UnitedHealthcare
4 Research Drive
Shelton, CT 06484
Phone: 1-866-764-7737

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for all your claim and benefit information.

October 18, 2022

DPS$$$PKG
VAVUDALA, SRIKANTH
8911 N KITMORE DR
HOUSTON TX 77099-1818

SUBSCRIBER NAME: Srikanth Vavudala
SUBSCRIBER ID: 20559220600
MEMBER NAME: Srikanth Vavudala
GROUP/POLICY: HOLLERITH IT SOLUTIONS LLC
GROUP/POLICY#: 1419005

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
$126.00	**Amount Billed** This is the total amount that your provider billed for the services provided to you.
$8.90	**Amount Allowed** The most that is available to pay for covered benefits under your plan.
$0.00	**Your Other Insurance Paid** Amount paid by other carrier if applicable.
$0.00	**Your Plan Paid** The amount paid by your health benefits plan.
$8.90	**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, co-pay, co-insurance 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 Srikanth Vavudala

Member ID: 20559220600
Patient Account Number: SAPA5439467

Claim Number: DN90425484

Rendering Provider: MILES, BRIAN
Rendering Provider NPI: 1356359335
Billing Provider NPI: 1538107875

Date(s) of Service	Description of Service	Adj Code	Amount Billed	Amount Not Owed	Amount Allowed	Your Other Insurance Paid	Paid Amount	Your Itemized Responsibility to Provider**			
								Deductible	Copay/ Coins	Patient Non Covered	Amount You Owe
09/10/2022	X-RAY EXAM CHEST 1 VIEW (71045-26)	DED003, PPO008	$126.00	$117.10	$8.90	$0.00	$0.00	$8.90	$0.00 $0.00	$0.00	$8.90
Claim Total:			**$126.00**	**$117.10**	**$8.90**	**$0.00**	**$0.00**	**$8.90**	**$0.00**	**$0.00**	**$8.90**

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

Adjustment Code Descriptions:

DED003 - The amount shown has been applied to your deductible.

PPO008 - Your participating (in-network) provider has agreed to a contracted rate. You are only responsible to pay your copay, coinsurance, or deductible.

RIGHTS OF REVIEW AND APPEAL

If this claim has or is currently in the process of being appealed, please disregard the Member Appeal Information provided below and follow the instructions that were previously mailed to you.

If we have requested additional information to process your claim, this information must be submitted to Member Claim Resubmissions, P.O. Box 31394 Salt Lake City, UT 84131. The requested information must be submitted within 45 days from the date of your receipt of this notice. Upon receipt of the information, we will elect to take the one-time, 15-day extension that is permitted under the Employee Retirement Income Security Act (ERISA) and will provide you with a written response no later than 15 days from receipt of the information. Failure to submit this information within 45 days will result in an automatic denial of this claim due to lack of information. No further notice will be provided to you. In the event that you fail to follow these procedures in the timeframe specified but wish to submit relevant information outside the timeframe and/or request an appeal, please follow the appeal procedure listed below.

Member Appeal Information

The claimant has the right to request a review of an adverse benefit determination. Please review the Explanation of Benefits for details of our claim determination. If you

think this decision was made in error, you or your authorized representative may request a review. Your request must be made within 180 days from the date you received this notice. Send your appeal in writing to: UNITEDHEALTHCARE SERVICES, INC., Appeals Review, P.O. Box 31393 Salt Lake City, UT 84131. You should include any new information that you want us to consider.

Within 30 days or less after receiving the appeal, the claimant or the claimant's authorized representative will be notified of the decision. If additional information is needed to make a determination, the claimant or claimant's authorized representative will be notified of what additional information is necessary, and the review will proceed upon receipt of the information. If the claimant or the claimant's authorized representative is not satisfied with the outcome of the first appeal, there may be an option of a second appeal.

If we continue to deny the payment, 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 issue a final decision.

For more information regarding available levels of appeals refer to the Summary Plan Description.

