

PacifiCare®

A UnitedHealthcare Company

FROM

**Linda Clark, Regulatory Appeals Analyst
5757 Plaza Drive MS CA 124-0157
Cypress, CA 90630
Toll-Free # 866-744-4543
Direct# (714) 226-6742**

RECEIVED
DEPT. OF INSURANCE
LOS ANGELES
FEB 7 1996 9:51 AM

5757 Plaza Drive, Mailstop CA124-0157
Cypress, California 90630

CDI00229708

February 6, 2007

Steven Brunelle
California Department of Insurance
300 S. Spring Street
Los Angeles, CA 90013

Insured: [REDACTED]
Patient: same
Patient ID: 074022400
Plan Type: PPO

California DOI file: CSB-6232755

Dear Mr. Brunelle:

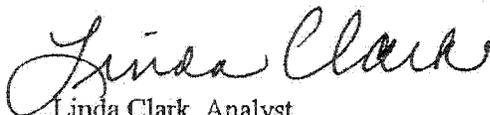
This letter is written in reference to your request for additional information regarding the claims reimbursement for the services Mr. [REDACTED] obtained from the Turner Eye Institute and Horizon Vision for dates of service July 24, 2006 and August 7, 2006.

You are asking that PacifiCare provide "true" copies of the Explanation of Benefits for each of Mr. [REDACTED] claims for dates of service July 24, 2006 and August 7, 2006.

Please see the attached copies of the Explanations of Benefits that PacifiCare was able to retrieve from the PacifiCare Claims Department.

We hope that this resolves the issues you have presented.

Sincerely,



Linda Clark, Analyst
Regulatory Appeals

5757 Plaza Drive, Mailstop CA124-0157
Cypress, California 90630

PLEASE
DO NOT
STAPLE
IN THIS
AREA

1. Program or Plan <input type="radio"/> (Medicare #) <input type="radio"/> (Medicaid #) <input type="radio"/> (Champus) <input type="radio"/> (ChampVA) <input type="radio"/> (Group) <input type="radio"/> (FECA) <input checked="" type="radio"/> (Other)		1a. Insured's I.D. Number [REDACTED]	
2. Patient's Name (last, first, mi) [REDACTED]		3. Patient's Birthdate (mm/dd/yyyy) Sex 11/16/1956 <input checked="" type="radio"/> M <input type="radio"/> F	
5. Patient's Address [REDACTED]		6. Patient Relationship To Insured <input checked="" type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	
		7. Insured's Address [REDACTED]	
9. Other Insured's Name (last, first, mi)		10. Is Patient's Condition Related To: a. Employment? (Current or Previous) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
a. Other Insured's Policy or Group Number		b. Auto Accident? Place (State) <input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Other Insured's Date of Birth (mm/dd/yyyy) Sex <input type="radio"/> M <input type="radio"/> F		c. Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Employer's Name or School Name		11. Insured's Policy Group or FECA Number 90219335	
d. Insurance Plan Name of Program Name		10d. Reserved for local use	
12. Patient's or Authorized Person's Signature SIGNED SIGNATURE ON FILE DATE		11. Insured's Date of Birth (mm/dd/yyyy) Sex 11/16/1956 <input checked="" type="radio"/> M <input type="radio"/> F	
14. Date of current illness (mm/dd/yyyy)		b. Employer's Name or School Name SPORTS LEADERSHIP GROUP	
15. If Patient has had same or similar illness give first date (mm/dd/yyyy)		c. Insurance Plan Name of Program Name SPORTS LEADERSHIP GROUP	
17. Name of Referring Physician or Other Source		d. Is there another health benefit plan? <input type="radio"/> Yes <input checked="" type="radio"/> No	
19. Reserved for local use		13. Insured's or Authorized Person's Signature SIGNED SIGNATURE ON FILE	
21. Diagnosis or nature of illness or injury. (Relate items 1,2,3 or 4 to item 24B by lines) 1. 780 3. 2. 4.		16. Dates Patient unable to work in current occupation (mm/dd/yyyy) FROM TO	
		18. Hospitalization Dates Related to Current Services (mm/dd/yyyy) FROM TO	
		20. Outside Lab? Charges <input checked="" type="radio"/> Yes <input type="radio"/> No \$0.00	
		22. Medicaid Resubmission Code Original Ref. No.	
		23. Prior Authorization Number	
24. A		B	
Date(S) of Service From To		Place of Service	
MM/DD/YYYY MM/DD/YYYY		Type of Service	
		Procedures, services, supplies (Explain unusual circumstances)	
		CPT/HCPCS MODIFIER	
08/07/2006 08/07/2006		LI	
		Diagnosis Code	
		\$ Charges	
		Days or Units	
		EPCS/DT Family Plan	
		EMG COB	
		Reserved for local use	
		99070	
		I	
		\$1,395.00	
		1.00	
25. Federal Tax I.D. Number		26. Patient's Account No.	
SSN BIN		27. Accept Assignment? <input type="radio"/> Yes <input checked="" type="radio"/> No	
[REDACTED]			
		28. Total Charges \$1,395.00	
		29. Amount Paid \$0.00	
		30. Balance Due \$0.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) FIRST HORIZON VISION CENTER MED GROUP M.I. LAST HORIZON VISION CENTER MED GROUP DATE		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) HORIZON VISION CENTER MED GROUP 14895 E 14TH ST STE 360 SAN LEANDRO CA 94578	
		33. Physicians, supplier's billing information HORIZON VISION CENTER MED GROUP 14895 E 14TH ST STE 360 SAN LEANDRO CA 94578 PIN# GRP#	

