EXPLANATION OF BENEFITS

UnitedHealthcare Oxford

48 Monroe Turnpike
Trumbull, CT 06611

THIS IS NOT A BILL

BAZ, ALEXA
377 BALTIC STREET
APT 6
BROOKLYN NY 11201

Subscriber Name: BAZ, ALEXA
Subscriber ID #: 11615169*01-11615169*02 — 11-21-2013

Member Name: BAZ, ALEXA
Member ID: 11615169*02
Patient Acct #: 51303
Provider Name: PAK, KEVIN
Provider ID: P4762800
Claim #: 3319S11466

Date of Service	CPT Code	Description	QTY	Billed Amt	Max Amt	Deductible Amt	Copay Amt	%	Co-Ins Amt	Adj Code	COB Amt	Payment Amt
11-06-13	99213	OFFICE/OUTPATIENT VISIT EST	1	150.00	85.08	85.08						0.00
TOTAL CLAIM: 3319S11466				150.00	85.08	85.08	0.00		0.00		0.00	0.00

Diagnostic Code: 729.1
Diagnostic Desc: UNSPECIFIED MYALGIA AND MYOSITIS

ATTENTION: THIS MAILING MAY CONTAIN DOCUMENTATION ON VARIOUS MATTERS

Please note: Check(s) associated with your claim(s) will be sent to the subscriber of your family, unless payment is made to the provider.

OHI INC

Please see last page for Appeals Rights

OHI INC

UnitedHealthcare Oxford

48 Monroe Turnpike, Trumbull, CT 06611

REMINDER - Effective January 1, 2007, Quest Diagnostics is no longer a participating laboratory with Oxford Health Plans. To locate a participating laboratory or for more information log in to www.oxfordhealth.com or call 1-800-666-1353.

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Summary Year: 01-AUG-13 To: 31-JUL-14	Individual Limits			Family Limits		
	Annual Limit	Year to Date	Remaining Balance	Annual Limit	Year to Date	Remaining Balance
In Network Deductible	10000.00	1585.60	8414.40	10000.00	1585.60	8414.40

	Billed Amt	Max Amt	Deductible Amt	Copay Amt	Co-ins Amt	COB Amt	Payment Amt
Claim Payment Summary	150.00	85.08	85.08	0.00	0.00	0.00	0.00

Check Summary Total Paid .... 0.00 Paid To ..... PHYSIO LOGIC MEDICINE PC
Check Date.... November 21, 2013 Check Number... 24228016

To expedite the review of your correspondence, please include the following information at the top of your introductory letter before mailing:

1. Your **Oxford Member ID #**
2. Include **all** relevant **Claim #'s** you are writing to us about
3. The **Date(s) of Service** associated with each claim
4. Please indicate the **purpose of your correspondence**
5. If applicable, please include any other related documentation

THE BASICS: WE'VE GOT YOU COVERED

At Oxford, we want to help you understand the benefits, programs and services available to you so that you can use them effectively. And we know that good care starts with your physician. Here are some of the basics that you can rely on from your Oxford coverage:

- Network of over 50,000 physicians* and over 200 of the area's finest hospitals;
- Area's first credentialed network of complementary and alternative medicine practitioners;
- Annual physical at no charge for most plans;
- No charge for routine preventive in-network pediatric care;
- 24-hour access to registered nurses for healthcare guidance through Oxford On-Call®; *and*
- Access to your choice of OB/GYN without a referral.

*The number of physicians available to you varies by geography and product type.

