United Healthcare

Atlanta, GA 30374[redacted]

APPROVED:
Service requested is covered by your plan

CHLOE JONES
[redacted]

Plan ID: [redacted]
Plan name: [redacted]
Member ID: [redacted]

August 9, 2024

Dear Chloe,

We received a request to cover health care services from an out-of-network provider. These services will be covered at the network level because currently there isn't a doctor, health care professional, or facility in your area to provide these services.

Member name: Chloe Jones
Authorization #: [redacted]
Place of service: Office
Out-of-network provider: [redacted]
Date(s) of service: 08/28/2024 to 11/26/2024
Service(s) approved:

- **Procedure code:** 92002
  - **Procedure description:** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
  - **Total requested:** 6 Units

- **Procedure code:** 92004
  - **Procedure description:** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
  - **Total requested:** 6 Units

- **Procedure code:** 92012
  - **Procedure description:** Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
  - **Total requested:** 6 Units

- **Procedure code:** 99215

[redacted]

- **Procedure description:** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
- **Total requested:** 6 Units

If these services are needed in the future, please submit a new request for evaluation in case we have added a network doctor, health care professional, or facility who can provide this care.

Remember:

- Your provider is out-of-network. Out-of-network providers sometimes bill members for more than they receive from the member's cost share (copay, coinsurance, deductible) and the amount we paid them (called "allowable expenses," the maximum amount providers are paid for services).
- Your plan may have limits on how many visits or services the plan covers.

To find or verify your PCP or network provider, visit **myuhc.com/exchange** or call the toll-free number on your health plan ID card.

This is a benefit determination, not a medical decision. Only you and your doctor can decide what medical care you need.

Questions? We're here to help.
If you have any questions, please call the toll-free number on your health plan ID card. TTY users should call 711.

Sincerely,

United HealthCare Services, Inc. on behalf of UnitedHealthcare Insurance Company
[redacted]
Cypress, CA 90630

Copy to: [redacted]
Copy to: [redacted]

Enclosure: *Non-Discrimination Notice*

United Healthcare

Atlanta, GA 30374[redacted]

[redacted]

APPROVED:
Service requested is covered by your plan

CHLOE JONES
[redacted]

Plan ID: [redacted]
Plan name: [redacted]
Member ID: [redacted]

August 17, 2024

Dear Chloe,

We received a request to cover health care services. Based on the information we received from your provider, we're pleased to tell you we've approved the service(s) below:

Member name: Chloe Jones
Authorization #: [redacted]
Provider/health care professional: [redacted]
Facility or office name: Ssm Hlth Cardinal Glennon Childrens Hosp
Service(s) approved:

- **Procedure code:** Hospitalization
  - **Procedure description:**
  - **Date(s) of service:** 10/01/2024 to 12/30/2024

- **Procedure code:** 67904
  - **Procedure description:** Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
  - **Date(s) of service:** 10/01/2024 to 12/30/2024

To find or verify your PCP or network provider, visit **myuhc.com/exchange** or call the toll-free number on your health plan ID card.

This is a benefit determination, not a medical decision. Only you and your doctor can decide what medical care you need.

Questions? We're here to help.
If you have any questions, please call the toll-free number on your health plan ID card. TTY users should call 711.

Sincerely,

United HealthCare Services, Inc. on behalf of UnitedHealthcare Insurance Company

[redacted]

Cypress, CA 90630

Copy to: [redacted]
Copy to: Ssm Hlth Cardinal Glennon Childrens Hosp

Enclosure: *Non-Discrimination Notice*

Prior Authorization Approval
Revised: 9/21

This approval does not guarantee that the plan will pay for the service. Other plan rules apply to claims payment.

You are responsible for deductibles, coinsurance, copayments, and items not covered by the plan. Before getting services, it's a good idea to check your provider's network status and cost of service.

