blue of california

Due September 21, 2010

By electronic mail

U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Attention: OCIIO–9993–IFC
P.O. Box 8016
Baltimore, MD 21244–1850

Re: Comments on Interim Final Rules Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

Dear Sir or Madam:

I am writing on behalf of Blue Shield of California to offer comments in response to the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act ("Appeal Rules"). The interim final regulations were published in the *Federal Register* on July 23, 2010 (75 Fed. Reg. 43330).

Founded in 1939, Blue Shield of California is a not-for-profit health plan with a deep commitment to expanding access to quality health care at a reasonable price for all Californians. We have roughly 3.5 million members and one of the largest provider networks in California. Over the past four years, we have donated more than $125 million to the Blue Shield of California Foundation—which this year was named one of BusinessWeek's 20 most generous corporate foundations. Blue Shield of California has a strong track record of leadership in the health reform movement. Blue Shield is committed to implementing health care reform, and will continue to work to ensure that every American has coverage and to make that coverage more affordable.

We believe that the reforms provided in the Patient Protection and Affordable Care Act (PPACA) offer many important protections to consumers, and we are working diligently to implement these reforms in accordance with the new law. However, we have concerns that the impact of many provisions in the Appeal Rules go beyond what may have been intended and will raise costs—which are ultimately passed on to consumers—in excess of any resulting benefit. We would appreciate the opportunity to work with you to ensure that these rules are implemented as effectively and efficiently as possible for the benefit of consumers.

Required Disclosure of Treatment Codes:

- *Privacy Concerns*:

The Patient Protection and Affordable Care Act (PPACA) includes new requirements to ensure that consumers have access to a full and fair appeals process for handling health plan benefit determinations. While Blue Shield of California understands and supports the need for an effective appeals process, the Appeal Rules will require plans to disclose detailed and very sensitive information about a patient's diagnosis and treatment on common Explanation of Benefit (EOB) statements. Health plans regularly send EOBs to consumers following each visit to a physician, lab test, or treatment at a hospital. While this information is currently provided in a general form to avoid privacy concerns, the new rules would legally require plans to send information, generally distributed through the mail, which provides very private and sensitive information about the health status of patients.

The Appeal Rules specifically require a health plan to supply additional information related to "adverse benefit determinations" by the plan. The goal is to provide consumers with information "sufficient to identify the claim involved," including the date of service, the name of the provider, and the amount of the claim. However, pursuant to the new Appeal Rules, health plans must also provide the diagnosis code (specifically ICD-9 code, ICD-10 code, or DSM-IV code), the treatment code (such as a CPT code) and the meaning of these codes. These codes provide very specific information about diagnosis and treatment.

Sensitive issues like mental health treatment, AIDS diagnosis, and abortion services would be identified by specific ICD-9 codes and CPT procedure codes. Additionally, health plans are required to provide "the corresponding meaning" of the codes on the EOB. For obvious reasons, requiring plans to disclose this information on EOBs raises significant privacy concerns. These privacy concerns may be magnified for dependents up to age 26 who may be covered by their parents' health plan.

It is important to understand that the Appeal Rules apply their requirements broadly so that almost every bill or statement of benefits from a health plan will include this information. That is because, while the Appeal Rules only apply to "adverse benefit determinations," the Department of Labor defines an "adverse benefit determination" to include any time a health plan fails to pay for all items billed on the claim or applies a co-payment.[1] Routinely, individual items on a claim may not be covered for any number of

[1] *See* Department of Labor Compliance Assistance, Group Health and Disability Plans, Benefit Claims Procedure Regulation (29 CFR 2560.503-1): "Question: If a claimant submits medical bills to a plan for reimbursement or payment, and the plan, applying the plan's limits on co-payment, deductibles, etc., pays less than 100% of the medical bills, must the plan treat its decision as an adverse benefit determination? Answer: Under the regulation, an "adverse benefit determination" generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving

reasons, including, but not limited to, claims payment rules. Moreover, plans commonly apply co-payments to services in accordance with the policy contract. Thus, the vast majority of EOBs issued by plans would be required to include ICD and CPT codes and descriptions. [Note, because of the high percentage of EOBs that include "adverse benefit determinations," for purposes of administrative efficiency it is likely that all EOBs will contain that information.] As a result, documents with sensitive (and previously private) health information will be routinely and broadly distributed. This very private information will be in mail that is commonly seen by a spouse or parent of the patient. We have attached mock-up EOBs (including the diagnosis and treatment codes) from random de-identified patient claims, along with the actual de-identified EOB sent to the patient, that we believe demonstrate the impact of these requirements.