MS-13-197

DEFINITION OF TERMS

%	Percent. The portion of the Maximum Amount you are responsible to pay. Please see the coinsurance amount description for additional information.
ADJ CODE	Adjustment code. The code we assign to describe how we processed this claim line. Generally, the adjustment code shows a correction, adjustment or denial.
ANNUAL LIMIT	The amount your plan requires you to pay for deductible and out of-pocket maximums during the plan year.
BILLED AMT	Billed amount. The amount billed by the provider.
CLAIM #	Claim Number. The number we assign to your claim. The first four digits of a claim number reflect the date the caim was received. (Example: Claim Number 8049234568 – The first digit (8) indicates the year 2008 and the following three digits (049) indicate the day of the year in Julian date format. In this example, the claim was received on the 49th day of the year, or February 18, 2008.)
COB AMT	Coordination of Benefits. The amount covered by your other health plan when that health plan is your "primary" plan.
CPT CODE	A five-digit alpha numeric identifier used to define the medical service, supply or drug billed. Unless otherwise noted, the code is assigned by your health care provider.
CO-INS AMT	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 AMT	Copayment 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 OF SERVICE	The date the physician or facility performed the service(s).
DEDUCTIBLE AMT	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.
DESCRIPTION	A brief explanation of a code used to describe the medical service, supply or medication billed.
DIAGNOSIS CODE	A three- to five-digit code used to explain the medical diagnosis code billed. Unless otherwise noted, the code is assigned by your health care provider.
DIAGNOSIS DESCRIPTION	A brief explanation of a code used to describe the medical diagnosis.

BE ON THE LOOKOUT FOR FRAUD

Fraud hurts everyone through increased insurance premiums and healthcare costs. Please scrutinize your medical bills and compare them to your Oxford explanation of benefits (EOBs) forms to verify that all services being reimbursed were actually provided.

A person who submits an application or files a claim with intent to defraud, or helps commit fraud against an insurer is guilty of a crime. Please contact us at 1-866-242-7727 if you suspect or are aware of any fraudulent activities.

DEFINITION OF TERMS

IN-NETWORK	Services provided by a participating health care provider with a referral (if required) or by a non-participating (out-of-network) provider through an approved in-network exception request.
MAX AMT	Maximum amount. 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.
OUT-OF-POCKET MAXIMUM	The most you have to pay in deductibles and coinsurance for covered health services during the plan year. Depending on your plan design, the out-of-pocket maximum may also include copayment amounts. Items not covered by your health benefits plan, such as excluded services and penalty amounts, do not count toward the out-of-pocket maximum. For out-of network services, amounts above the out-of-network reimbursement (shown in the maximum amount column) are your responsibility and do not count toward your out-of-pocket maximum. Please see your health benefit plan, including your Summary of Benefits, for details about your plan coverage.
OUT-OF-NETWORK	Services provided by either a non-participating health care provider or a health care provider who participates in our network when a required referral has not been obtained.
PATIENT ACCT #	Patient account number. The provider's account number or invoice number for you or your claim.
PATIENT RESP	Patient responsibility. 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 above the maximum amount. (The patient responsibility shown on this EOB does not take into account any amounts paid at the time of service.)
PAYMENT AMT	Payment amount. The amount reimbursed under your health benefits plan.
QTY	Quantity. Refers to the number of times a particular service was performed.
REMAINING BALANCE	The portion of the annual limit remaining for the current plan year.

EXPLANATION OF BENEFITS

Availability of Consumer Assistance/Ombudsman Services

In addition to the Explanation of Member Appeal Rights attached, there may be other resources available to help you understand the appeals process. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) **or www.askebsa.dol.gov.**

Additionally, a consumer assistance program may be able to assist you at:

Community Service Society of New York, Community Health Advocates
105 East 22nd Street, 8th floor
New York, NY 10010
Toll-free telephone: 1-888-614-5400
Web site: http://www.communityhealthadvocates.org/

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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 you would like further clarification or have any questions regarding this Explanation of Benefits (EOB), or if you are not fully satisfied with the resolution of your claim, you may contact Customer Service by calling 1(800)201-6953, or by writing to **Correspondence Department, c/o Oxford Health Plans, LLC, P.O. Box 29135, Hot Springs, AR 71903.** A Service Associate will investigate and attempt to resolve your concerns at the time of the call. If you remain dissatisfied, you may appeal the determination by following the Appeal Procedures outlined below.

