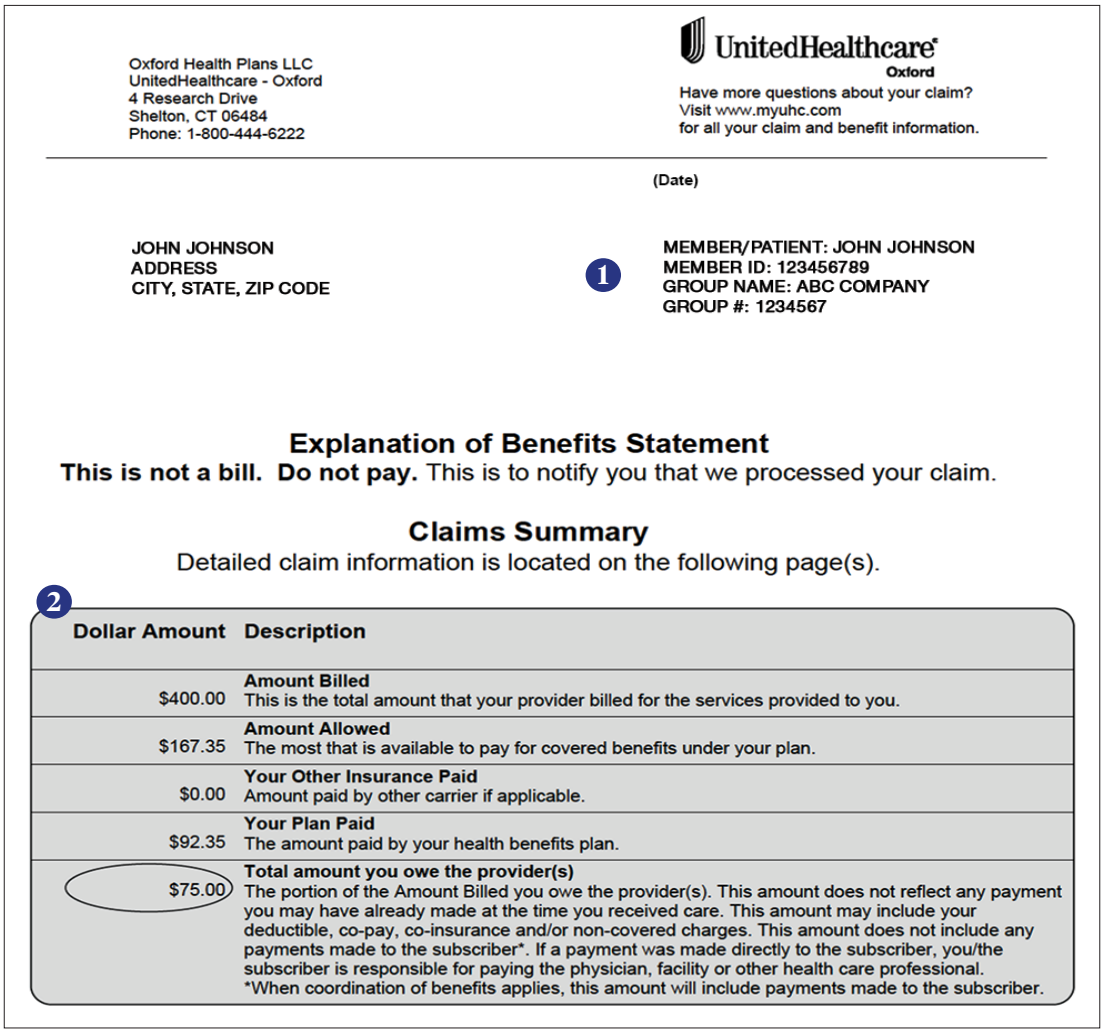
Understanding your Explanation of Benefits statement

An Explanation of Benefits (EOB) is a statement that describes what costs your plan will cover for medical care or products you've received. The EOB is generated when you or your provider submit a claim for the services you received. Use this guide to better understand details of your claim, including how much your plan covered, what you owe and your remaining out-of-pocket balances and more.



