Primary care provider

You should contact your regular provider for most urgent care and common health issues during office hours. Some examples are:

- infections
- cough
- digestive issues



Urgent care center

When you have a condition or illness that is not an emergency, but still needs quick attention, you could seek urgent care services. Urgent care could include treatment for:

- minor cuts
- minor back pain
- broken bones

Telemedicine

You can access a clinician remotely for diagnosis and treatment via phone, video or other technologies. Commonly treated conditions:

- pink eye
- rash
- flu symptoms



Make the right care choice.

Be informed now so that you can choose the appropriate care for your situation. Understanding all of your options may save you time and money.*

Get more information! Visit BCBSVT's **website**.

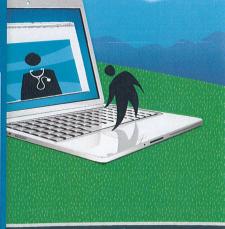




BlueCross BlueShield of Vermont

> An Independent Licensee of the Blue Cross and Blue Shield Association

We'll see you through.



Emergency room

In an emergency, you need care right away. Emergencies might include:

- chest pains
- head injury with fainting
- injury to spine

If you have an emergency at home or away, call 9-1-1 or go to the nearest doctor or emergency department.

You should call an ambulance if necessary.



*Prior approval requirements and member benefits vary according to the member's group or individual plan. Before receiving services, please check your benefits as outlined in your member materials or by calling the number on the back of your ID card.

Print this page.

Cut out the card.

Fill out the card with your PCP's, and urgent care center, contact information.

Keep it in your wallet so you have the numbers handy if you get sick!





Life of a Medical Claim

Member sees a network provider. Copayments are due at time of service by member.* Generally, member should not pay deductible or co-insurance at the time of medical service.**

Provider bills BCBSVT first, based on services performed



BCBSVT reimburses provider based on codes submitted and health plan of the member.



Member receives a bill from a provider and an EOB*** from BCBSVT.

If a member is responsible to pay can be done by one or more of the following methods:

- HRA
- FSA
- HSA
- Cash/Check/Credit Card
- Payment Plan

Provider sends bill to member, if appropriate, based on the allowed amount and member responsibility.



Determination of benefits sent by BCBSVT

- Member (via EOB***)
- Provider
- HRA/HSA vendor/Third Party Administrator (if applicable).

* Some providers may waive collection of copayments at time of service when an HRA will pay on member's behalf.

- ** Some providers may request a portion of a deductible be paid ahead of a planned major service
- *** Explanation of Benefits Members can find their EOBs online at the BCBSVT Member Resource Center.

Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186 (800) 344-6690 www.bcbsvt.com click here for email contact

Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.

Cost transparency tool for medical services

Are you interested in estimating the cost of your care before you go to the provider's office?

BCBSVT has a tool to help you **estimate** the cost of your medical care before you go to the provider's office. The cost estimator tool provides financial information for specific services related to your benefit plan that you receive with a network provider.

Depending on the services you receive, your actual charges may be different from the estimated charges found on the estimator tool. If you have questions about discrepancies between estimated and actual costs, speak with your provider or his/her office staff.

The cost estimator tool will not know whether you have specific benefit limits. If you are unsure whether benefit limits apply, contact BCBSVT's customer service team by dialing the number on the back of your ID card.

To access the cost-estimator tool follow these easy steps:

- Log in to our Member Resource Center.
- From the landing page, click the link to the cost estimator and then click the accept button to continue to the national doctor and hospital finder page.
- Once there, fill out your location and choose "costs for procedures" in the category dropdown box.
- Because you're logged into the MRC, your plan's alpha prefix (the three letters at the beginning of your ID number on your ID card) will automatically populate.
- You may review cost estimates for your 2018 benefit plan on or after January 1, 2018.
- Now that you're logged in, enter the type of service for which you'd like a cost estimate (e.g., specialist office visit). Certain services may have multiple options, so choose the one that fits your needs.
 - After you hit search, your estimated out-of-pocket cost will display next to the name of the provider on the right side of the page. You will also see the average total cost of the procedure.