To make the disclosure of this additional information HIPAA compliant, each EOB will need to be separately addressed and mailed to the patient only. For Blue Shield, that would mean individually mailing each EOB and not holding/bundling all EOBs for a household to be mailed in one envelope, which is the standard operating procedure allowed under current law. Blue Shield has estimated these additional postage/mailing costs to be $4 million—$5 million per year. Moreover, even if HIPAA concerns can be resolved in this way, this still would not address the fact that highly sensitive and private medical information will be on documents delivered in the mail that have a high risk of being seen by a spouse or parent.

The disclosure of these treatment codes goes well beyond what consumers need to identify the medical claim at issue. To bring an appeal, members need to know information related to the date of the service, the name of the provider, the general service provided, and the reason it was denied. Current EOB documents provided by plans present this information in a very general way that is sufficient to identify the service, but not to link that service to a diagnosis. For example, a visit to a doctor could specify an office visit and a lab test, but the detail would not be at the level necessary to identify diagnosis and treatment for a specific disease.

Blue Shield receives and processes, on average, 2,200 appeals per month from enrollees. Our staff is not aware of a single instance in which an enrollee indicated their ability to initiate and pursue an appeal was hampered in any way by not having the specific ICD and CPT codes from the claims involved in the appeal. Rather, our experience is that enrollees can and do very effectively pursue appeals without detailed technical codes and descriptions.

The current information provided gives the consumer sufficient information to bring an appeal without involving treatment details that could jeopardize his or her privacy.

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less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan's calculation of how much it is required to pay, the decision is treated as an adverse benefit determination under the regulation." Available at: http://www.dol.gov/ebsa/pdf/CAGHDP.pdf.

Including the treatment codes raises significant privacy concerns for consumers and will not improve the appeals process.[2]

- *Cost of Compliance*:

To assist the agencies in their consideration of this rule, we believe it is helpful to directly discuss the estimated compliance costs for Blue Shield of California. The IFR notes that it believes that "excessive delays and inappropriate denials of health benefits are relatively rare." This limited benefit must be balanced against the anticipated costs. The IFR assumes that the additional required information can be "automatically populated" by plans and issuers. However, we estimate that it will cost $2.5 million just to program our systems to make the changes to our EOBs necessary to provide this information. Because of the magnitude of the systems changes, this change will also take up to 12 months to implement. We believe that our experience is common in the industry. Additionally, disclosure of this data will require Blue Shield of California and other plans to mail EOBs to individuals instead of members at a cost of several million dollars each year in order to comply with HIPAA, as discussed above.

There will also be additional costs associated with having to provide notice of language assistances with each EOB and with translating the CPT and ICD descriptions into other languages (see below).

- *Recommendation*: We recommend that the requirement regarding diagnostic and treatment codes be modified so that plans are required to provide the enrollee with a copy of the claim in question on request, including any procedure and diagnostic codes noted on the claim.

Requirement to Provide Culturally and Linguistically Appropriate Notices:

The IFR requires that plans provide information related to adverse benefit determinations, appeals and external review in a culturally and linguistically appropriate manner. These requirements are particularly important to Blue Shield of California considering the broad diversity of California's population. According to Census data, more than 14 million people in California, or 42 percent of the population, speak a language other than English at home.[3] Largely because of this diversity, California already has detailed and broad statutes and regulations on language assistance.[4] These standards were developed in

[2] In addition, press articles have highlighted the fact that the information used in billing codes may not reflect actual diagnoses, and can cause significant confusion for patients. *See, e.g.*, *Boston Globe*, "Beth Israel Halts Sending Insurance Data to Google," April 18, 2009 ("The coding language is not always precise enough to describe a patient's actual problem. Doctors also sometimes provide insurers with the code for the very disease they hope a test or procedure will rule out.").

[3] U.S. Census, "Population 5 Years and Older Speaking a Language Other Than English at Home by English-Speaking Ability by State: 2007." Available at: http://www.census.gov/population/www/socdemo/language/ACS-12.pdf.

