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

MERCK

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

PO BOX 18
NEWARK, NJ 07101-0018

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 NAME	PROVIDER	AMOUNT BILLED	YOUR PLAN PAID	WHAT YOU OWE
780272232000014 00	RIYA SENTHIL	RAHUL VASIREDDY	200.00	152.09	38.02
			200.00 Total	**152.09 Total**	**38.02 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.

THERE MAY BE SOME DIFFERENCES BETWEEN THE WAY INFORMATION IS PRESENTED HERE COMPARED TO THE PRINTED VERSION YOU WOULD RECEIVE IN THE MAIL. THIS DOES NOT AFFECT THE WAY YOUR CLAIM(S) WERE PROCESSED OR PAID.

MERCK

DATE: 11/19/2022
SUBSCRIBER ID: 3HZN39743510
SEQUENCE NUMBER 0624317742

PO BOX 18
NEWARK, NJ 07101-0018

SENTHIL K MURUGAN
110 GALWAY CIR
CHALFONT PA 18914-3900

THIS IS NOT A CHECK

PO BOX 18
NEWARK, NJ 07101-0018

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

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

MERCK

SUBSCRIBER NAME: SENTHIL K MURUGAN SUBSCRIBER ID: 3HZN39743510

SUMMARY INFORMATION

CLAIM NUMBER	PATIENT NAME	RELATION	GROUP NUMBER	AMOUNT BILLED	YOUR PLAN PAID	WHAT YOU OWE
780272232000014 00	RIYA SENTHIL	DEPENDENT	000076091	200.00	152.09	38.02

DETAIL INFORMATION

DATE OF SERVICE	PROVIDER TYPE OF SERVICE	AMOUNT BILLED	ALLOWED AMOUNT	YOUR PLAN PAID	YOUR OTHER INSURANCE PAID	COPAY	COINSURANCE	DEDUCTIBLE	AMOUNT NOT COVERED	WHAT YOU OWE	CLAIM DETAIL
11/08/2022	RAHUL VASIREDDY OUTPATIENT/OFFICE VIS	130.00	120.81	96.65			24.16			24.16	
11/08/2022	RAHUL VASIREDDY THERAPEUTIC PROCEDURE	70.00	69.30	55.44			13.86			13.86	
	TOTAL	**200.00**	**190.11**	**152.09**			**38.02**			**38.02**	**Y755 Z028 Z084a Y049a Y125a Y126a Y127a**

Y127a YOU HAVE SATISFIED $1000.00 OF YOUR ANNUAL IN-NETWORK FAMILY DEDUCTIBLE FOR 2022.

Y125a YOU HAVE SATISFIED $1331.86 OF YOUR $9000.00 ANNUAL IN-NETWORK FAMILY OUT-OF-POCKET MAXIMUM FOR 2022.

Z084a YOUR TOTAL COST SHARE FOR THIS CLAIM IS $38.02. 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.

Z028 DO YOU HAVE OTHER HEALTH INSURANCE IF YES, YOU OR YOUR PROVIDER SHOULD SUBMIT THE CLAIM AND SHARE PLAN INFORMATION WITH ALL OF YOUR INSURANCE CARRIERS.

Y049a YOUR HEALTH PLAN HAS AN ANNUAL IN-NETWORK INDIVIDUAL OUT-OF-POCKET MAXIMUM OF $4500.00. YOU HAVE SATISFIED $658.08 OF THIS AMOUNT FOR 2022.

Y755 HORIZON PROVIDES ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

Y126a YOU HAVE SATISFIED $500.00 OF YOUR ANNUAL IN-NETWORK INDIVIDUAL DEDUCTIBLE FOR 2022.

PAYMENT HAS BEEN MADE TO PROVIDER OF SERVICES.

IF YOU SUSPECT HEALTH CARE FRAUD, PLEASE CALL THE SPECIAL INVESTIGATIONS FRAUD HOTLINE AT 1-800-624-2048.
PLEASE NOTE: MEMBER SERVICE ISSUES ARE NOT HANDLED VIA OUR FRAUD HOTLINE.

Three Penn Plaza East
Newark, NJ 07105-2200
www.HorizonBlue.com

IMPORTANT INFORMATION ABOUT THIS EXPLANATION OF BENEFITS (EOB) NOTICE AND YOUR APPEAL RIGHTS

What if I need help understanding this EOB notice?
Contact us at **1-877-663-7258** if you need help understanding this EOB or our decision to deny you services or coverage (in whole or in part).

What if I do not 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).