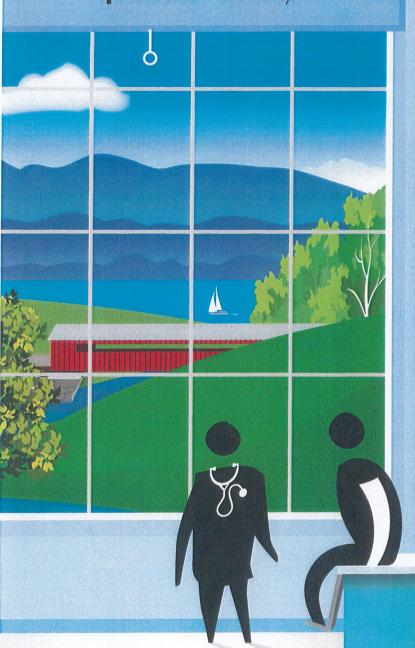




WHEN GO WHEN GO

Ask the right questions

Be informed now so that you can choose the appropriate care for your situation. Understanding all of your options may save you time and money.*



What is this test for?

If I get this test, will the results change my treatment plan?

Are there simpler, safer options other than diagnostic testing?

When can I expect to receive the results?

Are there any adverse side effects to this treatment or this drug?

How do I spell the name of that drug?

Will this drug interact with any medications, vitamins or over-the-counter treatments I'm currently taking?

Are there generic options we could explore that may save me money?

Can I wait to have this procedure?

How many times have you done this procedure?

Are there any alternative treatments we can explore?

Can you help me understand how much this treatment may cost?

Which hospital can best meet my needs?



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Other topics of interest:

For more details about preventive care benefits, click **here**.

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Understanding preventive care

Who defines the preventive care benefit?

Preventive care is defined by the Affordable Care Act and state mandates. The following committees determine what services fall under preventive, no-cost-to-you care:

- Services rated A or B by the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices
- Guidelines supported by the Health Resources and Services Administration
- Recommendations from the American Academy of Pediatrics' Bright Futures program
- Other applicable state and Federal mandates.

All of the committees and administrations listed above provide required guidelines about, and research on, preventive services to determine which are the most effective for population health.

This means that your plan covers services the majority of the population needs at no additional cost to you. The committees and administrations listed above do not base their recommendations on any one individual person's medical history or other risk factors.

Preventive care benefits include:

- Basic screenings
- Some provider visits
- Immunizations
- Some medications

For details, please visit BCBSVT's website.

Preventive care examples that do not require any cost-sharing:

- Annual flu shots
- Breast cancer screening by mammography for women over 40
- Tobacco use intervention and cessation
- Colorectal cancer screenings for adults age 50 to 75
- Cholesterol screening for children up to age 17

HELPFUL TIPS!

Recognize what preventive care is so you're not surprised when services require cost-sharing such as deductible and co-insurance or co-payments.

Preventive care is:

- When you have no signs or symptoms of disease, illness or other condition and
- your provider performs a preventive service (as defined by the committees listed in this document) and finds nothing of concern.

Review your plan documents to understand your benefits prior to seeking care.

Your plan does not cover all care received at a routine visit at no cost to you. Providers may order screenings, counseling or tests for various reasons such as:

- personal and family history
- specific risk factors you or your family may have

Your doctor may consider these types of services "preventive" for you, but they may require cost-sharing because they fall outside of nationally defined preventive care services.

Use our online tools and general information documents to learn more.

Always attempt to verify what services are preventive and what services are diagnostic. For more details, click **here**.

Life of a Pharmacy Claim

Member goes to pharmacy to pick up a prescription.

Pharmacy submits cost, based on the **BCBSVT** provides prescription and member health bill to BCBSVT. plan.

at the time of pickportion of the cost, Pharmacy charges the member their

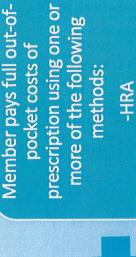


BCBSVT sends determination of benefits to:

-Member (via EOB**)

-HRA/HSA vendor (if applicable)

amount due from the health plan. Pharmacy any **BCBSVT** pays



methods:

-HRA -FSA

Cash/Check/Credit Card*

* You can pay with a debit card for an HRA, HSA and FSA, if you have one and it is activated.