[4] *See* "Language Assistance Programs," California Health and Safety Code §1300.67.04.

coordination with advocates for non-English speaking individuals and provide a targeted approach to improve the delivery of care to these populations. We believe these rules should serve as a model for the new federal requirements. Highlighted below are a few of the important differences to consider as the Departments finalize their requirements.

- *Threshold for Translation Requirements*:

Under the federal requirements, the threshold test for whether a group health plan must provide written documents in another language is as follows:

> (A) For a plan that covers fewer than 100 participants at the beginning of a plan year, . . . [any] non-English language in which 25 percent or more of all plan participants are literate only in the same non-English language; or
>
> (B) For a plan that covers 100 or more participants at the beginning of a plan year, . . . [any] non-English language in which the lesser of 500 or more participants, or 10 percent or more of all plan participants, are literate only in the same non-English language.

For individual plans, the test is:

> For . . . a health insurance issuer offering individual health insurance coverage . . . [any] non-English language in which 10 percent or more of the population residing in the claimant's county are literate only in the same non-English language, determined in guidance published by the Secretary of Health and Human Services.

This test for group policies appears to be measured at the employer level, so that <u>each</u> small group plan would have to perform an assessment of its language requirements. For a small employer of 4, a single enrollee would apparently trigger a requirement that the plan provide documents in any one of the estimated 176 living languages spoken in the United States.[5] A family business of a specific ethnicity could also trigger the requirement to translate notices into any language. For individual plans, there will be different language requirements county-by-county, which will be very difficult for plans to administer.

A carrier cannot administer this kind of requirement on a group-by-group or individual-by-individual basis. The administrative cost of being able to translate CPT, ICD-9, and treatment codes and other documents beyond common non-English languages would be enormous.

[5] Lewis, M. Paul (ed.), 2009. Ethnologue: Languages of the World, Sixteenth edition. Dallas, Tex.: SIL International. Online version: http://www.ethnologue.com/.

Under California law, the test for a plan the size of Blue Shield is:

> "A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, indicates in the needs assessment as required by this subdivision a preference for written materials in that language."[6]

Pursuant to this test, Blue Shield of California provides specified written documents in English, Spanish, Chinese and Vietnamese. We believe the Departments need to carefully consider the threshold requirements so that they are not imposing unrealistic translation requirements on health plans that would impose significant costs for the benefit of a very limited population of enrollees.

- *Scope of Translated Documents*:

California law requires plans to provide written "vital documents" in threshold languages upon request. These vital documents include, for example, applications (enrollment forms); consent forms; notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal; and notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials. Specifically, a health care service plan's explanation of benefits or similar claim processing information that is sent to enrollees does not have to be translated, unless the document requires a response from the enrollee.[7] For these documents (e.g., a customized letter), a plan must provide notice that translation is available. The plan is then permitted to either read the document to the person in their preferred language over the phone, or they have up to 21 days to translate the document in writing.[8] Thus, for Blue Shield, we are required to be able to translate specified vital documents into 1 of our 3 threshold languages and we may meet the requirement for enrollee-specific documents by having the document orally interpreted. A written translation of enrollee-specific documents is not required.

In contrast, the IFR applies to "all notices," which does not acknowledge the cost and difficulty in translating non-standardized documents. Additionally, the IFR makes no provision for interpreting documents over the phone (other than requiring that any hotlines be provided in non-English languages). Oral interpretation services can be both cost effective for less prevalent languages and convenient for enrollees.

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[6] Additionally, the federal Rules are based on the percentage of the population that is "literate only in" the threshold language. The California statute is based on the percentage of the population that expresses a "preference for written materials" in the threshold language.

[7] California Health and Safety Code 1367.04(a)(1)(B)(vi).

[8] In order to provide timely access to translation, Blue Shield of California seeks to provide over the phone interpreter services (to non-threshold languages) within 10 minutes, and in-person interpreter services will be made available on request. https://www.blueshieldca.com/provider/announcements/SB853Webinar.pdf.

