

Don't worry, this is not a bill.

Hi Anthony - Here's your  
**Health Care Summary**

January 27, 2024.

Also called an Explanation of Benefits (EOB), it shows you the care you received and who paid for it. Your EOB also includes information about saving money on health care and tips for staying healthy.

**Need help in a different language? Call us.**  
¿Necesita ayuda en español? Llámenos.  
**1-866-406-1182**

010718  
#WGECAE01VIEW#  
ANTHONY J BYRNES  
631 SUNSET AVE  
VENICE CA 90291-2732

**Helpful resources**

Log in at [member.accolade.com](https://member.accolade.com) to check on claims, review your benefits, and find care.



**Call**  
1-866-406-1182 TTY/TDD: 711

**Claims summary**

Doctor/facility charges:	<b>\$1,860.00</b>
Your discounts:	<b>-588.03</b>
Due to your doctor/facility (max allowed):	<b>\$1,271.97</b>
Anthem Blue Cross paid:	<b>-0.00</b>

**What you pay : \$1,271.97**

**Preventive care reminders**

**For ANTHONY**

- ☐ Annual wellness visit
- ☐ Diabetes check
- ☐ Flu shot

\* Your checklist is based on age and gender guidelines from the Centers for Disease Control and Prevention. If you have been to the doctor recently, it may not reflect your most recent services.

**Tips and tools**

**Want to learn more about your benefits?**

If you would like to learn more about your benefits and find copies of plan documents, please visit: [www.uchealthplans.com](https://www.uchealthplans.com).

\*010718040101\*

## 2024 year-to-date summary

Anne Marie Burke

Member ID: 536M87211

Coverage: Family

Group ID: 280509A440 - UNIVERSITY OF CALIFORNIA

Plan deductible	In-network deductible	Applied to date	Remaining deductible	Out-of-network deductible	Applied to date	Remaining deductible
Family	\$3,200.00	-\$2,028.07	\$1,171.93	\$5,200.00	-\$2,091.22	\$3,108.78

Out-of-pocket (OOP) maximum	In-network OOP max	Applied to date	Remaining OOP max	Out-of-network OOP max	Applied to date	Remaining OOP max
Family	\$6,400.00	-\$2,028.07	\$4,371.93	\$16,000.00	-\$2,091.22	\$13,908.78



**Copay** is the flat-dollar amount you pay for health care, such as doctor visits.

**Deductible** is the amount you pay for health care before we start sharing the cost.

**Out-of-pocket maximum** is the most you'll pay for covered health care in your plan year. After that, we'll pay for all your covered health care.

## Claims Details

Are you concerned about healthcare fraud?  
Learn more at [fighthealthcarefraud.com](https://www.fighthealthcarefraud.com)

Anthony Byrnes

Claim Number: 2024024EA9216

Received: 01/24/24

Doctor: HOUSE EAR CLINIC INC (In your plan)

Going to this doctor uses in-network benefits. That's your best value.

Service date	Service	Reason code*	Doctor charges	Your discounts	Due to your doctor (max allowed)	Anthem Blue Cross paid
				-	=	-
01/12/24	Surgery	066	950.00	6.55	943.45	0.00
01/12/24	Office Visit	066	198.00	136.94	61.06	0.00
<b>Totals:</b>			1,148.00	143.49	1,004.51	0.00

You pay \$1,004.51.  
Here's how it breaks down.

Copay	Deductible	Your share of the cost (coinsurance)	Services not covered
+	+	+	+
0.00	943.45	0.00	0.00
0.00	61.06	0.00	0.00
0.00	1,004.51	0.00	0.00

Your total cost

=943.45

=61.06

=\$1,004.51

\*066: You don't pay the "Your discount" amount. This is the benefit to using doctors/facilities in one of our plans.

Anthony Byrnes

Claim Number: 2024024EA9505

Received: 01/24/24

Doctor: HOUSE EAR CLINIC INC (In your plan)

Going to this doctor uses in-network benefits. That's your best value.

Service date	Service	Reason code*	Doctor charges	Your discounts	Due to your doctor (max allowed)	Anthem Blue Cross paid
				-	=	-
01/19/24	Office Visit	066	198.00	136.94	61.06	0.00
<b>Totals:</b>			198.00	136.94	61.06	0.00

You pay \$61.06.  
Here's how it breaks down.

Copay	Deductible	Your share of the cost (coinsurance)	Services not covered
+	+	+	+
0.00	61.06	0.00	0.00
0.00	61.06	0.00	0.00

Your total cost

=61.06

=\$61.06

\*066: You don't pay the "Your discount" amount. This is the benefit to using doctors/facilities in one of our plans.

## Claims Details

Are you concerned about healthcare fraud?  
Learn more at [fighthealthcarefraud.com](https://fighthealthcarefraud.com)

**Anthony Byrnes**

**Claim Number:** 2024024EA9513

**Received:** 01/24/24

**Doctor:** HOUSE EAR CLINIC INC (In your plan)

Going to this doctor uses in-network benefits. That's your best value.

**You pay \$103.20.**  
**Here's how it breaks down.**

**Your total cost**

Service date	Service	Reason code *	Doctor charges	Your discounts	Due to your doctor (max allowed)	Anthem Blue Cross paid	Copay	Deductible	Your share of the cost (coinsurance)	Services not covered	
				-	=	-	+	+	+	+	
01/19/24	Ear/Nose/Throat Test	066	180.00	108.22	71.78	0.00	0.00	71.78	0.00	0.00	=71.78
01/19/24	Ear/Nose/Throat Test	066	77.00	45.58	31.42	0.00	0.00	31.42	0.00	0.00	=31.42
<b>Totals:</b>			257.00	153.80	103.20	0.00	0.00	103.20	0.00	0.00	=\$103.20

\*066: You don't pay the "Your discount" amount. This is the benefit to using doctors/facilities in one of our plans.

