Excellus

165 Court St.
Rochester, NY 14647

STATEMENT PERIOD

March 1, 2012 - March 31, 2012

THIS IS NOT A BILL

JOHN Q. SAMPLE
124 MAIN ST.
ANYTOWN, NY 12345

PROFILE

Subscriber	John Q. Sample
Subscriber ID	200000001

Members Covered

John Q. Sample
Angelina Lynne Sample
Billy Bob Sample
Kenneth Sample
Krystina Sample
Amy Sample
Angelina Lynne Sample
Lucy Sample
Brandon Sample

myRx Statement

This summary information is for Rx claims processed for all members covered under the subscriber ID number noted above.

Benefits for In-Network Rx Services

Benefit Period	As of 03/31/2012
Copayments and Coinsurance	
Tier 1	$5 copay
Tier 2	40% coinsurance
Tier 3	50% coinsurance

Refer to your benefits information for details on out-of-network benefits

Monthly Health Tips

Easy ways to use medications safely:

Remember your meds - Always take your medications as directed by your doctor.

Don't skip! - If you forget a dose, you may be able to take it as soon as you remember - but each medication is different, so talk to your doctor.

Keep a diary - A good way to keep on top of your medications is to keep a diary or record and review it with your doctor periodically.

Sharing is not caring - It can be dangerous to share your medications with others or to take drugs that have not been prescribed for you.

Learn more at **excellusbcbs.com/health**

Prescription Savings

Check with your doctor to see if there's a generic equivalent for your medication – lower cost, same active ingredients.

Learn more about the benefits of generic drugs at **excellusbcbs.com/rx**

Ask the Pharmacist

Our online tool with answers to commonly asked medication questions including:

- Drug interactions
- Brand name vs. generic drugs
- Over the counter sleep aids

And much more!

excellusbcbs.com/pharmacist

CLICK IT!

Health Tips
Use a 2D barcode scanner app on your smart phone to take a photo of this coded image to visit our website.

Write Excellus BlueCross BlueShield, P.O. Box 22999, Rochester, NY 14692 Rx Help Desk 1-800-724-5033

Notice of Determination As Required By Law

Please refer to the enclosed correspondence for the reason(s) that your or your dependent's claim(s) or service(s) was not approved in whole or part. If present, please match the Reason Code with its corresponding explanation. If your claim, Pre-Treatment Estimate or service was not approved in full, then the information contained in this notice will apply. Diagnosis and treatment codes and meanings related to your services are available upon request. This information is available in other formats for members with special needs or who speak languages other than English. Call the phone number on your ID card for help.

Your Right to Appeal. Our Appeal procedure applies to medical necessity and experimental or investigational determinations. You, your authorized designee or your health care provider may file a standard appeal or an expedited appeal by contacting our Customer Service Department by phone (at the number on your ID card), in person or in writing to P.O. Box 22999, Rochester, NY 14692. Medicaid and Family Health Plus members have 60-business days from receipt of this notice to file an appeal. All other members have up to 180-calendar days from receipt of this notice to file the appeal. *Failure to comply with these requirements may lead to forfeiture of your right to challenge a denial, rejection or partial payment, even when a request for clarification has been made.* You have the right to be represented in the appeal process by anyone you choose. There is no penalty and we will not treat you differently for filing an appeal.

Standard Appeals.

All standard appeals for Medicaid and Family Health Plus members will be decided within 30-calendar days. For all other members, if your appeal relates to a pre-service matter (a request for a service or treatment that has not yet been received), we will decide the appeal within 30-calendar days and notify you or your designee (and your health care provider if he or she requested the review) of our determination in writing within two business days after the determination is made, but no later than 30-calendar days after receipt of the appeal request.

If your appeal relates to a post-service matter (a service or treatment that has already been provided), we will decide the appeal within 60-calendar days and notify you or your designee (and your health care provider if he or she requested the review) of our determination in writing within two business days after the determination is made, but no later than 60-calendar days after receipt of the appeal request.

Expedited Appeals.

If your appeal relates to a review of continued or extended health care services, additional services rendered in the course of treatment, services in which a provider requests an immediate review, a situation in which a delay would significantly increase a risk to your health or any other urgent matter, we will handle your appeal on an expedited basis. Expedited appeals are not available for retrospective reviews. For Medicaid and Family Health Plus members, all expedited appeals will be decided within 3-business days and notice will be given within 1-business day from the determination. For all other members, expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request. If you are not satisfied with the resolution of your expedited appeal, you may file a standard appeal. You may also have the right to file an external appeal.

Your Right To An External Appeal. If you are covered through an insured product, you can file an external appeal with a state-approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational. If you are covered through a self funded plan, you *may* be eligible for an external appeal. Eligibility will be included in the final adverse determination notice you receive from us. In order to be eligible, you must have received a final adverse determination as a result of our internal appeal process or we must have jointly agreed to waive the internal utilization review appeal process.

You may obtain an external appeal application from:

- For insured groups: The New York State Department of Financial Services at 1-800-400-8882 or its website at www.DFS.NY.GOV.
- For all eligible groups: our Customer Service Department by calling the phone number on your ID card.

You have 4 months to initiate an external appeal after receiving a final adverse determination from us. Please refer to your member handbook for additional information about the external appeal process.