Finally, the IFR requires that the plan "include a statement in the English version of all notices, prominently displayed in the non-English language [any language meeting the threshold], offering the provision of such notices in the non-English language." We understand this to mean that, at a minimum, all notices of adverse benefit determination must include this notice about translation. That would mean EOBs, denial letters, appeal response letters, etc., must include that notice. As discussed above, the plan may be required to offer translation in a very large number of languages. Thus, the notice that would have to be included could be many pages. Under California law, the plan is required to give a written notice of language assistance in 13 specified languages and in three languages by another regulator. The larger takes up a full page and must be sent with enrollment materials (we also include it in our evidences of coverage) and with specified vital documents. There is no requirement that it accompany every EOB or other "notice." If Blue Shield is required to expand this notice to a dozen, or even 50 or more, languages, and include it along with every "notice," that is going to result in a very material increase in printing and mailing costs.

- *Cost of Compliance*:

The IFR says that the Departments were unable to estimate the cost of providing notices in a linguistically and culturally appropriate manner. However, the Departments "believe the overall costs to be small as only a small number of plans are believed to be affected." It is impossible to accurately estimate the costs of complying with these new language requirements until we fully understand the number of languages and the scope of documents that will have to be translated. We do believe these costs will be significant, both for reprogramming our systems and for ongoing translation requirements. This cost is in addition to California's state-mandated translation requirements that we believe effectively serve the needs of non-English speaking consumers.

- *Recommendation*: We recommend that the IFR more closely model the translation requirements of California and other states that have working models providing culturally and linguistically appropriate communications to enrollees. If a state has requirements that address certain minimum standards for providing translation services, the plan should be permitted to comply by following those state standards. Administrative Services Only (ASO) plans should be able to comply by following the same state standards.

Scope of External Review – Self-Funded Accounts:

California has for many years had a very robust statutory external review program for resolution of disputes involving medical necessity, experimental/investigational denials, and other clinical decisions. That independent medical review (IMR) program substantially tracks all of the provisions of the NAIC model program and applies to all plans issued on an underwritten basis. Thus, enrollees in underwritten plans in California have access to and will continue to have access to appropriate IMR programs in compliance with the requirements of the IFR.

However, that IMR program does not apply to and is not available to enrollees in self-funded (ASO) plans of employers. Thus, the federal model outlined in the IMR would apply for those enrollees. We understand the IFR to describe a scope of disputes eligible for IMR that is broader than that in California (and almost all other states with IMR statutes) and with the NAIC model itself. The NAIC model and the California IMR program apply to disputes relating to, essentially, clinical decisions (medical necessity, experimental/investigational, level of care, etc.). They do not apply to pure coverage disputes; i.e., to instances in which the services are not covered regardless of any clinical factors (e.g., excluded services, services beyond benefit maximums, etc.). The IFR states that the federal IMR model, which would apply to self-funded employer plans in California, would extend IMR to benefit/coverage disputes – beyond the scope of the NAIC and California models. And those IMR decisions relating to the plan's coverage denials would be binding on the self-funded plan.

We believe that this is an inappropriate expansion of the scope of IMR. The federal model should track, and not exceed, the scope of IMR described in the NAIC model. Self-funded employers should not be subject to binding decisions of third parties relating to pure coverage decisions; those disputes should be resolved through existing ERISA remedies.

- *Recommendation:* We recommend that the IFR be modified so that the scope of IMR for the federal model, applicable to self-funded employer plans in California, be modified to mirror the scope of "adverse determinations" eligible for IMR in the NAIC model act.

Conflicting Times in Handling Appeals:

With respect to an appeal of an adverse benefit determination, the IFR requires as follows:

> "The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date."

Under California law, we have an obligation to respond to an appeal within 30 calendar days. If we do not respond in a timely fashion we are subject to fines by the regulator. [Note, the requirement under ERISA is for a response in 60 days – the same issue described below would occur with respect to plans governed by ERISA, only the number of days would be different.] Many of those appeals (particularly, but not exclusively, appeals of clinical matters) involve the plan obtaining and relying on new information and that information commonly takes some time to receive. Thus, Blue Shield would be required to provide newly developed information to the enrollee, allow them a reasonable opportunity to respond, and still give them a written determination within the time-frames

required by state law. Currently Blue Shield processes virtually 100 percent of its appeals within the required 30 day period. However, only 32% are resolved before the 20th day, only about half are resolved earlier than 25 days, and the remaining half are resolved between the 25th and the 30th day.

Thus, it unclear how the plan can comply with the requirement to give the enrollee advance notice of the new information and a reasonable opportunity to respond and, at the same time, send a timely final determination letter as required by California law (or by ERISA).