Coverage for these services is subject to the terms and conditions of your health benefit plan including exclusions, limitations, conditions, and patient eligibility. Payment is based on the submitted claim, the actual health care services you received, your plan benefit language when services are received, and other plan rules, including coordination of benefits.
If required by your plan, your primary care provider must send an electronic referral before you see a specialist. If you see a specialist without a referral, you might have to pay the full cost for services.

Visit **myuhc.com/exchange** to access the cost estimator tool, look up benefits, update account information, find a doctor or facility, learn more about healthy living, or view your claims, Health Statements, and Explanation of Benefits. Registration is easy and gives you access to useful tools and information to help you take charge of your health and health care.

Visit **justplainclear.com** to find simple definitions for complicated health care terms.

United Healthcare

UnitedHealthcare Insurance Company
[redacted]
Atlanta GA 30374-[redacted]

[redacted]
KEYANNA JONES
[redacted]

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

December 10, 2024

Member/Patient Information
Member/Patient: CHLOE JONES
Member ID: [redacted]
Group Name: [redacted]
Group Number: [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
$15,188.00	**Amount Billed** The amount your provider charged for services provided to you.
$0.00	**Plan Discount** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$1,775.79	**Your Plan Paid** The money your health benefit plan paid.
$13,412.21	**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.

Use this EOB statement as a reference or retain as needed

[redacted]

United Healthcare

UnitedHealthcare Insurance Company
[redacted]
Atlanta GA 30374-[redacted]
[redacted]

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

Claim Detail for CHLOE JONES
Provider: SSM HLTH CARDINAL GLENNON CHILDRENS HOSP

Claim Number: [redacted] Patient Account Number: [redacted]

							Your Itemized Responsibility to Provider**				
Date(s) of Service	**Type of Service**	**Notes***	**Amount Billed**	**Plan Discounts**	**Amount Allowed**	**Your Plan Paid**	Deductible	Copay	Coinsurance	Non-Covered	Amount You Owe
10/01/2024	Drugs and medications	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	Drugs and medications		$30.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$30.00	$30.00
10/01/2024	Drugs and medications		$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	SURGICAL SERVICE/PRO CEDURE	A1	$10,382.00	$0.00	$2,075.79	$1,775.79	$0.00	$300.00	$0.00	$8,306.21	$8,606.21
10/01/2024	Anesthesia	D3	$2,730.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2,730.00	$2,730.00
10/01/2024	DRUGS/IMMUN IZATIONS/INJE CTIONS	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	DRUGS/IMMUN IZATIONS/INJE CTIONS	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	DRUGS/IMMUN IZATIONS/INJE CTIONS	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	DRUGS/IMMUN IZATIONS/INJE CTIONS	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	DRUGS/IMMUN IZATIONS/INJE CTIONS	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50

**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.

Use this EOB statement as a reference or retain as needed

[redacted]

United Healthcare

UnitedHealthcare Insurance Company

[redacted]

Atlanta GA 30374-[redacted]

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

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Amount Allowed	Your Plan Paid	Your Itemized Responsibility to Provider**				
							Deductible	Copay	Coinsurance	Non-Covered	Amount You Owe
10/01/2024	DRUGS/IMMUNIZATIONS/INJECTIONS	D3	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$16.50	$16.50
10/01/2024	Specialty service/room	D3	$1,914.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,914.00	$1,914.00

**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*

D3 According to your plan, benefits are only available at the network level when a network health care provider is used. Since this service was performed by a non-network health care provider, no benefits are payable. You may be responsible for paying the full billed charges for the service(s).

A1 Your plan covers the eligible expense amount reimbursable under your plan for covered out-of-network health services. The eligible amount is based on a database of competitive fees for similar services or supplies in your area. Benefits are not available for that portion of the charge that exceeds the eligible amount determined for this service.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, [redacted] The request for your review must be made within 180 calendar 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 20 business days after we receive your request for review.

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.

Use this EOB statement as a reference or retain as needed

[redacted]