Horizon

PO BOX 18
NEWARK, NJ 07101-0018

MERCK
1-877-663-7258
MON-FRI 8AM-11PM ET
HORIZONBLUE.COM/MERCK

MERCK

SUBSCRIBER ADDRESS
SENTHIL K MURUGAN
110 GALWAY CIR
CHALFONT PA 18914-3900

SUBSCRIBER ID 3HZN39743510
GROUP NUMBER 000076091

Thank you for being a member of our health plan. This is your explanation of benefits (EOB). A summary of the claim(s) included is listed below. See claim details beginning on the reverse side or check your claims online at **<www.horizonblue.com/merck>.**

CLAIM NUMBER	PATIENT	PROVIDER	AMOUNT HORIZON PAID	SUBSCRIBER RESPONSIBILITY
780262102619436 00	SENTHIL K MURUGAN	BERGER AND HENRY	0.00	336.49
780272103310519 00	SENTHIL K MURUGAN	BERGER AND HENRY	0.00	127.59
780262101928216 00	RIYA SENTHIL	L CORBETT	0.00	109.00
780262103544402 00	RIYA SENTHIL	L CORBETT	0.00	218.00
			0.00 TOTAL	**791.08 TOTAL**

PAPERLESS EOBS ARE CONVENIENT, SECURE, A GREAT WAY TO HELP REDUCE THE VOLUME OF PRINTED MAIL AND GOOD FOR THE ENVIRONMENT. IT'S EASY TO SIGN UP. JUST GO TO MEMBER ONLINE SERVICES AT WWW.HORIZONBLUE.COM.

IF YOU SUSPECT HEALTH CARE FRAUD, PLEASE CALL OUR SPECIAL INVESTIGATIONS UNIT HOTLINE - 1-800-624-2048.

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MERCK DATE: 2/10/2021 SEQUENCE NUMBER
SUBSCRIBER ID: 3HZN39743510 527566754

NP-01N 005959

K250075C 026963 OSQ005959

SENTHIL K MURUGAN
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CHALFONT PA 18914-3900

THIS IS NOT A CHECK

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EXPLANATION OF BENEFITS

THIS IS NOT A BILL

MERCK

SUBSCRIBER NAME: SENTHIL K MURUGAN SUBSCRIBER ID: 3HZN39743510

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
SENTHIL K MURUGAN	SELF	780262102619436 00	000076091	550.00	0.00

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
1/21/21	BERGER AND HENRY ENT SPE DIAGNOSTIC SURGERY	350.00	245.04		245.04			0.00	P840	245.04
1/21/21	BERGER AND HENRY ENT SPE OFFICE/OUTPT VISIT	200.00	91.45		91.45			0.00	P840	91.45
	TOTAL:	**550.00**	**336.49**		**336.49**			**0.00**	**Z028 Y755 Z084a Y049a Y125a Y126a Y127a**	**336.49**

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
SENTHIL K MURUGAN	SELF	780272103310519 00	000076091	285.00	0.00

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
1/28/21	BERGER AND HENRY ENT SPE OFFICE/OUTPT VISIT	120.00	69.11		69.11			0.00	P840	69.11
1/28/21	BERGER AND HENRY ENT SPE DIAGNOSTIC PROCEDURES	75.00	20.88		20.88			0.00	P840	20.88
1/28/21	BERGER AND HENRY ENT SPE DIAGNOSTIC PROCEDURES	90.00	37.60		37.60			0.00	P840	37.60
	TOTAL:	**285.00**	**127.59**		**127.59**			**0.00**	**Z028 Y755 Z084b**	**127.59**

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SUBSCRIBER NAME: SENTHIL K MURUGAN SUBSCRIBER ID: 3HZN39743510

Y049b
Y125b
Y126b
Y127b

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
RIYA SENTHIL	DEPENDENT	780262101928216 00	000076091	120.00	0.00

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
1/17/21	L CORBETT THERAPEUTIC PROCEDURE	120.00	109.00		109.00			0.00		109.00
	TOTAL:	**120.00**	**109.00**		**109.00**			**0.00**	**Z028 Y755 Z084c Y049c Y125c Y126c Y127c**	**109.00**

SUMMARY INFORMATION

PATIENT NAME	RELATION	CLAIM NUMBER	GROUP NUMBER	TOTAL CHARGE	HORIZON PAID
RIYA SENTHIL	DEPENDENT	780262103544402 00	000076091	240.00	0.00

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	BILLED AMT	ALLOWED AMT	YOUR COINS/COPAY AMT	YOUR DEDUCTIBLE AMT	OTHER CARRIER PAYMENT AMT	NOT COV AMT	HORIZON PAID AMT	MESSAGE CODE	SUBSCRIBER RESPONSIBILITY
1/23/21	L CORBETT THERAPEUTIC PROCEDURE	120.00	109.00		109.00			0.00		109.00
1/30/21	L CORBETT THERAPEUTIC PROCEDURE	120.00	109.00		109.00			0.00		109.00
	TOTAL:	**240.00**	**218.00**		**218.00**			**0.00**	**Z028 Y755 Z084d Y049d Y125d**	**218.00**

