

**MEDICAL**

Patient Name: [REDACTED]

Date of Birth: [REDACTED]

Group Name: VERMONT

Date Range: 12/12/2017 - 12/12/2017

Claim Number: 0112191722408

Group Number: D27340014

Provider Practice: UVM MEDICAL CENTER INC

Provider Name: [REDACTED]

Date Processed: 12/27/2017

| Date of Service        | Service  | Billed Charges | Not Covered- Due From Patient | Amount You Saved | Allowed Amount | Other Insurance Payments | Co-Pay | Deductible | Co-Insurance | Amount Your Plan Paid | Amount You Owe |
|------------------------|----------|----------------|-------------------------------|------------------|----------------|--------------------------|--------|------------|--------------|-----------------------|----------------|
| 12/12/2017             | LABORATO | \$167.00       | \$0.00                        | \$48.23          | \$118.77       | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$118.77              | \$0.00         |
| Message Code: Z013     |          |                |                               |                  |                |                          |        |            |              |                       |                |
| <b>Total for Claim</b> |          | \$167.00       | \$0.00                        | \$48.23          | \$118.77       | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$118.77              | \$0.00         |

Patient Name: [REDACTED]

Date of Birth: [REDACTED]

Group Name: VERMONT

Date Range: 12/12/2017 - 12/12/2017

Claim Number: 0112191722408

Group Number: D27340014

Provider Practice: [REDACTED]

Provider Name: UVM MEDICAL CENTER INC

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|--------------------------|-----------|----------------|-------------------------------|------------------|----------------|--------------------------|--------|------------|--------------|-----------------------|----------------|
| 12/12/2017               | LABORATO  | \$158.50       | \$0.00                        | \$51.35          | \$107.15       | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$107.15              | \$0.00         |
| Message Code: Z013       |           |                |                               |                  |                |                          |        |            |              |                       |                |
| 12/12/2017               | SURGERY   | \$3,219.03     | \$0.00                        | \$614.83         | \$3,219.03     | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$2,604.20            | \$0.00         |
| Message Code: [REDACTED] |           |                |                               |                  |                |                          |        |            |              |                       |                |
| 12/12/2017               | ANESTHESI | \$346.63       | \$0.00                        | \$56.85          | \$346.63       | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$289.78              | \$0.00         |
| Message Code: [REDACTED] |           |                |                               |                  |                |                          |        |            |              |                       |                |
| 12/12/2017               | PHARMACY  | \$18.84        | \$0.00                        | \$6.02           | \$12.82        | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$12.82               | \$0.00         |
| Message Code: Z013       |           |                |                               |                  |                |                          |        |            |              |                       |                |
| 12/12/2017               | PHARMACY  | \$17.19        | \$0.00                        | \$0.00           | \$17.19        | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$17.19               | \$0.00         |
| Message Code: [REDACTED] |           |                |                               |                  |                |                          |        |            |              |                       |                |
| <b>Total for Claim</b>   |           | \$3,760.19     | \$0.00                        | \$729.05         | \$3,702.82     | \$0.00                   | \$0.00 | \$0.00     | \$0.00       | \$3,031.14            | \$0.00         |





UVM MEDICAL CENTER  
 HOSPITAL PATIENT FINANCIAL SERVICES  
 PO BOX 1810  
 BURLINGTON, VT 05402-1810  
 RETURN SERVICE REQUESTED

THE  
**University of Vermont**  
 MEDICAL CENTER

003701  
 0101

1105 01

[REDACTED]  
 [REDACTED]  
 [REDACTED] NY 12970

THIS BILL IS FOR **HOSPITAL**  
 SERVICES RENDERED TO:  
 PATIENT NAME: [REDACTED]  
 ACCOUNT #: [REDACTED]

INSURANCE INFORMATION ON FILE  
 [REDACTED]