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Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims. Cost transparency tool for prescription drugs

Are you interested in estimating the cost of your care before you go to the provider's office?

BCBSVT and Express Scripts, our pharmacy benefits manager, have a tool that can help you **estimate** the cost of your prescriptions. This estimator tool can provide you with financial information about prescription costs, including the names of pharmacies where you can find the same prescriptions at lower costs.

What you are actually charged for a prescription may differ, though, from the estimate on the estimator tool. If you have questions about discrepancies between estimated and actual costs for prescriptions, speak with your pharmacist.

Authorizations
ID Card Request
Pharmacy Center
HSA/HRA Accounts
Health and Wellness
Drine and Octabril

Tom Props Bootstanded Medicals

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And Props Bootstanded Medicals

Control

Coverage alert

The cost estimator tool will not know whether you have specific benefit limits. If you are unsure whether benefit limits apply, contact BCBSVT's customer service team by dialing the number on the back of your ID card.

To access the cost-estimator tool follow these easy steps:

- **Log in** to our Member Resource Center.
- Click the link to the Pharmacy Center on the left-hand navigation pane.
- Then, click the link to "price a drug" and click the "ok" button to continue to a secure website hosted by your pharmacy benefits manager.
- Once you reach the landing page, select the family member who will be using the prescription from the "select a patient" dropdown menu. You may also narrow your search to a specific retail pharmacy or up to three pharmacies to compare prices.
- Enter the name of the medication for which you'd like pricing information.
 A list of dosage options may populate if multiple doses are available. Select the dosage your provide prescribed.
- Fill out the fields to indicate your quantity and days' supply.
 - If the drug you entered requires prior approval or has other coverage restrictions, you will receive a coverage alert. Read the notes in the coverage alert to learn important information, including limitations on quantity, any step therapy requirements or other important notes.



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Pharmacy cost-sharing assistance programs

Humira

https://www.humira.com/humira-complete/cost-and-copay 1-800-4HUMIRA (1-800-448-6472)

https://www.enbrel.com/support/financial-assistance/ 1-888-4ENBREL

https://www.copaxone.com/shared-solutions/copaxone-savingsand-benefits 1-800-887-8100

Harvoni

https://www.harvoni.com/support-and-savings/co-pay-couponregistration 1-844-READY41

Gilenya

http://www.gilenya.com/c/ms-pill/co-pay 1-800-GILENYA

Tecfidera

https://www.tecfidera.com/en_us/home/join-biogen-support/ financial-support.html 1-800-456-2255

Revlimid

http://www.revlimid.com/mm-patient/affording-revlimid/financialassistance/ 1-800-931-8691

Genotropin

http://www.genotropin.com/savings-program 1-800-645-1280

Berinert

http://www.berinert.com/patients/support-services/berinert-expertnetwork.aspx 1-877-236-4423

Simponi

https://www.simponi.com/rheumatoid-arthritis/simponi-dosing/ patient-resources 1-877-CarePath (877-227-3728)

https://www.us.afinitor.com/angiomyolipoma-tsc/patient-support/ financial-resources/ 1-888-669-6682

Xolair

https://www.xolair.com/allergic-asthma/hcp/xolair-co-pay-cardprogram.html 1-(855) XOLAIR-CARD (855-965-2472)

Norditropin

https://www.norditropin.com/how-we-can-help/financialsupport 1-888-NOVO-444 (1-888-668-6444)

https://www.firazyr.com/firazyr-support/onepath-co-payassistance-program 1-866-888-0660

Ravicti

http://www.horizonpharma.com/patients/patient-support/ 1-866-479-6742

Sprycel

https://www.sprycel.com/sprycel-assist 1-855-SPRYCEL (1-855-777-9235)

