

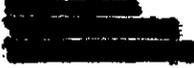
Business Hours: Mon. - Fri. 8:00AM-6:00PM Saturday 9:00AM-1:00PM  
If you have questions regarding this explanation of benefits,  
please contact our customer service department  
In Richmond: (804)355-8506 or Toll Free: (800)552-2682  
For our hearing impaired members, please dial '711'

The Local Choice



#BWNCOXF  
#VAECS02200000000#

004769



Health Benefits Program  
2015 Staples Mill Road  
Post Office Box 27401  
Richmond, Virginia 23279  
[www.anthem.com](http://www.anthem.com)

\*004769040101\*



### Need more information?

Anthem Blue Cross and Blue Shield makes coverage decisions based on members' benefits and the information submitted with their claims. Anthem Member Services representatives can provide more information about how your coverage was applied and answer any questions you may have about your benefits. To reach a representative, please call the number listed on the front of this form.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that Anthem relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

If after speaking with an Anthem Member Services representative you feel that our coverage decision was not correct, you or an authorized representative may appeal the decision by following the steps below.

#### **How to Appeal a Coverage Decision**

To appeal a coverage decision, please send to the address below a written explanation of why you feel the coverage decision was incorrect. Unless your plan specifies otherwise, this information may also be provided to an Anthem Member Services representative over the phone. Please include with the explanation:

- your name, address and telephone number
- your Anthem identification and group number (as shown on your identification card)
- the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge

Send written appeals to: **Anthem Blue Cross and Blue Shield**  
**Attn: Corporate Appeals Department**  
**P.O. Box 27401**  
**Richmond, VA 23279**

You must file within either 15 months of the date of service or 180 days of the date on the Explanation of Benefits notification of the coverage decision, whichever is later. In either case, Anthem Blue Cross and Blue Shield will resolve and respond in writing to appeals within 60 calendar days.

If you are a member of an ERISA-regulated group health care plan and you have completed the appeals process without satisfaction, you may have the right to bring civil action under 502 (a) of ERISA. Federal, state and local government programs, church plans, and individual policies are not regulated under ERISA.

**If you suspect fraud or abuse involving a claim, please call the Anthem Tipline: 1-800-368-3580**



# EXPLANATION OF BENEFITS (EOB)

Your Explanation of Benefits (EOB) is a claim summary mailed to you after a claim from a health care provider has been processed for you. Always save your EOB forms to compare to your health care providers bills for the services

PATIENT NAME: ██████████

THIS IS NOT A BILL - Retain This For Your Records

GROUP NAME: HAMPTON ROADS PLANNING DIST COMM

Payment was sent to the provider

Date Prepared: 11/23/2009

PATIENT RESPONSIBILITY												
Name of Provider Claim #	Date of Service	Service	Total Charge	Network Savings	Allowable Charge	Other Insurance Paid	Copayment	Deductible	Coinsurance	Non-Covered	Amount Paid by Plan	NOTE
SCHLOSSBERG STEVEN M MD	11/05/09	Manual Medic-Inte	90.00	15.30	74.70	0.00	25.00	0.00	0.00	0.00	49.70	1
									2.31	0.00		
	11/05/09	Physical Therapy	60.00	16.86	23.14	0.00	0.00	0.00	*What You May Owe	0.00	20.83	1
									**Total You May Owe	27.31		
<b>Total per Provider</b>			<b>130.00</b>	<b>32.16</b>	<b>97.84</b>	<b>0.00</b>					<b>70.53</b>	
<b>Total EOB</b>			<b>130.00</b>	<b>32.16</b>	<b>97.84</b>	<b>0.00</b>					<b>70.53</b>	

\* Total of Copayment, Deductible, Coinsurance, and Non-Covered amounts  
 \*\* Total of all What You May Owe amounts

\*004769040300\*



PATIENT NAME: [REDACTED]

Explanation of Note column:  
1 Our maximum payment has been made based on the coverage available under your benefit plan or policy.

**ACCUMULATIONS**

Plan Year - July 1, 2009 to June 30, 2010

**In Network**

Medical/Behavioral Health Deductible Accrual	Your Required Plan year deductible	Your Previous deductible met	Your Deductible amount for this EOB	Your Total deductible met for plan year	Your Deductible Carryover Credit*
Individual:	\$100.00	\$100.00	\$0.00	\$100.00	\$0.00
Family:	\$300.00	\$100.00	\$0.00	\$100.00	\$0.00

\*April 1 through June 30 deductible accrual also applies to next plan year.

Medical/Behavioral Health Out-of-Pocket (OOP) Expense* Maximum Accrual	Your Plan Year OOP Expense Limit	Your Previous OOP met	Your OOP applied for this EOB	Your Total OOP met plan year-to-date
Individual:	\$1,000.00	\$594.94	\$2.31	\$597.25
Family:	\$3,000.00	\$594.94	\$2.31	\$597.25

\*Includes deductibles and coinsurance for medical and behavioral health services.

Plan limits accruals	Member Benefits Limit	Benefits Previously used	Benefits Applied for this EOB	Total Benefits used plan year-to-date:
Manipulation and Manual Medical Intervention Services:	\$500.00 / plan year	\$248.60	\$49.70	\$298.30 / plan year

\*Plan limits for In-Network and Out-of-Network services display separately but accumulate together.



