univera HEALTHCARE

205 Park Club Lane
Buffalo, NY 14221

STATEMENT DATE

10/22/2012

THIS IS NOT A BILL

PROFILE

Subscriber	John Q. Sample
Subscriber ID	200000001

20
JOHN Q. SAMPLE
124 MAIN ST.
ANYTOWN, NY 12345

Explanation of Benefits

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This summary information is for claims processed for all members covered under the Subscriber ID indicated above.

Benefits for In-Network Services

Copayments and Coinsurance	
Office Visit - PCP	$0.00
Office Visit - Specialist	$0.00
Coinsurance	0%
Deductible	
Two Person	$11,100.00 remains of your $11,200.00 deductible

Refer to your benefits information for details on out-of-network benefits

Mammograms Save Lives

- A mammogram is a low-dose x-ray of the breast to find small tumors that you or your doctor are unable to detect
- Mammograms are important because the earlier breast cancer is found, the more successfully it can be treated
- Start talking with your doctor at age 40 about how often to have a screening mammogram. Women with a family history of breast cancer should get screened at earlier ages.

Learn more about mammograms, breast cancer and 6,000+ other health topics at **univerahealthcare.com/health**

Women's Health Tip:

If your gynecologist orders a screening test for you, make sure your test results are sent to your primary care physician.

Looking for a top-notch physician? Our Find A Doctor online tool helps you connect with the right primary care or specialist physician for your health care needs. Visit **univerahealthcare.com/member** to learn more.

Did You Know?

- Early-stage cervical cancer generally produces no signs or symptoms – which is why regularly scheduled screenings are important.
- Talk to your doctor about how often you need Pap tests and other women's health screenings.

Learn more about how to get and stay healthy at every age – including preventive health screenings – at **univerahealthcare.com/stayhealthy**

Notice of Determination As Required By Law

Please refer to the enclosed correspondence for the reason(s) that your or your dependent's claim(s) or service(s) was not approved in whole or part. If present, please match the Reason Code with its corresponding explanation. If your claim, Pre-Treatment Estimate or service was not approved in full, then the information contained in this notice will apply. Diagnosis and treatment codes and meanings related to your services are available upon request. This information is available in other formats for members with special needs or who speak languages other than English. Call the phone number on your ID card for help.

Your Right to Appeal. Our Appeal procedure applies to medical necessity and experimental or investigational determinations. You, your authorized designee or your health care provider may file a standard appeal or an expedited appeal by contacting our Customer Service Department by phone (at the number on your ID card), in person or in writing to P.O. Box 22999, Rochester, NY 14692. Medicaid and Family Health Plus members have 60-business days from receipt of this notice to file an appeal. All other members have up to 180-calendar days from receipt of this notice to file the appeal. *Failure to comply with these requirements may lead to forfeiture of your right to challenge a denial, rejection or partial payment, even when a request for clarification has been made.* You have the right to be represented in the appeal process by anyone you choose. There is no penalty and we will not treat you differently for filing an appeal.

Standard Appeals.

All standard appeals for Medicaid and Family Health Plus members will be decided within 30-calendar days. For all other members, if your appeal relates to a pre-service matter (a request for a service or treatment that has not yet been received), we will decide the appeal within 30-calendar days and notify you or your designee (and your health care provider if he or she requested the review) of our determination in writing within two business days after the determination is made, but no later than 30-calendar days after receipt of the appeal request.

If your appeal relates to a post-service matter (a service or treatment that has already been provided), we will decide the appeal within 60-calendar days and notify you or your designee (and your health care provider if he or she requested the review) of our determination in writing within two business days after the determination is made, but no later than 60-calendar days after receipt of the appeal request.

Expedited Appeals.

If your appeal relates to a review of continued or extended health care services, additional services rendered in the course of treatment, services in which a provider requests an immediate review, a situation in which a delay would significantly increase a risk to your health or any other urgent matter, we will handle your appeal on an expedited basis. Expedited appeals are not available for retrospective reviews. For Medicaid and Family Health Plus members, all expedited appeals will be decided within 3-business days and notice will be given within 1-business day from the determination. For all other members, expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of receipt of the appeal request. If you are not satisfied with the resolution of your expedited appeal, you may file a standard appeal. You may also have the right to file an external appeal.

Your Right To An External Appeal. If you are covered through an insured product, you can file an external appeal with a state-approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational. If you are covered through a self funded plan, you *may* be eligible for an external appeal. Eligibility will be included in the final adverse determination notice you receive from us. In order to be eligible, you must have received a final adverse determination as a result of our internal appeal process or we must have jointly agreed to waive the internal utilization review appeal process.