Ibrance

https://www.ibrance.com/financial-assistance 1-844-9-IBRANCE

https://www.cinryze.com/financial-support 1-866-888-0660

Zytiga

http://www.janssenprescriptionassistance.com/zytiga-costassistance 1-877-CarePath (877-227-3728)

https://ampyra.com/cost-patient-assistance 1-888-881-1918

https://www.stelarainfo.com/stelara-cost-insurance-information 1-877-CarePath (877-227-3728)

https://www.rebif.com/getting-started-with-rebif/rebif-copay 1-877-447-3243

https://www.plegridy.com/en_us/home/biogen-supportprogram/financial-support.html

1-800-456-2255



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Other topics of interest:

- www.express-scripts.com
- www.bcbsvt.com/pharmacy

Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.

Pharmacy benefits

As a VEHI member, you will get your prescription drugs through BCBSVT's network of pharmacies, here in Vermont and nationwide. Present your Blue Cross and Blue Shield of Vermont ID card at a network pharmacy and the pharmacist will file a claim for you.

Prescription drug prices are a leading cause of increases in health care costs and VEHI's health plan premiums. One way to reduce medication costs substantially is to use generic drugs whenever possible. Generics are less expensive than brand-name medications and are just as medically effective.

Almost all Vermont pharmacies and a large percentage of pharmacies nationwide currently belong to this network. Most major chains (Rite-Aid, Kinney, CVS, etc.) participate. Call (877) 493–1949 or visit the Find-a-Doctor page of BCBSVT's website for a list of network pharmacies.

VEHI Platinum and Gold Drug Coverage

VEHI is among the first of BCBSVT groups to offer the cost-saving "4-tier" drug program. This drug program applies to the VEHI Platinum plan and the VEHI Gold plan, but not to the CDHP plans. Please note that the 4-tier drug program will continue to cover medicines for diabetes at 100 percent.

VEHI Gold and Silver CDHP Drug Coverage

CDHP members will pay deductibles and co-insurance for most drug coverage to comply with federal guidelines.

To be sure that members get the important wellness drugs they need, VEHI will offer its CDHP members coverage (at no cost) on certain drugs that can prevent illness or keep chronic conditions from becoming more serious. For example, VEHI offers no-cost coverage on prenatal vitamins and many drugs that treat:

- diabetes (medications and testing supplies)
- high blood pressure
- high cholesterol
- asthma
- osteoporosis

The "wellness drug list" changes from time to time.The most recent copy appears on the Rx Center of the BCBSVT **website**.

For all plans

To align more closely with benefit products typically on the market, VEHI has eliminated coverage of drugs designed to treat sexual dysfunction and infertility. Please note that services to determine a couple's infertility will still be covered. Also, if you are taking infertility medication prior to January 1, 2018, VEHI will cover the end of your course of treatment under your previous terms of coverage.

If you are prescribed a maintenance drug for the first time, you may only obtain a 30-day supply. If this medication works for you, at your second fill, you may be eligible for up to a 90-day supply. For more details regarding your maintenance prescription drug coverage, please contact BCBSVT's customer service team at the number on the back of your ID card.



Drug list updates

Drug lists change and will be updated periodically to ensure that newer, more effective drugs are added.

Drugs automatically come off the preferred brand-name drug list and are added to the generic lists when alternatives become available. You may reduce your out-of-pocket expenses by asking your provider to authorize a generic solution whenever possible. The use of generics guarantees you the lowest cost.

When a generic is not available, ask your provider if one of the drugs on the preferred brand-name drug list would be appropriate for you. These drugs can often meet patients' needs at a lower cost. A list of preferred brand-name drugs is available at the Rx Center of BCBSVT's website.

Convenient refills and savings with BCBSVT's home delivery program

If you use prescription drugs on an ongoing basis, BCBSVT's home delivery service may be a less expensive, more convenient way for you to buy prescriptions. To begin using home delivery service for your maintenance drug, send BCBSVT's mail order pharmacy your doctor's prescription, an order form (available online or by phone) and any required cost–sharing amounts.

To request refills, you may use a online ordering **system** or call the toll-free number, (877) 493–1949. (Narcotics and antibiotics are not available through the home delivery service.)

