Understanding your health plan statement.

Service Center
P.O. Box 1234
Anywhere, US 12345-6789

Health Plan Name

Address Change? Please contact your employer's benefit department.
DPS$$$PKG
SUSAN TEST
123 Main St.
Anywhere US 12345-6789

Member ID
123456789
Statement Period
4/15/19-5/10/19

THIS IS NOT A BILL

Customer Care 1-888-888-8888

Visit Your Website

Have you visited your member website lately? If not, you've missed out on a lot of important information. Not only can you find your current account balance and track your claims activity but there are also a variety of tools to help you manage your health. So if you haven't logged in for a while, check out the site today. Don't worry if you forgot your password -- you can get a reminder on the website. The website address is on the back of your ID card.

Medical claims where payments may be needed from you:

Claims processed between **04/15/19** to **05/10/19**	Pay your provider(s) when they bill you	Applied To Deductible
05/07/19 services for **BRADLEY** provided by **'Test Provider'** Claim Number: 1234567890123 Provider Billed: **$303.00** Payments and Discounts: **-$136.62**	$166.38	$166.38
Total:	$166.38	$166.38

For more information about these claims, please refer to the 'Medical Claim Details' section of this document, the Explanation of Benefits, or visit: www.myuhc.com.
This is not a bill. Your provider will bill you directly unless you have already paid them. Please check your records.
These charges represent your responsibility as defined by your health benefit plan. They may include your deductible, coinsurance, or a product or service that is not an eligible expense. If you have coverage with another insurance carrier or Medicare, these charges may not include any product or service in which the other insurance carrier or Medicare was primary. In addition, the amount in the "Pay your provider(s) when they bill you" area above may include payments made to the subscriber. Please see your coverage documents for more information.

* If you have a Health Reimbursement Account (HRA) or a Flexible Spending Account (FSA), that payment may have been made after this statement was created and will be reflected on your next statement.

Your Account Balances

Your Account Balances as of 05/10/19 for Plan Year 01/01/19 to 12/31/19

Health Reimbursement Account (HRA)

Beginning	Used		Remaining
$1,000.00	$596.41		$403.59

Health care accounts that employers fund for covered workers or retired persons.

Flexible Spending Account (FSA)

Beginning	Used		Remaining
$500.00	$500.00	NO FUNDS REMAINING	$0.00

A benefit plan that lets employees put pre-tax dollars in special accounts to help pay medical costs, child care, and other health care services.

Tracking Your Deductibles and Maximums

Your Deductibles as of 05/10/19 for Plan Year 01/01/19 to 12/31/19

	Network				Out-of-Network			
	Annual	Applied		Remaining	Annual	Applied		Remaining
SUSAN S	$1,000.00	$450.00		$550.00	$1,500.00	$0.00	NONE USED	$1,500.00
BRADLEY	$1,000.00	$312.79		$687.21	$1,500.00	$0.00	NONE USED	$1,500.00
FAMILY (Employee and spouse)	$2,000.00	$762.79		$1,237.21	$3,000.00	$0.00	NONE USED	$3,000.00

Deductible: The amount you could owe during a coverage period for services your health benefit plan covers before your plan begins to pay.

Please see the next page for more information
Page 2 of 7
Customer Care 1-888-888-8888

Member ID Number

A unique employee number that protects your Social Security number.

Statement Period

Your benefit plan activity during a period of time.

Message Center

Messages that promote better health awareness.

What You Owe (if applicable)

The amount you need to pay your health care professional if you did not pay at the time you received services.

Your Account Balances (if applicable)

Financial balances for your health reimbursement account (HRA) or flexible spending account (FSA).

Tracking Your Deductibles and Limits

Summary of your deductible and out-of-pocket limit and balances. Your health statement contains both network and out-of-network balance information. You also will be able to see both your out-of-network deductible and out-of-pocket balance summaries.

CONTINUED

Medical claims where payments are not needed from you: continued

Claims for **NADA:** Processed between **04/15/19** to **05/1**

	A	B	C	D	E
	Provider Billed	**Plan Discount**	**Allowed Amount**	**Health Plan Paid**	**Copay**
04/17/19 services provided by 'TEST PROVIDER'					
Claim Number: **1234567890123**	$283.00	-$252.04	$30.96	-$30.96	...

- **THIS CLAIM WAS PROCESSED ON 04/29/19.**
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE ROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.

Medical Claims Where Payments Are Not Needed From You

A: Total amount billed by your health care professional or facility before any network discounts are applied.

B: The discount health care professionals and facilities in our network agree to give you as a member.

C: The amount the plan allows for health care services.

D: Amount paid by your benefit plan for covered expenses.

E: A fixed fee that medical plan subscribers must pay for their use of specific medical services covered by the plan. This may have been paid when you received services.

Depending on your benefit plan, your statement may have additional columns or sections.

Medical Claim Details

THIS IS NOT A BILL - Please compare this information to the bill you receive from your provider, then pay the provider directly when they bill you.

Claims for NADA Member ID **123456789**

Date of Service: **05/07/19** Claim #: **789012** Group Na **CUSTO**
Provider: **'TEST PROVIDER'** Process D **09/19** roup #: **57**

Service Type	Provider Billed (F)	Plan Discount (G)	Allowed Amount (H)	Health Plan Paid (I)	Copay (J)	Total You Owe (K)
A	$177.00	-$157.35	...	-$15.72	...	$3.93
A	$31.00	-$29.74	...	-$1.01	...	$0.25
A	$93.00	-$85.51	...	-$5.99	...	$1.50
Total	$301.00	-$272.60	$28.40	-$22.72	$0.00	$5.68

A=LABORATORY SERVICES

Total You Owe Provider: $5.68

Medical Claim Details

Detailed information from a claim for services you received. It will display what you may need to pay. This information can be used to support coordination of benefits for a secondary carrier or proof of claim for an external FSA.

F: Total amount billed by your health care professional or facility before any network discounts are applied.

G: The discount health care professionals and facilities in our network agree to give you as a member.

H: The amount the plan allows for health care services.

I: Amount paid by your benefit plan for covered expenses.

J: A fixed fee that medical plan subscribers must pay for their use of specific medical services covered by the plan. This may have been paid when you received services.

K: Amount you owe.

Columns will be shown only if part of your benefit plan.

Contact your UnitedHealthcare representative for additional information.

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

Facebook.com/UnitedHealthcare **Twitter**.com/UHC **Instagram**.com/UnitedHealthcare **YouTube**.com/UnitedHealthcare

B2C 9170165.1 6/19 ©2019 United HealthCare Services, Inc. 19-12654

UnitedHealthcare®