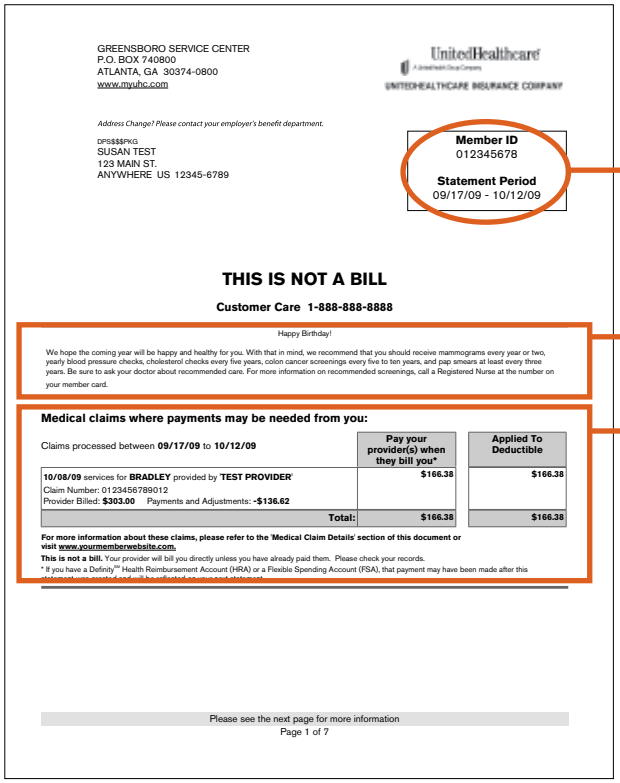
# Understanding your health statement



GREENSBORO SERVICE CENTER
P.O. BOX 740800
ATLANTA, GA 30374-0800
www.myuhc.com

UnitedHealthcare
A UnitedHealth Group Company
UNITEDHEALTHCARE INSURANCE COMPANY

*Address Change? Please contact your employer's benefit department.*

DPS$$$PKG
SUSAN TEST
123 MAIN ST.
ANYWHERE US 12345-6789

**Member ID**
012345678

**Statement Period**
09/17/09 - 10/12/09

**THIS IS NOT A BILL**

**Customer Care 1-888-888-8888**

Happy Birthday!

We hope the coming year will be happy and healthy for you. With that in mind, we recommend that you should receive mammograms every year or two, yearly blood pressure checks, cholesterol checks every five years, colon cancer screenings every five to ten years, and pap smears at least every three years. Be sure to ask your doctor about recommended care. For more information on recommended screenings, call a Registered Nurse at the number on your member card.

**Medical claims where payments may be needed from you:**

Claims processed between **09/17/09** to **10/12/09**

| | Pay your provider(s) when they bill you* | Applied To Deductible |
|---|---|---|
| **10/08/09** services for **BRADLEY** provided by '**TEST PROVIDER**'<br>Claim Number: 012345678901 2<br>Provider Billed: **$303.00** Payments and Adjustments: **-$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 or visit www.yourmemberwebsite.com.**
**This is not a bill.** Your provider will bill you directly unless you have already paid them. Please check your records.
* If you have a Definity℠ Health Reimbursement Account (HRA) or a Flexible Spending Account (FSA), that payment may have been made after this

Please see the next page for more information
Page 1 of 7

## Member number

A unique employee number that protects your Social Security number.

## Statement period

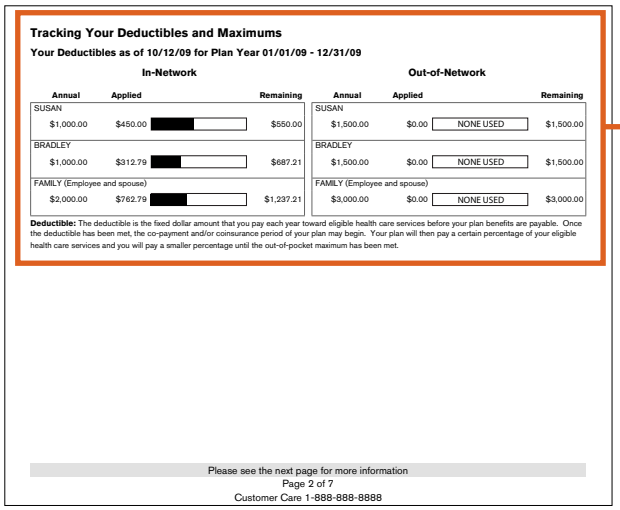
Your benefit plan activity during a period of time.

## 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.



**Tracking Your Deductibles and Maximums**

**Your Deductibles as of 10/12/09 for Plan Year 01/01/09 - 12/31/09**

| | In-Network | | | Out-of-Network | | | |
|---|---|---|---|---|---|---|---|
| | Annual | Applied | Remaining | Annual | Applied | | Remaining |
| SUSAN | $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 deductible is the fixed dollar amount that you pay each year toward eligible health care services before your plan benefits are payable. Once the deductible has been met, the co-payment and/or coinsurance period of your plan may begin. Your plan will then pay a certain percentage of your eligible health care services and you will pay a smaller percentage until the out-of-pocket maximum has been met.

