

Online Claim Submission

Code: BCE

Employer: The Buckle Inc

EmpID: 507040040

EmpName: PIERZINA, JENNIFER

Submitted: February 10, 2023

Batch: 30281593

Claim Total: \$88.38

Attachments: 5

Line	Service Date(s)	Type	Cost	Notes
1	6/3/2022	GENERAL	\$48.38	Provider: Bryan Physician Network. For whom: Ashlin Pierzina.
2	6/2/2022	GENERAL	\$27.00	Provider: Minute Clinic. For whom: Ashlin Pierzina.
3	1/19/2023	RX	\$13.00	Provider: Hyvee Pharmacy. For whom: Jason Pierzina.

Prairie States Enterprises, Inc.
PO Box 23
Sheboygan, WI 53082-0023



Explanation of Benefits

Retain this for tax purposes
THIS IS NOT A BILL

ASHLIN PIERZINA
5804 AVE P PL
KEARNEY NE 68847

Customer Service

If you have questions regarding
this claim, please call
(800)615-7020

Group Name: AUTO-OWNERS INSURANCE (AIM)

For the Service Period:

06/02/2022 thru 06/02/2022

The information below is a summary of the healthcare claims you incurred for the period 06/02/2022 thru 06/02/2022. This information is commonly referred to as an "Explanation of Benefits" (EOB). **This is not a bill.** It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or noncovered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

\$304.00

This is the total amount billed for the dates of service of 06/02/2022 thru 06/02/2022.

Reduction Amount

\$150.64

This is the amount of dollars saved using pricing programs and network arrangements provided by PSE. These dollars include reduction amounts exceeding usual and customary and penalties.

Total Amount Paid By Plan

\$126.36

This is the amount the plan paid in total for services rendered from 06/02/2022 thru 06/02/2022. Please see the "Claim Summary" section of this document for more information.

Your Financial Responsibility

\$27.00

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Claim Summary

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22228007100	ASHLIN PIERZINA	\$304.00	\$27.00	\$150.64	\$0.00	\$0.00	\$126.36
	Totals	\$304.00	\$27.00	\$150.64	\$0.00	\$0.00	\$126.36

Claim #: 22228007100
 Patient: ASHLIN PIERZINA

Provider: MINUTE CLINIC DIAGNOSTIC OF NE
 Employee: JASON P PIERZINA

Patient Acct: 375914V8419
 Check #: 1195787

Treatment Dates	Service Code	Procedure Description	Remark Code	Billed Amount	Not Covered	Co Payment	Co Insurance	Deductible Amount	Provider Discount	Other Plan Payments	Other Adjustment	Payment Amount
06/02-06/02/2022	COV	OFFICE O/P NEW LOW 30-44 MIN	P9	\$139.00	\$0.00	\$0.00	\$0.00	\$0.00	\$57.87	\$0.00	\$0.00	\$81.13
06/02-06/02/2022	COV	SARSCOV CORONAVIRUS AG IA	P9	\$120.00	\$0.00	\$0.00	\$0.00	\$0.00	\$74.77	\$0.00	\$0.00	\$45.23
06/02-06/02/2022	LAB	STREP A DNA AMP PROBE	P9	\$45.00	\$0.00	\$0.00	\$0.00	\$27.00	\$18.00	\$0.00	\$0.00	\$0.00
06/02-06/02/2022	C2C	TOBACCO NON-USER		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
06/02-06/02/2022	C2C	SYST BP LT 130 MM HG		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
06/02-06/02/2022	C2C	DIABT BP <80 MM HG		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Column Totals				\$304.00	\$0.00	\$0.00	\$0.00	\$27.00	\$150.64	\$0.00	\$0.00	\$126.36
Other Insurance Credits												\$0.00
Total Payment Amount												\$126.36

Coinurance Amount Total \$0.00

Patient's Responsibility Total \$27.00

Reason Code/Description:
 P9 FIRST HEALTH PPO DISCOUNT

Payment Details:			
Paid To	Transaction Date	Transaction ID	Amount
MINUTE CLINIC DIAGNOSTIC OF NE	12/20/2022	1195787	\$126.36

Important Updates Regarding COVID-19 Relief - Relief of Certain Plan Deadlines

UPDATED In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," the Plan will disregard the period from March 1, 2020 until the earlier of (1) one year from the date you were first eligible for relief and (2) sixty (60) days after the end of the public health emergency relating to COVID-19 (the "Outbreak Period") and declared pursuant to 42 U.S.C. § 247d, which is still ongoing. If you have experienced one of these events, this guidance means that the disregarded period will not exceed one year. For additional information, please contact Prairie States Enterprises, Inc.

Appeals Rights

This claim has been processed consistent with the benefit terms and conditions written in the Summary Plan Document. Contacting Prairie States at (800) 615-7020 may resolve your questions regarding benefit determination. A Claimant or their authorized representative has the right to appeal any claim, denied in whole or in part; and request free of charge a copy of any criteria or plan provision used in denying this claim. A review of this benefit determination may be requested in writing by submitting your appeal to us along with any additional material/information you have within 180 days of receipt of denial or the claimant loses the right to further appeal or file a suit in civil court. If you provide the plan with all information needed, you will receive a written reply no later than 60 days of receipt of the appeal. If your appeal is denied, you have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). For questions about your appeals rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

SEND APPEALS TO:
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Total Amount Billed

\$454.00

This is the total amount billed for the dates of service of 06/03/2022 thru 06/03/2022.

