AdventHealth

PO Box 538800
Orlando, FL 32853-8800
Return Mail Only

Electronic Service Requested

BISI BENNETT
[redacted]

Amount Due Upon Receipt

$550,124.76

Payment Methods

Pay online today
billpay.adventhealth.com
Your Access Code: [redacted]

Pay by phone 24 hours a day
(407) 205-0981

Account Summary
Access Code: [redacted]

Statement Date	09/15/2021
Total Patient Balance	$550,124.76
Payment Plan Amount Due	$0.00
Amount Due Not on Payment Plan	$550,124.76
Total Amount Due	**$550,124.76**

Payment Due Date Upon Receipt

Important Messages

Your health insurance claim was submitted and has been processed by your health insurance provider for recent care administered by our healthcare organization; however, there is a balance due.

Any financial activity from your statement date forward will be reflected on your statement. If you would like an itemized bill, please contact Customer Service. For questions or to inquire about financial assistance please call (800) 952-5462 or (407) 303-0500, or go to adventhealthorlando.com

Payment Options

Payment Plan
$45,843.73
x 12 months

OR

Pay In Full
$550,124.76
Due 10/15/2021

View All Options: **billpay.adventhealth.com**

Contact Us

(800) 952-5462 or (407) 303-0500

Hours of operation:
Monday - Friday 8:00 am - 6:00 pm

Please detach and return bottom portion with your payment.

Patients LOVE Paying Online!

4.6 out of 5 stars

billpay.adventhealth.com

Easy & Secure From Any Device

Still prefer mailing a check?

Please make check payable to **AdventHealth Orlando** and be sure to include your **Statement Number** on your check.

Amount Due	Statement Number	Guarantor Name
$550,124.76	[redacted]	BISI BENNETT

ADVENTHEALTH ORLANDO
PO BOX 105571
ATLANTA, GA 30348-5571
[redacted]

[redacted]

Frequently Asked Questions

Para asistencia en Español, favor de comunicarse con el departamento de Servicio al Cliente al (800) 952-5462 or (407) 303-0500.

Billing Policy

Each visit to AdventHealth Orlando generates a unique account number. It is possible to have several accounts open at the same time. This statement specifies the charges per account number(s) on the reverse side.

If health insurance was provided, the insurance company was billed as a courtesy service. The remaining balance was not covered by insurance and is the responsibility of the guarantor or responsible party.

Any concerns regarding a disputed balance should be submitted in writing to AdventHealth Orlando, Patient Financial Services, PO Box 538800 Orlando, FL 32853-8800. Written inquiries should include the following information:

- Patient's Name
- Account or Invoice Number
- Description of inquiry

While under review, AdventHealth Orlando will wave payment requirements for the disputed amounts. All non-disputed statement balances follow the normal billing practices. If this account remains unpaid and as a result is placed with an outstanding collection agency or attorney for handling, any and all additional fees will be added to the remaining balance and will become your responsibility.

Payment Options

For your convenience, AdventHealth Orlando has provided a number of option for receiving and paying patient bills. To access billing statements and submit credit card payments electronically, please visit billpay.adventhealth.com.

Cash, Check, or credit card (MasterCard, Visa, Amex, and Discover) payments are also accepted online, by mail, or by phone. AdventHealth now accepts CareCredit. Apply online today at carecredit.com/AdventHealth and get an instant credit decision.* Subject to credit approval. Minimum monthly payments required. See carecredit.com for details.

Please note, the state authorized returned service fee will be applied to the patient's account(s) for any returned checks. Paying by check authorizes AdventHealth Orlando to send the information from your check to your financial institution for payment.

To establish alternative payment arrangements or for payment inquiries, please contact AdventHealth Orlando Customer Service at (800) 952-5462 or (407) 303-0500. Advisors are available Monday - Thursday 8:00 am - 6:00 pm and Friday 8:00 am - 2:00 pm.

Physician Billing Information

This billing statement is for hospital services only. You may receive separate statements from physicians or other facilities involved with your care. For assistance with these additional statements, please feel free to contact the physician's office or facility directly.

JLR Anesthesiology	(407) 667-0505
FRI	(407) 303-1414
Radiology Specialists of FL	(866) 481-7571
Florida Emergency Physicians	(888) 952-6772

Have updates to your address and/or health insurance information?