**Anthony Byrnes**

**Claim Number:** 2024024EA9622

**Received:** 01/24/24

**Doctor:** HOUSE EAR CLINIC INC (In your plan)

Going to this doctor uses in-network benefits. That's your best value.

**You pay \$103.20.**  
**Here's how it breaks down.**

**Your total cost**

Service date	Service	Reason code *	Doctor charges	Your discounts	Due to your doctor (max allowed)	Anthem Blue Cross paid	Copay	Deductible	Your share of the cost (coinsurance)	Services not covered	
				-	=	-	+	+	+	+	
01/12/24	Ear/Nose/Throat Test	066	180.00	108.22	71.78	0.00	0.00	71.78	0.00	0.00	=71.78
01/12/24	Ear/Nose/Throat Test	066	77.00	45.58	31.42	0.00	0.00	31.42	0.00	0.00	=31.42
<b>Totals:</b>			257.00	153.80	103.20	0.00	0.00	103.20	0.00	0.00	=\$103.20

\*066: You don't pay the "Your discount" amount. This is the benefit to using doctors/facilities in one of our plans.

## Your appeal rights.

Anytime you pay for a portion of your care, you have the right to question whether we calculated it correctly. We call that your appeal rights.

**Call us at 1-866-406-1182.**

- Ask for help understanding this notice.
- Talk through your portion and our portion of these service costs, including any denials.

**If you think something should have been covered** (in whole or in part), but it wasn't, or it wasn't covered in the way you think it should be — you can appeal it and we'll take another look.

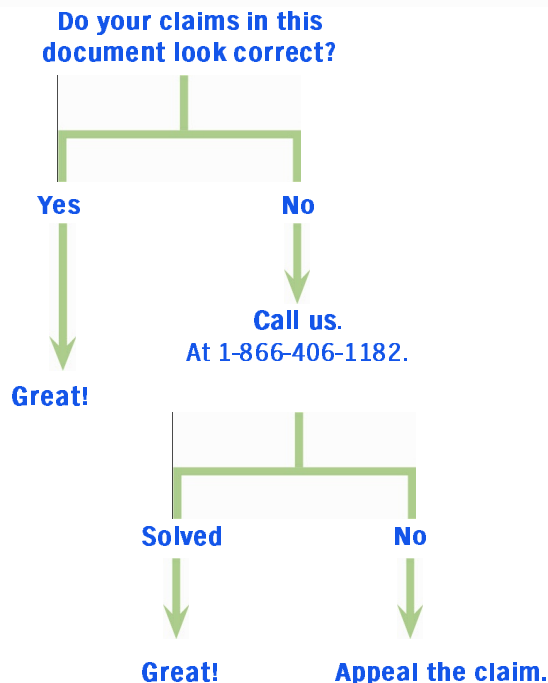
**Here's how you file an appeal.** Check your plan details for how long you have to file an appeal. Usually it's within 180 days of when we told you our decision. You or someone acting for you can file an appeal, but they need a signed authorization from you. You or they can file your appeal by:

Mailing Anthem a letter to:  
**Grievances and Appeals**  
**PO Box 4310**  
**Woodland Hills, CA 91365-4310**

**If your claim was denied in whole or part due to medical necessity or lack of prior authorization then appeal by calling Accolade at 1-866-406-1182.**

Be sure to include:

- Patient information: name, member ID, address, phone number, date of birth
- Claim information: date(s) of the service, your doctor's name/address/phone number
- Any other information about your claim that you think is important



**If you need a decision fast**, call us. You can ask for an "expedited appeal", and get an answer in about 72 hours, unless your benefits booklet or plan documents states otherwise. Use this option if:

- Your life or health is in danger
- In your doctor's opinion, your pain can't be adequately controlled while you wait
- You had emergency services, but haven't been discharged from the facility.

To ask for an expedited appeal or expedited review by someone outside our company — you, your doctor or someone acting for you can call the Member Services number on your ID card or by mailing to the address provided for appeals.

**Ask for more information on your claim — it's free.**

Call us to get billing, diagnosis or treatment codes and their meanings, or any other information we used to decide your claim, anytime. This includes any new or additional evidence or reasons for the decision on your claim. If we decided that any of the services are experimental or aren't medically necessary, or used a guideline, criteria or clinical rationale in making our decision, you can get a copy of it free of charge.

If you appeal, we'll do a review and give you a written decision within 30 calendar days from the date we received your appeal request. Check your benefits booklet to see if it gives a different time limit. If you still don't feel our response is right, or if you don't hear back from us in time, you may be able to ask for a review from someone outside our company, an independent third party. Their decision then is final.

For questions about your rights or for help, call Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.



# We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

## Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

## Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是需要人士，還可索取本文件的其他格式版本。

## Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể xin định dạng khác của tài liệu này."

## Korean

귀하는 자국어로 무료 지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

## Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

## Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживаания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

## Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես գրանցվածքեր Մեմբերների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

## Farsi

"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید. " دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید."

## French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

## Arabic

للك الحق في الحصول على مساعدة بلفك مجاً. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

## Japanese

お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

## Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

## Italian

Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

## Polish

Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

## Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਗਾਂਜਲ ਕਰਨ ਦਾ ਿਆਧਕਾਰ ਹੈ। ਬਸ

ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ?

ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

## TTY/TTD:711

## It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TTD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

