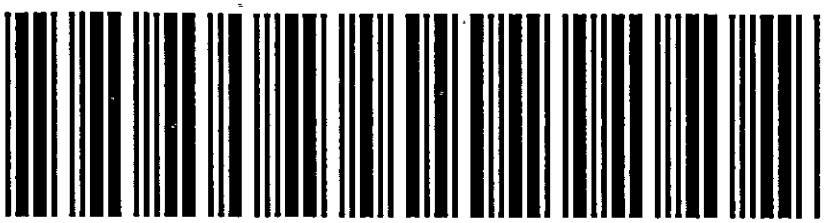
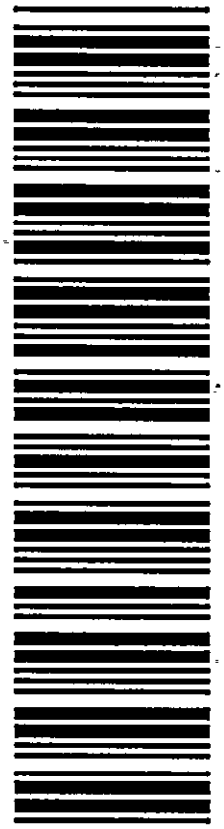


Patch II

9102108371587

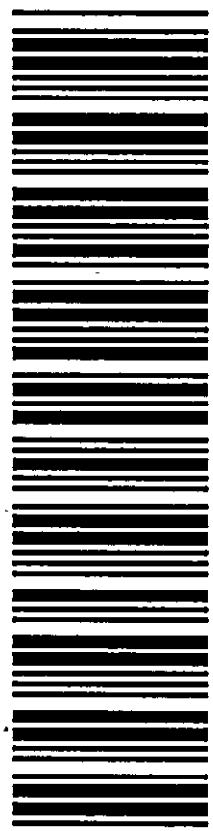


00BREAK00

Document Separator

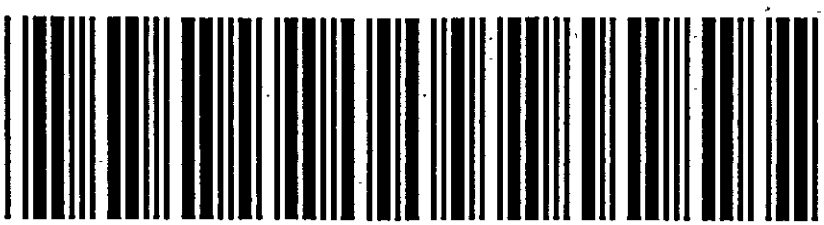
Used to Separate Each Transaction

00BREAK00



SourceHOV, Inc
4050 South 500 West
Salt Lake City, UT 84123

00BREAK00



UnitedHealthcare®

A UnitedHealth Group Company

This claim was received in the Appeals P.O. BOX 30432, Salt Lake City, UT, or through fax 801-938-2100

Ellyn Liew
19 Indigo Dr
Old Bridge, NJ
607-759-7325

March 14th, 2021

Attn: Complaint Processing Department
UnitedHealthcare
PO Box 30432
Salt Lake City, UT 84130

Re: Member/Patient: Ellyn Liew

- Member ID: 824243078
- Group Number: 905531
- Group Name: Bank of America

To whom it may concern:

You recently denied three claims dated 12/12/2020, 12/19/2020, and 12/22/2020 for acupuncture services conducted by Dr. Jenny Lin on the grounds that my plan does not cover the acupuncture services for Year 2020.

The denial of these claims was not justified, and I am filing a formal complaint. Prior to my first visit, Dr. Jenny Lin's office called the UnitedHealthcare provider's line on 12/8/2020 (call reference no: 1507) to confirm whether the acupuncture services would be covered by my plan. At that time, the provider was informed by a UnitedHealthcare representative that I have met my plan deductible for 2020 and that my upcoming acupuncture services will be covered by UnitedHealthcare. I made my decision to visit the provider based upon this confirmation by the United Healthcare representation and I should not be liable for all three services performed on the dates stated above.