Please contact Customer Service

AdventHealth

Access Code [redacted]
Statement Date 09/15/2021

Accounts Not On Payment Plan

Service Detail	Description	Charges	Insurance Payments & Adjustments	Patient Payments & Adjustments	Patient Balance
Encounter: [redacted]	**Patient Name: Dorian O Bennett**				
1/7/21	Room & Nursing Care	$467,115.00			
	Pharmacy Services	$58,534.27			
	IV Therapy	$195.00			
	Laboratory Services	$35,481.00			
	Radiology/ Services	$23,745.00			
	Operating Room Services	$3,606.00			
	Respiratory Services	$34,652.00			
	Emergency Center	$5,071.00			
	Cardiac Services	$3,353.00			
	Medical/Surgical Supplies	$3,057.41			
	Therapy Services	$15,586.00			
	Outpatient Services	$9,118.00			
	Audiology Services	$308.00			
	Pulmonary Services	$732.00			
	Negotiated Discounts		-$110,428.92		
	Visit Totals	$660,553.68	-$110,428.92	$0.00	$550,124.76
	Accounts (Non-Pay Plan) Totals	**$660,553.68**	**-$110,428.92**	**$0.00**	**$550,124.76**

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UnitedHealthcare

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

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

April 01, 2021

DPS$$$PKG
BISI BENNETT
[redacted]

Member/Patient Information

Member: BISI BENNETT
Member ID: [redacted]
Patient: DORIAN BENNETT
Relationship: CH
Group Name: ASSUREDPARTNERS
Group #: [redacted]

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
$467,115.00	**Amount Billed** The amount your provider charged for services provided to you.
$467,115.00	**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.
$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.

[redacted]

S VG-00528*01*003280-MO-21091-84306-AC US 22SYCP

UnitedHealthcare

United HealthCare Services, Inc.
GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-844-333-7525

April 01, 2021

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

Claim Detail for DORIAN BENNETT

Provider: ADVENTHEALTH **Claim Number:** [redacted] **Patient Account Number:** [redacted]

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	
11/13/2020 - 11/23/2020	ROOM AND BOARD	GZ	$92,565.00	$92,565.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11/24/2020 - 12/04/2020	ROOM AND BOARD	GZ	$92,565.00	$92,565.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12/05/2020 - 12/15/2020	ROOM AND BOARD	GZ	$92,565.00	$92,565.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12/16/2020 - 12/26/2020	ROOM AND BOARD	GZ	$92,565.00	$92,565.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12/27/2020 - 12/31/2020	ROOM AND BOARD	GZ	$42,075.00	$42,075.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
01/01/2021 - 01/07/2021	ROOM AND BOARD	GZ	$54,780.00	$54,780.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$467,115.00**	**$467,115.00**	**$0.00**	**$0.00**	**$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.

GZ - WE HAVE NOT RECEIVED ALL THE REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. PLEASE REFER TO OUR CORRESPONDENCE IDENTIFYING WHAT WE NEED SO WE CAN COMPLETE THE PROCESSING OF THIS CLAIM. THANK YOU.

[redacted]

Use this EOB statement as a reference or retain as needed

UnitedHealthcare

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GREENSBORO SERVICE CENTER
PO BOX 740800
ATLANTA, GA 30374-0800
Phone: 1-844-333-7525

April 01, 2021

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

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.

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 1-844-333-7525.

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.

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

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ATLANTA, GA 30374-0800
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April 01, 2021

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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.

[redacted]

S VG-00528*03*003283-MO-21091-84306-AC US 22SYCP

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April 01, 2021

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Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2020

DORIAN Relationship: CH	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$3,000.00	$3,000.00	Met
Out of Pocket	$3,000.00	$3,000.00	Met
OUT OF NETWORK			
Deductible	$3,000.00	$0.00	$3,000.00
Out of Pocket	$6,000.00	$0.00	$6,000.00

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$6,000.00	$6,000.00	Met
Out of Pocket	$6,000.00	$6,000.00	Met
OUT OF NETWORK			
Deductible	$6,000.00	$0.00	$6,000.00
Out of Pocket	$12,000.00	$0.00	$12,000.00

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.

