THIS IS NOT A BILL

FLORIDA
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Blue Cross and Blue Shield Association

Summary Claim Report

EXPLANATION OF BENEFITS

Plan Holder: LAKSHMI MOUNIKA CHERUKURI
(ID # PXN100010313288)
Benefit Plan Year: 01/01/2022 - 01/01/2023
Statement Period: 06/09/2022 - 06/29/2022
Notice Date: 06/30/2022

0029223

Publix Group Health Plan
Columbia Service Center
P.O. Box 100121
Columbia, SC 29202-3121

LAKSHMI MOUNIKA CHERUKURI
3860 GOLF VILLAGE LOOP
APT 3
LAKELAND, FL 33809

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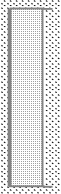
PAYMENTS SUMMARY

	Statement Period 06/09/2022 - 06/29/2022
Your health care providers' charges	$1,783.00
Amount **you saved**	$1,081.44
Total amount **your plan paid**	$352.05
AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)	**$349.51**

IN-NETWORK BENEFITS AT-A-GLANCE

Deductible

$ 500.00 Maximum



$500.00 Applied

Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.

Out-of-Pocket

$3,500.00 Maximum

$2,911.99 Remaining

$588.01 Applied

The most you could pay during a benefit plan year for your share of the cost of covered services.

WE'RE HERE!

Write: Publix Member Services
P. O. Box 100121
Columbia, SC 29202-3121

Web: Log on to **www.MyPublixHealthPlan.com**
Toll-free: 866-782-5495 (Monday - Friday, 8:00 a.m. - 8:00 p.m. EST)

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OUT-OF-NETWORK BENEFITS AT-A-GLANCE

	Deductible			***Out-of-Pocket***		
	Maximum	Applied	Remaining	Maximum	Applied	Remaining
LAKSHMI MOU CHERUKURI	$1,000.00	$0.00	$1,000.00	$7,000.00	$0.00	$7,000.00

Deductible Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.
Out-of-Pocket The most you could pay during a benefit plan year for your share of the cost of covered services.

Protect your back

Use proper lifting techniques to prevent back injuries. Lift with your legs and keep your feet shoulder-width apart.

Avoid back problems

Poor posture can cause many health problems, such as neck, shoulder and back pain; poor balance; and greater risk of falls.

Sit up straight

Maintain a good posture by sitting up straight with both feet flat on the floor. Stand up straight and tall.

GETTING THE MOST FROM YOUR PLAN

Network Providers Save You Money
Your health plan pays a higher percentage when you use in-network providers. You can easily locate in-network providers by using the Doctor/Hospital Finder.

Order ID Cards Online
Lost your ID card? Need one for your student going to college? It is simple to order it online. Just visit My Health Toolkit(R).

Other Insurance
Do you or any family members have other medical insurance? You can update your information today by visiting My Health Toolkit(R).

Value You'll Find Online
Visit www.MyPublixHealthPlan.com to check claim status, verify benefits, order ID cards and much more.

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MEDICAL CLAIMS for patient LAKSHMI MOUNIKA CHERUKURI

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Provider and Service Information		*Charges and Insurance Payments*			*Breakdown of Member Responsibility*				
Claim Number Provider Group	**Service Type** Date of Service(s) Provider Name Network	**Provider Charges**	**Covered Expense**	**Your Plan Paid**	**Copay**	**Deductible**	**Coinsurance**	**Not Covered**	**Amount You May Owe or Have Paid**
21780G8QN0000 OSPREY EMERGENCY PHY	**ER VISIT(S)** 03/08/2022 OSPREY EMERGENCY PHYS In-Network	1,783.00	701.56	352.05	0.00	261.50	88.01	0.00	349.51
Statement Period Total		**1,783.00**	**701.56**	**352.05**	**0.00**	**261.50**	**88.01**	**0.00**	**349.51**

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WHAT WE MEAN BY . . .

Coinsurance: The percentage of the allowed amount you pay as your share of the bill. If your plan pays 80 percent, the remaining 20 percent would be your coinsurance.

Copayment: A set fee you pay each time you receive a certain service. Some plans or services do not have copayments.

Covered Expense: This represents the maximum amount your health plan has agreed to pay for a given procedure or service. It is generally based on the contract between your Blue Plan and in-network providers. For out-of-network providers it is generally based on fee schedules set by Medicare.

