Anthem Blue Cross

#FCA007398A76/DS8#
P.O. BOX 60007
LOS ANGELES, CA, 90060

Lumenos

Your Claim Recap

#BWNCQXF
#FCA007398A76/DS8#
BRIAN ANDERSON
8033 WIRT CIRCLE
OMAHA, NE 68134-4934

Account Holder:
BRIAN ANDERSON

Health Program ID:
061A23992

Group Name:
GENESYS TELECOMMUNICATIONS LAB

Claim Number:
15238082350

Date Prepared:
09/01/15

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

How Much was the Expense?

The total charge was:	$	220.00
Amount allowed by your benefit:	$	183.23

How Much was Paid Under Your Program?

Amount paid by Traditional Health Coverage:	$	183.23
Total paid under your Program:	$	183.23

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

Other out-of-pocket responsibility:	$	.00
Coinsurance responsibility:	$	.00
You Are Responsible For This Amount:	$	.00

Your Provider should bill you directly for this amount.

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

Your Traditional Health Coverage

Begins after spending (on covered services):	$	3,000.00
Amount spent to date:	$	1,695.43

Your Annual Out-of-Pocket Maximum

Maximum for Network Providers:	$	6,000.00
Amount Accumulated Towards Maximum to Date:	$	1,695.43
Maximum for Non Network Providers:	$	6,000.00
Amount Accumulated Towards Maximum to Date:	$	1,695.43

Claim Highlights

Date of Service:
08/15/15

Consumer:
ABIGAIL ANDERSON

Provider:
MIDWEST URGENT CARE
727 N 120TH ST
OMAHA, NE 68154

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/ca** or call **1-866-207-9878**.

[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 1-866-207-9878.

Claim Number: **15238082350**

Your Claim Recap

3. Claim Payment Details

	Health Care Provider Information Date of Service From: **08/15/2015 TO 08/15/2015**				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	PREVENTIVE SERVICE - 1	$220.00	$36.77	$183.23	$183.23		$0.00	066 327
	TOTAL	$220.00	$36.77	$183.23	$183.23		$0.00	

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

You can learn more about the services listed by calling the customer service phone number on the back of your ID card. We can tell you the diagnosis and treatment codes included on your claim, along with the descriptions for those codes.

** Explanations

066 THIS IS THE AMOUNT IN EXCESS OF THE MAXIMUM ALLOWED AMOUNT FOR A PARTICIPATING PROVIDER. THE MEMBER, THEREFORE, IS NOT RESPONSIBLE FOR THIS AMOUNT.

327 THIS EXPLANATION OF BENEFITS SHOWS HOW WE PROCESSED THE CLAIMS FOR SERVICES RECEIVED BY YOU FROM YOUR MEDICAL PROVIDER. WE HAVE FORWARDED THIS INFORMATION TO THE LOCAL BLUE CROSS AND/OR BLUE SHIELD PLAN IN THE AREA OR STATE IN WHICH THE SERVICES WERE RENDERED. THE LOCAL BLUE CROSS AND/OR BLUE SHIELD PLAN IS RESPONSIBLE FOR THE PAYMENT OF THE CLAIM. BECAUSE OF THIS, THE ACTUAL PAYMENT TO YOUR PROVIDER MIGHT OCCUR AFTER YOU RECEIVE THIS EXPLANATION OF BENEFITS.