HealthSelect℠ of Texas

Understanding your Explanation of Benefits (EOB)

United HealthCare Services, Inc.
San Antonio Service Center
PO Box 740809
Atlanta, GA 30374-0809
(866) 336-9371

Have more questions about your claim?
Sign in to your online account at
healthselectoftexas.com
for all your claim and benefit information

Date

John Doe
Address
City, State, Zip

1 **Member/Patient Information**
Member/Patient: John Doe
Member ID: 123456789
Group Name: Employees Retirement System of Texas
Group #: 744260

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** This is the total amount that your provider billed for the services that were provided to you.
$32.23	**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.
$75.00	**Your Plan Paid** This is the portion of the amount billed that was paid by your plan.
$121.77	**Total Amount You Owe the Provider** The portion of the charges you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care or any amount that may have been paid to you. This amount may include your deductible, copay, coinsurance and/or non-covered charges.

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

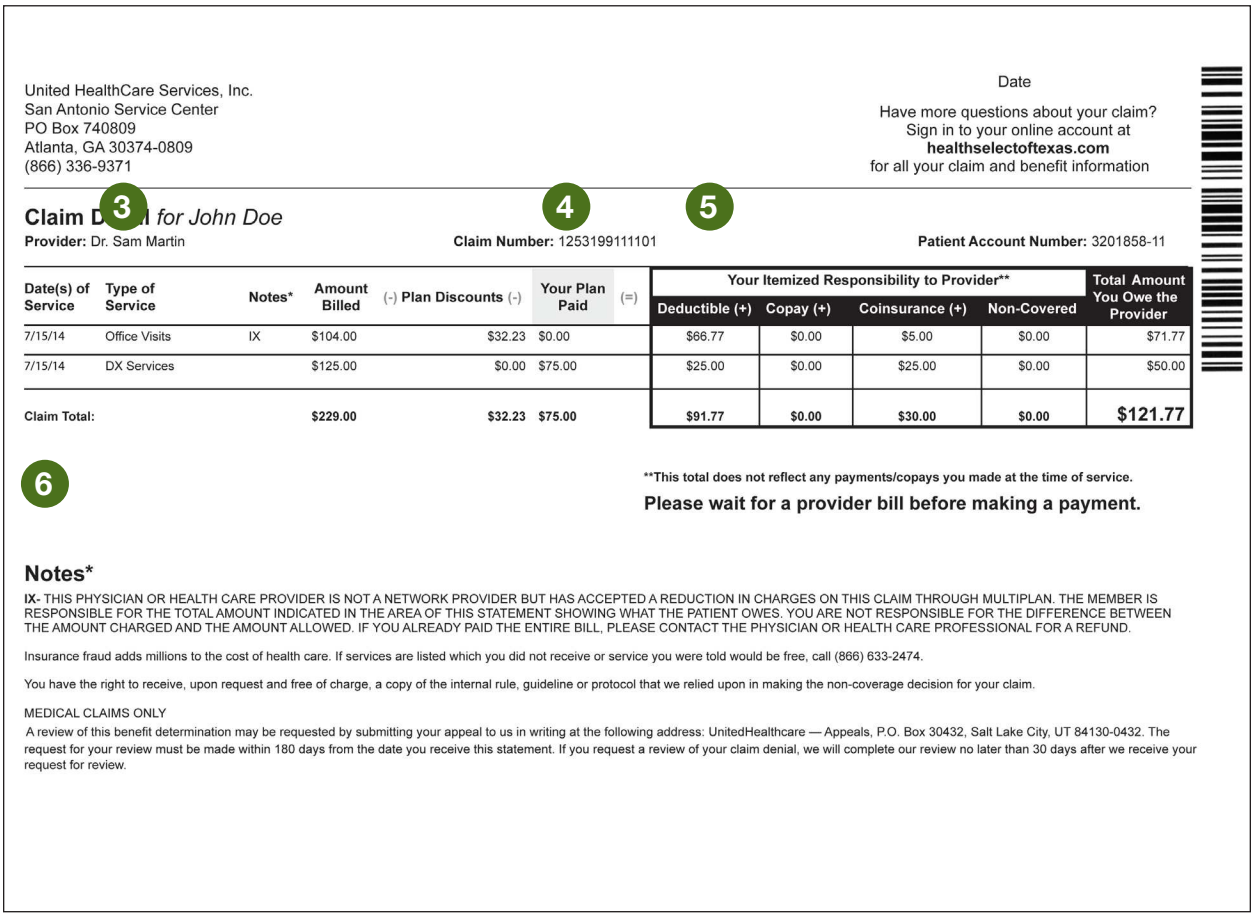
1. Patient

The name of the person who received services.