Oxford Health Plans LLC
UnitedHealthcare - Oxford
4 Research Drive
Shelton, CT 06484
Phone: 1-800-444-6222

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

(Date)

JOHN JOHNSON
ADDRESS
CITY, STATE, ZIP CODE

1
MEMBER/PATIENT: JOHN JOHNSON
MEMBER ID: 123456789
GROUP NAME: ABC COMPANY
GROUP #: 1234567

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).

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Dollar Amount	Description
$400.00	**Amount Billed** This is the total amount that your provider billed for the services provided to you.
$167.35	**Amount Allowed** The most that is available to pay for covered benefits under your plan.
$0.00	**Your Other Insurance Paid** Amount paid by other carrier if applicable.
$92.35	**Your Plan Paid** The amount paid by your health benefits plan.
$75.00	**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, co-pay, co-insurance 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.

Your EOB may look different depending on your plan

1 **Member/Patient information**
Member — The name of the individual with group health coverage through their employer or other plan sponsor. Patient — The name of the person who received the medical care.

2 **Claims Summary**
This section summarizes how much your plan paid, plan discounts, and how much you may owe your provider for all claims included in the EOB.

continued

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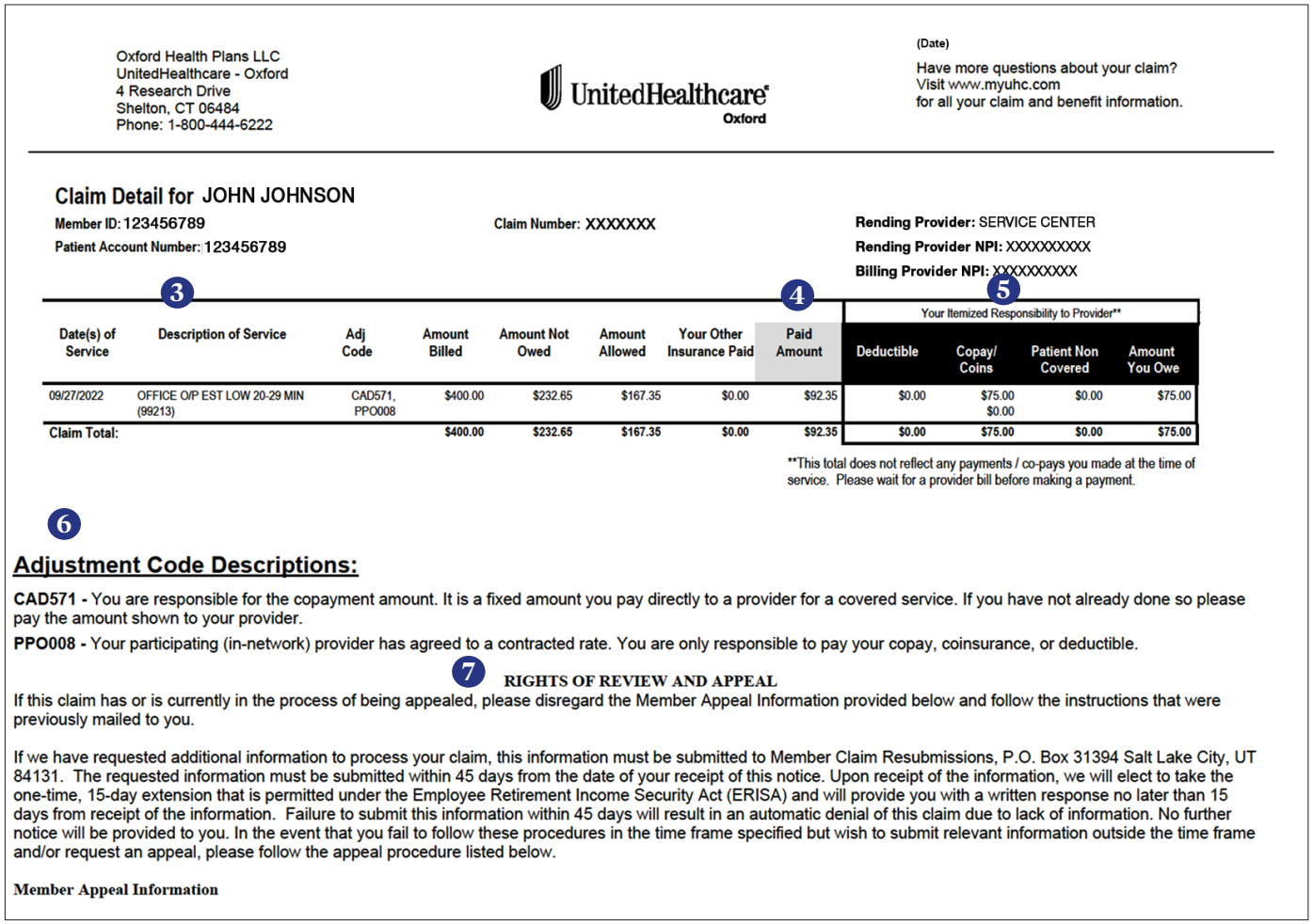
Claim Detail page