If we have requested additional information to process your claim, this information must be submitted to **Correspondence Department - Resubmissions, c/o Oxford Health Plans, LLC, P.O. Box 29133, Hot Springs, AR 71903**. The requested information must be submitted within 45 days of the date of your receipt of this notice. Upon receipt of the information, Oxford will elect to take the one-time, 15-day extension that is permitted under the Employment Retirement Income Security Act (ERISA) and will provide you with a written response not 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 procedures outlined below.

Failure to comply with appeal process requirements as communicated by Oxford may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.

Note: A claim is any request by a covered Member for certification of a benefit, or payment for a service, as required under the terms of the Member's health plan. A claim is denied when it does not meet the criteria established by your plan. If your claim has been denied in whole or in part and you would like a copy of the criteria used, you must send a written request to **ERISA Disclosure Requests, c/o Oxford Health Plans, LLC, 48 Monroe Turnpike, Trumbull, CT 06611**. The criteria will be provided to you free of charge.

Member Appeal Information

You may designate a person ("Designee") to act on your behalf to appeal this decision. To do so, you must provide Oxford with the designation, in writing, at the time of the appeal. The designation must be signed by you, or by your guardian, if you are a minor.

First-Level Appeal

You or your Designee must submit a request for appeal within **180 days** of receipt of this EOB. Unless otherwise specified in the denial description, the appeal must be submitted in writing to **Correspondence Department, c/o Oxford Health Plans, Inc., P.O. Box 29134, Hot Springs, AR 71903**, or by calling Customer Service at 1-800-444-6222 and requesting an appeal. The request must include the reason(s) you believe that the claim should not have been denied, your name and Oxford ID number, a copy of this form (or the claim number on this form), and any documentation/information you would like to submit in support of the appeal. Oxford will provide you with a written response not later than **30 days** from the Correspondence Department's (or other Department indicated in this correspondence) receipt of your request for a First-Level Appeal.

Second-Level Appeal

If Oxford upholds its prior determination as a result of the First-Level Appeal, you will receive additional information concerning your appeal rights as part of the First-Level Appeal. If you remain dissatisfied, you or your Designee may appeal to Oxford's Grievance Review Board (GRB) for further consideration. Requests for a Second-Level Appeal must be made within **60 business days** of your receipt of the First-Level Appeal determination letter. The request for appeal and any additional information must be submitted to **Grievance Review Board, c/o Oxford Health Plans, LLC, 48 Monroe Turnpike, Trumbull, CT 06611**. You or your Designee will need to include all information previously requested by Oxford (if not already submitted), and any additional facts or information that you believe to be relevant to the issue. The appeal will be resolved not later than **30 days** from the GRB's receipt of your request for a Second- Level Appeal.

Employee Retirement Income Security Act (ERISA) Rights

If we have not approved your claim after all reviews have been completed, you may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act. ERISA rights do not apply if your coverage for health benefits (1) obtained through employment with a church or government group or (2) purchased as an individual plan from Oxford.

New York State External Appeal Process

A denial based upon (1) lack of medical necessity or (2) experimental and/or investigational issues for life-threatening or disabling conditions may be eligible to be appealed through New York's external appeal program. You will be notified of your eligibility to pursue an external appeal in the appeal determination notice. You may obtain additional information about the New York external appeals process by contacting Oxford's Customer Service Department at 1-800-444-6222.

TDD/TTY and Language Assistance Notice

If you are hearing impaired and require assistance, please call our TTY/TDD line at 1-800-201-4875. Please call 1-800-303-6719 for assistance in Chinese, 1-888-201-4746 for assistance in Korean, or the number on your Oxford ID card for assistance in other languages. Interpreters are available Monday through Friday between 8:00 AM and 6:00 PM.

NY-07-081