PATIENT NAME: [REDACTED]

Explanation of Note column:  
 1 Our maximum payment has been made based on the coverage available under your benefit plan or policy.

**ACCUMULATIONS**

Plan Year - July 1, 2009 to June 30, 2010

**Out of Network**

Medical/Behavioral Health Deductible Accrual	Your Required Plan Year deductible	Your Previous deductible met	Your Deductible amount for this EOB	Your Total deductible met for plan year	Your Deductible Carryover Credit*
Individual:	\$200.00	\$0.00	\$0.00	\$0.00	\$0.00
Family:	\$600.00	\$0.00	\$0.00	\$0.00	\$0.00

\*April 1 through June 30 deductible accrual also applies to next plan year.

Medical/Behavioral Health Out-of-Pocket (OOP) Expense* Maximum Accrual	Your Plan Year OOP Expense Limit	Your Previous OOP met	Your OOP applied for this EOB	Your Total OOP met plan year-to-date
Individual:	\$2,000.00	\$0.00	\$0.00	\$0.00
Family:	\$6,000.00	\$0.00	\$0.00	\$0.00

\*Includes deductibles and coinsurance for medical and behavioral health services.

Plan limits accruals	Member Benefits Limit	Benefits Previously used	Benefits Applied for this EOB	Total Benefits used plan year-to-date:
Manipulation and Manual Medical Intervention Services:	\$500.00 / plan year	\$248.60	\$49.70	\$298.30 / plan year

\*Plan limits for In-Network and Out-of-Network services display separately but accumulate together.

## GLOSSARY OF TERMS

- 1 Name of Provider and Claim #:** The name of the provider who rendered treatment to the patient and the number assigned to the claim as it is received.
- 2 Date of Service:** The date or dates of service for the claim.
- 3 Service:** The type of care you received.
- 4 Total Charge:** The amount the provider billed for the treatment you received.
- 5 Network Savings:** The amount that the patient saves by utilizing an in-network provider.
- 6 Allowable Charge:** The most that a provider, hospital, or other health care provider will be paid for a service under your health care plan. For a more detailed definition of this term, see your member handbook.
- 7 Other Insurance Paid:** The amount that other insurance may have paid.
- 8 Copayment:** This is the copayment you must pay as cost sharing under your health care plan.
- 9 Deductible:** This is the deductible you must pay as cost sharing under your health care plan.
- 10 Coinsurance:** This is the penalty or coinsurance amount you must pay as cost sharing under your health care plan.
- 11 Non-Covered:** If applicable, this is any charge for services received that are not covered under your health care plan. If we paid you for the services you received, you would also owe the amount of that payment to the provider.
- 12 Amount Paid by Plan:** This is the sum of the Allowable Charge for every covered service shown on this EOB - LESS any copayment, deductible, penalty, or coinsurance amounts you pay under your health care plan - and LESS charges for any services not covered under your health care plan.
- 13 Comments:** Messages that provide further information about the claim. The number corresponds with the number in the Comments column.

## EXPLANATION OF BENEFITS (EOB)

Your Explanation of Benefits (EOB) is a claim summary which details a service your Anthem care provider rendered to you. Please use your Anthem EOB terms to compare to your health care provider's bills for the same services.



THIS IS NOT A BILL - Retain This For Your Records

Payments sent to the provider

PATIENT NAME: John Doe Date of Service: 03/15/2009	GROUP NAME	PATIENT RESPONSIBILITY															
		1 Name of Provider	2 Date of Service	3 Service	4 Total Charge	5 Network Savings	6 Allowable Charge	7 Other Insurance Paid	8 Copayment	9 Deductible	10 Coinsurance	11 Non-Covered	12 Amount Paid by Plan	13 Comments			
INTEGRITY HEALTH SERVICES	03/15/2009	100787000	100787000	100787000	\$12,850	\$817	\$11,662	\$2,725	\$8,937	\$1,917	\$1,885	\$1,052	\$1,885	\$1,885	\$1,885	\$1,885	
INTEGRITY HEALTH SERVICES	03/15/2009	100787000	100787000	100787000	\$12,850	\$817	\$11,662	\$2,725	\$8,937	\$1,917	\$1,885	\$1,052	\$1,885	\$1,885	\$1,885	\$1,885	
INTEGRITY HEALTH SERVICES	03/15/2009	100787000	100787000	100787000	\$12,850	\$817	\$11,662	\$2,725	\$8,937	\$1,917	\$1,885	\$1,052	\$1,885	\$1,885	\$1,885	\$1,885	
INTEGRITY HEALTH SERVICES	03/15/2009	100787000	100787000	100787000	\$12,850	\$817	\$11,662	\$2,725	\$8,937	\$1,917	\$1,885	\$1,052	\$1,885	\$1,885	\$1,885	\$1,885	



PATIENT NAME: [REDACTED]

Explanation of Note column:

Regardless of the amount that this Explanation of Benefits (EOB) shows you may owe (if any), if you received a check with this EOB, and the services you received were from a non-participating provider, the non-participating provider may also bill you for the difference between our allowance and the provider's actual charge. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.