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Claim Detail for JOHN JOHNSON

Member ID: 123456789
Patient Account Number: 123456789
Claim Number: XXXXXXX
Rending Provider: SERVICE CENTER
Rending Provider NPI: XXXXXXXXXX
Billing Provider NPI: XXXXXXXXXX

Date(s) of Service	Description of Service	Adj Code	Amount Billed	Amount Not Owed	Amount Allowed	Your Other Insurance Paid	Paid Amount	Your Itemized Responsibility to Provider**			
								Deductible	Copay/ Coins	Patient Non Covered	Amount You Owe
09/27/2022	OFFICE O/P EST LOW 20-29 MIN (99213)	CAD571, PPO008	$400.00	$232.65	$167.35	$0.00	$92.35	$0.00	$75.00 $0.00	$0.00	$75.00
Claim Total:			**$400.00**	**$232.65**	**$167.35**	**$0.00**	**$92.35**	**$0.00**	**$75.00**	**$0.00**	**$75.00**

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

Adjustment Code Descriptions:

CAD571 - You are responsible for the copayment amount. It is a fixed amount you pay directly to a provider for a covered service. If you have not already done so please pay the amount shown to your provider.

PPO008 - Your participating (in-network) provider has agreed to a contracted rate. You are only responsible to pay your copay, coinsurance, or deductible.

RIGHTS OF REVIEW AND APPEAL

If this claim has or is currently in the process of being appealed, please disregard the Member Appeal Information provided below and follow the instructions that were previously mailed to you.

If we have requested additional information to process your claim, this information must be submitted to Member Claim Resubmissions, P.O. Box 31394 Salt Lake City, UT 84131. The requested information must be submitted within 45 days from the date of your receipt of this notice. Upon receipt of the information, we will elect to take the one-time, 15-day extension that is permitted under the Employee Retirement Income Security Act (ERISA) and will provide you with a written response no later than 15 days from receipt of the information. Failure to submit this information within 45 days will result in an automatic denial of this claim due to lack of information. No further notice will be provided to you. In the event that you fail to follow these procedures in the time frame specified but wish to submit relevant information outside the time frame and/or request an appeal, please follow the appeal procedure listed below.

Member Appeal Information

3 Description of Service
Description of care provided. Remark code text is listed below the service details box.

4 Your plan paid amount
The amount of benefits paid to you or the provider.

5 Deductible/Copay/Coinsurance/Non-covered
Itemized responsibility. This section shows the amount you owe to the provider.

6 Adjustment Code Description
This section explains why a claim or service line was paid differently than it was billed.

7 Rights of Review and Appeal
This section provides an explanation of the availability of your appeal rights if you disagree with or believe any information stated is incorrect.

continued

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The claimant has the right to request a review of an adverse benefit determination. Please review the Explanation of Benefits for details of our claim determination. If you think this decision was made in error, you or your authorized representative may request a review. Your request must be made within 180 days from the date you received this notice. Send your appeal in writing to: UNITEDHEALTHCARE SERVICES, INC., Appeals Review, P.O. Box 31393 Salt Lake City, UT 84131. You should include any new information that you want us to consider.

Within 30 days or less after receiving the appeal, the claimant or the claimant's authorized representative will be notified of the decision. If additional information is needed to make a determination, the claimant or claimant's authorized representative will be notified of what additional information is necessary, and the review will proceed upon receipt of the information. If the claimant or the claimant's authorized representative is not satisfied with the outcome of the first appeal, there may be an option of a second appeal.

