Understanding your Summary of Health Plan Payments (SHPP)

1. totals page

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SUMMARY OF HEALTH PLAN PAYMENTS
Member name

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

Summary Date: 05/01/20

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.

Member Information
Service for: Member name
Member ID number: V846343427000
Group Number: 1N93001 SS01
Group Name: Group name

PAYMENT OVERVIEW

Amount Billed The amount your provider charged for these services.	**$150.00**
Provider Responsibility You may not be billed for these amounts if the provider is participating with Blue Cross and Blue Shield.	**$0.00**
Allowed Amount The amount we consider reasonable for a covered service or supply.	**$106.47**
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	$106.47
Coinsurance	$0.00
Non Covered	$0.00
	$106.47

This document is an important tool for tracking and understanding your health care expenses.

Most importantly, your SHPP is:

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

Reviewing your SHPP, whenever you receive care, will help you understand what your services cost you and your plan.

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

This is an important box. It details the amount you may be billed if you have not already paid your provider.

EOB IS NOW SHPP

2. terms-you-should-know page

Review the terms on this page! At times, health care language can feel confusing and difficult to follow. We want you to understand what you pay, what BCBSVT pays and how these terms affect your coverage. So, it's important to review the terms below!

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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Keep for your records
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The SHPP contains three items of importance:

1. A **totals page** that provides high-level details about the costs for all of the claims processed in the previous month.
2. A **terms-you-should-know** page to help you understand health care terminology.
3. **Claims pages**, which you should use to compare the services you received, to the services your provider billed BCBSVT, as shown on your SHPP.

Please note we use service categories on your SHPP to maintain your privacy and avoid overly complicated medical terminology. If you have any questions, please call the number listed on the back of your ID card.

Understanding your Summary of Health Plan Payments (SHPP)

EOB IS NOW SHPP

3. claims page

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

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

C ***Amount billed:*** the total amount your provider billed for your care

D ***Provider responsibility:*** this is the amount your provider isn't allowed to charge you in most cases.

E ***Allowed amount:*** the amount BCBSVT considers reasonable for a covered service or supply

F ***Plan payment:*** the amount BCBSVT paid for the care you received. This amount goes directly to your in-network providers.

G ***What you owe:*** the total amount you owe for the care you received.

H ***Benefit limits:*** these boxes provide a quick review of the total expenses applied toward your out-of-pocket limits and other benefit limits like chiropractic care and physical therapy.

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

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HEALTH PLAN PAYMENT BREAKDOWN

Service Date A	Service Type B	C Amount Billed	D Provider Responsibility	E Allowed Amount	F Plan Payment	G What You Owe	Breakdown of What You Owe: I Copayments	J Deductible	K Coinsurance	L Non Covered (See Remarks)	M What You Owe	Remark Codes N
Provider Name: Morris Physical Therapy Pc	**Patient Name: Plain**	**Claim #: 26182260665600**	**(In–Network)**									
03/12	Physical Therapy	$80.00	$0.00	$60.56	$0.00	$60.56	$0.00	$60.56	$0.00	$0.00	**$60.56**	
03/12	Physical Therapy	$40.00	$0.00	$28.36	$0.00	$28.36	$0.00	$28.36	$0.00	$0.00	**$28.36**	
03/12	Physical Therapy	$30.00	$0.00	$17.55	$0.00	$17.55	$0.00	$17.55	$0.00	$0.00	**$17.55**	
Subtotal		**$150.00**	**$0.00**	**$106.47**	**$0.00**	**$106.47**	**$0.00**	**$106.47**	**$0.00**	**$0.00**	**$106.47**	O
Grand Total		**$150.00**	**$0.00**	**$106.47**	**$0.00**	**$106.47**	**$0.00**	**$106.47**	**$0.00**	**$0.00**	**$106.47**	

H

IN NETWORK FAMILY DEDUCTIBLE (Y102)
Amount Applied as of 5/1/2020*
$0 — $3,100.00
Family: $998.79 of $3,100.00

IN NETWORK OUT OF POCKET (Y112)
Amount Applied as of 5/1/2020*
$0 — $12,800.00
Family: $998.79 of $12,800.00

CHIROPRACTIC CARE MAXIMUM (Y200)
Amount Applied as of 5/1/2020*
0 — 12
Individual: 1 of 12

PHYSICAL/OCCUPATIONAL/SPEECH THERAPY MAX (Y201)
Amount Applied as of 5/1/2020*
0 — 30
Individual: 2 of 30

HABILITATIVE THERAPY VISIT MAXIMUM (Y203)
Amount Applied as of 5/1/2020*
0 — 30
Individual: 3 of 30

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

*includes charges from this PLAN YEAR only

BCBSVT's customer service team is available to answer any questions you may have about your SHPP. Can't locate their number? You can find it on the back of your ID card!

I ***Co-payments:*** the fixed dollar amount, you must pay for specific services as shown on your Outline of Coverage

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

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

L ***Non covered:*** shows the amount you must pay for non-covered services billed to us by your provider.

M ***What you owe:*** the total amount you owe for the care you received.

N ***Remark codes:*** explain what informational messages belong to each line of a claim.

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