Understanding your Explanation of Benefits statement.

Use this guide to better understand details of your claim, including how much your plan covered, what you owe and your remaining out-of pocket balances and more.

Service Center
Address
City, State, ZIP Code
Phone: 1-888-888-8888

Have more questions about your claim?
Visit (name of member website)
for all your claim and benefit information.

Date

John Johnson
Address
City, State, ZIP Code

1 **Member/Patient Information**
Member/Patient: John Johnson
Member ID: 123456789
Group Name: ABC Company
Group #: 1234567

Explanation of Benefits Statement
This is not a bill. Do not pay. This is to notify you that we processed your claim.

2 **Claims Summary** Detailed claim information is located on following page(s)

Dollar Amount	Description
$229.00	**Amount Billed** The amount your provider changed for services provided to you.
$32.23	**Plan Discounts** The money your health benefit plan paid.
$80.00	**Your Plan Paid** The money your health benefit plan paid.
$116.77	**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.

Use this EOB statement as a reference or retain as needed. **Page 1 of 4**

Your EOB may look different depending on your plan.

1 Member/Patient Information

Member - The name of the individual with group health coverage through their employer.

Patient - The name of the person who received the medical care.

2 Claims Summary

Summary section shows the “math” with details on how much your plan paid, plan discounts, and how much you may owe your provider.

CONTINUED

UnitedHealthcare®

Claim Detail page.

Date

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Claim Detail *for John Johnson*
Provider: D[illegible] Martin **Claim Numbe**[illegible]3199111101 **Patient Account Number:** 3201858-11

Date(s) of Service	Type of Service	Notes*	Amount Billed	Plan Discounts	Allowed Amount	Your Plan Paid	Your Itemized Responsibility to Provider**				Amount You Owe
							Deductible	Copay	Coinsurance	Non-Covered	
7/1/18	Office Visits	D1	$104.00	$32.23	$71.77	$0.00	$71.77	$0.00	$0.00	$0.00	$71.77
7/1/18	Laboratory		$125.00	$0.00	$125.00	$80.00	$25.00	$0.00	$20.00	$0.00	$45.00
Claim Total:			**$229.00**	**$32.23**	**$196.77**	**$80.00**	**$96.77**	**$0.00**	**$20.00**	**$0.00**	**$116.77**

****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*

D1 - The discount shown is your savings. Your network physician or health care provider has agreed to the plan discount. The amount you owe may include what you need to pay if you have reached a benefit limit on covered health services. If you need more information about your benefits, please go to your member website or 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 1-866-633-2474.

You have the right to receive, upon request and free of charge, a copy of the internal rule, guideline or protocol that we relied upon in making the non-coverage decision for your claim.

MEDICAL CLAIMS ONLY

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 9999, Salt Lake City, UT 99999. 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.

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

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3 Service Description
Description of care provided. Remark code text is listed below the Service Details box.

4 Your Plan Paid
The amount of benefits paid to the employee or provider.

5 Deductible/Copay/Coinsurance/Non-Covered
Itemized Responsibility. This section shows the amount you owe to the provider.

6 Notes
This section gives more detail on how the claim was processed. It also shows your appeals options and other helpful information.

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Notes*

Rather view this online?
Sign up for myuhc.com to easily view claims and account balances, see where you're at against your deductible, locate a network doctor, compare costs, select paperless delivery of your important plan documents and more.

Rather view this on your mobile device?
Download our free Health4Me® app, then sign up to easily find and map care, compare costs, view claims and account balances and more. Get access to the same personalized health plan information while you're on the go.

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 identifier on UnitedHealthcare correspondence, including Health Plan 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 call the number on your health plan ID card.

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Account Summary page.

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Date

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7 Account Summary

Summary of Deductible and Out-of-Pocket
Plan Year 2018

JOHN

Relationship: EE	Total Plan Year Amount	(-) Applied to Date	(=) Remaining Balance
In-Network			
Deductible	$750.00	$750.00	Met
Out of Pocket	$2,500.00	$770.00	$1,730.00
Out-of-Network			
Deductible	$1,500.00	$0.00	$1,500.00
Out of Pocket	$5,500.00	$0.00	$5,500.00

FAMILY

	Total Plan Year Amount	(-) Applied to Date	(=) Remaining Balance
In-Network			
Deductible	$2,500.00	$900.00	$1,600.00
Out of Pocket	$5,750.00	$1,000.00	$4,750.00
Out-of-Network			
Deductible	$4,500.00	$0.00	$4,500.00
Out of Pocket	$8,000.00	$0.00	$8,000.00

8 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 plan benefit 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.

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7 Account Summary
Shows the year-to-date deductible and maximum amounts for you and your covered dependents.

8 Definitions
This section defines the key terms used to explain your claim.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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