Claim Number: CPH07008AMRR.C0
Date Received: 08/07/2006

PLEASE
DO NOT
STAPLE
IN THIS
AREA

1. Program or Plan <input type="radio"/> (Medicare #) <input type="radio"/> (Medicaid #) <input type="radio"/> (Champus) <input type="radio"/> (ChampVA) <input type="radio"/> (Group) <input type="radio"/> (FBCA) <input checked="" type="radio"/> (Other)		1a. Insured's I.D. Number ██████████	
2. Patient's Name (last, first, mi) ██████████		3. Patient's Birthdate (mm/dd/yyyy) Sex 11/16/1956 <input checked="" type="radio"/> M <input type="radio"/> F	
5. Patient's Address ██████████ ██████████		6. Patient Relationship To Insured <input checked="" type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	
9. Other Insured's Name (last, first, mi)		8. Patient Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other <input type="radio"/> Employed <input type="radio"/> Full-Time Student <input type="radio"/> Part-Time Student	
10. Is Patient's Condition Related To: a. Employment? (Current or Previous) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Insured's Policy Group or FBCA Number 90219335	
b. Auto Accident? Place (State) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		12. Insured's Date of Birth (mm/dd/yyyy) Sex 11/16/1956 <input checked="" type="radio"/> M <input type="radio"/> F	
c. Other Accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Employer's Name or School Name SPORTS LEADERSHIP GROUP	
14. Date of current illness (mm/dd/yyyy)		14. Insurance Plan Name of Program Name SPORTS LEADERSHIP GROUP	
15. If Patient has had same or similar illness give first date (mm/dd/yyyy)		15. Reserved for local use	
16. Dates Patient unable to work in current occupation (mm/dd/yyyy) FROM TO		16. Is there another health benefit plan? <input type="radio"/> Yes <input checked="" type="radio"/> No	
17. Name of Referring Physician or Other Source		17. Insured's or Authorized Person's Signature SIGNED SIGNATURE ON FILE DATE	
18. Hospitalization Dates Related to Current Services (mm/dd/yyyy) FROM TO		18. Insured's or Authorized Person's Signature SIGNED SIGNATURE ON FILE	
19. Reserved for local use		19. Dates Patient unable to work in current occupation (mm/dd/yyyy) FROM TO	
20. Outside Lab? Charges <input type="radio"/> Yes <input checked="" type="radio"/> No \$0.00		20. Hospitalization Dates Related to Current Services (mm/dd/yyyy) FROM TO	
21. Diagnosis or nature of illness or injury. (Relate items 1,2,3 or 4 to item 24E by lines) 1.371.60 3. 2. 4.		21. Medicaid Resubmission Code Original Ref. No.	
22. Prior Authorization Number		22. Medicaid Resubmission Code Original Ref. No.	
23. A		23. B	
Date(S) of Service From To		Place of Service	
MM/DD/YYYY MM/DD/YYYY		Type of Service	
08/07/2006 08/07/2006		24	
C		D	
Procedures, services, supplies (Explain unusual circumstances)		Diagnosis Code	
CPT/HCPCS MODIFIER		I	
0099T		I	
E		F	
Charges		G	
\$3,000.00		Days or Units	
1.00		H	
I		J	
K		L	
Reserved for local use		Reserved for local use	
25. Federal Tax I.D. Number SSN EIN		26. Patient's Account No.	
██████████		059685	
27. Accept Assignment? <input checked="" type="radio"/> Yes <input type="radio"/> No		28. Total Charges	
		\$3,000.00	
29. Amount Paid		30. Balance Due	
\$0.00		\$0.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) FIRST STEPHEN M.I. G LAST TURNER MD DATE		32. NAME AND ADDRESS OF FACILITY WHEN SERVICES WERE RENDERED (If other than home or office) TURNER EYE INSTITUTE M 420 ESTUDILLO AVE SAN LEANDRO CA 94577 5106141515	
33. Physician's, supplier's billing information TURNER EYE INSTITUTE 420 ESTUDILLO AVE SAN LEANDRO CA 94577 5106141515 PIN# GRP#			

Claim Number: H6223PXY0005022
Date Received: 08/11/2006

PacifiCare[®]
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 TURNER EYE INSTITUTE MEDICAL GRP

CLAIM NUMBER 19454499-01	CHECK NUMBER 006004030069
CHECK DATE 09/14/2006	CHECK AMOUNT ***\$1,038.34

VOID VOID

PacifiCare[®]
 Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 08/07/2006-08/07/2006
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: 0059685
 Provider: TURNER EYE INSTITUTE MEDICAL GRP

Group: SPORTS LEADERSHIP GROUP
 Contract Name: California Network

Check Date: 09/14/2006
 Check Number: 006004030069
 Check Amount: \$1,038.34
 Group #: 90219335
 Claim #: 19454499-01

It is your responsibility to pay: \$161.66
 It is NOT your responsibility to pay: \$2,538.34

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT				COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient Responsibility	Patient Responsibility					
08/07/06	Transplant	3,000.00	Ab	1,500.00				166.66	70	1,038.34	
TOTALS		3,000.00		1,500.00				166.66		\$1,038.34	
TOTAL PAID FOR THIS CLAIM										\$1,038.34	

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

Ab This amount represents the PacifiCare Network discount.