In reviewing the matter with a United Healthcare representative on 3/8/2021 (call reference no: D1872), the representative stated that acupuncture services for Year 2020 were excluded except when it was performed by a physician in place of anesthesia. The 2020 summary plan of benefits on the Bank of America My Benefits Resources did not provide adequate information to establish the validity of this decision. If this information were included in the 2020 summary plan of benefits, I would not have made my decision to receive acupuncture services as a form of pain management as well.

Please kindly re-review and reconsider all three claims dated above again given the circumstances. If the appeal is to be denied, please provide a copy of the 2020 summary plan benefits that specify details and restrictions applicable to acupuncture services that are available to Bank of America employees.

Thank you,

Ellyn Liew

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

UnitedHealthcare

Have more questions about your claim?
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for all your claim and benefit information.

9102108371587

December 30, 2020

DPS$$$PKG
ELLYN LIEW
19 INDIGO DR
OLD BRIDGE NJ 08857-3591

Member/Patient Information
Member/Patient: ELLYN LIEW
Member ID: A824243078
Relationship: EE
Group Name: BANK OF AMERICA
Group #: 0905531

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
$275.00	**Amount Billed** The amount your provider charged for services provided to you.
$50.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$0.00	**Your Plan Paid** The money your health benefit plan paid.
$225.00	**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.

UnitedHealthcare

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PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-877-240-4075

December 30, 2020

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

Claim Detail for ELLYN LIEW

Provider: J LIN **Claim Number:** CJ5372286001 **Patient Account Number:** 121

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
12/12/2020	MEDICAL SERVICES	8E	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65.00	$65.00
12/12/2020	MEDICAL SERVICES	8E	$95.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$95.00	$95.00
12/12/2020	MEDICAL SERVICES	8E	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65.00	$65.00
12/12/2020	OFFICE VISITS	I4	$50.00	$50.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$275.00**	**$50.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$225.00**	**$225.00**

**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.

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.

8E - YOUR PLAN DOES NOT COVER THIS ACUPUNCTURE OR ACUPRESSURE SERVICE. PLEASE REFER TO YOUR BENEFIT PLAN FOR ADDITIONAL INFORMATION.

I4 - THIS SERVICE OR SUPPLY IS DENIED. IT IS CONSIDERED PART OF ANOTHER SERVICE PERFORMED ON THE SAME DAY, OR IT IS NOT ALLOWED AS A SEPARATE CHARGE.

You have the right to receive, upon request and free of charge, a copy of the internal rule, guideline or protocol that we relied upon in making the non-coverage decision or your claim.

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 740816, Atlanta, GA 30374-0816. 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 not later than 30 days after we receive your request for review.

S VB-08959*02*056821-MO-20365-63044-AFUS 22SYMS

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December 30, 2020

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

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f 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 o the appeal address referenced above.

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:
New Jersey Department of Banking and Insurance
Consumer Protection Services, Office of Managed Care
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
Telephone: (888) 393-1062 (appeals)
Website: http://www.state.nj.us/dobi/consumer.htm
Email: ombudsman@dobi.nj.gov

f 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.

nsurance 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 1-877-240-4075.

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.

S VB-08959*02*056822-MO-20365-63044-AFUS 22SYMS

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December 30, 2020

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Visit **www.myuhc.com**
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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. .

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 néého zinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíílnih.

S VB-08959*03*056823-MO-20365-63044-AFUS 22SYMS

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December 30, 2020

Have more questions about your claim?
Visit **www.myuhc.com**
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Account Summary

Summary of Deductible and Out of Pocket

Plan Year: 2020

ELLYN
Relationship: EE

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$500.00	$500.00	Met
Out of Pocket	$2,000.00	$2,000.00	Met
OUT OF NETWORK			
Deductible	$1,000.00	$1,000.00	Met
Out of Pocket	$4,000.00	$2,573.80	$1,426.20
CUSTOMER NETWORK			
Out of Pocket	$2,000.00	$2,000.00	Met

