Name Taksali | | PCP: Brian W Blair, MD

Outstanding Account Details ( )

Outstanding Accounts

Patient: Taksali

Date	Description	Charges	Payments / Adjustments	Insurance Balance	Patient Balance
Procedure Visit at OHSU General Pediatrics at Marquam Hill with Megan Jacobs, MD on Jan 24, 2020				*Account*	
	HISTRELIN IMPLANT (VANTAS), 50 MG (67979-500-01) - J9225 (HCPCS)	12,598.47			
	INSERTION DRUG IMPLANT DEVICE - 11981 (CPT®)	608.00			
	United Healthcare Payments and Adjustments		-7,900.02		
	Professional Services	***13,206.47***	***-7,900.02***	***608.00***	***4,698.45***

Total Outstanding Balance: $4,698.45

Informational Accounts

Patient: Taksali

Date	Description	Charges	Payments / Adjustments	Insurance Balance	Patient Balance
Lab Visit at Lab Center at DCH 7th Floor with Margaret Hayes, MD on Aug 1, 2018				*Account*	
	LABORATORY - GENERAL	1,232.00			
	UA, DIPSTK ONLY - 81003 (CPT®)	*31.00*			
	ROUTINE VENIPUNCTURE - 36415 (CPT®)	*21.00*			
	CBC W/AUTO DIFFERENTIAL - 85025 (CPT®)	*85.00*			
	COMP METABOLIC SET - 80053 (CPT®)	*63.00*			
	PHOSPHORUS,PLASMA - 84100 (CPT®)	*24.00*			
	TSH-THYROID STIM HORMONE - 84443 (CPT®)	*103.00*			
	LEAD, BLOOD - 83655 (CPT®)	*53.00*			
	ZINC PROTOPORPHYRIN, WB - 84202 (CPT®)	*85.00*			

Date	Description	Charges	Payments / Adjustments	Insurance Balance	Patient Balance
	QUANTIFERON TB GOLD - 86480 (CPT®)	*254.00*			
	HIV1/HIV2 AB P24 AG SCREEN - 87389 (CPT®)	*103.00*			
	RUBELLA IGG AB - 86762 (CPT®)	*60.00*			
	VARICELLA ZOSTER,IGG - 86787 (CPT®)	*103.00*			
	DIPHTHERIA AB, IGG IMMUNOASSAY IAA, QUANT, NES - 86317 (CPT®)	*83.00*			
	TETANUS AB, IGG IMMUNOASSAY IAA, QUANT, NES - 86317 (CPT®)	*61.00*			
	MUMPS IGG AB, SERUM - 86735 (CPT®)	*53.00*			
	SEROLO TST SYPH RPR SER QUA - 86592 (CPT®)	*50.00*			
	Moda Health Payments and Adjustments		-711.92		
	Hospital Services	***1,232.00***	***-711.92***	***520.08***	***0.00***

There may be prorated balances on your current statement that are not included in the totals.

UnitedHealthcare

UnitedHealthcare Insurance Company
RICHARDSON/SPRGFLD SRVC CNTR
PO BOX 30555
SALT LAKE CITY, UT 84130-0555

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for all your claim and benefit information.

February 11, 2020

DPS$$$PKG
SUDEEP TAKSALI

Member/Patient Information

Member: SUDEEP TAKSALI
Member ID:
Patient: TAKSALI
Relationship: CH
Group Name: HOPE ORTHOPEDICS OF OREGON
Group #:

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
$12,598.47	**Amount Billed** The amount your provider charged for services provided to you.
$7,900.02	**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.
$4,698.45	**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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Claim Detail for TAKSALI

Provider: M JACOBS **Claim Number:** **Patient Account Number:**

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	
01/24/2020	PRESCRIPTION DRUGS	UG	$12,598.47	$7,900.02	$4,698.45	$0.00	$4,698.45	$0.00	$0.00	$0.00	$4,698.45
Claim Total:			**$12,598.47**	**$7,900.02**	**$4,698.45**	**$0.00**	**$4,698.45**	**$0.00**	**$0.00**	**$0.00**	**$4,698.45**

**This total does not reflect any payments / copays you made at the time of service. Please wait for a provider bill before making a payment.

Notes*

UG - THE PLAN DISCOUNT SHOWN IS YOUR SAVINGS FOR USING A NETWORK PROVIDER. YOU HAVE NOT MET YOUR DEDUCTIBLE AND OWE THE AMOUNT SHOWN.

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 30573, Salt Lake City, UT 84130-0573. 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.

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.

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

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PO BOX 30555
SALT LAKE CITY, UT 84130-0555
Phone: 1-866-270-5311

February 11, 2020

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for all your claim and benefit information.

- By the toll free message line at (888) 877-4894.
- By writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, PO Box 14480, Salem, OR 97309-0405.
- Through the Internet at http://www.insurance.oregon.gov
- Or by e-mail at: cp.ins@oregon.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.

Benefit Notice: If you require services for hearing loss, information can be found in your plan documents.

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 1-866-270-5311.

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 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

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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 hodíílnih.

Account Summary

Summary of Out of Pocket
Plan Year: 2020

Relationship: CH

	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Out of Pocket	$5,500.00	$4,698.45	$801.55
OUT OF NETWORK			
Out of Pocket	$11,000.00	$0.00	$11,000.00

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NET MEDICAL/RX COMBINED			
Deductible	$5,000.00	$4,698.45	$301.55
Out of Pocket	$11,000.00	$4,698.45	$6,301.55
OUT OF NETWORK			
Deductible	$10,000.00	$0.00	$10,000.00
Out of Pocket	$22,000.00	$0.00	$22,000.00

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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.