VOID VOID VOID

PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: 0.00

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HOW TO READ YOUR
EXPLANATION OF BENEFITS

Date(s) of Service: To - From dates of service.
Patient: Patient's Name
Insured: Insured's Name
Patient Account #: Patient Acct #
Provider: Provider Name

Group: Employer Group Name
Contract Name: PPO Contract Name

Check Date: 08/02/03
Check Number: 1234567890
Check Amount: \$\$. \$\$
Group #: Employer Group #
Claim #: Claim #

It is your responsibility to pay: (1) * Please pay this amount to the provider of service. It is NOT your responsibility to pay: (2) *											
Other Insurance Allowed: (3)						Other Insurance Paid: (4)					
SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT			PATIENT RESPONSIBILITY	COPAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient responsibility						
(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
Here is a brief description of what each field means. Note: The fields marked with an asterisk do not display if Benefits were coordinated with another carrier. If benefits were coordinated, your responsibility is calculated by taking the other insurance allowed amount (3) less the other Insurance paid amount (4) less the Total Paid for this claim (18).											
1 * The total amount the insured is responsible to pay to the provider for this claim. 2 * The total amount the insured is NOT responsible to pay to the provider for this claim. 3 The Amount your other insurance has allowed. 4 The amount your other insurance has paid on this claim. 5 Date the service was rendered. 6 A short description of the type of service performed. 7 Is the amount billed for the service rendered. 8 Is a 2 character code to help you understand how this line item is being paid. 9 Amount the line item is reduced due to a provider discount. 10 Amount that is ineligible for payment by the insurance and is NOT the patient's responsibility to pay. 11 Amount that is ineligible for payment by the insurance and is the patient's responsibility to pay. 12 Copayment made by the patient or any other deductible amount. 13 Amount of this line item that is being applied to the patient's annual deductible. 14 Amount the patient is responsible to pay after the insurance has paid their percentage unless coordination of benefits applies. See note above. 15 The percentage the insurance is paying for this line item. 16 Amount the insurance has paid toward this line item. 17 The total savings you gained by having another insurance. 18 Total amount the insurance is paying for all line item above. 19 Description of the 2 character remark code in #8 above. 20 The amount remaining before the patient has satisfied their annual deductible.											
TOTALS		\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$
										Other Insurance Savings	(17)
										TOTAL PAID FOR THIS CLAIM	(18)
REMARK CODE(S), DESCRIPTIONS AND CLAIM COMMENTS: (19) Detail description of what the remark code means and any additional claims comments to help you understand your explanation of benefits.											
VOID VOID VOID											
PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING:										(20)	

THIS IS NOT A BILL

PacifiCare®

Life and Health Insurance Company

KNOW YOUR RIGHTS

An Insured or the Insured's authorized representative ("Insured"), has the right to appeal adverse decisions regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) Medical Necessity, effectiveness or efficiency.

The Company offers Standard review levels. For detailed information related to the review levels, please refer to your Certificate.

Insureds may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and/or Insured's employee benefits representative. Insureds may have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews of the claim have been completed and the claim has not been approved.

Participation in any appeal process waives any privilege of confidentiality the Insured may have regarding medical records that any person examines or may examine in connection with the reviewed condition during the appeal process.

To request an Appeal:

1. Insureds must make an oral or written appeal request at the telephone number or address provided below within one year of the receipt date of the adverse decision notice. Insureds making oral requests will be sent a form (the "Appeal Form") to complete and return.
2. The Company will evaluate appeals of adverse decisions. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding Medical Necessity.
3. Insureds are responsible for providing any additional documentation supporting their reconsideration request with the written appeal request. The Company will evaluate a request based on the information in its possession.
4. The Company will issue a written determination notice to the Insured within 30 days of receiving a written appeal request. The notice will include the reason(s) for the Company's decision, the documentation on which the decision is based and the process for filing a formal appeal.

Contact and Other Important Information:

Insureds may call the Company with questions regarding the claim determination. Additionally, the Department of Insurance can assist with questions about the health care appeals process or if an Insured believes that there has been a violation of the State's unfair practices or other similar state laws.

To contact the Company concerning Suspected Fraud or Irregular Billing Practices, call 1-866-686-6350.

Insurance Company

Appeals Department
P.O. Box 400046
San Antonio, TX 78229
(866) 316-9776
Monday - Friday (7:00 AM to 9:00 PM CST)

State Insurance Regulatory Agency

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833

PacifiCare[®]
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

Chase Manhattan Bank Delaware
 1201 Market Street
 Wilmington, DE, 19801

0474-09

CLAIM NUMBER
 19454499-01

CHECK NUMBER
 006004030069

6226
 511 PFO_EJHC

CHECK DATE
 09/14/2006

CHECK AMOUNT
 ***\$1,038.34

PAY One thousand thirty eight and 34/100 Dollars

VOID IF NOT CASHED IN 180 DAYS

TO THE ORDER OF

TURNER EYE INSTITUTE MEDICAL GRP
 420 ESTUDILLO AVE
 SAN LEANDRO CA 94577-4908

VOID

VOID
 [Signature]
 AUTHORIZED SIGNATURE

PacifiCare[®]
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Record.
 (866) 316-9776

Date(s) of Service: 08/07/2006-08/07/2006

Patient: [Redacted]

Insured: [Redacted]

Patient Account #: 0059685

Provider: TURNER EYE INSTITUTE MEDICAL GRP

Group: SPORTS LEADERSHIP GROUP

Contract Name: California Network

Check Date: 09/14/2006

Check Number: 006004030069

Check Amount: \$1,038.34

Group #: 90219335

Claim #: 19454499-01

SERVICE DATE(S)	PROCEDURE CODE	BILLED AMOUNT	INELIGIBLE AMOUNT				COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	PROVIDER DISCOUNT	Not Patient Responsibility	Patient Responsibility					
08/07/06	0099T-LT	3,000.00	Ab	1,500.00				1,666.00	445.00	70	1,038.34
TOTALS		3,000.00		1,500.00				1,666.00	445.00		\$1,038.34
										TOTAL PAID FOR THIS CLAIM	\$1,038.34

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

Ab This amount represents the PacifiCare Network discount.

