selecthealth

P.O. Box 30192
Salt Lake City, UT 84130-0192

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EXPLANATION OF BENEFITS

000001 01-01

JOHN DOE
12345 Drive
PARK CITY, UT 84098

PATIENT	**JANE DOE**
SUBSCRIBER	**JOHN DOE**
SUBSCRIBER #	**800000000 02**
PROVIDER OF SERVICE	**BIRKIN, MARY M., MD**
PATIENT ACCOUNT #	**680711222B**
DATE PROCESSED	**01/04/2012**
CLAIM #	**119XXXXXX**
DATE(S) OF SERVICE	**12/21/2011** TO **12/21/2011**
PLAN YEAR	**01/01/2011** TO **12/31/2011**

THIS IS NOT A BILL

This is an explanation of how your claim was processed by SelectHealth. If you have questions about payments or payment arrangements, contact your provider.

	DATE OF SERVICE / SERVICE CODE AND DESCRIPTION / DIAGNOSIS CODE AND DESCRIPTION	BILLED CHARGES	ALLOWED AMOUNT	PLAN PAID	DEDUCTIBLE	COPAY	COINSURANCE	NOT COVERED CHARGES
1.	12/21/2011 70551: MRI BRAIN W/O DYE	1222.05	575.00	460.00	0.00	0.00	115.00	0.00
	TOTALS	1222.05	575.00	460.00	0.00	0.00	115.00	0.00

REMARK CODE AND DESCRIPTION	
1. PXN	PXN - The charge exceeds the allowed amount for this service/procedure.

PLAN YEAR ACCRUALS	PARTICIPATING		NONPARTICIPATING	
	PATIENT	FAMILY	PATIENT	FAMILY
MEDICAL DEDUCTIBLE, TO DATE:	1000.00	2308.68	0.00	0.00
MEDICAL OUT-OF-POCKET MAXIMUM, TO DATE:	1161.24	2815.16	0.00	0.00
MENTAL HEALTH DEDUCTIBLE, TO DATE:	0.00	0.00	N/A	N/A
MENTAL HEALTH OUT-OF-POCKET MAXIMUM, TO DATE:	0.00	0.00	N/A	N/A

THIS AMOUNT DOES NOT REFLECT PAYMENTS YOU HAVE MADE TO THE PROVIDER.

TOTAL MEMBER RESPONSIBILITY

$115.00

THE AMOUNTS LISTED ABOVE ARE SUBJECT TO CHANGE DUE TO CLAIM ADJUSTMENTS AND/OR THE ORDER IN WHICH CLAIMS ARE RECEIVED.

IF YOU HAVE QUESTIONS, PLEASE CALL MEMBER SERVICES AT 801-442-5038 (SALT LAKE AREA) OR 800-538-5038.

DEFINITIONS OF TERMS

BILLED CHARGES: Total amount billed by your provider or facility.

COINSURANCE: A percentage of the plan allowance that you must pay for your care. You may also be responsible for additional amounts.

COPAYMENT: A fixed amount of money you pay when you receive covered services.

DEDUCTIBLE: A fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

DESCRIPTION OF SERVICES: The type of service rendered by your provider or facility.

EXPERIMENTAL AND/OR INVESTIGATIONAL: A service for which one or more of the following apply:

a. It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use or proposed use;

b. It is the subject of a current investigational new drug or new device application on file with the FDA;

c. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;

d. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or

e. If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the service.

MEDICAL NECESSITY: Services that a prudent healthcare professional would provide to a patient for the purpose of preventing,

diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

a. In accordance with generally accepted standards of medical practice in the United States;

b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

c. Not primarily for the convenience of the patient, physician, or other provider.

When a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level of service for the member in question, considering potential benefit and harm to the member. Medical necessity is determined by the treating physician and by SelectHealth's Medical Director or his or her designee. The fact that a provider or facility, even a participating provider or facility, may prescribe, order, recommend, or approve a service does not make it medically necessary, even if it is not listed as an exclusion or limitation. FDA approval, or other regulatory approval, does not establish medical necessity.

NOT COVERED CHARGES: This amount reflects charges either for services not covered by SelectHealth or charges that exceed the plan allowance from nonparticipating providers and facilities. You are responsible for paying this amount to the provider or facility.