FAMILY

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$1,000.00	$500.00	$500.00
Out of Pocket	$4,000.00	$2,225.00	$1,775.00
OUT OF NETWORK			
Deductible	$2,000.00	$1,000.00	$1,000.00
Out of Pocket	$8,000.00	$2,798.80	$5,201.20
CUSTOMER NETWORK			
Out of Pocket	$4,000.00	$2,225.00	$1,775.00

Definitions of Key Terms

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

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

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

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

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

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

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

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

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

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

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January 04, 2021

DPS$$$PKG
ELLYN LIEW
19 INDIGO DR
OLD BRIDGE NJ 08857-3591

Member/Patient Information
Member/Patient: ELLYN LIEW
Member ID: A824243078
Relationship: EE
Group Name: BANK OF AMERICA
Group #: 0905531

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
$1,120.00	**Amount Billed** The amount your provider charged for services provided to you.
$714.17	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$180.83	**Your Plan Paid** The money your health benefit plan paid.
$225.00	**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.

S VC-00809*01*005134-MO-21004-63044-AFUS O32SYCP

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January 04, 2021

Have more questions about your claim?
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for all your claim and benefit information.

Claim Detail for ELLYN LIEW

Provider: J LIN **Claim Number:** CJ6435447301 **Patient Account Number:** 121

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
12/19/2020	MEDICAL SERVICES	8E	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65.00	$65.00
12/19/2020	MEDICAL SERVICES	8E	$95.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$95.00	$95.00
12/19/2020	MEDICAL SERVICES	8E	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65.00	$65.00
Claim Total:			**$225.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$225.00**	**$225.00**

**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.

9102108371587

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Phone: 1-877-240-4075

January 04, 2021

Have more questions about your claim?
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Claim Detail for ELLYN LIEW

Provider: A MISKEWICZ ZASTROW **Claim Number:** CJ8639230801 **Patient Account Number:** 000103399524

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
12/28/2020	DIAGNOSTIC SERVICES	D1, YD	$82.50	$60.63	$21.87	$21.87	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	DIAGNOSTIC SERVICES	0K, YD	$100.00	$92.67	$7.33	$7.33	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	RADIOLOGY SERVICES	0K, YD	$43.75	$40.77	$2.98	$2.98	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	DIAGNOSTIC SERVICES	D1	$80.00	$63.94	$16.06	$16.06	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	DIAGNOSTIC SERVICES	D1	$70.00	$60.88	$9.12	$9.12	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$376.25**	**$318.89**	**$57.36**	**$57.36**	**$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.

S VC-00809*02*005136-MO-21004-63044-AFUS O32SYCP

UnitedHealthcare

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ATLANTA, GA 30374-0800
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January 04, 2021

Have more questions about your claim?
Visit **www.myuhc.com**
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Claim Detail for ELLYN LIEW

Provider: A MISKEWICZ ZASTROW **Claim Number:** CJ8639230802 **Patient Account Number:** 000103399524

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider				Amount You Owe**
							Deductible	Copay	Coinsurance	Non-Covered	
12/28/2020	DIAGNOSTIC SERVICES	D1, YD	$67.50	$51.79	$15.71	$15.71	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	DIAGNOSTIC SERVICES	D1, YD	$150.00	$137.30	$12.70	$12.70	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	OFFICE VISITS	D1	$220.00	$132.22	$87.78	$87.78	$0.00	$0.00	$0.00	$0.00	$0.00
12/28/2020	RADIOLOGY SERVICES	D1, YD	$81.25	$73.97	$7.28	$7.28	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$518.75**	**$395.28**	**$123.47**	**$123.47**	**$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.

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.

OK - WE HAVE APPLIED THE MAXIMUM AMOUNT ALLOWED FOR THIS DIAGNOSTIC SERVICE. THE AMOUNT ALLOWED FOR THIS SERVICE HAS BEEN REDUCED BASED UPON THE MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY FOR DIAGNOSTIC CARDIOVASCULAR AND OPHTHALMOLOGY SERVICES.

