Administrator
Patrick McCullough

MASTERS, MATES & PILOTS HEALTH & BENEFIT PLAN
700 MARITIME BLVD, SUITE A, LINTHICUM HEIGHTS, MD 21090-1996
EXPLANATION OF BENEFITS

Telephone
(410) 850-8500

PLANNED PARENTHOOD GULF COAST
4600 GULF FRWY.
HOUSTON TX 77023

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PATIENT: CASSANDRA A CLARK PROVIDER ID: 74-1100163 CLAIM#: 020187018
MEMBER: CASSANDRA A CLARK MEMBER ID: CLA006400 00 LL CHECK#:

PROCEDURE CODE	DATE OF SERVICE	BILLED AMOUNT	NOT COVERED	DISCOUNT/ DISALLOWED	COVERED CHARGES	DEDUCTIBLE/ COPAY	PAY %	AMOUNT PAID BY OTHER PLAN/MEDICARE	BENEFIT PAYMENT	REMARKS CODE
FOR SERVICE FROM 7/22/2022 TO 7/22/2022 PATIENT ID: PPGC101366020										
99385	7/22/2022	350.00	350.00	.00	.00	.00		.00	.00	939
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
87591	7/22/2022	150.00	150.00	.00	.00	.00		.00	.00	248
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
87491	7/22/2022	150.00	150.00	.00	.00	.00		.00	.00	248
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
99000	7/22/2022	23.00	23.00	.00	.00	.00		.00	.00	649
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
36415	7/22/2022	6.00	6.00	.00	.00	.00		.00	.00	720
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
86703	7/22/2022	98.00	98.00	.00	.00	.00		.00	.00	248
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
36416	7/22/2022	8.00	8.00	.00	.00	.00		.00	.00	248
Not eligible for benefits at the time service performed. Benefits paid in accordance with MM&P H&B Plan Rules & Regulation. Refer to Article III, Section 1 thru 7.										
Claim Totals		785.00	785.00	.00	.00	.00		.00	.00	

Remarks Code

939
HEALTH CARE PROFESSIONAL: REIMBURSEMENT IS BASED ON PLACE OF SERVICE: Non-FACILITY

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CUSTOMER: THANK YOU FOR USING CIGNA'S OPEN ACCESS PLUS NETWORK. THE DISCOUNT SHOWN IS HOW MUCH YOU SAVED. YOU DON'T NEED TO PAY THAT AMOUNT. IF YOU ALREADY PAID YOUR HEALTH CARE PROFESSIONAL MORE THAN THE "What I owe" amount, please ask your health care professional for a refund.
HEALTH CARE PROFESSIONAL: YOUR CIGNA AGREEMENT DOES NOT ALLOW YOU TO BILL THE PATIENT FOR THE DIFFERENCE. If you are in Indiana, California or Tennessee, please contact Cigna customer service at 1.800.88CI GNA (882.4462) FOR MORE INFORMATION ON YOUR DISCOUNTED RATE.

649
HEALTH CARE PROFESSIONAL: WE HAVE RECEIVED YOUR CLAIM FOR A NON-PAYABLE SERVICE. VISIT CIGNAFORHCP.COM TO VIEW OUR REIMBURSEMENT POLICIES.

NOT ELIGIBLE FOR BENEFITS AT THE TIME OF SERVICE

Ctl# 54

M.M.&P. Health and Benefit Plan is accepting electronic claims with the AVAILITY clearing house utilizing the Payor ID "MMPHB". Should you have any questions pertaining to AVAILITY'S operations, please visit their website at www.availity.com or call the AVAILITY EDI Helpline at (800) 282-4548.

PLEASE SEE THE BACK OF THIS FORM FOR IMPORTANT INFORMATION CONCERNING THE PLAN'S CLAIMS REVIEW PROCEDURES.

Under the Rules and Regulations of the M.M.& P. Health and Benefit Plan, if you believe this Explanation of Benefits does not correctly reflect amounts you owe or amounts that should be covered under the Plan, you or your duly authorized representative may seek review of this decision, treating such decision as a claim denial (either in whole or in part). In order to do so, you must file a written appeal requesting such a review to the Board of Trustees or the Plan Administrator within 180 days after your receipt of this denial letter. You must address your appeal to the Board of Trustees and must state your name, address, the fact that you are appealing the initial decision (giving the date of the decision appealed from), and the basis of your appeal. Any appeals review will not afford deference to the initial adverse benefit determination and will be conducted by an entity independent from the initial reviewer. The reviewers will provide you with the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits and will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The decision on appeal will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted in the initial benefit determination. If an adverse benefit determination is appealed on the basis of medical judgment, the reviewers on appeal will consult with an independent health care professional who is qualified in the areas of dispute and who was not involved in the initial claim denial. The reviewers on appeal will identify medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision. You also have the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

In the case of an urgent care claim, you may make a request for an expedited appeal of an adverse benefit determination to the Plan Administrator orally or in writing. If you request an expedited appeal, all necessary information concerning the urgent care claim, including the benefit determination on review, will be transmitted between the reviewer and you by telephone, facsimile or other available expeditious method.

Generally, the time it takes to conduct a review on appeal depends on the type of claim you are appealing. Urgent care claims are decided as soon as possible, but in no event later than 72 hours after your request for an appeal is received. Pre-service claims are decided no later than 30 days. Post-service claims are decided by the date of the Board of Trustees' next regularly scheduled meeting if your appeal is received within 30 days of such meeting. Otherwise, a decision will be made by the date of the Board of Trustees' second regularly scheduled meeting. If special circumstances exist, the decision may take longer; however, you will be notified if this occurs.

Please review your summary plan description for the Plan for detailed information concerning the Plan's claims procedures, including what constitutes an urgent care claim, pre-service claim or post-service claim.