Reduction Amount

\$178.36

This is the amount of dollars saved using pricing programs and network arrangements provided by PSE. These dollars include reduction amounts exceeding usual and customary and penalties.

Total Amount Paid By Plan

\$227.26

This is the amount the plan paid in total for services rendered from 06/03/2022 thru 06/03/2022. Please see the "Claim Summary" section of this document for more information.

Your Financial Responsibility

\$48.38

This is the amount the provider(s) of service may bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim #	Patient	Billed Amount	Patient Responsibility	Provider Discount	Other Plan Payments	Other Adjustment	Payment Amount
22235086000	ASHLIN PIERZINA	\$454.00	\$48.38	\$178.36	\$0.00	\$0.00	\$227.26
	Totals	\$454.00	\$48.38	\$178.36	\$0.00	\$0.00	\$227.26

Claim #: 22235086000
Patient: ASHLIN PIERZINA

Provider: BRYAN PHYSICIAN NETWORK
Employee: JASON P PIERZINA

Patient Acct: 31937031
Check #: 1208557

Treatment Dates	Service Code	Procedure Description	Remark Code	Billed Amount	Not Covered	Co Payment	Co Insurance	Deductible Amount	Provider Discount	Other Plan Payments	Other Adjustment	Payment Amount
06/03-06/03/2022	LAB	ROUTINE VENIPUNCTURE	P9	\$10.00	\$0.00	\$0.00	\$0.00	\$3.96	\$6.04	\$0.00	\$0.00	\$0.00
06/03-06/03/2022	COV	OFFICE O/P NEW LOW 30-44 MIN	P9	\$200.00	\$0.00	\$0.00	\$0.00	\$0.00	\$53.69	\$0.00	\$0.00	\$146.31
06/03-06/03/2022	COV	SARSCOV & INF VIR A&B AG IA	P9	\$165.00	\$0.00	\$0.00	\$0.00	\$0.00	\$84.05	\$0.00	\$0.00	\$80.95
06/03-06/03/2022	LAB	STREP A ASSAY W/OPTIC	P9	\$36.00	\$0.00	\$0.00	\$0.00	\$21.11	\$14.89	\$0.00	\$0.00	\$0.00
06/03-06/03/2022	LAB	COMPLETE CBC W/AUTO DIFF WBC	P9	\$15.00	\$0.00	\$0.00	\$0.00	\$9.67	\$5.33	\$0.00	\$0.00	\$0.00
06/03-06/03/2022	LAB	COMPREHEN METABOLIC PANEL	P9	\$28.00	\$0.00	\$0.00	\$0.00	\$13.64	\$14.36	\$0.00	\$0.00	\$0.00
Column Totals				\$454.00	\$0.00	\$0.00	\$0.00	\$48.38	\$178.36	\$0.00	\$0.00	\$227.26
Other Insurance Credits												\$0.00
Total Payment Amount												\$227.26

Coinsurance Amount Total \$0.00

Patient's Responsibility Total \$48.38

Reason Code/Description:

P9 FIRST HEALTH PPO DISCOUNT

Payment Details:

Paid To	Transaction Date	Transaction ID	Amount
BRYAN PHYSICIAN NETWORK	02/09/2023	1208557	\$227.26

Important Updates Regarding COVID-19 Relief - Relief of Certain Plan Deadlines

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SEND APPEALS TO:

Prairie States Enterprises, Inc.
Attn: Appeals
PO Box 23
Sheboygan, WI 53082-0023

Select Member:

JASON PIERZINA



Claim Number	SV1708751
Claim Status	Paid
Date Prescribed	01/19/2023
Date Filled	01/19/2023
Date Paid	01/19/2023
Provider	BERANEK
Pharmacy	HY-VEE PHARMACY (1323) 1323
Drug	AMOX/K CLAV TAB 875-125
Supply (Days)	10
Dispensing Fee	0.65
Sales Tax	0.00
Copay	13.00
Deductible	0.00
Paid By Plan	14.70

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 Check #: 1195787

Treatment Dates	Service Code	Procedure Description	Remark Code	Billed Amount	Not Covered	Co Payment	Co Insurance	Deductible Amount	Provider Discount	Other Plan Payments	Other Adjustment	Payment Amount
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06/02-06/02/2022	C2C	SYST BP LT 130 MM HG		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
06/02-06/02/2022	C2C	DIAST BP <80 MM HG		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
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Coinurance Amount Total \$0.00

Patient's Responsibility Total \$27.00

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Coinsurance Amount Total \$0.00

Patient's Responsibility Total \$48.38

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P9 FIRST HEALTH PPO DISCOUNT

Payment Details:			
Paid To	Transaction Date	Transaction ID	Amount
BRYAN PHYSICIAN NETWORK	02/09/2023	1208557	\$227.26

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