United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800

UnitedHealthcare

Have more questions about your claim?
Visit **www.myuhc.com**
for all your claim and benefit information.

June 07, 2022

Member Name and Address

Member/Patient Information

Member/Patient:
Member ID:
Relationship:
Group Name:
Group #:

Explanation of Benefits Statement

This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary

Detailed claim information is located on the following page(s).

Dollar Amount	Description
$22,200.00	**Amount Billed** The amount your provider charged for services provided to you.
$13,369.75	**Amount You Do Not Owe** You do not owe this amount because either (1) you chose a network provider that gives us a standing discount, (2) you chose an out-of-network provider that agreed to an amount less than billed, or (3) it is a surprise bill and the law protects you from having to pay it.
$8,830.25	**Your Plan Paid** The money your health benefit plan paid.
$0.00	**Total amount you owe the provider(s)** The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance and/or non covered charges. This amount does not include any payments made to the subscriber*. If a payment was made directly to the subscriber, you/the subscriber is responsible for paying the physician, facility or other health care professional. * When coordination of benefits applies, this amount will include payments made to the subscriber.

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Claim Detail for Patient Name

Provider:
Provider Status:

Claim Number:

Patient Account Number: AIR AMBULANCE

Date(s) of Service	Type of Service	Notes*	Amount Billed	Amount Not Owed	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
09/02/2021	AMBULANCE	CI	$22,200.00	$13,369.75	$8,830.25	$8,830.25	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$22,200.00**	**$13,369.75**	**$8,830.25**	**$8,830.25**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

**This total does not reflect any payments / copays you made at the time of service or purchase.
Please wait for a provider bill before making a payment.

This claim has been identified as a surprise bill. Additional information is at the end of this statement.

Notes*

Please note that appeal deadlines have been extended until further notice due to COVID-19. You should consult with your employer and visit the US Department of Labor website at dol.gov for more information and additional notices about the deadline extensions and how they may apply to you.

CI - THIS SERVICE WAS RECEIVED FROM AN OUT-OF-NETWORK PROVIDER AND THE CLAIM WAS PROCESSED PER APPLICABLE LAW USING NETWORK BENEFITS. PROVIDER: YOU CANNOT BILL THE PATIENT ABOVE THE AMOUNT OF COPAY, COINSURANCE, AND/OR DEDUCTIBLE. IF YOU DISAGREE WITH THE REIMBURSEMENT, YOU MAY CHOOSE TO ENTER INTO NEGOTIATION BY CONTACTING US AT 877-842-3210 OR SUBMITTING TO OUR ONLINE PROVIDER PORTAL HTTPS://WWW.UHCPROVIDER.COM/.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432, Salt Lake City, UT 84130-0432. The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review.

If your plan is governed by ERISA, you may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

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You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Availability of Consumer Assistance/Ombudsman Services:
There may be other resources available to help you understand the appeals process. If your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). If your plan is not governed by ERISA, you can contact the Department of Health and Human Services Health Insurance Assistance Team at 1-888-393-2789.Your state consumer assistance program may also be able to assist you at:
The Office of the Insurance Ombudsman
NJ Department of Banking and Insurance
20 West State Street
PO Box 472
Trenton NJ 08625-0472
1-800-446-7467
FAX: 609-292-2431
E-mail: ombudsman@dobi.nj.gov

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-888-697-8323.

Rather view this online?

Sign up for **myuhc.com** or download the UnitedHealthcare app to easily view claims and account balances, see where you're at against your deductible, locate a network doctor, view your health plan ID card and more. You can also skip the clutter by selecting paperless delivery of your important plan documents.

Maintaining the privacy and security of individuals' personal information is very important to us at UnitedHealthcare. To protect your privacy, we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier. You may see the unique individual identifier on UnitedHealthcare correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBs), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer care professional at the number shown at the top of this Statement.

Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

Para obtener asistencia en español, llame al número de teléfono que se incluye en este documento o al dorso de su tarjeta de identificación.