Plan Year: The time period the benefit maximums apply.

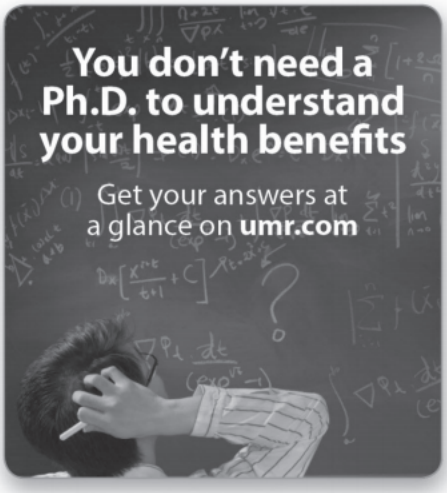
Your Plan Paid: The money your health benefit plan paid.

[redacted]

Use this EOB statement as a reference or retain as needed

UMR

PO BOX 30541
SALT LAKE CITY UT 84130-0541



DPS$$$PKG
BISI BENNETT
[redacted]

Explanation of Benefits (EOB)

Why are you receiving this EOB?

First things first. **This is not a bill.** This is an overview of claims we've processed for you. You may receive a bill from your provider if you owe any remaining balance. Use this as a reference to compare to any bill you receive. Keep it for your records, or access a copy anytime on **www.umr.com**. If you have questions about this EOB, you can always call us at **1-800-207-3172** or visit our resources 24/7 on **www.umr.com**.

Here's a summary for you.

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

Amount billed:	$660,553.68	This is the total amount that your provider billed for the services that were provided to you.
Your discount:	$0.00	Your plan negotiates discounts with providers and facilities to help save you money.
Your plan paid:	$0.00	This is the portion of the amount billed that was paid by your employer-sponsored benefits plan.
You saved:	$0.00	0% of your service was covered by your plan discounts, your employer-sponsored benefits plan, or other amounts for which you are not responsible.
TOTAL YOU MAY OWE:	**$660,553.68**	The portion of the amount billed that you may owe to the provider. This amount includes your deductible, co-pay, co-insurance and non-covered charges. Not allowed amounts and any amount you paid when you received care may not be reflected in this amount.

GO TO
www.umr.com

CALL US
1-800-207-3172

PO BOX 30541 SALT LAKE CITY UT 84130-0541
1-800-207-3172 • www.umr.com

Employee	BISI BENNETT
Employee Address	[redacted]
Employer Number	
Member ID	
Employer Name	AssuredPartners
Notice Date	02-25-21

Patient:
DORIAN O BENNETT

Claim Number: [redacted]

Provider Name:
ADVENTHEALTH

Patient Account: [redacted]

							PLAN PAYS		YOU PAY				
Service(s) you received	Reason code	Service date(s)	Amount billed by provider	Your discount -	Not allowed -	Amount due to provider	%	Plan Paid -	Co-pay +	Applied to deductible +	Co-insurance +	Not covered +	Total you may owe*
HOSPITAL MISC	028	11/13-01/07/21	$256.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$256.00	$256.00
ROOM & BOARD	028	11/13-12/31/20	$412,335.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$412,335.00	$412,335.00
ROOM & BOARD	028	01/01-01/06/21	$54,780.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$54,780.00	$54,780.00
HOSPITAL MISC	028	11/13-01/07/21	$308.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$308.00	$308.00
HOSPITAL X-RAY	028	11/13-01/07/21	$3,353.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$3,353.00	$3,353.00
HOSPITAL MISC	028	11/13-01/07/21	$738.85	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$738.85	$738.85
HOSPITAL MISC	028	11/13-01/07/21	$8,862.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$8,862.00	$8,862.00
HOSPITAL THERAPY	028	11/13-01/07/21	$5,867.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$5,867.00	$5,867.00
HOSPITAL THERAPY	028	11/13-01/07/21	$704.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$704.00	$704.00
OTHER	028	11/13-01/07/21	$5,071.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$5,071.00	$5,071.00
HOSPITAL MISC	028	11/13-01/07/21	$732.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$732.00	$732.00
HOSPITAL X-RAY	028	11/13-01/07/21	$8,227.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$8,227.00	$8,227.00

