

See the key on the back side of this page for help understanding the various parts of your Explanation of Benefits (EOB).

797292800A

PO Box 12659  
Seattle, WA 98111-4659

Forwarding Service Requested

19938 0.6871 AB 0.357  
ALL FOR AADC 59D  
290

**First Choice Health.**

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**EXPLANATION OF BENEFITS**  
**\*\*THIS IS NOT A BILL\*\***  
RETAIN FOR FUTURE RECORDS

Customer Service # - 1-877-714-5556  
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ENV 19938

GROUP:  
PARTICIPANT ID:  
PARTICIPANT NAME:

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PATIENT:  
PROVIDER:  
CLAIM #:

3	4	5	6	7	8	9	10	11			
Billed Amount	Contract Adjustment	UCR/MEE Adjustment	Allowed Amount	Not Covered Amount	Reason Code	Copay	Deductible	Co-Insurance	Other Carrier Paid	Paid Amount	Total Patient Responsibility
Service Date: _____ Procedure: _____ Diagnosis Code: _____											
12											
Totals for Claim:											
13											

Family level maximums apply only when multiple family members are enrolled on the plan.

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Summary for plan year 07/01/2010 - 06/30/2011

	<u>Satisfied</u>	<u>Maximum</u>
Plan Year Deductible - Individual		
Plan Year Deductible - Family		
Plan Year Out-of-Pocket - Individual		
Plan Year Out-of-Pocket - Family		

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**myFirstChoice puts you in the driver's seat. View your claims history and account information on-line at [myFirstChoice.fchn.com](http://myFirstChoice.fchn.com)**

You have the right to appeal if you disagree with the decision made on your claim. The appeal must be in writing and must include the reasons for your appealing the decision and all pertinent information and documentation related to your appeal.

Please refer to your plan booklet, brochure or other documentation to obtain specific information on your appeal rights. There may be time limits restricting your right to appeal.

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Original Print Date 03/25/2011

## Key to your Explanation of Benefits (EOB)

1. Information specific to the Plan Participant (not necessarily the patient).
2. Information specific to this particular claim, including provider and patient names and a unique claim number.
3. Billed Amount. The amount the provider charged for the service.
4. Contract Adjustment. The amount the provider has agreed to write off. This is not part of the patient's responsibility.
5. UCR/MEE Adjustment. For out-of-network providers, the amount that is charged beyond the MUST Allowable charge for this service, plus the non-network differential. The provider may bill the patient for this amount.
6. Allowed Amount. This is the amount that MUST will process according to the Plan Benefits (deductible and co-insurance may apply).
7. Not Covered Amount/Reason Code. An amount MUST is not covering, as of the date of this EOB, and the reason the amount is not being covered.
8. The patient's responsibility (as it pertains to this claim) in the areas of co-payment, deductible, and co-insurance.
9. Amount paid by another carrier(s). This is not part of the patient's responsibility.
10. Amount of this claim paid by MUST.
11. The amount of this claim that is the patient's responsibility. This includes co-payments, co-insurance, deductible, and any MEE adjustments.
12. Information specific to this claim: date of service, procedure, and diagnosis codes.
13. Totals for all line items represented on this claim.
14. Additional detail – if available on any items listed in #7 – will appear in this section.
15. Plan Year Summary Data. Often referred to as Accumulator Information, this section details the out-of-pocket amounts that the participant has accumulated towards his/her individual and family (if applicable) deductible and out-of-pocket maximum amounts as of the date of this EOB.
16. Original Print Date. The date of this EOB.