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EXPLANATION OF BENEFITS

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SUBSCRIBER NAME: SENTHIL K MURUGAN

SUBSCRIBER ID: 3HZN39743510

Y126d
Y127d

MESSAGE CODE EXPLANATION

Z028	IF YOU ARE COVERED BY MORE THAN ONE HEALTH PLAN, YOU OR YOUR PROVIDER SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN. YOU SHOULD ALSO GIVE EACH PLAN INFORMATION REGARDING THE OTHER PLANS UNDER WHICH YOU ARE COVERED.
Y755	HORIZON PROVIDES ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.
Z084a	YOUR TOTAL COST SHARE FOR THIS CLAIM IS $336.49., THIS INCLUDES ANY APPLICABLE DEDUCTIBLES, COINSURANCE, COPAYMENTS AND ANY OTHER AMOUNTS NOT COVERED BY YOUR HEALTH PLAN, INCLUDING ANY AMOUNT PAID BY ANOTHER CARRIER. PLEASE DO NOT SEND THIS AMOUNT TO HORIZON BCBSNJ. YOU MAY RECEIVE A BILL FROM YOUR HEALTH CARE PROFESSIONAL OR FACILITY IF YOU HAVE NOT YET PAID THIS AMOUNT.
Y049a	YOUR HEALTH PLAN HAS AN ANNUAL IN-NETWORK INDIVIDUAL OUT-OF-POCKET MAXIMUM OF $4500.00. YOU HAVE SATISFIED $336.49 OF THIS AMOUNT FOR 2021.
Y125a	YOU HAVE SATISFIED $445.49 OF YOUR $9000.00 ANNUAL IN-NETWORK FAMILY OUT-OF-POCKET MAXIMUM FOR 2021.
Y126a	YOU HAVE SATISFIED $336.49 OF YOUR ANNUAL IN-NETWORK INDIVIDUAL DEDUCTIBLE FOR 2021.
Y127a	YOU HAVE SATISFIED $445.49 OF YOUR ANNUAL IN-NETWORK FAMILY DEDUCTIBLE FOR 2021.
P840	PAYMENT FOR THIS SERVICE MAY HAVE BEEN REDUCED. THE SERVICE WAS DONE BY A NETWORK PROVIDER. THIS MEANS THE PROVIDER HAS AGREED TO ACCEPT THE CONTRACTED AMOUNT, LESS ANY PRICING CHANGES DUE TO MODIFIER(S) THAT MAY HAVE BEEN SUBMITTED ON THE CLAIM, AS PAYMENT IN FULL.
Z084b	YOUR TOTAL COST SHARE FOR THIS CLAIM IS $127.59. THIS INCLUDES ANY APPLICABLE DEDUCTIBLES, COINSURANCE, COPAYMENTS AND ANY OTHER AMOUNTS NOT COVERED BY YOUR HEALTH PLAN, INCLUDING ANY AMOUNT PAID BY ANOTHER CARRIER. PLEASE DO NOT SEND THIS AMOUNT TO HORIZON BCBSNJ. YOU MAY RECEIVE A BILL FROM YOUR HEALTH CARE PROFESSIONAL OR FACILITY IF YOU HAVE NOT YET PAID THIS AMOUNT.
Y049b	YOUR HEALTH PLAN HAS AN ANNUAL IN-NETWORK INDIVIDUAL OUT-OF-POCKET MAXIMUM OF $4500.00. YOU HAVE SATISFIED $464.08 OF THIS AMOUNT FOR 2021.
Y125b	YOU HAVE SATISFIED $573.08 OF YOUR $9000.00 ANNUAL IN-NETWORK FAMILY OUT-OF-POCKET MAXIMUM FOR 2021.
Y126b	YOU HAVE SATISFIED $464.08 OF YOUR ANNUAL IN-NETWORK INDIVIDUAL DEDUCTIBLE FOR 2021.
Y127b	YOU HAVE SATISFIED $573.08 OF YOUR ANNUAL IN-NETWORK FAMILY DEDUCTIBLE FOR 2021.
Z084c	YOUR TOTAL COST SHARE FOR THIS CLAIM IS $109.00. THIS INCLUDES ANY APPLICABLE DEDUCTIBLES, COINSURANCE, COPAYMENTS AND ANY OTHER AMOUNTS NOT COVERED BY YOUR HEALTH PLAN, INCLUDING ANY AMOUNT PAID BY ANOTHER CARRIER. PLEASE DO NOT SEND THIS AMOUNT TO HORIZON BCBSNJ. YOU MAY RECEIVE A BILL FROM YOUR HEALTH CARE PROFESSIONAL OR FACILITY IF YOU HAVE NOT YET PAID THIS AMOUNT.
Y049c	YOUR HEALTH PLAN HAS AN ANNUAL IN-NETWORK INDIVIDUAL OUT-OF-POCKET MAXIMUM OF $4500.00. YOU HAVE SATISFIED $109.00 OF THIS AMOUNT FOR 2021.