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

## Tracking your deductibles and maximums

Summary of your deductible and out-of-pocket maximums and balances. Your Health Statement contains both in-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.

UnitedHealthcare®

## Medical claims where payments are not needed from you

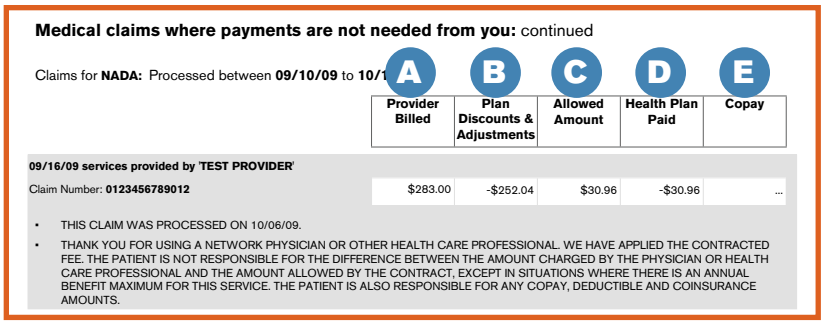
**A:** Total amount billed by your health care professional or facility before any network discounts are applied.

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



**Medical claims where payments are not needed from you:** continued

Claims for **NADA:** Processed between **09/10/09** to **10/1**

| | A Provider Billed | B Plan Discounts & Adjustments | C Allowed Amount | D Health Plan Paid | E Copay |
|---|---|---|---|---|---|
| **09/16/09 services provided by 'TEST PROVIDER'** | | | | | |
| Claim Number: **0123456789012** | $283.00 | -$252.04 | $30.96 | -$30.96 | ... |

- THIS CLAIM WAS PROCESSED ON 10/06/09.
- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. 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.

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

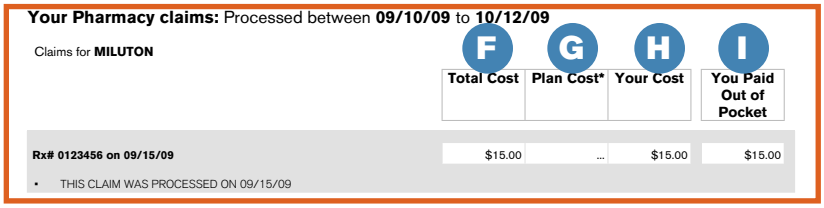
## Your pharmacy claims

**F:** The total cost of your prescription claims.

**G:** The plan's cost of your prescription claims.

**H:** Your portion of the cost for your prescription claims.

**I:** Your portion of the cost after any consumer account payment.



**Your Pharmacy claims:** Processed between **09/10/09** to **10/12/09**

Claims for **MILUTON**

| | F Total Cost | G Plan Cost* | H Your Cost | I You Paid Out of Pocket |
|---|---|---|---|---|
| **Rx# 0123456 on 09/15/09** | $15.00 | ... | $15.00 | $15.00 |

- THIS CLAIM WAS PROCESSED ON 09/15/09

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

## 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.

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

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

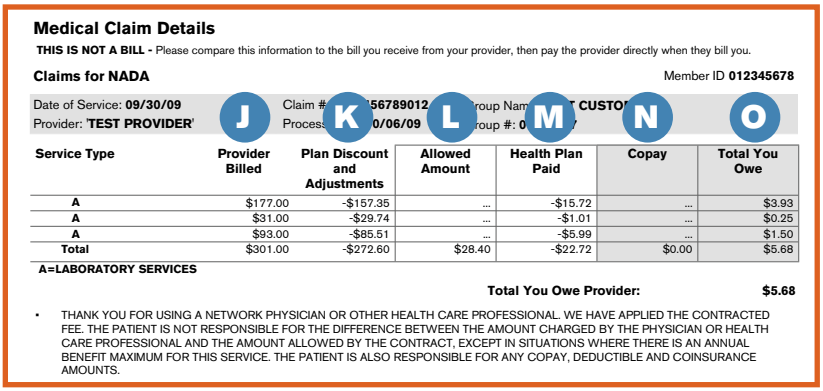
**L:** The amount the plan allows for health care services.

**M:** Amount paid by your benefit plan for covered expenses.

**N:** 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.

**O:** Amount you owe.

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



**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 **012345678**

Date of Service: **09/30/09** Claim # **56789012**
Provider: **'TEST PROVIDER'** Proces**0/06/09**

| Service Type | J Provider Billed | K Plan Discount and Adjustments | L Allowed Amount | M Health Plan Paid | N Copay | O Total You Owe |
|---|---|---|---|---|---|---|
| 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**

- THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. 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.

UnitedHealthcare®