



First Choice Health Administrators  
P.O. BOX 12659  
Seattle, WA 98101-4659

# First Choice Health™

Healthy Employees. Healthy Companies.™

98729028002

ENR 37  
10/2/06

## EXPLANATION OF BENEFITS

**\*\*THIS IS NOT A BILL\*\***

RETAIN FOR FUTURE RECORDS

### Forwarding Service Requested

SINGLE PIECE

37 0.5176 SP 0.396



JAMIE D. DOE  
123 MAIN ST  
SEATTLE, WA 98001-1234

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Customer Service #: 1-800-455-3591

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GROUP: ABC COMPANY  
PARTICIPANT ID: 870002621 - 01  
PARTICIPANT NAME: JANE A. DOE

The **Participant ID** and **Participant Name** represent the subscriber.

The **Patient** is the individual whose claim is being reflected in this EOB.

PATIENT: JAMIE D. DOE 870002621 - 03  
PROVIDER: MICHAEL W. SMITH 12345-Specialist  
CLAIM #: C020212345

The **Contract Adjustment** is the amount the provider has agreed to write off. This is not part of the patient's responsibility.

Billed Amount	Contract Adjustment	UCR Adjustment	Allowed Amount	Not Covered Amount	Reason Code	Copay	Deductible	Co-Insurance	Other Carrier Paid	Paid Amount	Total Patient Responsibility
Service Date: 03/06/2006 Procedure: 99214 - Office/outpatient visit, est											
\$140.00	\$14.00	\$0.00	\$126.00	\$0.00		\$20.00	\$0.00	\$0.00	\$0.00	\$106.00	\$20.00
Service Date: 03/06/2006 Procedure: 81003 - Urinalysis, auto, w/o scope											
\$55.00	\$0.00	\$0.00	\$0.00	\$55.00	DRC	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Service Date: 03/06/2006 Procedure: 73110 - X-ray exam of wrist											
\$100.00	\$10.00	\$0.00	\$90.00	\$0.00		\$0.00	\$0.00	\$9.00	\$0.00	\$81.00	\$9.00
Service Date: 03/06/2006 Procedure: 84153 - Assay of psa, total											
\$100.00	\$10.00	\$0.00	\$90.00	\$0.00		\$0.00	\$0.00	\$9.00	\$0.00	\$81.00	\$9.00
<b>Totals for Claim:</b>											
\$395.00	\$34.00	\$0.00	\$306.00	\$55.00		\$20.00	\$0.00	\$18.00	\$0.00	\$268.00	\$38.00

The **Total Patient Responsibility** is the amount the patient is responsible for paying. This amount includes Copays, Coinsurance, Deductible, and any UCR Adjustments.

### Reason Code Description:

DRC Denied, Code Review - Provider Billing Issue

The **Other Carrier Paid** is the amount that was paid by another insurance carrier.

Summary for plan year 01/01/2006 - 12/31/2006

	Satisfied	Maximum
Plan Year Deductible Met - Individual	\$106.11	\$250.00
Plan Year Deductible Met - Family	\$106.11	\$500.00
Plan Year Out of Pocket Met - Individual	\$402.80	\$2,500.00
Plan Year Out of Pocket Met - Family	\$402.80	\$5,000.00

For online claims status and instructions on how to read your EOB visit [www.1stchoiceadmin.com](http://www.1stchoiceadmin.com) and select "For Members".

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.

Original Print Date : 03/24/2006

The **UCR Adjustment** is the amount that is charged above the Usual and Customary rate that First Choice covers for that service. The provider may bill the patient for this amount.

The **Summary for Plan Year** shows what the patient/family has accumulated to date.