2. Claims Summary

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

Claim detail page



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Claim D *for John Doe*

Provider: Dr. Sam Martin

Claim Number: 1253199111101

Patient Account Number: 3201858-11

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-) Plan Discounts (-)	Your Plan Paid (=)	Your Itemized Responsibility to Provider**				Total Amount You Owe the Provider
						Deductible (+)	Copay (+)	Coinsurance (+)	Non-Covered	
7/15/14	Office Visits	IX	$104.00	$32.23	$0.00	$66.77	$0.00	$5.00	$0.00	$71.77
7/15/14	DX Services		$125.00	$0.00	$75.00	$25.00	$0.00	$25.00	$0.00	$50.00
Claim Total:			**$229.00**	**$32.23**	**$75.00**	**$91.77**	**$0.00**	**$30.00**	**$0.00**	**$121.77**

**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*

IX- THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER BUT HAS ACCEPTED A REDUCTION IN CHARGES ON THIS CLAIM THROUGH MULTIPLAN. THE MEMBER IS RESPONSIBLE FOR THE TOTAL AMOUNT INDICATED IN THE AREA OF THIS STATEMENT SHOWING WHAT THE PATIENT OWES. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROFESSIONAL FOR A REFUND.

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 (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 30432, Salt Lake City, UT 84130-0432. 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.

3. Types of Service

Description of the type of service provided.

4. Your Plan Paid

The amount of benefits paid to the provider by the HealthSelect plan. If you submitted a claim for reimbursement, this will be the amount paid to you by the HealthSelect plan.

5. What You May Owe

This section shows any responsibility you may have related to services provided, such as copayments, deductibles and coinsurance. Any services or amounts not covered by the HealthSelect plan will be listed here.

6. Notes

This section will provide additional information on how your claim was processed and paid or indicate why your claim was not paid. This section also outlines your appeal options if you disagree with the way your claim was processed.

Claim detail page

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(8[illegible]336-9371

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Notes*

Meet Your Needs Online

At almost anytime of the day or night, you can review claims, check eligibility, locate a network physician, request an ID card, refill prescriptions if eligible and more: For immediate, secure self-service, sign in to your online account at **healthselectoftexas.com**.

How to Register?

You can register and begin using **healthselectoftexas.com** in the same session. Navigate to **healthselectoftexas.com** to register. The information required for registration is on your insurance ID card (first name, last name, member ID, group number and date of birth).

Maintaining the privacy and security of an individual's personal information is very important to us at your Health Plan. To protect your privacy we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier on your Health Plan 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 page.