If the claimant is not satisfied with the outcome of the appeals, the claimant has the right to bring a civil action under section 502(a) of the Employment Retirements Security Act of 1974.
An internal rule, guideline, protocol, or other similar criterion was referenced in making this possible adverse benefit determination. A copy of the rule, guideline, protocol, or other similar criterion may be requested free of charge. If the line adverse benefit determination was based upon medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment of the determination, if not already indicated, may be requested free of charge. Please send the written request indicating the specific information being requested to: **Information Request P.O. Box 31394 Salt Lake City, UT 84131.**

There may be other resources available to help you understand the appeals process. You can contact the Employee Benefits Security Administration at 1-866-44-EBSA(3272).

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) or www.askebsa.dol.gov. 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. Your state consumer assistance program may also be able to assist you at:

Texas Health Options
Toll-free telephone: 1-800-252-3439
Web site: www.texashealthoptions.com

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Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2022

Srikanth
INDIVIDUAL

	Annual Amount	(-)	Applied to Date	(=)	Remaining Balance
In Network					
Deductible	$3,500.00		$2,835.70		**$664.30**
Out of Pocket	$8,150.00		$3,135.70		**$5,014.30**

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Definitions of Key Terms

Adjustment Code: The code we assign to describe how we processed a claim line. Generally, the adjustment code shows a correction, adjustment, or denial.

Amount Not Owed: You do not owe this amount because either (1) you chose a network provider that gives us a standing discount, (2) you chose an out-of-network provider that agreed to an amount less than billed, or (3) it is a surprise bill and the law protects you from having to pay it.

Amount Allowed: The most that is available to pay for covered benefits under your plan. For a participating provider, it is an agreed upon amount. If your plan has out-of-network benefits, it is the lower of the billed amount, the amount available for payment using the plan's out-of-network reimbursement rates and rules, or the amount the provider has agreed to accept as payment. Please see your health benefits plan, including your Summary of Benefits for more information.

Amount Billed (Charges): This is the total amount that your provider billed for the services provided to you.

Your Other Insurance Paid: The amount covered by your other health plan when that health plan is "primary".

Amount You Owe: The amount you are responsible to pay. This includes items not covered by your health benefits plan, such as excluded services, penalty amounts, deductibles, coinsurance, copayments and for out-of-network services, amounts about the maximum amount. (The patient responsibility shown on this EOB does not take into account any amounts paid at the time of service).

Billing Provider NPI: The National Provider ID (NPI) of the billing entity responsible for billing a patient for healthcare services.

Claim Number: The number the system assigns to your claim. A claim number is assigned to every claim.

Coinsurance Amount: The portion of the maximum amount you must pay for covered benefits during the plan year. Please see your Summary of Benefits for the coinsurance amount. Coinsurance (when part of your plan) typically does not apply until after you meet the deductible.

Copay Amount: The amount you are required to pay directly to a Provider for in-network covered benefits at the time of the service. Copayments generally apply when receiving services from participating providers. Please see your Summary of Benefits for the applicable copayment amount.

Date(s) of Service: The date the physician or facility performed the service(s).

Description of Service: A brief description of the medical service, supply or medication billed along with the procedure code or Revenue Code. A procedure code is an alpha numeric identifier used to define the medical service, supply or medication billed. A Revenue Code is used by hospitals to report services rendered - revenue codes are three digits.

Deductible Amount: The amount you must pay for covered benefits during the plan year before we begin making payments for covered benefits. Please see your Summary of Benefits for the applicable deductible amount. In most instances, the deductible amount must be met before coinsurance applies.

Patient Non Covered: A service or expense that you do not have coverage for under your health benefit plan.

Rendering Provider: The Rendering Provider is the name of the person or company (laboratory or other facility) who rendered the care.

Rendering Provider NPI: The NPI was put in place so that each provider has one unique, government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

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。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: 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.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية الخاص بك.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે. કૃપા કરી તમારા આઇડેન્ટીફિકેશન કાર્ડ પર આપેલા ટોલ-ફ્રી નંબર પર કૉલ કરો.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: In caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

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 shoodí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

توجہ درکار ہے: اگر آپ اردو (Urdu) زبان بولتے ہیں تو آپ کے لئے زبان معاون خدمات دستیاب ہے۔ براہ کرم آپ کے شناختی کارڈ پر دیے گئے ٹول فری فون نمبر پر کال کریں۔