- *Recommendation:* We recommend that this requirement be modified so that the plan can send a notice of final determination which identifies what additional or new information was obtained and relied upon. The enrollee would then be provided with an opportunity to request a copy of the additional information and to respond to the determination. In the alternative, the IFR should be modified to state that, if applicable state or federal law or regulations do not provide sufficient time before the appeal must be finalized, then the plan can provide the new evidence to the enrollee in a preliminary final determination letter which is then deemed to be final if the enrollee does not respond and request further consideration within the next 30 days.

Blue Shield of California remains committed to making health reform a success, and we look forward to working cooperatively on this and other issues to expand affordable access to health care.

Sincerely,

Seth Jacobs

Senior Vice President and General Counsel, Blue Shield of California

Enclosures

EXPLANATION OF BENEFITS

Tom Jones
1234 Elm Drive
Anytown, Calif.

This is NOT a Bill
This Explanation of Benefits (EOB) is to notify you That we have processed your claim. It clarifies your payment responsibility or reimbursement.

CLAIM SUMMARY AT A GLANCE

Patient: Tom Jones Subscriber ID: XXXXXXXX Claim No.: YYYYYYYYY

Provider Name/Address Anytown Medical Center Lab

Patient Responsibility: $ 18.56

Amount We Paid $ 64.32

Network Saving: $ 103.38

Amount Bill by Provider $ 196.17

Diagnoses Billed by Provider: V8 = Asymptomatic human immunodeficiency virus (hiv) infection status
V58.69 = Long-term (current) use of other medications

DETAIL:

Service Date	Type of Service Procedure Code	Amount Billed	Amount Allowed	Non-Covered	Paid	Note
05/04/10	Outpt Lab/Xray 64435	$ 196.17	$ 92.78	$ 0.00	$ 18.56	1
	Claim Total	$ 196.17	$ 92.78	$ 0.00	$ 18.56	

Notes:

1. Contracting physicians and health care providers agree to accept the allowable amount as payment in full. The subscriber is responsible only for deductible, cop-payment amounts and non-covered amounts.

Procedure Code Descriptions:

87536 = Infection agent detection by nucleic acid (DNA or RNA): HIV-1 quantification

[See reverse side for important information including appeal rights]

Blue Shield of California
PO Box 272560
Chico, CA 95927-2560

Blue Shield of California
An Independent Member of the Blue Shield Association

EXPLANATION OF BENEFITS

This is NOT a Bill

Retain for your records along with any provider bills.

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of **www.mylifepath.com**. If you have any questions about this document or your benefits, please call us at **(800) 200-3242**.

CLAIM SUMMARY AT A GLANCE

Patient:		Subscriber ID: Claim Number:
Patient responsibility: (Amount you paid or owe to provider.)	$18.56	**Your claim was received 05/14/10 and processed in 4 days.**
Amount we paid:	$74.23	We paid CEDARS SINAI MEDICAL CENTER.
Network savings: (Amount saved by using a network provider.)	$103.38	**Deductible Status** The deductible has been met for 2010.
Amount billed by Provider:	$196.17	

DETAIL **Provider: CEDARS SINAI MEDICAL CENTER**
Preferred Hospital: Yes

Service Date	Type of Service and Procedure Number	Amount Billed Provider billed for services	Amount Allowed Preferred providers accept as payment	Amount We Paid	Patient Responsibility: Non Covered	Patient Responsibility: Deductible You pay provider before we begin payments	Patient Responsibility: Copayment/ Coinsurance	Notes
05/04/10	OUTPT LAB/X-RAY	196.17	92.79	74.23	0.00	0.00	18.56	
	Claim Totals:	196.17	92.79	74.23	0.00	0.00	18.56	

Messages

We have received a claim for the above referenced amount and have paid our full liability directly to the provider of service.

Thank you for choosing Blue Shield.
To see the extra services and support available to you, go to www.mylifepath.com.

Issue Date: 05/18/10
EOB Number:

Please see reverse side for more information.

Group ID:
Group Name:

EXPLANATION OF BENEFITS

Mother Jane Doe
1234 Myrtle Drive
Anytown, Calif.

This is NOT a Bill
This Explanation of Benefits (EOB) is to notify you
That we have processed your claim. It clarifies
your payment responsibility or reimbursement.

