 180 calendar days from the date you were told of our decision. But be sure to check your description of benefits to see if you must appeal sooner than 180 days, or if you can more time than that.

How do I file an appeal?
Send a written request to:

Grievances and Appeals
PO Box 12345
Anytown, USA 12345-1234

You should request appeals in writing. However, unless your description of benefits states otherwise, you may request an appeal verbally by calling **800-421-1880**. You can request an appeal online at **anthem.com**.

What if my situation is urgent?
You'll need to request an expedited appeal. If it's urgent, your review will generally be done in 72 hours. Follow the directions above for filing an internal appeal. To request an expedited appeal or expedited external review, you, your provider or your representative can contact us at **800-421-1800**.

An urgent situation is one in which:
- Your health may be in jeopardy, or
- in your doctor's opinion, your pain can't be adequately controlled while you wait.

Who may file an appeal?
Who may file an appeal? You or someone you name to act for you (your authorized representative) may appeal. Please provide a signed document that includes:

- Member name
- Address
- Birth date
- Daytime phone number
- ID number
- Date of service and/or appeal issue
- Specific consent to appeal
- Provider name, address and phone number

Send the document to the Grievances and Appeals Department at the address above.

Can I provide additional information about my claim?
Yes, you can send more information. Send it to Grievances and Appeals address.

Can I request copies of information relevant to my claim?
Yes, you may request copies free of charge. If you think a coding error may have caused a denial, you have the right to have billing and diagnosis codes sent to you too. You can request this information by calling **800-421-1880**.

What happens next?
If you appeal, we'll do a review and give you a written decision within 30 calendar days. (Your description of benefits might give a different time limit.) If we still issue a denial, you may be able to request an external review by an independent third party. You can also do this if you don't get a timely decision from us. The third party will review the denial and issue a final decision.

Other resources to help you:
For questions about this notice, your rights or for help, contact:

- Employee Benefits Security Administration at **866-444-EBSA (3272)**.
- State Regulatory contact at:
  State Department of Insurance
  123 Somewhere Street
  Anytown, USA 12345
  http://www.website.us/
- State Ombudsman contact:
  Community Health Advocate
  123 Somewhere Street
  Anytown, USA 12345
  http://www.website.us/