MASSACHUSETTS
BLUE CROSS BLUE SHIELD OF
MASSACHUSETTS*
ONE ENTERPRISE DRIVE
MAIL STOP 02-04
NO. QUINCY MA 02171-2126

>007017 2895783 0001 092007 10Z

ALEXANDER D GREENSPUN
[redacted]

Introducing our new simpler Summary of Health Plan Payments

You talked, and we listened. Using feedback and input from our members, we simplified our plan summary to clearly show how we process your claims and determine if you owe a balance. You can also view your claims online at **www.bluecrossma.com/membercentral**.

Any questions? Feel free to call Member Service at the number on the front of your ID card.

Important Information about Your Appeal Rights

What if I need help understanding this?
Contact us at the toll-free Member Service telephone number on your identification card if you need assistance understanding this notice or how we processed the claim. Have the enclosed statement with you if you call. You can also ask questions by including them with the enclosed statement and sending it to:

Member Service Center
Blue Cross Blue Shield of Massachusetts
P.O. Box 9134
N. Quincy, MA 02171- 9134

What if I don't agree with this decision?
You have a right to appeal any decision not to provide or pay for an item or 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: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. The toll free telephone number is 1-800-472-2689. The fax number is (617) 246-3616. We must receive your appeal within one year of the date that your claim was denied. Your benefit materials include more details. See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

Who may file an appeal?
You or someone you name to act for you (your authorized representative) may file an appeal. If you choose to have another person act on your behalf you must designate this person in writing to us. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. When you are an inpatient, a health care provider may act as your authorized representative. In this case, you do not have to designate the health care provider in writing.

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; 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 information relevant to my claim?
Yes, you may request copies (free of charge). If our decision was based on a coverage guideline or medical necessity criterion, we will provide that information on request free of charge. You can request copies of this information by contacting us at our Member Service Center.

What happens next?
If you appeal, we will review our decision and provide you with a written determination within 30 days. If your health plan is subject to the federal ERISA law, you have the right to bring a lawsuit. You can bring a lawsuit under Section 502(a) of ERISA, if, after completing the member grievance program review, you disagree with our decision. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you:
For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program may be able to assist you at www.massconsumerassistance.org.

Additional Information

Language Assistance
To obtain language assistance, please call the toll-free Member Service number on your ID card.

Spanish (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

Tagalog (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

Chinese (中文): 如果您需要中文語言幫助，請撥打寄送卡上的客戶服務免費電話號碼。

Navajo (Dine): Dinek'ehji shika' a'dowoł ninizingo, kwojí hodiilnė t'áá jíkeh béésh bee' hane'jį T'áá doolé'é bina'ishdilkidgo yechąká'adoojah éi binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Claim Codes
Claim codes are submitted by health care providers to Blue Cross Blue Shield of Massachusetts and used to determine coverage for services rendered. Members likely know about their treatment and diagnosis based on their interactions with their health care provider. However, members may request that any applicable treatment and diagnosis codes and their meanings, for the service listed in the enclosed claim notice, be sent to them by Blue Cross Blue Shield of Massachusetts. To make such a request, the member or their authorized representative must submit a signed and dated request to the Member Service address included with this notice, and must also include a copy of the claim summary notice accompanying this statement.

SUMMARY OF HEALTH PLAN PAYMENTS
FOR ALEXANDER GREENSPUN

MASSACHUSETTS

What is this?
This summary shows the amount covered by Blue Cross for the claim(s) below, and the amount that is your responsibility.
This is not a bill; your health care provider(s) will bill you directly for the amount not covered.

Summary Date: 05/09/14

Member information
Service for: Alexander D Greenspun
Member ID number: [redacted]
Group Plan Number:

PAYMENT OVERVIEW

Adjusted amount charged
The amount charged by your health care provider(s) based on Blue Cross' contract rates. **$362.17**

Amount covered
Benefits provided by Blue Cross for your medical services. **$362.14**

Your financial responsibility
The amount not covered by your Blue Cross health plan. This includes copayments, co-insurance, and deductible.

Copayments	$0.00
Deductible	$0.00
Co-insurance	$0.00
Not Covered	$0.00
	$0.00

Adjusted amount charged

Amount your provider charged	Blue Cross discount	Adjusted amount
$465.03	–$102.86	**$362.17**

View up-to-date information about your health plan.
Go to bluecrossma.com/membercentral

Glossary

Blue Cross discount
Your savings from the discounted rate Blue Cross negotiated with your health care provider.

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

Deductible
The amount you pay for specific services each plan year before Blue Cross starts paying.

Co–insurance
The amount you pay for specific health care services, calculated as a percent.

Out–of–pocket maximum
The most you'll pay each plan year for health care services, including copayments, co-insurance, and deductible amounts.

Health care provider
A doctor, hospital, health care professional,or health care facility.

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

HEALTH PLAN PAYMENT BREAKDOWN

		Amount charged					Your financial responsibility calculation					
Service date	Service type	Amount your provider charged	Blue Cross discount	Adjusted amount	Amount covered	Your financial responsibility	Copayments	Deductible	Co–insurance	Not covered (see notes)	Total cost	See notes
[redacted]		Patient Name: Alexander Claim #: 26141016331900										
04/09/14	PREVENTIVE MEDICINE	$180.00	-$30.94	$149.06	$149.06	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	A
04/09/14	OTHER MED SERVICES	$100.00	-$23.16	$76.84	$76.84	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	A
04/09/14	OTHER MED SERVICES	$50.00	-$35.32	$14.68	$14.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	A
04/09/14	OTHER MED SERVICES	$45.00	-$4.48	$40.52	$40.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	A
04/09/14	OTHER MED SERVICES	$45.00	-$4.48	$40.52	$40.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	A
04/09/14	OTHER MED SERVICES	$45.00	-$4.48	$40.52	$40.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	A
04/09/14	OTHER MED SERVICES	$0.01	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	B
04/09/14	OTHER MED SERVICES	$0.01	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	B
04/09/14	OTHER MED SERVICES	$0.01	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	B
Subtotal		**$465.03**	**–$102.86**	**$362.17**	**$362.14**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**
Grand Total		**$465.03**	**–$102.86**	**$362.17**	**$362.14**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**

To see the amount you've paid toward your deductible and out-of-pocket maximum, log in to Member Central at **www.bluecrossma.com/membercentral.**

HAVE QUESTIONS?

Call the number on your ID card.

Or log in to your account at bluecrossma.com/membercentral

For TTY, call 1-800-522-1254

07017 2695783 021052 042103 0003/0003

Keep for your records

547692149 700/700

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NOTES

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BENEFITS FOR THIS SERVICE ARE BASED ON A FEE SCHEDULE AND THE MAXIMUM REIMBURSABLE ALLOWANCE FOR THIS BENEFIT HAS BEEN PROVIDED. YOU ARE ONLY RESPONSIBLE FOR ANY COINSURANCE, DEDUCTIBLE OR COPAYMENT. /P017/

B

BENEFITS ARE NOT AVAILABLE BECAUSE THIS VACCINE IS PROVIDED BY THE STATE TO PATIENTS OF THIS AGE. YOU ARE NOT RESPONSIBLE FOR PAYMENT OF THESE CHARGES. /U237/

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