BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

BLUE CROSS BLUE SHIELD OF VERMONT
P.O. BOX 186
MONTPELIER, VT 05601-0186

017556 2293811 000 01 002

NON DESCRIPT MEMBER
123456 Waterdirt ln
WATERVILLE VT 00000

Member Name:NON DESCRIPT MEMBER
Member ID: V8**********

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SUMMARY OF HEALTH PLAN PAYMENTS

BlueCross BlueShield of Vermont
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What is this?
This summary shows the amount covered by Blue Cross and Blue Shield of Vermont (BCBSVT) for the claim(s) listed below, and the amount that is your financial responsibility. **This is not a bill;** your health care provider(s) will bill you directly for the amount you owe, if you have not already paid that amount.

Summary Date: 06/07/22

Member Information
Service for*************
Member ID number: ********
Group Number: *********
Group Name: ************

PAYMENT OVERVIEW

Amount Billed
The amount your provider charged for these services. **$25.00**

Provider Responsibility
You may not be billed for these amounts if the provider is participating with Blue Cross and Blue Shield. **$6.66**

Allowed Amount
The amount we consider reasonable for a covered service or supply. **$18.34**

Other Insurance Payments
Any payment made by another policy that covers you. Please keep in mind that if your Other Insurance policy made their payment directly to you, your provider may bill you for this amount in addition to the Amount You Owe that is shown below. **$0.00**

Plan Payment
Payments provided by your plan for your services. **$0.00**

What You Owe
The amount you may be billed if you have not already paid your provider. This includes your copayments, coinsurance, deductibles, and any amounts not covered by your health plan.

Copayments	$0.00
Deductible	$18.34
Coinsurance	$0.00
Non Covered	$0.00
	$18.34

Keep for your records

(For a detailed breakdown of your payments, please see next page)

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Important information about your appeal rights

What if I need help understanding this?

Contact us at the toll-fee Customer Service telephone number on your identification card if you need assistance understanding this notice or how we processed the claim. Please have this statement with you if you call. You can also submit questions in writing by including them with the enclosed statement and sending it to:

Customer Service Department
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601

What if I don't agree with this decision?

You have the right to appeal any decision not to provide benefits for a service (in whole or in part).

How do I file an appeal?

We recommend that you review your benefit materials, since we pay claims according to your benefits. If you decide to appeal, the mailing address is:

Blue Cross and Blue Shield of Vermont
ATTN: First or Second Level Appeals
P.O. Box 186
Montpelier, VT 05601

The fax number is (802) 229-0511. We must receive your appeal within 180 days of the date that your claim was denied. Your benefit materials include more details.

Can I provide additional information about my claim?

Yes, you should include any information you believe will help us in evaluating your appeal. You should include: the name, ID number, and daytime phone number of the member, a description of the problem, all relevant dates; any relevant clinical information, names of health care providers or administrative staff involved; and details of any attempt that has been made to resolve the problem.

Can I request copies of my information relevant to my claim?

You may request copies of information about your claim (free of charge) by contacting us at the number on the back of your ID card. We will provide this immediately for an urgent or concurrent appeal or within two business days for other appeals.

What happens next?

If you file a first level appeal, we will review and provide you with a written determination within 60 days of the receipt of the appeal. If you don't agree with our decision after your first level appeal and you have coverage through an employer group, you may file a voluntary second level appeal with us. In some circumstances, you may request the State of Vermont to do an Independent External Review. Please call our Customer Service team or view your benefit materials for additional details. Contact your employer for your rights under ERISA section 502(a).

Other resource available to you:

For questions about your rights, this notice, or for assistance, you can contact:

Employee Benefits Security Administration
(866) 444-EBSA (3272)

State of Vermont's Health Care Advocate
(800) 917-7787 or (802) 863-2316

Vermont Department of Financial Regulation
(800) 964-1784.

The Department of Financial Regulation's Health Insurance Consumer Services unit can provide free help to you if you need general information about health insurance, have concerns about our activities, or are not satisfied with how we resolved your complaint.

Additional Information

Claim Codes

Claim codes are submitted by health care providers to Blue Cross and Blue Shield of Vermont and are used to determine coverage for services rendered. If you are interested in knowing your diagnosis code or treatment code, please call customer service using the number on the back of your ID card.

Glossary

Co-payment

A fixed dollar amount typically collected at your medical appointment, at a doctor's office or other medical facility.

Co-Insurance

The amount you pay for specific health care services, calculated as a percentage of the allowed amount.

Deductible

The amount you must pay toward the cost of specific services each Plan Year before we pay any benefits. Some services may not be subject to the Deductible amount.

Not Covered

Any billed charges not covered by your plan, including services performed by out-of-network or non-participating providers.

Out-of-Pocket Limit

After you meet your Out-of-Pocket Limit, you pay no Co-Insurance for the rest of the Plan Year. You may still be responsible for any Co-Payments when they apply. Please check your Outline of Coverage for details.

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HEALTH PLAN PAYMENT BREAKDOWN

Service Date	Service Type	Amount Billed	Provider Responsibility	Allowed Amount	Plan Payment	What You Owe	Breakdown of What You Owe: Copayments	Deductible	Coinsurance	Non Covered (See Remarks)	What You Owe	Remark Codes
Provider Name: S E Kapsalis		**Patient** **********		**Claim #: 26221241439500**		**(In–Network)**						
01/05/22	**Medical Care**	$25.00	$6.66	$18.34	$0.00	$18.34	$0.00	$18.34	$0.00	$0.00	**$18.34**	
Subtotal		**$25.00**	**$6.66**	**$18.34**	**$0.00**	**$18.34**	**$0.00**	**$18.34**	**$0.00**	**$0.00**		**$18.34**
Grand Total		**$25.00**	**$6.66**	**$18.34**	**$0.00**	**$18.34**	**$0.00**	**$18.34**	**$0.00**	**$0.00**		**$18.34**

IN NETWORK FAMILY DEDUCTIBLE

Amount Applied as of 5/4/2022*

$0 $10,000.00

Family: $1,862.93 of $10,000.00

IN NETWORK FAMILY OUT OF POCKET

Amount Applied as of 5/4/2022*

$0 $10,000.00

Family: $1,862.93 of $10,000.00

CHIROPRACTIC CARE MAXIMUM

Amount Applied as of 5/4/2022*

0 12

Individual: 0 of 12

PHYSICAL/OCCUPATIONAL/SPEECH THERAPY MAX

Amount Applied as of 5/4/2022*

0 30

Individual: 0 of 30

HABILITATIVE THERAPY VISIT MAXIMUM

Amount Applied as of 5/4/2022*

0 30

Individual: 0 of 30

*includes charges from this PLAN YEAR only

HAVE QUESTIONS?

Please call:

Local	**(802) 223–3494**
Vermont	**(800) 247–2583**
BlueCare	**(888) 882–3600**
UVM	**(888) 222–7886**
UVM Medical Center	**(800) 422–6668**
Qualified Health Plans	**(800) 310–5249**
State of Vermont Group	**(888) 778–5570**

Hours of Operation: 7am–6pm EST, Monday–Friday

or log into your account at **www.bcbsvt.com/login**

TDD: 1–800–535–2227

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