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PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING:

0.00

THIS IS NOT A BILL

0000002018544990160040300697

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PROVIDER DISPUTE INFORMATION

Per California law, PacifiCare is obligated to notify you of your dispute rights. If you would like to submit a provider dispute, please submit a request to:

PacifiCare
Provider Dispute
P.O. Box 6098
Cypress, CA 90630

The dispute request must include the following information:

1. Name, address and phone number of the provider of service.
2. Provider's PacifiCare individual provider identification number, if applicable.
3. A complete and accurate explanation of the issue.
4. Supporting documentation including copies of claims (if applicable), claim number, medical records, or supporting documentation to challenge reports as necessary from the initial adverse determination.

PacifiCare will process your dispute request within 45 working days. Inquiries can be made at 1-866-316-9776.

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PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 HORIZON VISION CENTER MED GROUP

CLAIM NUMBER 19661755-01	CHECK NUMBER nochk1836074
CHECK DATE 09/14/2006	CHECK AMOUNT 0.00

VOID

VOID
 CA 94526

VOID

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 07/24/2006-07/24/2006
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: 0
 Provider: HORIZON VISION CENTER MED GROUP

Check Date: 09/14/2006
 Check Number: nochk1836074
 Check Amount: 0.00
 Group #: 90219335
 Claim #: 19661755-01

Group: SPORTS LEADERSHIP GROUP

It is your responsibility to pay: \$2,245.00
 It is NOT your responsibility to pay: 0.00

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT				PATIENT RESPONSIBILITY	CO-PAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient Responsibility	Patient Responsibility						
07/24/06	INV PL EX CD	2,245.00	vb			2,245.00						
TOTALS		2,245.00				2,245.00						

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

vb Eye exams, glasses, contact lenses and routine eye refractions are not covered. Please refer to you Certificate, Section 8, "Exclusions and Limitations," Part I, "Exclusions," #14.

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**HOW TO READ YOUR
EXPLANATION OF BENEFITS**

Date(s) of Service: To - From dates of service.
Patient: Patient's Name
Insured: Insured's Name
Patient Account #: Patient Acct #
Provider: Provider Name

Group: Employer Group Name
Contract Name: PPO Contract Name

Check Date: 08/02/03
Check Number: 1234567890
Check Amount: \$\$. \$\$
Group #: Employer Group #
Claim #: Claim #

It is your responsibility to pay (1) * Please pay the amount to the provider of service.
It is NOT your responsibility to pay (2) *

Other Insurance Allowed (3)			Other Insurance Paid (4)								
SERVICE DATE(S) (5)	TYPE OF SERVICE (6)	BILLED AMOUNT (7)	INELIGIBLE AMOUNT				COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT (12)	APPLIED TO ANNUAL DEDUCTIBLE (13)	PATIENT COINSURANCE AMOUNT (14)	PAY % (15)	CLAIMS PAYMENT AMOUNT (16)
			RMK CODE (8)	INSURED'S DISCOUNT (9)	Not Patient responsibility (10)	Patient responsibility (11)					

Here is a brief description of what each field means.

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- * The total amount the insured is responsible to pay to the provider for this claim.
- * The total amount the insured is NOT responsible to pay to the provider for this claim.
- The Amount your other insurance has allowed.
- The amount your other insurance has paid on this claim.
- Date the service was rendered.
- A short description of the type of service performed.
- Is the amount billed for the service rendered.
- Is a 2 character code to help you understand how this line item is being paid.
- Amount the line item is reduced due to a provider discount.
- Amount that is ineligible for payment by the insurance and is NOT the patient's responsibility to pay.
- Amount that is ineligible for payment by the insurance and is the patient's responsibility to pay.
- Copayment made by the patient or any other deductible amount.
- Amount of this line item that is being applied to the patients annual deductible.
- Amount the patient is responsible to pay after the insurance has paid their percentage unless coordination of benefits applies. See note above.
- The percentage the insurance is paying for this line item.
- Amount the insurance has paid toward this line item.
- The total savings you gained by having another insurance.
- Total amount the insurance is paying for all line item above.
- Description of the 2 character remark code in #8 above.

TOTALS	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	
										Other Insurance Savings	(17)
										TOTAL PAID FOR THIS CLAIM	(18)

REMARK CODE(S), DESCRIPTIONS, AND CLAIM COMMENTS:

(19) Detail description of what the remark code means and any additional claims comments to help you understand your explanation of benefits.

VOID VOID VOID

THIS IS NOT A BILL



Life and Health Insurance Company

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To contact the Company concerning Suspected Fraud or Irregular Billing Practices, call 1-866-686-6350.