If we continue to deny the payment, 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 issue a final decision.

For more information regarding available levels of appeals refer to the Summary Plan Description.

If the claimant is not satisfied with the outcome of the appeals, the claimant has the right to bring a civil action under section 502(a) of the Employment Retirements Security Act of 1974.
An internal rule, guideline, protocol, or other similar criterion was referenced in making this possible adverse benefit determination. A copy of the rule, guideline, protocol, or other similar criterion may be requested free of charge. If the line adverse benefit determination was based upon medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the determination, if not already indicated, may be requested free of charge. Please send the written request indicating the specific information being requested to: **Information Request P.O. Box 31394 Salt Lake City, UT 84131.**

There may be other resources available to help you understand the appeals process. You can contact the Employee Benefits Security Administration at 1-866-44-EBSA(3272).

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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) or www.askebsa.dol.gov. 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:

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
Telephone: 866-466-4446
Fax: 860-331-2499
Website: www.ct.gov/oha
E-mail: healthcare.advocate@ct.gov

If your claim is subject to the No Surprises Act, additional information about your rights will be available at the end of this statement.

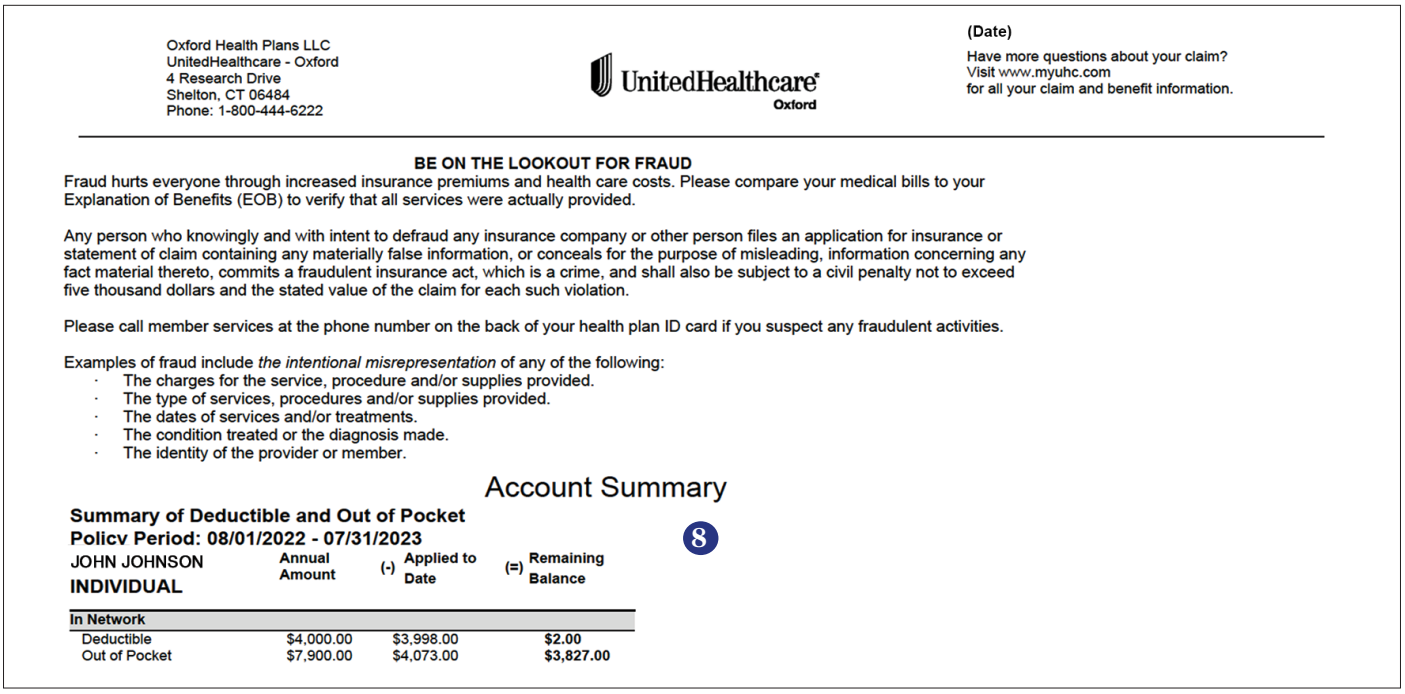
If you believe you've been wrongly billed by your provider, you may contact:

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
Telephone: 866-466-4446
Fax: 860-331-2499
Website: www.ct.gov/oha
E-mail: healthcare.advocate@ct.gov

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

continued

Account Summary page



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BE ON THE LOOKOUT FOR FRAUD

Fraud hurts everyone through increased insurance premiums and health care costs. Please compare your medical bills to your Explanation of Benefits (EOB) to verify that all services were actually provided.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please call member services at the phone number on the back of your health plan ID card if you suspect any fraudulent activities.

Examples of fraud include *the intentional misrepresentation* of any of the following:

- The charges for the service, procedure and/or supplies provided.
- The type of services, procedures and/or supplies provided.
- The dates of services and/or treatments.
- The condition treated or the diagnosis made.
- The identity of the provider or member.

Account Summary

Summary of Deductible and Out of Pocket
Policy Period: 08/01/2022 - 07/31/2023

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JOHN JOHNSON **INDIVIDUAL**	Annual Amount	(-) Applied to Date	(=) Remaining Balance
In Network			
Deductible	$4,000.00	$3,998.00	**$2.00**
Out of Pocket	$7,900.00	$4,073.00	**$3,827.00**

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Definitions of Key Terms 9

Adjustment Code: The code we assign to describe how we processed a claim line. Generally, the adjustment code shows a correction, adjustment, or denial.

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.

Amount Allowed: The most that is available to pay for covered benefits under your plan. For a participating provider, it is an agreed upon amount. If your plan has out-of-network benefits, it is the lower of the billed amount, the amount available for payment using the plan's out-of-network reimbursement rates and rules, or the amount the provider has agreed to accept as payment. Please see your health benefits plan, including your Summary of Benefits for more information.

Amount Billed (Charges): This is the total amount that your provider billed for the services provided to you.

Your Other Insurance Paid: The amount covered by your other health plan when that health plan is "primary".

Amount You Owe: The amount you are responsible to pay. This includes items not covered by your health benefits plan, such as excluded services, penalty amounts, deductibles, coinsurance, copayments and for out-of-network services, amounts about the maximum amount. (The patient responsibility shown on this EOB does not take into account any amounts paid at the time of service).

Claim Number: The number the system assigns to your claim. A claim number is assigned to every claim.

Coinsurance Amount: The portion of the maximum amount you must pay for covered benefits during the plan year. Please see your Summary of Benefits for the coinsurance amount. Coinsurance (when part of your plan) typically does not apply until after you meet the deductible.

Copay Amount: The amount you are required to pay directly to a Provider for in-network covered benefits at the time of the service. Copayments generally apply when receiving services from participating providers. Please see your Summary of Benefits for the applicable copayment amount.

Date(s) of Service: The date the physician or facility performed the service(s).

Description of Service: A brief description of the medical service, supply or medication billed along with the procedure code or Revenue Code. A procedure code is an alpha numeric identifier used to define the medical service, supply or medication billed. A Revenue Code is used by hospitals to report services rendered - revenue codes are three digits.

Deductible Amount: The amount you must pay for covered benefits during the plan year before we begin making payments for covered benefits. Please see your Summary of Benefits for the applicable deductible amount. In most instances, the deductible amount must be met before coinsurance applies.

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

8 Account Summary
Shows your year-to-date deductible and maximum amounts.

9 Definitions of Key Terms
This section defines the key terms used to explain the claim.

continued

To view your EOB online:

1. Sign in to **myuhc.com®**
2. Select **Claims & Accounts** at the top of the page
3. Select **My claims**
4. Scroll down and select your **Claim Date of Service**
5. Select **View Details**
6. Select **View Explanation of Benefits**

Sign up today and choose paperless in a few simple steps:

Sign in on **myuhc.com,** go to **Account Settings,** then choose **Paperless.**

By choosing paperless, you agree to our Required Plan Communications Notice.

Have more questions about your EOB? Visit **myuhc.com** or call the toll-free number on your health plan ID card.

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