CLAIM SUMMARY AT A GLANCE

Patient: Daughter Sara Doe Subscriber ID: XXXXXXXX Claim No.: YYYYYYYYY

Provider Name/Address Religious Hospital, Anytown, Calif.

Patient Responsibility: $ 50.00

Amount We Paid $ 1,830.00

Network Saving: $ 995.00

Amount Bill by Provider $ 2,875.00

Diagnoses Billed by Provider: 301.3 = Explosive Personality Disorder
300.9 = Unspecified nonpsychotic mental disorder
V11.8 = Personal history of other mental disorders

DETAIL:

Service Date	Type of Service Procedure Code	Amount Billed	Amount Allowed	Non-Covered	Paid	Note
05/06/10	Room Charge	$ 38.00	[See below]			
05/06/10	Outpt Lab/Xray 36415	$ 32.00	[See below]			
05/06/10	Outpt Lab/Xray 36415	$ 32.00	[See below]			
05/06/10	Outpt Lab/Xray 80053	$ 311.00	[See below]			
05/06/10	Outpt Lab/Xray 80100	$ 261.00	[See below]			
05/06/10	Outpt Lab/Xray 80164	$ 141.00	[See below]			
05/06/10	Outpt Lab/Xray 80196	$ 175.00	[See below]			
05/06/10	Outpt Lab/Xray 81001	$ 90.00	[See below]			
05/06/10	Outpt Lab/Xray 81025	$ 97.00	[See below]			
05/06/10	Outpt Lab/Xray 82003	$ 274.00	[See below]			

05/06/10	Outpt Lab/Xray 82055	$ 211.00	[See below]			
05/06/10	Outpt Lab/Xray 85025	$ 148.00	[See below]			
05/06/10	ER Clinic 99284-25	$1075.00	[See below]			
	Claim Total	$ 2875.00	$ 1880.00	$ 0.00	$ 1830.00	1

Notes:

1. Contracting physicians and health care providers agree to accept the allowable amount as payment in full. The subscriber is responsible only for deductible, cop-payment amounts and non-covered amounts.

Procedure Code Descriptions:

36415 = Collection of venous blood by venipuncture
80053 = Complete metabolic blood panel test
80100 = Drug screen, qualitative; multiple drug classes chromatographic method
80164 = Therapeutic drug assay – dipropylacetic acid (valproic acid)
80196 = Therapeutic drug assay - Salicylate
81001 = Urinalysis, automated, with microscopy
81025 = Urine pregnancy test, by visual color comparison methods
82003 = Blood chemistry - acetaminophen
82055 = Blood chemistry – alcohol (ethanol)
85025 = Hematology – complete (CBC), automated (Hbg, Hct, RBC, WBC and platelet count) and automated differential WBC count
99284-25 = Emergency department visit for evaluation and management of a patient. – significant, separately identifiable evaluation

[See reverse side for important information including appeal rights]

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EXPLANATION OF BENEFITS

This is NOT a Bill

Retain for your records along with any provider bills.

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of **www.mylifepath.com**. If you have any questions about this document or your benefits, please call us at **(800) 424-6521**.

CLAIM SUMMARY AT A GLANCE

Patient:		Subscriber ID:	Claim Number: 20
Patient responsibility: (Amount you paid or owe to provider.)	$50.00	**Your claim was received 05/18/10 and processed in 3 days.**	
Amount we paid:	$1,830.00	We paid METHODIST HOSP OF SOUTHERN.	
Network savings: (Amount saved by using a network provider.)	$995.00	**Deductible Status** This plan has no deductible.	
Amount billed by Provider:	$2,875.00		

DETAIL **Provider:**

Service Date	Type of Service and Procedure Number	Amount Billed Provider billed for services	Amount Allowed Preferred providers accept as payment	Amount We Paid	Patient Responsibility: Non Covered	Patient Responsibility: Deductible You pay provider before we begin payments	Patient Responsibility: Copayment/ Coinsurance	Notes
05/06/10	SUPPLIES	38.00	1880.00	1830.00	0.00	0.00	50.00	
05/06/10	OUTPT LAB/X-RAY	32.00						
05/06/10	OUTPT LAB/X-RAY	311.00						
05/06/10	OUTPT LAB/X-RAY	261.00						
05/06/10	OUTPT LAB/X-RAY	141.00						
05/06/10	OUTPT LAB/X-RAY	90.00						
05/06/10	OUTPT LAB/X-RAY	87.00						
05/06/10	OUTPT LAB/X-RAY	274.00						
05/06/10	OUTPT LAB/X-RAY	211.00						
05/06/10	OUTPT LAB/X-RAY	148.00						

Issue Date: 05/21/10
EOB Number:

Please see reverse side for more information.