Insurance Company

Appeals Department
P.O. Box 400046
San Antonio, TX 78229
(866) 316-9776
Monday - Friday (7:00 AM to 9:00 PM CST)

State Insurance Regulatory Agency

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833

Member Reimbursement

PacifiCare®
Life and Health Insurance Company
P.O. Box 6098
Cypress, CA 90630

Chase Manhattan Bank Delaware
1201 Market Street
Wilmington, DE, 19801

0474-09

CLAIM NUMBER
19661755-02

CHECK NUMBER
6004449776

CHECK DATE
12/27/2006

CHECK AMOUNT
****\$772.60

62-X
J11 EPO_PLHC

PAY Seven hundred seventy two and 60/100 Dollars

VOID IF NOT CASHED IN 180 DAYS

TO THE ORDER OF

[Redacted Name]

VOID

VOID
Pat W. Okenander
AUTHORIZED SIGNATURE

PacifiCare®
Life and Health Insurance Company

EXPLANATION OF BENEFITS
Retain for Your Records.
(800) 310-9776

Date(s) of Service: 07/24/2006-07/24/2006
Patient: [Redacted]
Insured: [Redacted]
Patient Account #: 0
Provider: HORIZON VISION CENTER MED GROUP

Group: SPORTS LEADERSHIP GROUP

Check Date: 12/27/2006
Check Number: 006004449776
Check Amount: \$772.60
Group #: 90219335
Claim #: 19661755-02

It is your responsibility to pay: \$1,495.00
It is NOT your responsibility to pay: \$772.60

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT				COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED DISCOUNT	Not Patient Responsibility	Patient Responsibility					
07/24/06	Hsp Svcs	2,245.00	IA			745.00		750.00	50	750.00	
07/24/06	Interest	22.60	IN							22.60	
TOTALS		2,267.60				745.00		750.00		\$772.60	
TOTAL PAID FOR THIS CLAIM										\$772.60	

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

IN INTEREST PAYMENT
IA This charge exceeds the maximum benefit provision of your plan. Please refer to your Schedule of Benefits.

This is an adjustment to a previously considered claim: 19661755-01.

VOID VOID VOID

PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: 0.00

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HOW TO READ YOUR
EXPLANATION OF BENEFITS

Date(s) of Service: To - From dates of service.

Patient: Patient's Name

Insured: Insured's Name

Patient Account #: Patient Acct #

Provider: Provider Name

Group: Employer Group Name

Contract Name: PPO Contract Name

Check Date: 08/02/03

Check Number: 1234567890

Check Amount: \$\$. \$\$

Group #: Employer Group #

Claim #: Claim #

It is your responsibility to pay: (1) *
It is NOT your responsibility to pay: (2) *

Other Insurance Allowed: (3) * Other Insurance Paid: (4) *

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT			Patient Responsibility	COPAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient responsibility						
(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)

Here is a brief description of what each field means.

Note: The fields marked with an asterisk do not display if Benefits were coordinated with another carrier. If benefits were coordinated, your responsibility is calculated by taking the other insurance allowed amount (3) less the other insurance paid amount (4) less the Total Paid for this claim (18).

- 1 * The total amount the insured is responsible to pay to the provider for this claim.
- 2 * The total amount the insured is NOT responsible to pay to the provider for this claim.
- 3 The Amount your other insurance has allowed.
- 4 The amount your other insurance has paid on this claim.
- 5 Date the service was rendered.
- 6 A short description of the type of service performed.
- 7 Is the amount billed for the service rendered.
- 8 Is a 2 character code to help you understand how this line item is being paid.
- 9 Amount the line item is reduced due to a provider discount.
- 10 Amount that is ineligible for payment by the insurance and is NOT the patient's responsibility to pay.
- 11 Amount that is ineligible for payment by the insurance and is the patient's responsibility to pay.
- 12 Copayment made by the patient or any other deductible amount.
- 13 Amount of this line item that is being applied to the patient's annual deductible.
- 14 Amount the patient is responsible to pay after the insurance has paid their percentage unless coordination of benefits applies. See note above.
- 15 The percentage the insurance is paying for this line item.
- 16 Amount the insurance has paid toward this line item.
- 17 The total savings you gained by having another insurance.
- 18 Total amount the insurance is paying for all line item above.
- 19 Description of the 2 character remark code in #8 above.
- 20 The amount remaining before the patient has satisfied their annual deductible.

TOTALS	\$\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$	\$\$
Other Insurance Savings										(17)	
TOTAL PAID FOR THIS CLAIM										(18)	

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

(19) Detail description of what the remark code means and any additional claims comments to help you understand your explanation of benefits.

PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING:

(20)

THIS IS NOT A BILL

PacifiCare®

Life and Health Insurance Company

KNOW YOUR RIGHTS

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4. The Company will issue a written determination notice to the Insured within 30 days of receiving a written appeal request. The notice will include the reason(s) for the Company's decision, the documentation on which the decision is based and the process for filing a formal appeal.

Contact and Other Important Information:

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To contact the Company concerning Suspected Fraud or Irregular Billing Practices, call 1-866-686-6350.

Insurance Company

Appeals Department
P.O. Box 400046
San Antonio, TX 78229
(866) 316-9776
Monday - Friday (7:00 AM to 9:00 PM CST)

State Insurance Regulatory Agency

California Department of Insurance
Consumer Communications Bureau
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Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

There was no payment made on this claim

CLAIM NUMBER
 33155154-01

CHECK NUMBER
 nochk2047364

CHECK DATE
 01/13/2007

CHECK AMOUNT
 0.00

HORIZON VISION CENTER MED GROUP
 14895 E 14TH ST STE 360
 SAN LEANDRO CA 94578

VOID
 8/7/06 DOS
 CE OB to provide
 improper denial
 w/ POI review
 lang.

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records
 (866) 316-9776

Date(s) of Service: 08/07/2006-08/07/2006
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: 0
 Provider: HORIZON VISION CENTER MED GROUP

Group: SPORTS LEADERSHIP GROUP

Check Date: 01/13/2007
 Check Number: nochk2047364
 Check Amount: 0.00
 Group #: 90219335
 Claim #: 33155154-01

SERVICE DATE(S)	PROCEDURE CODE	BILLED AMOUNT	INELIGIBLE AMOUNT			COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	PROVIDER DISCOUNT	Not Patient Responsibility					
08/07/06	99070	1,395.00	SC			1,395.00				
TOTALS		1,395.00				1,395.00				
TOTAL PAID FOR THIS CLAIM										

REMARK CODE(S)/DESCRIPTIONS AND CLAIM COMMENTS:
 SC SEE COMMENTS BELOW Please refer to the Exclusions and Limitations section in your Benefits Information Materials.