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We do not treat members differently because of sex, age, race, color, disability or national origin. If you think you weren't treated fairly you can send a complaint to: Civil Rights Coordinator, United HealthCare Civil Rights Grievance, P.O. Box 30608, Salt Lake City, UTAH 84130, UHC_Civil_Rights@uhc.com. You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free member number listed on your health plan ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

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Account Summary

Summary of Deductible and Out of Pocket

Plan Year: 2021

Patient Name
Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$750.00	$0.00	$750.00
Out of Pocket	$3,000.00	$3,000.00	Met
OUT OF NETWORK			
Deductible	$2,000.00	$2,000.00	Met
Out of Pocket	$6,000.00	$6,000.00	Met

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$1,500.00	$0.00	$1,500.00
Out of Pocket	$6,000.00	$3,000.00	$3,000.00
OUT OF NETWORK			
Deductible	$4,000.00	$2,000.00	$2,000.00
Out of Pocket	$12,000.00	$6,583.72	$5,416.28

Definitions of Key Terms

Amount Allowed: Maximum amount on which benefits are based for covered services.

Amount Billed: The amount your provider charged for services provided to you.

Amount You Owe: The amount of money you pay for the services you receive.

Applied to Date: The total amount applied to your deductible or out of pocket maximum on the date the claim(s) was processed.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service or fill a prescription.

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services. You generally pay less if you see a network provider.

Non-Covered: A service or expense that you do not have coverage for under your health benefit plan.

Out of Network: The facilities, providers and suppliers who do not have a contract with your health plan to provide health care services. You generally pay more if you see an out-of-network provider.

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Definitions of Key Terms

Out of Pocket: The most money you have to pay for covered expenses in a plan year or policy period.

Plan Year: The time period the benefit maximums apply.

Amount Not Owed: You do not owe this amount because either (1) you chose a network provider that gives us a standing discount, (2) you chose an out-of-network provider that agreed to an amount less than billed, or (3) it is a surprise bill and the law protects you from having to pay it.

Your Plan Paid: The money your health benefit plan paid.

How you re protected from surprise medical bills
Frequently asked questions about the No Surprises Act

Sometimes, where you get health care--or who provides it--is out of your control. Like when you need emergency care or when an out-of-network provider is involved in your care without your choice. When this happens, the No Surprises Act may protect you from paying more than your copayment, coinsurance or deductible.

Q: What is a surprise bill?
A: When you receive health care services, you may owe certain out-of-pocket costs, like a copayment, coinsurance or deductible. If an out-of-network provider is involved in your care, you may owe these costs *and* face additional costs--or even the entire bill.

This is called a surprise bill--and it can happen when out-of-network providers bill you for more than your health plan determines it and you (through your copayment, coinsurance or deductible) should pay. While out-of-network providers sometimes bill you for the difference, network providers do not.

Q: What is an out-of-network provider?
A: An out-of-network provider has not signed a contract with your plan. Out-of-network providers service rates are likely higher and may not count toward your deductible or out-of-pocket limit. That s why it s best to visit network providers whenever possible. Find them anytime on your member website or your member mobile app.

Q: When am I now protected from surprise bills?
A: You re protected from surprise bills when you receive:

- Out-of-network emergency services, including air ambulance (but not ground ambulance)
- Out-of-network nonemergency ancillary services* provided at a network facility
- Nonemergency nonancillary services provided at a network facility, and the out-of-network provider did not get your prior consent as the No Surprises Act requires

For the above services, your plan must ensure your copayment, coinsurance or deductible:

- Be the same as it would have been if the service was provided in your plan s network
- Be based on what your plan would pay a network provider
- Count toward your network deductible
- Count toward your out-of-pocket limit

Remember: Out-of-network providers may not ask you to give up your protections against surprise billing, and you are never required to do so.

Q: If I get a surprise bill in one of these situations, what should I do?
A: In these situations, you are only responsible to pay the copayment, coinsurance or deductible that would have been charged if you had seen a provider in your plan s network.

You should not get a surprise bill from an out-of-network provider. If you do, keep it for your records but do not pay it. Call the phone number on your health plan ID card or other member materials.

If you believe you ve been wrongly billed, please call 1-800-985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Q: What if I choose to see an out-of-network provider or visit an out-of-network facility outside of these situations?
A: Choosing to visit an out-of-network provider or facility under different circumstances means you may face paying the entire bill, because providers are generally not prohibited by law from sending you a surprise bill. That's why it's so important to stay in your network whenever possible.

Q: What if I have questions?
A: We're here for you. If you believe you've been wrongly billed, please call 1-800-985-3059.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

*Ancillary services include services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; certain diagnostic services (including radiology and laboratory services); items and services provided by other specialty practitioners; and items and services provided by an out-of-network provider if there is no network provider who can provide that service.