BlueCross BlueShield
Federal Employee Program

Explanation of Benefits
THIS IS NOT A BILL

BlueCross BlueShield of Vermont
PO Box 186
MONTPELIER, VT 056010186
(800) 328-0365
(800) 535-2227 TDD NUMBER
www.bcbsvt.com

ERIC T VAN BUREN
243 HARTE CIRCLE
WILLISTON VT
05495-5225

ONLINE EXPLANATION OF BENEFITS AT A GLANCE

We Sent Check To: ASSOCIATES IN ORTHOPEDIC SURGERY PC	ID Number: R59792789
Patient Name: ERIC VAN BUREN	Claim Number: 0102251512944
	Claim Paid On: 03/04/2015
Dates of Service: 02/19/2015 - 02/19/2015	Claim Received On: 02/25/2015
	Claim Processed On: 02/25/2015
You Owe the Provider: $45.70	

Provider: MICHELLE L MACHESKY
Type: PREFERRED PROVIDER

Dates of Service: 02/19/2015 - 02/19/2015

Type of Service	Submitted Charges	Plan Allowance	Remark Codes	Deduct	Coinsurance Or Copay	Medicare/ Other Ins.	What We Paid	You Owe the Provider
OFFICE VISIT	198.00	124.00	610		25.00		99.00	25.00
MEDICAL EQUIP/SUPPLY	19.00	19.00			5.70		13.30	5.70
XRAY	110.00	43.14	610		15.00		28.14	15.00
TOTALS:	327.00	186.14		0.00	45.70	0.00	140.44	45.70

EXPLANATION OF REMARK CODES

610--THE SUBMITTED CHARGES EXCEED OUR ALLOWABLE CHARGES FOR THESE SERVICES. OUR ALLOWABLE CHARGES ARE THE SUBMITTED CHARGES LESS ANY NON-COVERED CHARGES. BECAUSE THIS PROVIDER IS A PREFERRED OR PARTICIPATING NETWORK PROVIDER, YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE SUBMITTED CHARGES AND OUR ALLOWABLE CHARGES.

Summary of Out-of-Pocket Expenses for 2015

	Calendar Year Deductible	Catastrophic Protection Preferred	Catastrophic Protection Non-Preferred/ Preferred Total
What You Have Paid			
Individual	$0.00	$0	$0
Family	$0.00	$153	$0
Annual Maximum			
Individual	$0.00	$0	$0
Family	$0.00	$7,000	$0

Your Out-of-Pocket Expenses On This Claim

Calendar Year Deductible	$0.00
Per Admission Copay	$0.00
Coinsurance	$5.70
Copayment	$40.00
Non-covered Charges	$0.00
Precertification Penalty	$0.00
TOTAL:	$45.70

If you have questions, please call a customer service representative at your local Blue Cross and Blue Shield Plan. You may also request the diagnosis codes, the treatment codes, and the corresponding meanings of the codes for your claim. If you disagree with the decision on your claims or request for services, and wish to have the decision reconsidered, you must notify your Plan in writing within 6 months from the date of this decision i.e. 09/04/2015. You may request copies, free of charge, of any relevant materials and Plan documents relating to your claim. Your Plan will not accept unauthorized reconsiderations from See the Disputed Claims section of your Service Benefit Plan Brochure.

THANK YOU FOR ALLOWING US TO SERVE YOU

Listed below are definitions to help describe this Explanation of Benefits.

PROVIDER: The hospital, health care facility, physician or other health care professional who provided services to you.

PROVIDER TYPE: Each local Blue Cross and Blue Shield Plan can contract with providers in its service area. There are two types of professional contracting providers, Preferred and Participating, and two types of contracting facilities, Preferred or Member. If providers do not contract with the Plan, they are considered to be non-participating or non-member.

DATE OF SERVICE: The month, day and year you actually received services.

TYPE OF SERVICE: This is a general description of the service or supply provided.

SUBMITTED CHARGES: This is the amount the provider has billed.

PLAN ALLOWANCE: The amount used to determine our payment and your coinsurance for covered services or the amount we use to calculate our payment for covered services.

REMARK CODES: An explanation of the payment determination for a particular service.

DEDUCTIBLE: The fixed amount of covered expenses you must incur each calendar year for certain covered services and supplies before we start paying benefits.

COINSURANCE: The percentage of the Plan Allowance that you must pay for your care.

COPAY: The fixed amount of money you pay to the physician, facility, pharmacy, etc. when you receive certain services.

MEDICARE/OTHER INS.: The amount paid by another health insurance carrier when you or covered family members have coverage with Medicare or another health benefit plan.

NON-COVERED CHARGES: We did not pay for these services. The Blue Cross and Blue Shield Service Benefit Plan does not consider these charges as a covered benefit. You are responsible for these charges.

PRECERTIFICATION PENALTY: We will reduce your benefit by $500 if no one (you, your physician or the hospital) contacts us to obtain precertification of inpatient hospital services, when required.

CATASTROPHIC PROTECTION: Your Service Benefit Plan coverage limits your out-of-pocket expenses; coinsurance, copayments and deductibles you pay per calendar year. If you reach your catastrophic protection limit within a calendar year, we will pay 100 percent of certain covered out-of-pocket expenses for the remainder of the year. Please note that not all of your out-of-pocket expenses will count toward meeting your catastrophic protection limit. See your Service Benefit Plan brochure for more information.

If you have any questions, please refer to your Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005), or call us at the telephone number shown on the front of this form.

HELP STOP FRAUD AND ABUSE!

IF YOU SUSPECT FRAUD OR ABUSE
CALL THE FEP ANTIFRAUD HOTLINE:

1-800-FEP-8440 (337-8440)