VOID **VOID** **VOID**

PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

There was no payment made on this claim

CLAIM NUMBER
 33155154-01

CHECK NUMBER
 nochk2047364

CHECK DATE
 01/13/2007

CHECK AMOUNT
 0.00

HORIZON VISION CENTER MED GROUP
 14895 E 14TH ST STE 360
 SAN LEANDRO CA 94578

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-8776

Date(s) of Service: 08/07/2006-08/07/2006

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: 0

Provider: HORIZON VISION CENTER MED GROUP

Group: SPORTS LEADERSHIP GROUP

Check Date: 01/13/2007
 Check Number: nochk2047364
 Check Amount: 0.00
 Group #: 80219335
 Claim #: 33155154-01

SERVICE DATE(S)	PROCEDURE CODE	BILLED AMOUNT	INELIGIBLE AMOUNT			COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	PROVIDER DISCOUNT	Not Patient Responsibility					
08/07/06	99070	1,395.00	SC			1,395.00				
TOTALS		1,395.00				1,395.00				

TOTAL PAID FOR THIS CLAIM

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:
 SC SEE COMMENTS BELOW Please refer to the Exclusions and Limitations section in your Benefits Information Materials.

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PROVIDER DISPUTE INFORMATION

Per California law, PacifiCare is obligated to notify you of your dispute rights. If you would like to submit a provider dispute, please submit a request to:

PacifiCare
Provider Dispute
P.O. Box 6098
Cypress, CA 90630

The dispute request must include the following information:

1. Name, address and phone number of the provider of service.
2. Provider's PacifiCare individual provider identification number, if applicable.
3. A complete and accurate explanation of the issue.
4. Supporting documentation including copies of claims (if applicable), claim number, medical records, or supporting documentation to challenge reports as necessary from the initial adverse determination.

PacifiCare will process your dispute request within 45 working days. Inquiries can be made at 1-866-316-9776.

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PacifiCare®
 Life and Health Insurance Company
 P.O. Box 6098
 Cypress, CA 90630

This Claim was paid to Provider:
 HORIZON VISION CENTER MED GROUP

CLAIM NUMBER 33155154-01	CHECK NUMBER nochk2047364
CHECK DATE 01/13/2007	CHECK AMOUNT 0.00

VOID VOID VOID

PacifiCare®
 Life and Health Insurance Company

EXPLANATION OF BENEFITS
 Retain for Your Records.
 (866) 316-9776

Date(s) of Service: 08/07/2006-08/07/2006
 Patient: [REDACTED]
 Insured: [REDACTED]
 Patient Account #: 0
 Provider: HORIZON VISION CENTER MED GROUP

Group: SPORTS LEADERSHIP GROUP

Check Date: 01/13/2007
 Check Number: nochk2047364
 Check Amount: 0.00
 Group #: 00219335
 Claim #: 33155154-01

If it is your responsibility to pay: \$1,395.00
 If it is NOT your responsibility to pay: 0.00

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT			COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient Responsibility					
08/07/06	Ineligible	1,395.00	SC			1,395.00				
TOTALS		1,395.00				1,395.00				
TOTAL PAID FOR THIS CLAIM										

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:
 SC SEE COMMENTS BELOW Please refer to the Exclusions and Limitations section in your Benefits Information Materials.

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**HOW TO READ YOUR
EXPLANATION OF BENEFITS**

Date(s) of Service: To - From dates of service.
Patient: Patient's Name
Insured: Insured's Name
Patient Account #: Patient Acct #
Provider: Provider Name

Group: Employer Group Name
Contract Name: PPO Contract Name

Check Date: 08/02/03
Check Number: 1234567890
Check Amount: \$\$. \$\$
Group #: Employer Group #
Claim #: Claim #

SERVICE DATE(S)		TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT			COPAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
<p>It is your responsibility to pay (1) * It is NOT your responsibility to pay (2) * Please pay this amount to the provider of service.</p> <p>Other Insurance Allowed: (3) * Other Insurance Paid: (4) *</p>											
<p>Here is a brief description of what each field means.</p> <p>Note: The fields marked with an asterisk do not display if Benefits were coordinated with another carrier. If benefits were coordinated, your responsibility is calculated by taking the other insurance allowed amount (3) less the other Insurance paid amount (4) less the Total Paid for this claim (18).</p> <p>1 * The total amount the insured is responsible to pay to the provider for this claim. 2 * The total amount the insured is NOT responsible to pay to the provider for this claim. 3 The Amount your other insurance has allowed. 4 The amount your other insurance has paid on this claim. 5 Date the service was rendered. 6 A short description of the type of service performed. 7 Is the amount billed for the service rendered. 8 Is a 2 character code to help you understand how this line item is being paid. 9 Amount the line item is reduced due to a provider discount. 10 Amount that is ineligible for payment by the insurance and is NOT the patient's responsibility to pay. 11 Amount that is ineligible for payment by the insurance and is the patient's responsibility to pay. 12 Copayment made by the patient or any other deductible amount. 13 Amount of this line item that is being applied to the patients annual deductible. 14 Amount the patient is responsible to pay after the insurance has paid their percentage unless coordination of benefits applies. See note above. 15 The percentage the insurance is paying for this line item. 16 Amount the insurance has paid toward this line item. 17 The total savings you gained by having another insurance. 18 Total amount the insurance is paying for all line item above. 19 Description of the 2 character remark code in #8 above.</p>											
TOTALS			\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$
										Other Insurance Savings	(17)
										TOTAL PAID FOR THIS CLAIM	(18)
<p>REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:</p> <p>(19) Detail description of what the remark code means and any additional claims comments to help you understand your explanation of benefits.</p> <p>VOID VOID VOID</p>											

THIS IS NOT A BILL

PacifiCare®

Life and Health Insurance Company

KNOW YOUR RIGHTS

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The Company offers Standard review levels. For detailed information related to the review levels, please refer to your Certificate.