Over-the-counter drugs

The plan covers certain over-the-counter drugs if you have a prescription from your provider. For example, the plan covers drugs like Claritin for allergies or Prilosec for stomach acid and reflux.

With a prescription, your pharmacist can dispense up to a 30-day supply of the medication and charge you the same amount you would pay for generic drugs.

BCBSVT's review of certain drug classes keeps costs down for you

Prior approval

BCBSVT's prior approval list changes periodically. The most current list can be found on the BCBSVT website or by calling toll-free (877) 493–1949. Prior approval is required for drugs that have been on the market less than 12 months and/or medications without National Drug Code numbers. For example:

- Chemotherapeutics
- Growth hormone replacement therapy
- Hepatitis C medications
- Low molecular weight heparin anticoagulants (for use in excess of 30 days per calendar year)
- Primary pulmonary hypertension therapy
- Biologics and other medications
- Brand-name drugs with generic equivalents

A complete list of drugs that require prior approval is available at the Rx Center of BCBSVT's **website**.

Quantity limits

If your doctor prescribes a drug in an amount that exceeds certain criteria, such as the manufacturer's recommendations, BCBSVT may ask for documentation. Visit BCBSVT's **website** or call toll–free (877) 493–1949 to get a current list of drugs covered by this review or to learn the quantity limit for a particular drug. At present, BCBSVT places quantity limits on the following types of drugs:

- Sleeping agents (such as Ambien*)
- Glucose test strips
- Inhalers (like Advair*)
- Pain medications (like OxyContin*)
- Anti-migraine medications (like lmitrex*)

Step therapy

BCBSVT's step therapy program saves members money by encouraging patients and their doctors to try less expensive drugs in a therapeutic class before using the newest, most expensive ones. Step therapy applies to drugs in categories such as:

- Certain anti-migraine agents (like Zomig*)
- Certain medications for depression (like Prozac Weekly*)
- Non-sedating antihistamines (like Allegra*)
- COX-2 inhibitors (like Celebrex*)
- Medications for stomach acid (like Nexium*)
- Medications for hypertension (like Cozaar*)
- Anti-viral medications
- Sleeping agents (like Lunesta*)
- Statins (cholesterol-lowering drugs)
- Nasal steroids (like Nasacort*AQ)
- Osteoporosis agents (like Boniva*)

Visit BCBSVT's **website** or call toll-free (877) 493–1949 to get a current list of drugs covered by this review or to learn the procedures to follow for review of your prescription use.

Understanding your Explanation of Benefits

is an important tool for tracking and understanding your health care expenses. Your Explanation of Benefits (EOB)

Most importantly, your EOB is:

- a confirmation or record of what Blue Cross and Blue Shield or VEHI has paid on your behalf.
- a detailed account of the service(s) for which your provider billed you and VEHI
- a record for how much money you've spent throughout a plan year.

what your services cost you and VEHI. receive care, will help you understand Reviewing your EOB, whenever you

EOB. So, we've organized it in this document so you can find what matters most to you. There's a lot of information packed into an

The EOB contains three items of importance:

- 1. A"Totals" page that provides high-level processed in the previous month. details about the costs for all of the claims
- 2. A"Terms You Should Know" page to help you understand health care terminology.
- 3. Any "Claims" pages, which you should use to Shield of Vermont or VEHI, as shown on your services your provider billed Blue Cross and Blue compare the services you received, to the

number listed on the back of your ID card overly complicated medical terminology your EOB to maintain your privacy and avoid Please note BCBSVT uses service categories on t you have any questions, please call the

totals page



NOW AVAILABLE: Through the Member Resource Center (ARC) to <u>n.m.h.Schwi.comframe</u>. For more information, call consoner services (400) 247-2583.