You may obtain an external appeal application from:

- For insured groups: The New York State Department of Financial Services at 1-800-400-8882 or its website at www.DFS.NY.GOV.
- For all eligible groups: our Customer Service Department by calling the phone number on your ID card.

You have 4 months to initiate an external appeal after receiving a final adverse determination from us. Please refer to your member handbook for additional information about the external appeal process.

Your Right to Grievance. Our Grievance procedure applies to any benefit denial not relating to a medical necessity or experimental or investigational determination. You or your authorized designee may file a grievance by contacting our Customer Service Department by phone (at the number on your ID card), in person or in writing to P.O. Box 22999, Rochester, NY14692. Medicaid and Family Health Plus members have 60-business days from receipt of this notice to file a grievance. All other members have up to 180-calendar days from receipt of this notice to file the grievance. *Failure to comply with these requirements may lead to forfeiture of your right to challenge a denial, rejection or partial payment, even when a request for clarification has been made.*

All grievances for Medicaid and Family Health Plus members will be decided within 30-calendar days. For all other members, if your grievance relates to a pre-service matter (a request for a service or treatment that has not yet been received), we will decide the grievance and notify you of our determination in writing within 15-calendar days of receipt of your grievance request.

If your grievance relates to an urgent matter, we will decide the grievance and notify you of our determination by phone within 48 hours of receipt of your grievance request. Written notice will follow within 24 hours of our determination.

If your grievance relates to a post-service matter (a service or treatment that has already been provided), we will decide the grievance and notify you of our determination in writing within 30-calendar days of receipt of your grievance request.

If your coverage is through an employer subject to ERISA, you may have the right to appeal your matter to your employer consistent with the provisions of your employer's Summary Plan Description (SPD). Your employer may have the final decision regarding your coverage. Please refer to your Plan Administrator for specific information. In addition, if our determination is upheld on grievance or appeal, including final review by or on behalf of your group (if you are covered through a self-funded plan), you have the right to bring a civil action under section 502(a) of ERISA. With questions about your rights, this notice or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

You, or your authorized designee, have the right to submit written comments, documents, records, or other information relevant to your appeal or grievance.

A copy of the review criteria upon which our decision was based is available free of charge upon written request to the address listed on the enclosed correspondence.

Miscellaneous Information.

If you are covered under an insured product and you are dissatisfied with any of the above decisions or at any other time you are dissatisfied, you may call the:

- New York State Department of Health Complaint Hotline at 1-800-206-8125 or,
- New York State Department of Financial Services at 1-800-342-3736

You can also contact Community Health Advocates, the State's consumer assistance program, at 1-888-614-5400 or at www.communityhealthadvocates.org.

Nuestro Plan de Salud tiene representantes bilingües así como otros servicios disponible para ayudarlo. Si usted tiene preguntas acerca de este documento o la necesidad de contactarnos con otras preguntas, llamanos por favor al número del Servicio al Cliente que esta listado en su tarjeta de identificación y usted será conectado a alguien que puede ayudarle. Hay también un sitio en el web español disponible para usted.

Kung kailangan niyo ang tulong sa Tagalog tumawag sa Kung kailangan mo ng tulong sa Tagalog, pakitawagan kami sa customer service number na nakalista sa likuran ng iyong identification card

如果需要中文的帮助，请拨打这个号码 如果您需要以中文提供協助，請撥打您識別卡背面載有之客戶服務電話

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' Dii bik'ih siniligii shiŁ beehodooziiŁ ninizingo ei beesh bee hodiil nih

If your EOB indicates a claim adjustment, you may have overpaid/underpaid your cost sharing expense to the provider. If this is the case, you should contact your provider directly.

Explanation of Benefits

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Medical Services

Claim Activity for John Q. Sample

Claim Number 100000000000

Provider May Bill You: $100.00

Provider (Network) Smith, Lauri D. (OutofNetwork)

Claim Level Explanation

Date(s) of Service	Description of Service	Provider Charged	Allowed	Other Insurance	Paid	MEMBER RESPONSIBILITY Not Covered	Deductible	Copay	Coinsurance	Remarks
08/02/2012 - 08/02/2012	Surgery	$100.00	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	
	Total	$100.00	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	

Definitions

Here are a few definitions off requently used health care terms for your convenience.

Copay - A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount - The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance - A cost-sharing method that requires you pay a portion of the allowed amount for certain medical services.

Deductible - A set dollar amount you pay for covered services you receive before your insurer will make a payment.

Out-of-pocket Maximum - The maximum amount of deductible and coinsurance payments that you will pay for health services each calendar year.

Suspect Claims Fraud?
Join the fight against health care fraud. If you suspect fraud is occurring, such as false or altered claims being submitted or services being billed which were not provided, call the Special Investigations Unit Hotline at 1 (877) 800-0910. All calls will be kept confidential.