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To request an Appeal:

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4. The Company will issue a written determination notice to the Insured within 30 days of receiving a written appeal request. The notice will include the reason(s) for the Company's decision, the documentation on which the decision is based and the process for filing a formal appeal.

Contact and Other Important Information:

Insureds may call the Company with questions regarding the claim determination. Additionally, the Department of Insurance can assist with questions about the health care appeals process or if an Insured believes that there has been a violation of the State's unfair practices or other similar state laws.

To contact the Company concerning Suspected Fraud or Irregular Billing Practices, call 1-866-686-6350.

Insurance Company

Appeals Department
P.O. Box 400046
San Antonio, TX 78229
(866) 316-9776
Monday - Friday (7:00 AM to 9:00 PM CST)

State Insurance Regulatory Agency

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833

Member Reimbursement

PacifiCare®
Life and Health Insurance Company
P.O. Box 6098
Cypress, CA 90630

Chase Manhattan Bank Delaware
1201 Market Street
Wilmington, DE. 19801

0474-09

CLAIM NUMBER
33155154-02

CHECK NUMBER
6004523338

CHECK DATE
01/15/2007

CHECK AMOUNT
****\$697.50

62-28
311 WFO_PLBHC

PAY Six hundred ninety seven and 50/100 Dollars

VOID IF NOT CASHED IN 180 DAYS

TO THE ORDER OF

[REDACTED]

VOID

VOID
Pat W Okenander

AUTHORIZED SIGNATURE

PacifiCare®
Life and Health Insurance Company

EXPLANATION OF BENEFITS

Retain for Your Records.

(866) 316-9776

Date(s) of Service: 08/07/2006-08/07/2006

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: 0

Provider: HORIZON VISION CENTER MED GROUP

Group: SPORTS LEADERSHIP GROUP

Check Date: 01/15/2007

Check Number: 006004523338

Check Amount: \$697.50

Group #: 90219335

Claim #: 33155154-02

It is your responsibility to pay \$697.50
It is NOT your responsibility to pay \$697.50
Please pay this amount to the provider(s) service.

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT				CO-PAYMENT/ ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Non-Patient Responsibility	Patient Responsibility					
08/07/06	Hsp Svcs	1,395.00							697.50	50	697.50
TOTALS		1,395.00							697.50		697.50
										TOTAL PAID FOR THIS CLAIM	697.50

REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS:

This is an adjustment to a previously considered claim 33155154-01.

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PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: 0.00

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**HOW TO READ YOUR
EXPLANATION OF BENEFITS**

Date(s) of Service: To - From dates of service.
Patient: Patient's Name
Insured: Insured's Name
Patient Account #: Patient Acct #
Provider: Provider Name

Group: Employer Group Name
Contract Name: PPO Contract Name

Check Date: 08/02/03
Check Number: 1234587890
Check Amount: \$\$. \$\$
Group #: Employer Group #
Claim #: Claim #

(1) * If it's your responsibility to pay, please pay the amount to the provider of service. (2) * If it's NOT your responsibility to pay.											
Other Insurance Allowed (3)						Other Insurance Paid (4)					
SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT			PATIENT RESPONSIBILITY	COPAYMENT ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient responsibility						
(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
Here is a brief description of what each field means. Note: The fields marked with an asterisk do not display if Benefits were coordinated with another carrier. If benefits were coordinated, your responsibility is calculated by taking the other insurance allowed amount (3) less the other insurance paid amount (4) less the Total Paid for this claim (18).											
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TOTALS			\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$	\$.\$
										Other Insurance Savings	(17)
										TOTAL PAID FOR THIS CLAIM	(18)
REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS: (19) Detail description of what the remark code means and any additional claims comments to help you understand your explanation of benefits.											
PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: (20)											

THIS IS NOT A BILL

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State Insurance Regulatory Agency

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Consumer Communications Bureau
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Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833

Member Reimbursement

PacifiCare®
Life and Health Insurance Company
P.O. Box 6098
Cypress, CA 90630

This Claim was paid to Provider:
TURNER EYE INSTITUTE MEDICAL GRP

CLAIM NUMBER
19260082-01

CHECK NUMBER
006003998386

CHECK DATE
09/07/2006

CHECK AMOUNT
****\$655.49

VOID VOID VOID

PacifiCare®
Life and Health Insurance Company

EXPLANATION OF BENEFITS
Retain for Your Records.
(866) 316-9776

Date(s) of Service: 07/24/2006-07/24/2006

Patient: [REDACTED]

Insured: [REDACTED]

Patient Account #: 0059077

Provider: TURNER EYE INSTITUTE MEDICAL GRP

Group: SPORTS LEADERSHIP GROUP

Contract Name: California Network

Check Date: 09/07/2006

Check Number: 006003998386

Check Amount: \$655.49

Group #: 90219335

Claim #: 19260082-01

It is your responsibility to pay \$844.51
It is NOT your responsibility to pay \$185.49

Please pay this amount to the provider of service.

SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	RMK CODE	INELIGIBLE AMOUNT		Patient Responsibility	CO-PAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT GOV'T INSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
				INSURED'S DISCOUNT	Not Patient Responsibility						
07/24/06	Transplant	3,000.00	Ab	1,500.00				265.78	280.93	70	655.49
TOTALS		3,000.00		1,500.00				265.78	280.93		\$655.49
										TOTAL PAID FOR THIS CLAIM	\$655.49

REMARK CODE(S), DESCRIPTIONS AND CLAIM COMMENTS:
Ab This amount represents the PacifiCare Network discount.

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PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING: 0.00

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HOW TO READ YOUR
EXPLANATION OF BENEFITS

Date(s) of Service: To - From dates of service.
Patient: Patient's Name
Insured: Insured's Name
Patient Account #: Patient Acct #
Provider: Provider Name

Check Date: 08/02/03
Check Number: 1234567890
Check Amount: \$\$. \$\$
Group #: Employer Group #
Claim #: Claim #

Group: Employer Group Name
Contract Name: PPO Contract Name

It is your responsibility to pay (1)											Please pay this amount to the provider of care.
It is NOT your responsibility to pay (2)											
Other Insurance Allowed (3)						Other Insurance Paid (4)					
SERVICE DATE(S)	TYPE OF SERVICE	BILLED AMOUNT	INELIGIBLE AMOUNT				COPAYMENT/ADDITIONAL DEDUCTIBLE AMOUNT	APPLIED TO ANNUAL DEDUCTIBLE	PATIENT COINSURANCE AMOUNT	PAY %	CLAIMS PAYMENT AMOUNT
			RMK CODE	INSURED'S DISCOUNT	Not Patient responsibility	Patient responsibility					
(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)

Here is a brief description of what each field means.

Note: The fields marked with an asterisk do not display if Benefits were coordinated with another carrier. If benefits were coordinated, your responsibility is calculated by taking the other insurance allowed amount (3) less the other insurance paid amount (4) less the Total Paid for this claim (18).

- 1 * The total amount the insured is responsible to pay to the provider for this claim.
- 2 * The total amount the insured is NOT responsible to pay to the provider for this claim.
- 3 The Amount your other insurance has allowed.
- 4 The amount your other insurance has paid on this claim.
- 5 Date the service was rendered.
- 6 A short description of the type of service performed.
- 7 Is the amount billed for the service rendered.
- 8 is a 2 character code to help you understand how this line item is being paid.
- 9 Amount the line item is reduced due to a provider discount.
- 10 Amount that is ineligible for payment by the insurance and is NOT the patient's responsibility to pay.
- 11 Amount that is ineligible for payment by the insurance and is the patient's responsibility to pay.
- 12 Copayment made by the patient or any other deductible amount.
- 13 Amount of this line item that is being applied to the patients annual deductible.
- 14 Amount the patient is responsible to pay after the insurance has paid their percentage unless coordination of benefits applies. See note above.
- 15 The percentage the insurance is paying for this line item.
- 16 Amount the insurance has paid toward this line item.
- 17 The total savings you gained by having another insurance.
- 18 Total amount the insurance is paying for all line item above.
- 19 Description of the 2 character remark code in #8 above.
- 20 The amount remaining before the patient has satisfied their annual deductible.

TOTALS	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$	\$. \$\$
										Other Insurance Savings	(17)
										TOTAL PAID FOR THIS CLAIM	(18)
REMARK CODE(S), DESCRIPTIONS AND CLAIM COMMENTS:											
(19) Detail description of what the remark code means and any additional claims comments to help you understand your explanation of benefits.											
PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING:											(20)

THIS IS NOT A BILL

PacifiCare®

Life and Health Insurance Company

KNOW YOUR RIGHTS

An Insured or the Insured's authorized representative ("Insured"), has the right to appeal adverse decisions regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) Medical Necessity, effectiveness or efficiency.

The Company offers Standard review levels. For detailed information related to the review levels, please refer to your Certificate.

Insureds may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and/or Insured's employee benefits representative. Insureds may have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act if all required reviews of the claim have been completed and the claim has not been approved.

Participation in any appeal process waives any privilege of confidentiality the Insured may have regarding medical records that any person examines or may examine in connection with the reviewed condition during the appeal process.

To request an Appeal:

1. Insureds must make an oral or written appeal request at the telephone number or address provided below within one year of the receipt date of the adverse decision notice. Insureds making oral requests will be sent a form (the "Appeal Form") to complete and return.
2. The Company will evaluate appeals of adverse decisions. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding Medical Necessity.
3. Insureds are responsible for providing any additional documentation supporting their reconsideration request with the written appeal request. The Company will evaluate a request based on the information in its possession.
4. The Company will issue a written determination notice to the Insured within 30 days of receiving a written appeal request. The notice will include the reason(s) for the Company's decision, the documentation on which the decision is based and the process for filing a formal appeal.

Contact and Other Important Information:

Insureds may call the Company with questions regarding the claim determination. Additionally, the Department of Insurance can assist with questions about the health care appeals process or if an Insured believes that there has been a violation of the State's unfair practices or other similar state laws.

To contact the Company concerning Suspected Fraud or Irregular Billing Practices, call 1-866-686-6350.

Insurance Company

Appeals Department
P.O. Box 400046
San Antonio, TX 78229
(866) 316-9776
Monday - Friday (7:00 AM to 9:00 PM CST)

State Insurance Regulatory Agency

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free Number (800) 927-4357
Phone Number (213) 897-8921
TDD (800) 482-4833