- Paperleta KOR Statemental: To go out of reaching upper LOB saturannah log it to MRC, click communication preferences and select Opt Out of mailed EOBs. Identification Number: VEH885909981
Date Printed: Your name or your
Patient Name: deposed on the first dependent child's name here

hillightel heldindillinghiquile lithidilligh Your name and address here

\$1,113.07 Amount billed by a provider for a service(s). TOTALS FOR ALL CLAIMS ON THIS EOB

Billed Charges	\$1,113.07	Amount billed by a provider for a service(s).
Amount You Saved	\$\$45.53	Any billed charges not covered by your benefit plan. You may not be billed for these amounts if the provider is participating with Blue Cross and Blue Shield.
Other Insurance Payments	\$0.00	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.
Amount Your Plan Paid	\$486.64	Amount paid by Blue Cross and Blue Shield of Vermont for covered service(s).
Amount You Owe	\$80.90	The amount you may be billed if you have not already paid the provider or pharmacy for these services. This amount includes any deductibles, co-insurance, co-pay, not covered-due from patient and the amount my plan paid if payment was

made to the subscriber on this policy.

In instances where a claim is member payable, any payment made by BCBNVT for the claim(s) indicated on the EOB is sent to the subscriber of this account because the subscriber has an account with us. If you have any questions, please call our Customer Service Top- and the number on the back of your card.

The Benefit Summary information below is accurate as of 09/29/2017 and does not reflect services not yet billed or claims that have not yet

The "Benefil" column reflects benefil limits and/or benefit maximums for your current benefit plan. This may be a dollar amount or a specific number of visits. Please refer to your plan documents for further information.

The "Actual" column reflects the total dollars or visits that have applied toward the resp



visit limits your plan may have as well as This is an important box. It details any your deductible and your out-of-pocket limit. It also shows how much you've deductible and your out-of-pocket limit paid in that plan year towards your

Internet:

www.bcbsvt.com

terms you should know page

Review the terms on this page! At

confusing and difficult to follow. VEHI times, health care language can feel

Allowed Amount Terms You Should Know pay, what VEHI pays and how these wants you to understand what you the terms below! terms affect your coverage. So, it's important to reivew

The maximum amount the Plan will pay for a service(s).

Benefit Summary

Specific aspects of your coverage may have a dollar amount limitation or specify a certain number of allowed visits listed here to help you understand how your coverage works.

ENV 12281

1 OF 3 B

The allowed benefit that is mentioned in your contract documents.

The percentage of the allowed amount(s) that you are required to pay your provider The portion of your benefit that has already been used so far this year

Co-Insurance

- Actual - Benefit - Type of Benefit

Co-Pay

The fixed dollar amount you are required to pay your provider for a service(s).

Date of Service Deductible The date you received the services recorded on this statement.

An amount you must pay toward the cost of specific services each calendar year before the Plan pays any benefits.

Any billed charges not covered by your policy, including services provided by an out-of-network or non-participating provider. You may be billed for these amounts

Any payment made by another policy that covers you.

Other Insurance Payments

Not Covered - Due From Patient

A code referring you to a message shown at the end of your Explanation of Benefits that explains how charges were processed for the claim line above.

7:00 AM - 6:00 I Local FOR ASSISTANCE CONTACT CUSTOMER SERVICE

Phone:

Customer Service Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186	TDD	Qualified Health Plans	UVM Medical Center	UVM	BlueCare	Vermont	Local	7:00 AM - 6:00 PM EST
	(800) 535-2227	(800) 310-5249	(800) 422-6668	(888) 222-7886	(888) 882-3600	(800) 247-2583	(802) 223-3494	Monday-Friday
Customer service team is available to answer any questions you may have	DUBSV15	PCPG -						

Can't locate their number? You can find it on the about your EOB. back of your ions you may have

your date(s) of service for the care you received A Date of service:

B Service: your service medical, laboratory, X-ray, physical therapy and more. pharmacy, surgery, office, category, which may include

for your care your provider billed the total amount Billed charges:

D Not covered - due from you had that VEHI doesn't cover allowed amount, or for services include charges above the your provider, which may patient: the amount owed to

E Amount you **BCBSVT** member being a VEHI and you received from saved: the savings

Understanding your Explanation of Benefits

daims page

MEDICAL

name of the billing or supervising Provider name contains the actually saw for your care. the name of the provider you provider and may not match