OUT-OF-POCKET MAXIMUM: The maximum amount specified in your brochure that you must pay each year to providers and/or facilities as deductibles, copayments, and coinsurance. Except when otherwise noted, SelectHealth will pay 100 percent of the plan allowance during the remainder of the year once the out-of-pocket maximum is satisfied. Some categories of benefits may be subject to separate out-of-pocket maximums. Payments you make for excess charges, noncovered services, and any other categories of services specified in your Brochure are not applied to the out-of-pocket maximum.

PLAN ALLOWANCE/ ALLOWED AMOUNT: The amount SelectHealth uses to determine our payment and your coinsurance for covered services. Participating providers and facilities accept this allowed amount as payment in full for covered services.

PLAN PAID: The amount paid to your provider or facility by SelectHealth.

TOTAL MEMBER RESPONSIBILITY: You are responsible for paying the deductible, copayments, coinsurance, and any noncovered charges to the provider or facility. Any payments made to the provider or facility will not be reflected on this Explanations of Benefits (EOB).

GENERAL INFORMATION

Detailed information about your plan is available in your member materials and on our secure member website, *My Health*, at **selecthealth.org.** You can access and print your EOBs free of charge. If you call to request duplicate copies, you will be charged a $2 fee for each EOB or $25 for an entire year for each member. You may also call Member Services to request the diagnosis code(s) billed on this claim and their description(s).

BENEFIT DETERMINATIONS

The reasons for our determination, including reference to plan provisions or an explanation of any additional information needed to process your request, are indicated on the reverse side.

We rely on internal rules, guidelines, protocols, or similar criteria to make adverse benefit determinations. A copy of the relevant information used to make our decision will be provided upon written request and free of charge.

If the adverse determination is based on medical necessity, an experimental/investigational treatment, or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination will be provided free of charge. This explanation will apply the terms of the plan to your medical circumstances.

FILING LIMITS

Claims must be submitted by December 31 of the year following the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Corrections and adjustments must be submitted within one year from the date the claim was first processed. Coordination of benefit claims must be submitted within one year from the date the claim was first processed by the primary carrier.

PROBLEM SOLVING

If you have questions or problems with your coverage or claims, or if you need help understanding this EOB, call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**. A representative will attempt to resolve the matter informally.

APPEALS PROCESS

If you disagree with our decision on your claim, you or your authorized representative have the right to appeal the decision in writing to the following address:

SelectHealth
Attn: Appeals Department
P.O. Box 30192
Salt Lake City, UT 84130-0192

Appeals must be filed within six months from the date the claim was denied. The appeal should include a statement about why you believe our decision was wrong and copies of any documents that support your claim, such as physicians' letters, operative reports, bills, medical records and Explanation of Benefits (EOB) forms. Upon receipt, our Appeals department will investigate the appeal and all relevant information. Appeal decisions will be made by fiduciaries of the plan that did not make the initial decision on your claim. Where applicable, a medical professional with appropriate training and experience will be consulted. He or she will not give any deference to the initial claims denial.

You or your authorized representative will be notified in writing of the decision, including an explanation of any plan provisions or criteria used, within 30 days of the date you requested the review. If we need additional information, the decision may be delayed. You will be notified in writing of the reason for the delay. If you would like to receive our decision via e-mail, please include your e-mail address with your appeal.

If you do not agree with our decision you may ask OPM to review it. For a complete description of the appeals process, please refer to your brochure.

APPEALS RESOURCES

If you have any questions about your appeal rights, call the Appeals department at **801-442-4684**.

THIS NOTICE MAY BE PROVIDED IN SPANISH AND NAVAJO UPON REQUEST. FREE INTERPRETING SERVICE MAY BE PROVIDED UPON REQUEST.
ESTE AVISO PUEDE SER PROPORCIONADO EN ESPAÑOL A PETICIÓN. SE OFRECEN SERVICIOS DE INTERPRETACIÓN GRATIS A SOLICITUD.
DINEK'EHGO SHIKA AT'OHWOL NINISINGO, KWIIJIGO HOLNE' 801-442-5038 (SALT LAKE AREA) A'DO' 800-538-5038.