BILLING QUESTIONS: TEL 802-847-8000  
 TOLL FREE 800-639-2719

PLEASE VERIFY THAT INSURANCE INFORMATION IS CORRECT  
 SEE REVERSE SIDE OF THIS FORM FOR OUR PAYMENT POLICY  
 STATEMENT DATE: 01/18/19 DUE DATE: 02/12/19

| ADMIT/DATE OF SERVICE                                  | VISIT NUMBER / PROCEDURE CODE | SERVICE PROVIDER / TYPE OF SERVICE | BILLED CHARGES | PAID BY PLAN / ADJUSTMENT | PATIENT PAYMENT                      | DUE FROM PATIENT |
|--|-------------------------------|------------------------------------|----------------|---------------------------|--------------------------------------|------------------|
| 12/04/18   | 20362571                      | OUTPATIENT                         |                |                           |                                      |                  |
|  |                               | PHARMACY                           | 688.99         |                           |                                      |                  |
|  |                               | ANESTHESIA                         | 934.04         |                           |                                      |                  |
|  |                               | AMBUL SURG                         | 5476.00        |                           |                                      |                  |
|  |                               | RECOVERY ROOM                      | 549.70         |                           |                                      |                  |
|  | 12/19/18                      | ELEC PMT REC EX                    |                | -5648.50                  |                                      |                  |
|  | 12/19/18                      | CONTRACTUAL ALL                    |                | -1299.51                  |                                      |                  |
|  |                               | BALANCE DUE                        |                |                           |                                      | 700.72           |
| ADDITIONAL DETAILED INFORMATION AVAILABLE UPON REQUEST |                               |                                    |                |                           | ACCOUNT TOTAL DUE FROM YOU \$ 700.72 |                  |

**IMPORTANT MESSAGE:**  
 THANK YOU FOR SELECTING UVM MEDICAL CENTER AS YOUR HEALTH CARE PROVIDER.  
 PLEASE PAY AMOUNT DUE BY THE DATE SHOWN ON YOUR STATEMENT. IF YOU HAVE  
 QUESTIONS, PLEASE CALL CUSTOMER SERVICE AT 802-847-8000 OR 800-639-2719.

RETURN BOTTOM PORTION WITH YOUR PAYMENT • RETAIN TOP PORTION FOR YOUR RECORDS

ADDRESS CHANGE, PLEASE MAKE CHANGES ON REVERSE SIDE OF REMITTANCE

DUE DATE: 02/12/19 STATEMENT DATE: 01/18/19

PATIENT NAME: [REDACTED] ACCOUNT NUMBER: [REDACTED]

IF PAYING BY CREDIT/DEBIT CARD, PLEASE FILL OUT INFORMATION BELOW

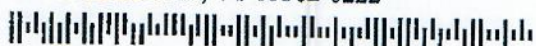
|                               |                                     |                                   |                               |   |
|-------------------------------|-------------------------------------|-----------------------------------|-------------------------------|---|
| <input type="checkbox"/> HSA  | <input type="checkbox"/> MASTERCARD | <input type="checkbox"/> DISCOVER | <input type="checkbox"/> VISA | <input type="checkbox"/> AMERICAN EXPRESS |
| CARD NUMBER                   |                                     |                                   | SECURITY CODE                 |   |
| SIGNATURE                     |                                     |                                   | EXP. DATE                     |   |
| TOTAL DUE \$ 700.72           | SHOW AMOUNT PAID HERE \$            |                                   |                               |   |
| APPROVED BUDGET AMOUNT DUE \$ |                                     |                                   | 100.00                        |   |

**Payment Options:**

- ONLINE: bit.ly/uvmmedicalcenterpay or via your MyHealth Online account
- BY PHONE: 802-847-8000 (Local) or 1-800-639-2719 (Toll Free)
- BY MAIL: To the address below with this payment coupon

MAKE CHECKS PAYABLE TO:

UVM MEDICAL CENTER  
 PAYMENTS DEPARTMENT - HOSPITAL  
 PO BOX 6222  
 BRATTLEBORO, VT 05302-6222



00000773846 00000070072  
 8633-FAHCHP... 4024315-27752163274, 19224151-2-1100, 00341950-1, 1





**Claim Details**

- A claim for services you received was sent to MVP. This EOB can help you understand the amount charged by your health care provider and what your health plan paid. It also shows the out-of-pocket costs that you must pay.
- If you received covered services from an MVP-participating provider, that provider has agreed to accept the Allowed Amount shown below as payment in full, minus any Deductible, Copay or Coinsurance.
- If services were from a provider not participating with MVP, you may need to pay the difference between the Billed Charges shown below and the Allowed Amount.

| Billed Charges                              | Allowed Amount | Not Allowed/ Not Due from Patient | Not Covered/ Due from Patient | Other Insurance Payments  | Deductible | Coinsurance | Copay | Paid By Plan | Reason Code(s) |
|---|----------------|-----------------------------------|-------------------------------|---|------------|-------------|-------|--------------|----------------|
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Fentanyl Citrate Injeciton/Pharmacy  |            |             |       |              |                |
| 21.03                                       | 15.77          | 5.26                              | 0.00                          | 0.00  | 0.00       | 4.73        | 0.00  | 11.04        |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Inj Midazolam Hydrochloride/Pharmacy                                       |            |             |       |              |                |
| 19.12                                       | 14.34          | 4.78                              | 0.00                          | 0.00  | 0.00       | 4.30        | 0.00  | 10.04        |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Pharmacy   |            |             |       |              |                |
| 6.74  | 5.86           | 0.88                              | 0.00                          | 0.00  | 0.00       | 1.76        | 0.00  | 4.10         |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Diphenhydramine Hcl Inj ectio/Pharmacy                                     |            |             |       |              |                |
| 6.00  | 4.50           | 1.50                              | 0.00                          | 0.00  | 0.00       | 1.35        | 0.00  | 3.15         |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Surg Path; Level 4 Gross & Micro/Laboratory Pathological                   |            |             |       |              |                |
| 120.00                                      | 120.00         | 0.00                              | 0.00                          | 0.00  | 0.00       | 36.00       | 0.00  | 84.00        |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Colonoscopy Splenic Flex; Diagnost/Operating Room Services - Minor Surgery |            |             |       |              |                |
| 2,825.83                                    | 2,295.27       | 530.56                            | 0.00                          | 0.00  | 0.00       | 688.56      | 0.00  | 1,606.69     |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Endoscopy Upper Gi W Biopsy/Operating Room Services - Minor Surgery        |            |             |       |              |                |
| 2,609.55                                    | 1,065.48       | 1,544.07                          | 0.00                          | 0.00  | 0.00       | 319.64      | 0.00  | 745.84       | PMP            |

| Billed Charges                              | Allowed Amount | Not Allowed/ Not Due from Patient | Not Covered/ Due from Patient | Other Insurance Payments  | Deductible | Coinsurance | Copay | Paid By Plan | Reason Code(s) |
|---|----------------|-----------------------------------|-------------------------------|---|------------|-------------|-------|--------------|----------------|
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Moderate sedation services provided by the same physician or other qualified health care professional performing the |            |             |       |              |                |
| 693.26                                      | 602.44         | 90.82                             | 0.00                          | 0.00  | 0.00       | 180.73      | 0.00  | 421.71       |                |
| Date(s) of Service: 04/09/2019 - 04/09/2019 |                |                                   |                               | Description: Moderate sedation services provided by the same physician or other qualified health care professional performing a   |            |             |       |              |                |
| 350.10                                      | 304.24         | 45.86                             | 0.00                          | 0.00  | 0.00       | 91.27       | 0.00  | 212.97       |                |

**Reason Codes:**

PMP Price Adjusted Due to Additional Line Item Modifiers.