SE - YOUR PLAN DOES NOT COVER THIS ACUPUNCTURE OR ACUPRESSURE SERVICE. PLEASE REFER TO YOUR BENEFIT PLAN FOR ADDITIONAL INFORMATION.

D1 - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. THE AMOUNT YOU OWE MAY INCLUDE YOUR COPAY, COINSURANCE, DEDUCTIBLE, PLUS ANY AMOUNT DUE IF YOU'VE REACHED YOUR BENEFIT LIMIT ON A COVERED SERVICE.

YD - FOR PROCESSING PURPOSES, THIS SERVICE LINE HAS BEEN RECODED FROM THE GLOBAL SERVICE TO THE PROFESSIONAL OR TECHNICAL COMPONENT.

S VC-00809*03*005137-MO-21004-63044-AFUS O32SYCP

UnitedHealthcare

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ATLANTA, GA 30374-0800
Phone: 1-877-240-4075

January 04, 2021

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New Jersey Department of Banking and Insurance
Consumer Protection Services, Office of Managed Care
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
Telephone: (888) 393-1062 (appeals)
Website: http://www.state.nj.us/dobi/consumer.htm
Email: 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.

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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

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Phone: 1-877-240-4075

January 04, 2021

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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.

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'déé' 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: 2020

ELLYN Relationship: EE	Annual Amount	(-) Applied to Date	(=) Remaining Balance
N NETWORK			
Deductible	$500.00	$500.00	Met
Out of Pocket	$2,000.00	$2,000.00	Met
OUT OF NETWORK			
Deductible	$1,000.00	$1,000.00	Met
Out of Pocket	$4,000.00	$2,573.80	$1,426.20
CUSTOMER NETWORK			
Out of Pocket	$2,000.00	$2,000.00	Met

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$1,000.00	$500.00	$500.00
Out of Pocket	$4,000.00	$2,225.00	$1,775.00
OUT OF NETWORK			
Deductible	$2,000.00	$1,000.00	$1,000.00
Out of Pocket	$8,000.00	$2,798.80	$5,201.20
CUSTOMER NETWORK			
Out of Pocket	$4,000.00	$2,225.00	$1,775.00

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.

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

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

Plan Discounts: Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.

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Definitions of Key Terms

Plan Year: The time period the benefit maximums apply.

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

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January 07, 2021

DPSSSSPKG
ELLYN LIEW
19 INDIGO DR
OLD BRIDGE NJ 08857-3591

Member/Patient Information
Member/Patient: ELLYN LIEW
Member ID: A824243078
Relationship: EE
Group Name: BANK OF AMERICA
Group #: 0905531

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
$225.00	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$0.00	**Your Plan Paid** The money your health benefit plan paid.
$225.00	**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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January 07, 2021

Have more questions about your claim?
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Claim Detail for ELLYN LIEW

Provider: J LIN **Claim Number:** CJ7635749801 **Patient Account Number:** 121

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider: Deductible	Copay	Coinsurance	Non-Covered	Amount You Owe**
12/22/2020	MEDICAL SERVICES	8E	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65.00	$65.00
12/22/2020	MEDICAL SERVICES	8E	$95.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$95.00	$95.00
12/22/2020	MEDICAL SERVICES	8E	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$65.00	$65.00
Claim Total:			**$225.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$225.00**	**$225.00**

**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.

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.

8E - YOUR PLAN DOES NOT COVER THIS ACUPUNCTURE OR ACUPRESSURE SERVICE. PLEASE REFER TO YOUR BENEFIT PLAN FOR ADDITIONAL INFORMATION.

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 740816, Atlanta, GA 30374-0816. 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 not 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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/ou 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:
New Jersey Department of Banking and Insurance
Consumer Protection Services, Office of Managed Care
20 West State Street, 9th Floor
P.O. Box 329
Trenton, NJ 08625-0329
Telephone: (888) 393-1062 (appeals)
Website: http://www.state.nj.us/dobi/consumer.htm
Email: 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 1-877-240-4075.

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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

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Deductible	$1,000.00	$1,000.00	Met
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CUSTOMER NETWORK			
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FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
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