	This amount represents your savings. You do not have to pay this amount because your physician is within the BCBSV I network. If you have already that	ctwork If you h	ne BCBSV n	and a within	to your physic	mount becaus	to pay this at	a do not have	Savings You	epiesenis vour	Junoune Stirk Cray
											Medical Messages
\$43.50	\$0.00	\$0.00	\$43.50	\$0.00	\$0.00	\$50.00	\$6.50	\$0.00	\$50.00		Total for Claim
									de:	Message Code	
\$43.50	\$0.00	\$0.00	\$43.50	\$0.00	\$0.00	\$50.00	\$6.50	\$0.00	\$50.00	LABORATO	09/15/2017-09/15/2017 LABORATO
Amount You Owe	Amount Your Plan Paid	Deductible Co-Insurance	Deductible	Co-Pay	Other Insurance Payments	Allowed Amount	Amount You Saved	Not Covered- Due From Patient	Billed Charges	Service	Date of Service
	27/2017	Date Processed: 09/27/2017	Date		Provider Name: PROVIDER NAME	Name: PRO	Provider		ACTICE NAM	PROVIDER PR	Provider Practice: PROVIDER PRACTICE NAME
	008006	Group Number: D20008006	Grou		201718874	Claim Number: 0109201718874	Claim Nu		19/15/2017	09/15/2017 - 09/15/2017	Date Range:
	UPNAME	Group Name: GROUP NAME	Grou		DYYYY	Date of Birth: MM/DD/YYYY	Date of B		Æ	MEMBER NAME	Patient Name:
\$28.80	\$138.03	\$0.00	\$28.80	\$0.00	\$0.00	\$178.03	\$146.17	\$0.00	\$313.00		Total for Claim
									de: Z013	Message Code: ZIII	
\$0.00	\$10.12	\$0.00	\$0.00	\$0.00	\$0.00	\$10.12	\$10.88	\$0.00	\$21.00		09/15/2017-09/15/2017
									de:	Message Code	
\$28.80	\$0.00	\$0.00	\$28.80	\$0.00	\$0.00	\$40.00	\$11.20	\$0.00	\$40.00	MEDICAL	09/15/2017-09/15/2017
									de: 7013	Message Code: Z013	
\$0.00	\$127.91	\$0.00	\$0.00	\$0.00	\$0.00	\$127.91	\$124.09	\$0.00	\$252.00	MEDICAL	09/15/2017-09/15/2017
Amount You Owe	Amount Your Plan Paid	Barrier .	Deductible Co-Insurance	H Co-Pay	G Other Allowed Insurance Amount Payments	Allowed Amount	Amount You Saved	Not Amoun Covered Amoun Due From You Patient Saved	Billed Charges	Service	A Date of Service
	27/2017	Date Processed: 09/27/2017	Date		Provider Name: PROVIDER NAME	Name: PROV	Provider	te D	ACTICE NAM	PROVIDER PRA	Provider Practice: PROVIDER PRACTICE NAME
	1008006	Group Number: D20008006	Grou		191707125	Claim Number: 0109191707125	Claim Nu		9/15/2017	09/15/2017 - 09/15/2017	Date Range:
	GROUP NAME	Group Name: GRO	Grou		AAAAAGC	Date of Birth: MM/DD/YYYY	Date of B		TE.	MEMBER NAME	r attent rame.

F Allowed amount: the amount VEHI

service or supply

considers reasonable

of the claims BCBSVT has processed for you. message codes to gain a full understanding Your EOB will also contain mess. message code for you. Be sure to review your within each claim, and we will define each

or secondary health plans payments your providers already payments: insurance **G** Other insurance received from your primary

Outline of Coverage you must pay for specific or fixed dollar amount, H Co-pay: the visit fee, services as shown on your

the care you received. L Amount you owe: the total amount you owe for

to your in-network providers. received. This amount goes directly amount VEHI paid for the care you K Amount your plan paid: the

annual deductible amount must pay after you meet your of the allowed amount you J Co-insurance: a percentage

plan pays certain benefits each plan year before your cost of specific services you must pay toward the Deductible: the amount

