



**GENERIC FAKE CORPORATION  
EMPLOYEE HEALTH BENEFIT PLAN**

**MONTHLY  
claims statement**

The information in this statement is current as of DATE

Jane Doe  
123456789

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
JANE DOE  
3372 MAIN STREET  
PIKEVILLE TN 37367

**Your Family's Medical Claims**

You can see further details about your claims listed below by going to [bcbst.com](http://bcbst.com)

Member Name	Date of Service	Claim Number	Provider Name	Total Charge	Network Savings	Paid Provider Processed Date	HRA Paid	You Paid
Jane	00/00/2009	EXTKGRK42300	Leach, Anthony B. Provider Code Here Non-covered Codes: COS	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
Jane	00/00/2009	070183160900	Out of State Professional Provider Code Here Non-covered Codes: INV, W54	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
Jane	00/00/2009	070183160900	Out of State Professional Provider Code Here Non-covered Codes: TRO	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
Jane	00/00/2009	070183160900	Out of State Professional Provider Code Here Non-covered Codes: W04	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>



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123456789

**Your Family's Dental Claims**

You can see further details about your claims listed below by going to [bcbst.com](http://bcbst.com) or by contacting our Dental Customer Service area at 1-800-523-1478


Member Name	Date of Service	Claim Number	Provider Name	Total Charge	Network Savings	Paid Provider Processed Date	HRA Paid	You Paid
John	00/00/2009	DENBDMX89401	Scruggs IV, Oscar D. Provider Code Here Non-covered Codes: UM1	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
John	00/00/2009	DENBDMX89401	Scruggs IV, Oscar D. Provider Code Here Non-covered Codes: COS, INV, TRO, UM1, W04, W54	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
John	00/00/2009	DENBDMX89401	Scruggs IV, Oscar D. Provider Code Here Non-covered Codes: UM1	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
John	00/00/2009	DENBDMX89401	Scruggs IV, Oscar D. Provider Code Here Non-covered Codes: UM1	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>
John	00/00/2009	DENBDMX89401	Scruggs IV, Oscar D. Provider Code Here Non-covered Codes: INV	\$9999,999.99	\$9999,999.99	\$9999,999.99 00/00/2009	\$99,999.99	Copay \$99,999.99 Deductible \$99,999.99 Coinsurance \$999,999.99 Non-covered \$9999,999.99 Other Insurance Paid \$9999,999.99 <b>Amount You Owed \$9999,999.99</b>

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Jane Doe  
123456789

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have questions about this statement, please call

 **1-800-565-9140**  
**1-888-000-0000**

or use BlueAccess on our Web site, [bcbst.com](http://bcbst.com), to view this information and more.

Chattanooga 8:00 A.M.-5:15 P.M. (ET)  
Memphis 8:00 A.M.-5:15 P.M. (CT)  
Monday - Friday

**Your Family Deductibles & Out-Of-Pocket Maximums**

At the end of day (date \_\_\_/\_\_\_/\_\_\_) for the year \_\_\_\_\_:

**Medical**

	Deductible Met		Out-of-Pocket Met	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Family	\$99,999.99	\$99,999.99	\$99,999.99	\$99,999.99
Individual:				
Jane	\$99,999.99	\$99,999.99	\$99,999.99	\$99,999.99
John	\$99,999.99	\$99,999.99	\$99,999.99	\$99,999.99
Jim	\$99,999.99	\$99,999.99	\$99,999.99	\$99,999.99
Jack	\$99,999.99	\$99,999.99	\$99,999.99	\$99,999.99

**Dental**

	Deductible Met	Annual Max Met	Orthodontic Lifetime Max Met
Individual:			
Jane	\$999,999.99	\$999,999.99	\$999,999.99
John	\$999,999.99	\$999,999.99	\$999,999.99
Jim	\$999,999.99	\$999,999.99	\$999,999.99
Jack	\$999,999.99	\$999,999.99	\$999,999.99

**Explanation of Codes**

**COS** – This procedure is not eligible for benefits under this member’s coverage because it was performed for Cosmetic purposes. Upon written request, a copy of any Internal guidelines or similar criteria relied on to make this decision and an explanation of the clinical decision applying your Member EOC to your condition will be provided free of charge.

**INV** – This procedure is considered investigative and is not covered under this member’s plan. Upon written request, a copy of any Internal guidelines or similar criteria relied on to make this decision and an explanation of the clinical decision applying your member EOC to your condition will be provided free of charge.

**TRO** – Benefits cannot be provided because there was no authorization and/or referral for this service. Upon written request, a copy of any Internal guidelines or similar criteria relied on to make this decision and an explanation of the clinical decision applying your member EOC to your condition will be provided free of charge.

**UM1** – The number of services provided exceeds the number approved in the Utilization Management authorization.

**W04** – The provider must submit the NDC, drug name, RX number, strength, day supply and quantity before benefits can be provided.

**W54** – The provider must submit this patient’s medical records. Please reference this claim number and member id when you submit the records.

You have the right to appeal the results of this claim. If your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the appeal must be submitted within 180 days of this Explanation of Benefits. Under ERISA you may file a civil action after the appeal decision. Please refer to the appeals section of your Evidence of Coverage or contact Customer Service.