BlueCross BlueShield of Illinois
PO Box 7344
Chicago, IL 60680-7344

# EXPLANATION OF BENEFITS

Log into **Blue Access for Members**℠ at **bcbsil.com**
- View plan and claim details
- Contact us through our secure Message Center
- Sign up for digital health plan info
- Search for health care providers

Text* **BCBSILAPP** to **33633** to download the mobile app.

Have questions about this EOB? Customer Advocates are here to help! **1-800-734-8254**

**AAKASH RASTOGI**
**1509 EAST SOUTHERN AVENUE**
**TEMPE, AZ 85282-5608**

## SUBSCRIBER INFORMATION

**MCDONALD'S CORPORATION**
Member ID#: **XXXXXXXX2329** Group #: **000021531**

**Dear AAKASH RASTOGI,**

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

## HELPFUL INFORMATION

**Health Care Fraud Hotline: 800-543-0867**
Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Illinois, please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to **bcbsil.com.**

### GLOSSARY OF TERMS - **We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.**

**Amount Billed:** The amount your provider billed for the service(s) rendered.

**Amount Covered (Allowed):** Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

**Coinsurance:** The percentage of the allowed amount you pay as your share of the bill. For example, if your plan pays 80% of the allowed amount, 20% would be your coinsurance.

**Copay Amount (Also known as Copayment):** The set fee you pay each time you receive a certain service. Some plans do not have copayments.

**Deductible:** The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

**Non-Participating Provider:** An out-of-network provider who does not accept rates for services we set to keep your costs down.

**Out-of-Pocket Limit (Maximum):** Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

**Participating Provider:** An in-network or out-of-network provider who accepts agreed-upon rates for services.

**Your Total Costs:** This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this.

BlueCross BlueShield of Illinois

## CLAIM DETAIL (1 of 1)

**PATIENT:** AAKASH RASTOGI
**PROVIDER:** MINUTECLINIC LLC
**CLAIM #:** 22915551E680H **DATE PROCESSED:** 10/18/2022

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Member ID#:**XXXXXXXX2329** Group #: **000021531**
Customer Advocates are here to help! **1-800-734-8254**

| | |
|---|---|
| Amount Billed | $139.00 |
| Discounts and Reductions | **-** $74.31 |
| Health Plan Responsibility | - $0.00 |
| Paid from your HCA account | - $64.69 |
| **You may owe your health care provider for these services** | **$0.00** |

| | | | YOUR BENEFITS APPLIED | | | YOUR RESPONSIBILITY | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Service Description** | **Service Dates** | Amount Billed | Discounts and Reductions | Amount Covered (Allowed) | Health Plan Responsibility | Deductible Amount | Copay Amount | Coinsurance | Amount Not Covered | **Your Total Costs** |
| Medical Visits | 07/17/2022 | 139.00 | (1) 74.31 | 64.69 | | 64.69 | | | | 64.69 |
| Performance Measures | 07/17/2022 | 0.00 | | | | | | | | 0.00 |
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| Performance Measures | 07/17/2022 | 0.00 | | | | | | | | 0.00 |
| Performance Measures | 07/17/2022 | 0.00 | | | | | | | | 0.00 |
| **CLAIM TOTALS** | | **$139.00** | **$74.31** | **$64.69** | **$0.00** | **$64.69** | **$0.00** | **$0.00** | **$0.00** | **$64.69** |

**Total covered benefits approved for this claim: $64.69 to MINUTECLINIC LLC on 10-18-22.**

**Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"**

(1) The amount billed is more than what is allowed for this service. Your provider should not bill you for any balance over what is allowed.

**For your up-to-date Medical Spending summary, visit Blue Access for Members℠ on our website, the BCBSIL Mobile App or call the phone number on the back of your ID card.**

AAKASH RASTOGI - Benefit Period: 01-01-22 Through 12-31-22 To date this patient has met $370.49 of her/his $1,000.00 Health Care Plan Deductible. To date, $449.78 of this patient's $4,000.00 Out-of-pocket Expense has been met.

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**IMPORTANT INFORMATION (Retain for your records)**

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

| **Your Right to Appeal** |
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| You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.<br>Send a written appeal request to: Blue Cross and Blue Shield of Illinois<br>Claim Review Section<br>PO Box 2401<br>Chicago, IL 60690 |
| To file an appeal or if you have questions, please call 800-458-6024 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members℠ (BAM℠) at bcbsil.com |

| **Authorized Representative** |
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| You can name a person to act for you (including an attorney) on your appeal or external review – known as an "authorized representative." To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form. |

| **Standard Appeal** | |
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| You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:<br>• A copy of the decision letter or Explanation of Benefits (EOB)<br>• The reference number or claim number (often found on the decision letter or EOB)<br>You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your appeal. | |
| **What happens next?** | We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days. |

| **Expedited (Urgent) Appeal** | |
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| You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at 800-458-6024 (TTY/TDD: 711) or fax your request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling 800-458-6024. | |
| **What happens next?** | If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request. |

## Your Right to a Standard External (Outside) Review

You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (see your Benefit Booklet for details)

If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.

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| **What happens next?** | If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you. |

## Expedited (Urgent) External Review

You can ask for this type of review if:

- failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
- the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
- the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
- we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call 800-458-6024.

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| **What happens next?** | If you qualify for this type of review, the IRO will give you a decision within 72 hours. |

## Notice about Provider Appeals

If you used an in-network provider, your provider may be able to file an appeal request for benefits you've been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

## Additional Rights

If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).

**Department of Insurance**

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below.

IDOI
320 W. Washington St.
Springfield, Illinois 62767-0001

Review Request: 877-850-4740
Fax: 217-577-8495

IDOI, Office of Consumer Health Insurance
122 S. Michigan Ave .,19th Floor
Chicago, Illinois 60603

Complaints: 877-527-9431
Email: DOI.InfoDesk@illinois.gov

IDOI Web: https://mc.insurance.illinois.gov

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

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| Español<br>Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984. |
| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文<br>Chinese | 如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。 |
| Français<br>French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984. |
| Deutsch<br>German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।. |
| Italiano<br>Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984. |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984. |
| فارسی<br>Persian | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید. |
| Polski<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский<br>Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Tagalog<br>Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |