Blue Cross Blue Shield of Montana
3645 Alice Street, P.O. Box 7982
Helena, MT 59604-7982

BlueCross BlueShield of Montana

Questions? Contact us:

All Claims: 000-000-0000

Website: MyBlueElementMT.com

SAMPLE MEMBER
1234 MAIN ST

TOWN NAME MT 00000

EMPLOYER NAME

Group Number 000000
Print Date January 11, 2024

Consolidated Family Explanation of Benefits

This is not a Bill

SAMPLE MEMBER

Patient's Name Type of Service	Service Date(s)	Billed Charges	Discount Amount	Other Adjust-ments	Other Plan Payment	Patient Responsibility After Payments				Plan Benefit	Plan Paid At	Reason Codes
						Ineligible	Co-Pay	Deductible	Co-Ins			
SAMPLE MEMBER												
Claim #: 000000-000-00 Pat. Acct. #: X0000000000 Provider: SAMPLE PROVIDER Network: BCBSIL PPO												**Issued: 12/29/23**
MEDICAL CARE	04/04/2023	443.00	224.62	0.00	0.00	0.00	0.00	0.00	0.00	218.38	100%	HC1
	Totals:	443.00	224.62	0.00	0.00	0.00	0.00	0.00	0.00	218.38		

Patient Responsibility 0.00

Reason Code Descriptions:

HC1 DISCOUNT AMOUNT (ALLOWED) IS A LOWER PROVIDER FEE BCBSIL NEGOTIATED. DEDUCTIBLES, COINSURANCE AND COPAYS ARE BASED ON THIS AMOUNT. COINSURANCE IS A PERCENTAGE OF THE ALLOWED AFTER DEDUCTIBLE IS MET.

Please see your Summary Plan Description for a more detailed explanation of your plan benefits, exclusions, and maximums.

The dollars displayed on this statement are as of the Print Date and are subject to change. Your next Consolidated Explanation of Benefits, if any claims are processed, will be issued no later than the week of: 02/11/2024

IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to: Claims Office
PO Box 25946
Overland Park, IA 66225-5946

To file an appeal or if you have questions, please call the phone number on the first page of this EOB or on your ID card, send a fax to 888-860-6962, or send a secure email using our Message Center by logging into MyBlueElementMT.com.

Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review - known as an “authorized representative.” To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

* A copy of the decision letter or Explanation of Benefits (EOB)
* The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your initial appeal.

What happens next?	We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call the phone number on the first page of this EOB or on your ID card or fax your request to 888-860-6962. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling the phone number on the first page of this EOB or on your ID card.

What happens next?	If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.

Expedited (Urgent) External Review

You may ask for this type of review if:

* failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
* the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
* the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
* we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call the phone number on the first page of this EOB or on your ID card.

What happens next?	If you qualify for this type of review, the IRO will give you a decision within 72 hours.

Notice about Provider Appeals

If you used an in-network provider, your provider may be able to file an appeal request for benefits you've been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

Additional Rights

If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601		

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TY/TDD:	800-537-7691
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયકમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ánánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'idíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے. مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں.
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.