**2019 Limit Summary**

| Limit Name                                 | Current Amount | Maximum Amount |
|--|----------------|----------------|
| YEARLY IN-NETWORK DEDUCTIBLE (INDIVIDUAL)  | 1,495.00       | 3,100.00       |
| YEARLY IN-NETWORK DEDUCTIBLE (FAMILY)      | 3,100.00       | 3,100.00       |
| YEARLY INDIVIDUAL IN-NETWORK OUT-OF-POCKET | 4,629.43       | 7,900.00       |
| YEARLY FAMILY IN-NETWORK OUT-OF-POCKET     | 6,267.71       | 13,300.00      |





SCRANTON CLAIM OFFICE  
 P.O. BOX 182223  
 CHATTANOOGA TN 37422-7223

## Explanation of benefits

09/07/18



**Patient's name** [Redacted]  
**Date of service** 09/07/18  
**Service provider** UNIV OF VT MED CTR  
**Reference #** [Redacted]

**Amount paid by plan** \$3,584.03  
**Amount you may be billed** \$0.00  
**Your annual deductible** Not Applicable  
**Deductible met to date** Not Applicable

### Claim detail

~~Claim~~ received this claim on September 14, 2018 and processed it on September 22, 2018.

| Date of service | Type of service | Billed charges    | Discount        | Not allowed/ Not covered |               | Due from Patient      |                          |               |                   |                    |                            |                        | Reason Code   |    |
|-----------------|-----------------|-------------------|-----------------|--------------------------|---------------|-----------------------|--------------------------|---------------|-------------------|--------------------|----------------------------|------------------------|---------------|----|
|                 |                 |                   |                 | from Patient             | from Patient  | Equals allowed amount | Insurance other payments | Minus co-pay  | Minus deductibles | Minus co-insurance | Equals amount paid by Plan | Total due from Patient |               |    |
| 09/07/18        | INJECTIONS      | 26.95             | 1.87            | 0.00                     | 0.00          | 25.08                 | 0.00                     | 0.00          | 0.00              | 0.00               | 0.00                       | 25.08                  | 0.00          | A0 |
| 09/07/18        | INJECTIONS      | 2.70              | 0.19            | 0.00                     | 0.00          | 2.51                  | 0.00                     | 0.00          | 0.00              | 0.00               | 0.00                       | 2.51                   | 0.00          | A0 |
| 09/07/18        | LABORATORY      | 317.00            | 52.46           | 0.00                     | 0.00          | 264.54                | 0.00                     | 0.00          | 0.00              | 0.00               | 0.00                       | 264.54                 | 0.00          | A0 |
| 09/07/18        | OPERATING ROOM  | 3,219.03          | 223.08          | 0.00                     | 0.00          | 2,995.95              | 0.00                     | 0.00          | 0.00              | 0.00               | 0.00                       | 2,995.95               | 0.00          | A0 |
| 09/07/18        | ANESTHESIA SUP. | 317.98            | 22.03           | 0.00                     | 0.00          | 295.95                | 0.00                     | 0.00          | 0.00              | 0.00               | 0.00                       | 295.95                 | 0.00          | A0 |
| <b>Total</b>    |                 | <b>\$3,883.66</b> | <b>\$299.63</b> | <b>\$0.00</b>            | <b>\$0.00</b> | <b>\$3,584.03</b>     | <b>\$0.00</b>            | <b>\$0.00</b> | <b>\$0.00</b>     | <b>\$0.00</b>      | <b>\$0.00</b>              | <b>\$3,584.03</b>      | <b>\$0.00</b> |    |

### What I need to know for my next claim

- You've paid a total of \$0.00 toward your \$250 out of network individual deductible for 2018
- You've paid a total of \$0.00 toward your \$500 out of network family deductible for 2018
- You've paid a total of \$0.00 toward your \$4,000 out of network individual out of pocket expenses for 2018
- You've paid a total of \$0.00 toward your \$8,000 out of network family out of pocket expenses for 2018
- You've paid a total of \$20.00 toward your \$2,000 in network individual out of pocket expenses for 2018
- You've paid a total of \$20.00 toward your \$4,000 in network family out of pocket expenses for 2018
- You've paid a total of \$27,326.02 toward your Unlimited all medical benefits individual lifetime maximum

RETAIN THIS FOR YOUR RECORDS.