MASSACHUSETTS
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS
25 TECHNOLOGY PLACE
HINGHAM, MA 02043-4360

SAI S MANUR
1203 BOYLSTON ST
BOSTON MA 02215-3550

What is this? Why am I getting this?

This is not a bill. If you owe money, your doctor or medical facility will send you a bill.
This statement includes information about your processed claims and your financial responsibility.

Member Service
Call the number on the front of your ID card, Monday through Friday, from 8:00 a.m. to 6:00 p.m. ET.

525330854 700/700

MASSACHUSETTS
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS*
25 TECHNOLOGY PLACE
HINGHAM, MA 02043-4360

CHECK NO. **863533105**

62-22
311

Wells Fargo Bank, NA

DATE	PAYEE NO.	CHECK REF.
12/04/23	9624644830000	525201881

VOID 180 DAYS AFTER DATE AMOUNT

PAY TO THE ORDER OF
SAI S MANUR
1203 BOYLSTON STREET
BOSTON MA 02215-3550

$150.00

THE SUM OF ONE HUNDRED FIFTY DOLLARS AND NO/100

VOID

AUTHORIZED SIGNATURE

Glossary

Allowed amount
The most your health plan pays for a covered service. This may also be called the "allowed charge," "payment allowance," or "negotiated rate." If an out-of-network health care provider charges more than the allowed amount, you may have to pay the remaining cost.

Amount covered
The amount your health plan pays for covered services. This amount doesn't include non-covered services, copayments, deductibles, or co-insurance. If you select health care providers outside of our network, you may pay a lot more for the services you receive.

Amount your health care provider charged
The health care provider's actual charge for services you received. The actual charge may be more than the allowed amount.

Balance-billed amount
This is the difference between a charge from an out-of-network health care provider and the allowed amount. For example, if the health care provider's charge is $10,000 and the allowed amount is $7,000, the health care provider may bill you for the remaining $3,000. In-network health care providers won't balance bill you for covered services.

Blue Cross discount
The amount you save by using health care providers in our network. If you select health care providers outside of our network, you may pay a lot more for the services you receive.

Co-insurance*
Your share of the costs for a covered health care service. This is calculated as a percentage (for example, 20%) of the health care provider's actual charge or the allowed amount, whichever is less.

Copayment*
A fixed dollar amount (for example, $15) you pay for a covered health care service, usually paid when you receive the service. The amount can vary by the type of service.

Deductible*
The amount you pay during your annual coverage period for certain health care services before your plan begins to pay. For example, if your plan deductible is $1,000, your plan will begin to pay once you've met this amount for covered services subject to the deductible. The deductible may not apply to all services.

Not covered
Services, or procedures not covered by your plan. For example, this includes services that aren't medically necessary and any balance-billed amounts.

Out-of-pocket maximum*
The most you have to pay during your annual coverage period for copayments, deductible, and co-insurance. What you pay for your premiums, any balance-billed amounts, and charges for services not covered don't count toward your out-of-pocket maximum.

What you owe
The amount you'll pay your health care provider for the services listed on the Payment Details page. It can include amounts for copayments, deductibles, and co-insurance.* If you received services from an out-of-network health care provider, it may include a balance-billed amount. It will also include amounts for services you received that aren't covered by your plan. This amount doesn't include any of your premium payments.

For more information on your benefits, please refer to your plan materials.

*Only applies if your plan includes this.

SUMMARY OF HEALTH PLAN PAYMENTS
FOR SAI MANUR

MASSACHUSETTS

What is this? Why am I getting this?

This is not a bill. If you owe money, your doctor or medical facility will send you a bill.

Blue Cross Blue Shield of Massachusetts discloses that it does not underwrite or assume any financial risk with respect to claims liability; and discloses the nature of the services and/or network access Blue Cross Blue Shield of Massachusetts is providing.

Summary Date: 12/4/23
Statement Period: 12/04/23 – 12/04/23

Member information

Service for: Sai S Manur
Member ID number: XXXXX4483
Group Plan Number: 004955301 0002
Plan name: Student Blue

Claim no.: 27233380523900

PAYMENT OVERVIEW*

Allowed amount		**$150.00**
Amount covered		**$150.00**
What you owe	Copayments	$0.00
	Deductible	$0.00
	Co-insurance	$0.00
	Not Covered	$0.00
		$0.00

* See the glossary on the previous page to find out more about the terms included in the payment overview and payment details pages.

Allowed amount

Amount your health care provider charged	Blue Cross discount	**Allowed amount**
$150.00	$0.00	**$150.00**

Your Delivery Options
Go paperless!

To no longer receive these statements in the mail, use your secure MyBlue account and change your delivery preference. You'll get a notification when a statement is available to view. You can view your statements in **My Inbox** by logging into your MyBlue account at **bluecrossma.org**, or through the MyBlue app by clicking **Profile** and selecting **Communication Preferences.**

Note: We typically deliver statements to the subscriber's address that we have on file, unless you've notified us otherwise. If you have concerns about protecting the privacy of your medical information, you may be able to have statements delivered to a different address. Under certain circumstances, you can also request not to receive these statements for a specific service. For details, please call Member Service at the number on your ID card.

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

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 Appeal & 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 180 days 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 Appeal & 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 1-800-272-4232.

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，請撥打會員卡上的客戶服務免費電話號碼。

Navajo (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jį T'áá doolé'é bina'íshdiłkidgo yeeháká' adoojah éí 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.

MASSACHUSETTS

HEALTH PLAN PAYMENT DETAILS

		Allowed amount					Breakdown of what you owe					
Service date	Service type	Amount your health care provider charged	Blue Cross discount	**Allowed amount**	**Amount covered**	**What you owe**	**Copayments**	**Deductible**	**Co–insurance**	**Not covered (see notes)**	**What you owe**	**See notes**
Fitness Reward Patient Name: Sai Claim #: 27233380523900 (In–Network)												
12/04/23	**Other Med Services**	$150.00	$0.00	$150.00	$150.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	
Subtotal		**$150.00**	**$0.00**	**$150.00**	**$150.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**		**$0.00**
Grand Total		**$150.00**	**$0.00**	**$150.00**	**$150.00**	**$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 your account at **bluecrossma.com/myblue**.

HAVE QUESTIONS?

Call the number on your ID card.

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

For TTY, call 711

MASSACHUSETTS

Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.

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MASSACHUSETTS

Translation Resources
Proficiency of Language Assistance Services

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/عربية:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:

توجه: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígííjį' béésh bee hodíílnih (TTY: **711**).

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