Group ID:
Group Na

EXPLANATION OF BENEFITS

Mother Smith
1234 Elm Drive
Anytown, Calif.

This is NOT a Bill
This Explanation of Benefits (EOB) is to notify you That we have processed your claim. It clarifies your payment responsibility or reimbursement.

CLAIM SUMMARY AT A GLANCE

Patient: Daughter Smith Subscriber ID: XXXXXXXX Claim No.: YYYYYYYYY

Provider Name/Address Planned Parenthood – Anytown, Calif

Patient Responsibility: $ 51.25

Amount We Paid $ 205.10

Network Saving: $ 655.74

Amount Bill by Provider $ 912.00

Diagnoses Billed by Provider: 635.50 – Legally induced abortion

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DETAIL:

Service Date	Type of Service Procedure Code	Amount Billed	Amount Allowed	Non-Covered	Paid	Note
06/03/10	Surgical 64435	$ 80.00	$ 0.00	$ 0.00	$ 0.00	1
06/30/10	OB Surgeon 59840	$ 760.00	$ 256.26	$ 0.00	$ 205.01	2
06/30/10	OB Surgeon 59840	$ 72.00	$ 0.00	$ 0.00	$ 0.00	3
	Claim Total	$ 912.00	$ 256.26	$ 0.00	$ 205.01	

Notes:

1. This procedure is included with payment for another procedure performed on the same day.
2. Contracting physicians and health care providers agree to accept the allowable amount as payment in full. The subscriber is responsible only for deductible, cop-payment amounts and non-covered amounts.
3. Based on the patient's history, this service is not medically necessary

Procedure Code Descriptions:

64435 = Injection, anesthetic agent, sciatic nerve, single
59840 = Induced abortion, by dilation and curettage

[See reverse side for important information including appeal rights]

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This is NOT a Bill

Retain for your records along with any provider bills.

This Explanation of Benefits (EOB) is to notify you that we have processed your claim. It clarifies your payment responsibility or reimbursement.

Your claim information is also available in the My Health Plan section of **www.mylifepath.com**. If you have any questions about this document or your benefits, please call us at **(707) 462-7607**.

CLAIM SUMMARY AT A GLANCE

Patient:		Subscriber ID:	Claim Number:
Patient responsibility: (Amount you paid or owe to provider.)	$51.25	**Your claim was received 07/13/10 and processed in 3 days.**	
Amount we paid:	$205.01	We paid '	
Network savings: (Amount saved by using a network provider.)	$655.74	**Deductible Status** The deductible has been met for 2010.	
Amount billed by Provider:	$912.00		

DETAIL **Provider:**
Participating Provider: Yes

Service Date	Type of Service and Procedure Number	Amount Billed Provider billed for services	Amount Allowed Preferred providers accept as payment	Amount We Paid	Patient Responsibility: Non Covered	Patient Responsibility: Deductible You pay provider before we begin payments	Patient Responsibility: Copayment/ Coinsurance	Notes
06/30/10	SURGICAL	80.00	0.00	0.00	0.00	0.00	0.00	1
06/30/10	OB SURGEON	760.00	256.26	205.01	0.00	0.00	51.25	2
06/30/10	OB SURGEON	72.00	0.00	0.00	0.00	0.00	0.00	3
	Claim Totals:	912.00	256.26	205.01	0.00	0.00	51.25	

Notes

1 This procedure is included with payment for another procedure performed on the same day.

2 Contracting physicians and health care providers agree to accept the allowable amount as payment in full. The subscriber is responsible only for deductible, co-payment amounts, and non-covered items.

3 Based on the patient's history, this service exceeds the maximum number of times it can be performed in a given time period.

Thank you for choosing Blue Shield.
To see the extra services and support available to you, go to www.mylifepath.com.

Please see reverse side for more information.