

This Claim was paid to Provider:

**KAWEAH DELTA DISTRICT HOS**

CLAIM NUMBER
16547XXX-01

CHECK NUMBER
NOCHK 143XXXX

CHECK DATE
11/13/2005

CHECK AMOUNT
0.00

EMPLOYEE NAME  
 ADDRESS  
 CITY, STATE ZIP

**EXPLANATION OF BENEFITS**

Retain for Your Records  
 (866) 316-9776

Date(s) of Service: 11/02/2005 – 11/02/2005  
 Patient: EMPLOYEE OR DEPENDENT NAME  
 Insured: EMPLOYEE NAME  
 Patient Account#: 0005-2XXXX  
 Provider: KAWEAH DELTA DIS  
 Group: EMPLOYEE NAME  
 Contract Name: California Network

Check Date: 11/13/2005  
 Check Number: nochk143xXXX  
 Check Amount: 0.00  
 Group #: 90XXXXXXXXX  
 Claim #: 16547XXX-01

It is your responsibility to pay: \$157.93 Please pay this amount to the provider of service  
 It is NOT your responsibility to pay: \$355.32

SERVICE DATES	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					
11/02/05	Phys Svc	193.25	Ab	117.37				75.88			
11/02/05	Immun	320.00	Ab	237.95				82.05			
<b>TOTALS</b>		513.25		355.32				<b>157.93</b>			
										<b>TOTAL PAID FOR THIS CLAIM</b>	

**REMARK CODE(S) DESCRIPTIONS AND CLAIM COMMENTS**

Ab This amount represents the PacifiCare Network discount.

**PATIENT'S ANNUAL (CALENDAR/PLAN) DEDUCTIBLE REMAINING:** \$1,212.21