Deductible: The amount, if any, you are responsible for paying each benefit plan year before your plan begins to pay. You do not send this amount to us. You must pay this amount to your provider.

HRA Paid: The amount paid to your provider from your Health Reimbursement Account or Health Incentive Account.

HSA Paid: The amount paid to your provider from your Health Savings Account.

In-Network: Indicates the provider of services participates in your plan's network.

Less Benefit Limitation: The amount that exceeds the amount allowed under your plan for this service.

Out-of-Network: Indicates the provider of services does not participate in your plan's network.

Out-of-Pocket: Is the most you could pay during a benefit plan year for your share of the cost covered services depending on your plan.

ADDITIONAL COMMENTS

DID YOU KNOW YOU CAN VIEW YOUR EOBS ONLINE? YOU CAN ALSO CHOOSE NOT TO RECEIVE SUMMARY EOBS IN THE MAIL. LOG IN TO MY HEALTH TOOLKIT AT THE WEB ADDRESS AS SHOWN ON THE FIRST PAGE OF YOUR EOB TO CHANGE YOUR MAIL OPTIONS, VIEW EOBS AND MUCH MORE.

WE PROVIDE ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND DO NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS.

IF YOU NEED INFORMATION REGARDING THE SPECIFIC TREATMENT AND/OR DIAGNOSIS CODES FILED ON THE CLAIM(S) IN THIS NOTICE, PLEASE CALL THE CUSTOMER SERVICE NUMBER SHOWN ON THE FIRST PAGE OF THIS NOTICE.

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Suspect claims fraud? Please help by calling our hotline at 800-763-0703

IMPORTANT INFORMATION ABOUT YOUR APPEALS RIGHTS

What if I need help understanding this denial?
Call us at the Customer Service numbers shown on the first page of your explanation of benefits notice if you need help understanding this notice or our decision to deny a service or coverage.

What if I don't agree with this decision?
You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal?
Submit a written request for appeal within 180 days from the date of this notice. Be sure to include the following information and anything else you think we should know:

- Name and ID number
- Patient name
- Claim number
- Name of person filing appeal
- Whether the person filing the appeal is the covered person, patient, or authorized representative.

Mail your written request for appeal with the above information to:

Columbia Service Center
P.O. Box 100121
Columbia, SC 29202-3121

What if my situation is urgent?
If your situation meets the definition of urgent under the law, we will conduct your review on an expedited, or faster, basis. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal when you contact us.

Who may file an appeal?
You or someone you name to act on your behalf may file an appeal. In order for someone to appeal on your behalf, you must appoint that person in writing. For your convenience, we have created a form that you may use, called "Designation of Authorized Representative to Appeal". This form can be obtained by visiting our website or by calling us at the Customer Service numbers shown on the explanation of benefits.

Can I provide additional information about my claim?
Yes.

Can I request copies of information relevant to my claim?
Yes, you may request copies (free of charge) by contacting us at the Customer Service numbers shown on the explanation of benefits notice, or at the appeals address listed on this form.

What happens next?
If you appeal, we will review our decision and give you our answer in writing. If we still deny the payment, coverage or service requested or you do not receive a timely decision, you may be able to ask for an external review of your claim. In this case, an independent third party will review the denial and make a final decision.

Other resources to help you:
For questions about your appeal rights or this notice, or for more help, you can call the Employee Benefits Security Administration at 1-866-444-EBSA(3272). You may also receive help through an applicable state consumer assistance program. Contact information by state is available at:
www.stateconsumerassistance.com.

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Para obtener asistencia en español, llame al número de atención al cliente que aparece en la primera página de esta notificación.

Upang makakuha ng tulong sa Tagalog, tawagan ang numero ng customer service na makikita sa unang pahina ng paunawang ito.

T'áá Dinéjí shił hane'go shíká i'doolwoł nínízingo éí Nidaalnishígíí Áká Anídaalwo'ígíí, customer service, bich'į' hodíilnih. Bik'ehgo bich'į' hane'ígíí éí díí naaltsoos neiyí'nilígíí akáa'gi siłtsoozígíí bikáá' íishją́ąh.

如需中文服务，请致电列于本通知首页的客户服务号码。

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Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

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Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

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Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳 とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'ą́hóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)