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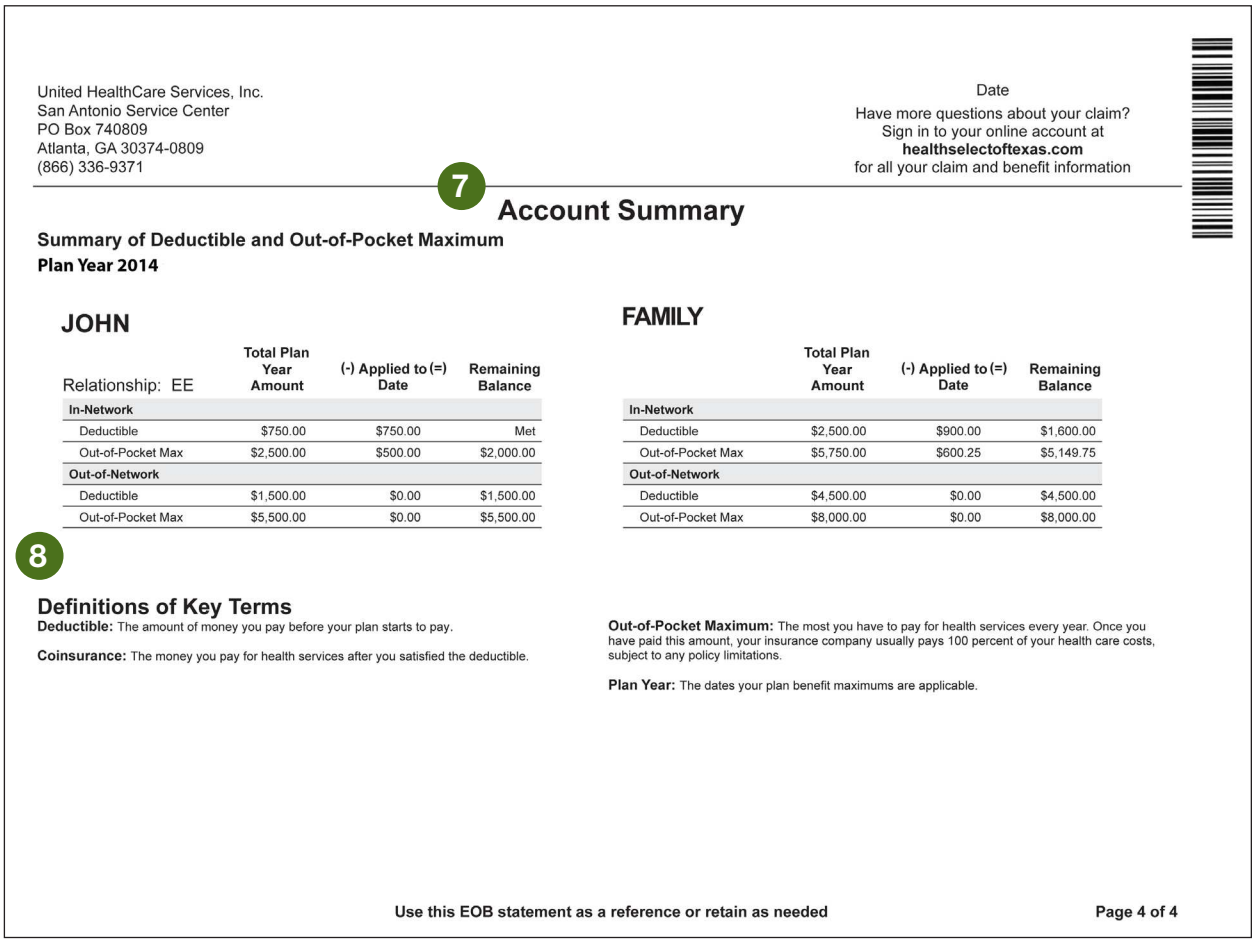
6. Notes (continued)

Additional tools and information are available to you on the HealthSelect website.

Claim detail page

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



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Account Summary

Summary of Deductible and Out-of-Pocket Maximum
Plan Year 2014

JOHN

Relationship: EE	Total Plan Year Amount	(-) Applied to (=) Date	Remaining Balance
In-Network			
Deductible	$750.00	$750.00	Met
Out-of-Pocket Max	$2,500.00	$500.00	$2,000.00
Out-of-Network			
Deductible	$1,500.00	$0.00	$1,500.00
Out-of-Pocket Max	$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 Max	$5,750.00	$600.25	$5,149.75
Out-of-Network			
Deductible	$4,500.00	$0.00	$4,500.00
Out-of-Pocket Max	$8,000.00	$0.00	$8,000.00

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Definitions of Key Terms

Deductible: The amount of money you pay before your plan starts to pay.

Coinsurance: The money you pay for health services after you satisfied the deductible.

Out-of-Pocket Maximum: The most you have to pay for health services every year. Once you have paid this amount, your insurance company usually pays 100 percent of your health care costs, subject to any policy limitations.

Plan Year: The dates your plan benefit maximums are applicable.

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7. Account Summary

Even though this is an individual EOB, it also displays the family year-to-date deductible and out-of-pocket maximums when applicable.

8. Definitions

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

ERS Employees Retirement System of Texas | UnitedHealthcare®

275-7843 07/14