							PLAN PAYS		YOU PAY				
Service(s) you received	Reason code	Service date(s)	Amount billed by provider	Your discount -	Not allowed -	Amount due to provider	%	Plan Paid -	Co-pay +	Applied to deductible +	Co-insurance +	Not covered +	Total you may owe*
HOSPITAL MISC	028	11/13-01/07/21	$34,652.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$34,652.00	$34,652.00
HOSPITAL THERAPY	028	11/13-01/07/21	$8,440.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$8,440.00	$8,440.00
HOSPITAL THERAPY	028	11/13-01/07/21	$575.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$575.00	$575.00
HOSPITAL LAB	028	11/13-01/07/21	$219.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$219.00	$219.00
HOSPITAL X-RAY	028	11/13-01/07/21	$11,358.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$11,358.00	$11,358.00
HOSPITAL X-RAY	028	11/13-01/07/21	$4,160.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$4,160.00	$4,160.00
OPERATING ROOM	028	11/13-01/07/21	$3,606.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$3,606.00	$3,606.00
HOSPITAL LAB	028	11/13-01/07/21	$17,854.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$17,854.00	$17,854.00
HOSPITAL LAB	028	11/13-01/07/21	$1,512.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$1,512.00	$1,512.00
HOSPITAL LAB	028	11/13-01/07/21	$5,473.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$5,473.00	$5,473.00
HOSPITAL LAB	028	11/13-01/07/21	$2,674.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$2,674.00	$2,674.00
HOSPITAL MISC	028	11/13-01/07/21	$32,195.79	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$32,195.79	$32,195.79
HOSPITAL MISC	028	11/13-01/07/21	$195.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$195.00	$195.00
HOSPITAL MISC	028	11/13-01/07/21	$3,057.41	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$3,057.41	$3,057.41
HOSPITAL LAB	028	11/13-01/07/21	$7,749.00	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$7,749.00	$7,749.00
HOSPITAL MISC	028	11/13-01/07/21	$1,472.77	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$1,472.77	$1,472.77
HOSPITAL MISC	028	11/13-01/07/21	$104.91	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$104.91	$104.91
HOSPITAL MISC	028	11/13-01/07/21	$23,380.83	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$23,380.83	$23,380.83
HOSPITAL MISC	028	11/13-01/07/21	$641.12	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$641.12	$641.12
Totals			$660,553.68	$0.00	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$660,553.68	**$660,553.68**

*This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment.
(+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

Reason code explanations:

028	Charge(s) denied. Services received prior to coverage effective date. Need documentation of coverage. See plan Eligibility.
50	YOUR EFFECTIVE DATE IS 01/01/21.

What if I don't agree with this claim decision?

If your claim has been denied in whole or in part , you may file an appeal by sending a written request and pertinent information (eg: office notes, lab results, operative notes/reports, and medical history) within 180 days from the date of this notice. A printable appeal form is available for download on umr.com to assist you. Be sure to also check your benefits booklet for information about claim determination and your plan's specific appeal process.

If we continue to deny payment, coverage or service requested, or if you do not receive a timely decision, you may request an independent, third party to review the denial and issue a final decision. Your written request must be received by us within four months of the date you receive this notice.

How do I file an appeal?

Send your written appeal request to:

Claims Appeal Unit
P.O. Box 30546
Salt Lake City, UT 84130-0546

Your rights and other resources

If your plan is governed by the Employee Retirement Income Security Act (ERISA), you may have the right to bring a civil action under section 502(a) of ERISA after you have exhausted the mandatory appeal levels that are described in your benefit booklet. You may supply additional information with your appeal. You may request copies (free of charge) of information relevant to your claim by contacting us at address mentioned in this section. Diagnosis and/or treatment code information for this claim is available upon request by calling the Customer Service number.

For questions about your appeal rights, this notice, or for help if your plan is governed by ERISA, you can contact the Employee Benefits Security Administration at 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.

Protect your health care dollars! Be on the lookout for fraud, abuse or improper billing.

If you know or suspect any illegal activity concerning claims, contact our anti-fraud unit by calling **1-800-356-5803**.
You do not need to identify yourself.

Questions about health care terminology?

Go to **www.justplainclear.com** to search health care terms defined in plain, clear language to help you make informed decisions.