Your Right to Grievance. Our Grievance procedure applies to any benefit denial not relating to a medical necessity or experimental or investigational determination. You or your authorized designee may file a grievance by contacting our Customer Service Department by phone (at the number on your ID card), in person or in writing to P.O. Box 22999, Rochester, NY14692. Medicaid and Family Health Plus members have 60-business days from receipt of this notice to file a grievance. All other members have up to 180-calendar days from receipt of this notice to file the grievance. *Failure to comply with these requirements may lead to forfeiture of your right to challenge a denial, rejection or partial payment, even when a request for clarification has been made.*

All grievances for Medicaid and Family Health Plus members will be decided within 30-calendar days. For all other members, if your grievance relates to a pre-service matter (a request for a service or treatment that has not yet been received), we will decide the grievance and notify you of our determination in writing within 15-calendar days of receipt of your grievance request.

If your grievance relates to an urgent matter, we will decide the grievance and notify you of our determination by phone within 48 hours of receipt of your grievance request. Written notice will follow within 24 hours of our determination.

If your grievance relates to a post-service matter (a service or treatment that has already been provided), we will decide the grievance and notify you of our determination in writing within 30-calendar days of receipt of your grievance request.

If your coverage is through an employer subject to ERISA, you may have the right to appeal your matter to your employer consistent with the provisions of your employer's Summary Plan Description (SPD). Your employer may have the final decision regarding your coverage. Please refer to your Plan Administrator for specific information. In addition, if our determination is upheld on grievance or appeal, including final review by or on behalf of your group (if you are covered through a self-funded plan), you have the right to bring a civil action under section 502(a) of ERISA. With questions about your rights, this notice or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You, or your authorized designee, have the right to submit written comments, documents, records, or other information relevant to your appeal or grievance.

A copy of the review criteria upon which our decision was based is available free of charge upon written request to the address listed on the enclosed correspondence.

Miscellaneous Information.

If you are covered under an insured product and you are dissatisfied with any of the above decisions or at any other time you are dissatisfied, you may call the:

- New York State Department of Health Complaint Hotline at 1-800-206-8125 or,
- New York State Department of Financial Services at 1-800-342-3736

You can also contact Community Health Advocates, the State's consumer assistance program, at 1-888-614-5400 or at www.communityhealthadvocates.org.

Nuestro Plan de Salud tiene representantes bilingües así como otros servicios disponible para ayudarlo. Si usted tiene preguntas acerca de este documento o la necesidad de contactarnos con otras preguntas, llamanos por favor al número del Servicio al Cliente que esta listado en su tarjeta de identificación y usted será conectado a alguien que puede ayudarle. Hay también un sitio en el web español disponible para usted.

Kung kailangan niyo ang tulong sa Tagalog tumawag sa Kung kailangan mo ng tulong sa Tagalog, pakitawagan kami sa customer service number na nakalista sa likuran ng iyong identification card

如果需要中文的帮助，请拨打这个号码 如果您需要以中文提供協助，請撥打您識別卡背面載有之客戶服務電話

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Dii bik'ih siniligii shiŁ beehodooziiŁ ninizingo ei beesh bee hodiil nih

If your EOB indicates a claim adjustment, you may have overpaid/underpaid your cost sharing expense to the provider. If this is the case, you should contact your provider directly.

My Rx Statement

Monthly Totals

Claim Activity for John Q. Sample
Relationship to Subscriber: Subscriber

Totals - Claims Processed during:	Provider Charged	Allowed	Other Insurance	Paid	MEMBER RESPONSIBILITY			
					Not Covered	Deductible	Copay	Coinsurance
February	$210.00	$150.00	$0.00	$48.00	$0.00	$0.00	$0.00	$120.00

Prescription Drug

Claim Activity for John Q. Sample
Relationship to Subscriber: Subscriber

Provider (Network): Dr. Juan (Out of Network)

Date of Service	Claim Number	Provider Charged	Allowed	Other Insurance	Paid	MEMBER RESPONSIBILITY				
						NotCovered	Deductible	Copay	Coinsurance	Remarks
02/22/11	9999991234567	$210.00	$150.00	$0.00	$48.00	$0.00	$0.00	$0.00	$120.00	H52

Remarks	Explanation
H52	Claim has been adjusted using corrected information from the Provider

Definitions

Here are a few definitions of frequently used health care terms for your convenience.

Copay - A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount - The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance - A cost-sharing method that requires you pay a portion of the allowed amount for certain medical services.

Deductible - A set dollar amount you pay for covered services you receive before your insurer will make a payment.

Out-of-pocket Maximum - The maximum amount of deductible and coinsurance payments that you will pay for health services each calendar year.

Messages

Suspect Claims Fraud?
Join the fight against health care fraud. If you suspect fraud is occurring, such as false or altered claims being submitted or services being billed which were not provided, call the Special Investigations Unit Hotline at 1 (800) 378-8024. All calls will be kept confidential.

Need Cumulative Totals?
Please call the phone number on the back of your identification card.

Diabetic Supplies and Medications
Benefits for medications, equipment and supplies used in the treatment of diabetes and purchased at a pharmacy may be applied under your medical benefit insurance. Please refer to the benefits section of your contract for specific information.