If your claim was denied for lack of medical necessity or the service is considered to be experimental or investigational, refer to the definitions found in your plan documents for further clarification.

Who may file an appeal?
As our member, you, your duly authorized representative, physician or other health care professional acting on your behalf and with your consent, have the right to request an appeal.

How do I file an appeal?
If you wish to file an appeal, your request should be made in writing and include the following:

- Name and address of patient and member.
- Member ID number.
- Provider of service.
- Date(s) of service.
- Claim number(s).
- Reason for appeal.

Your appeal must be filed within 180 days of your receipt of this EOB.

No member who pursues a right of appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ.

Your appeals should be sent to one of the following addresses:

For general health claims:
Merck Dedicated Service Team
Horizon BCBSNJ
Attn: Appeals Coordinator
P.O. Box 18
Newark, NJ 07101-0018

For mental health, alcohol/substance use disorder claims:
Horizon BCBSNJ
Horizon Behavioral Health
Attention: Complaints and Appeals
PO Box 10191
Newark NJ 07101-3189

Can I provide additional information about my claim?
You may submit any documents, records or any other information that you would like to have considered to support your appeal request. We will also consider all previous documentation that applies to your appeal.

Can I request copies of information relevant to my claim?
You have a right to request copies (free of charge) of all information that was used in determining your claim for benefits.

You are also entitled to receive a copy of any rule, guideline, protocol, exclusion or contract limitation, or an explanation of any clinical and/or scientific judgment that was relied upon in our decision-making process. This information can be provided to you free of charge by contacting the toll-free number listed above.

If you think a coding error may have caused your claim to be denied, you have a right to have the diagnosis and treatment codes used in the bill for services sent to you. You can request those codes by calling the toll-free number listed above.

(over please)

What happens next?
Once we have received your appeal request, you will be notified of our determination within 30 days of our receipt of your request if your claim is for an item or service that your plan requires our approval in advance in order to receive benefits, or within 60 days in all other cases.

What if our decision is not favorable to you?
You will be advised of what further appeal rights you may have and how to file for further review.

Do you have further appeal rights if your case involves medical judgment?
You may have the right to an external review of your claim by an independent third party who will review the denial and issue a final, binding decision. If it applies to your case, you will be notified of this right during and following the completion of the internal appeals process.

Do you have other rights under the federal law known as ERISA?
You have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) of 1974 if you are still not satisfied after exhausting the internal appeal process.

Are there other resources available to you?
Members with group health plan coverage may also contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

Notice of Nondiscrimination

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583) (TTY 711) or the phone number on the back of your member ID card,** if you need the free aids and services noted above and for **all other Member Services issues.**

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. **Horizon BCBSNJ's Civil Rights Coordinator** can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address: **Horizon BCBSNJ**
Civil Rights Coordinator
PO Box 820, Newark, NJ 07101.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697** (TDD). OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación.
如果您讲英语以外的语言，可获取免费帮助。请拨打您的身份证背面的号码。
영어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.
Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade.
જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હોવ, તો મફતમાં મદદ ઉપલબ્ધ છે. તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર પર કૉલ.
Jeśli mówisz w języku innym niż angielski, pomoc udzielana jest bezpłatnie. Zadzwoń pod numer podany na odwrocie dowodu osobistego.
Se parli una lingua diversa dall'inglese, è disponibile un servizio di assistenza gratuito. Chiama il numero sul retro della tua carta d'identificaz ione.
Kung nagsasalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.
Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне вашей ID-карты.
Si ou pale on lòt lang ke Anglè, gen èd ki disponib gratis. Rele nan nimewo ki ekri nan do kat idantifyan w lan.
यदि आप अंग्रेज़ी से भिन्न कोई अन्य भाषा बोलते हैं, तो निःशुल्क सहायता उपलब्ध है। अपने आईडी कार्ड के पीछे दिए गए नंबर पर .
Nếu bạn nói ngôn ngữ khác ngoài tiếng Anh, thì chúng tôi có thể giúp bạn miễn phí. Hãy gọi số ở mặt sau thẻ ID của bạn.
Si vous parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.
إذا كنت تتحدث لغة أخرى غير الإنجليزية، نوفر لك المساعدة مجانًا. يُمكنك الاتصال بالرقم الموجود على ظهر بطاقة الهوية
اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بول سکتے ہیں تو مفت مدد دستیاب ہے۔ براہ مہربانی شناختی کارڈ کی پچھلی طرف درج شدہ نمبر پر کال کریں۔