HealthSelect of Texas

CONSUMER DIRECTED HealthSelect℠

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**

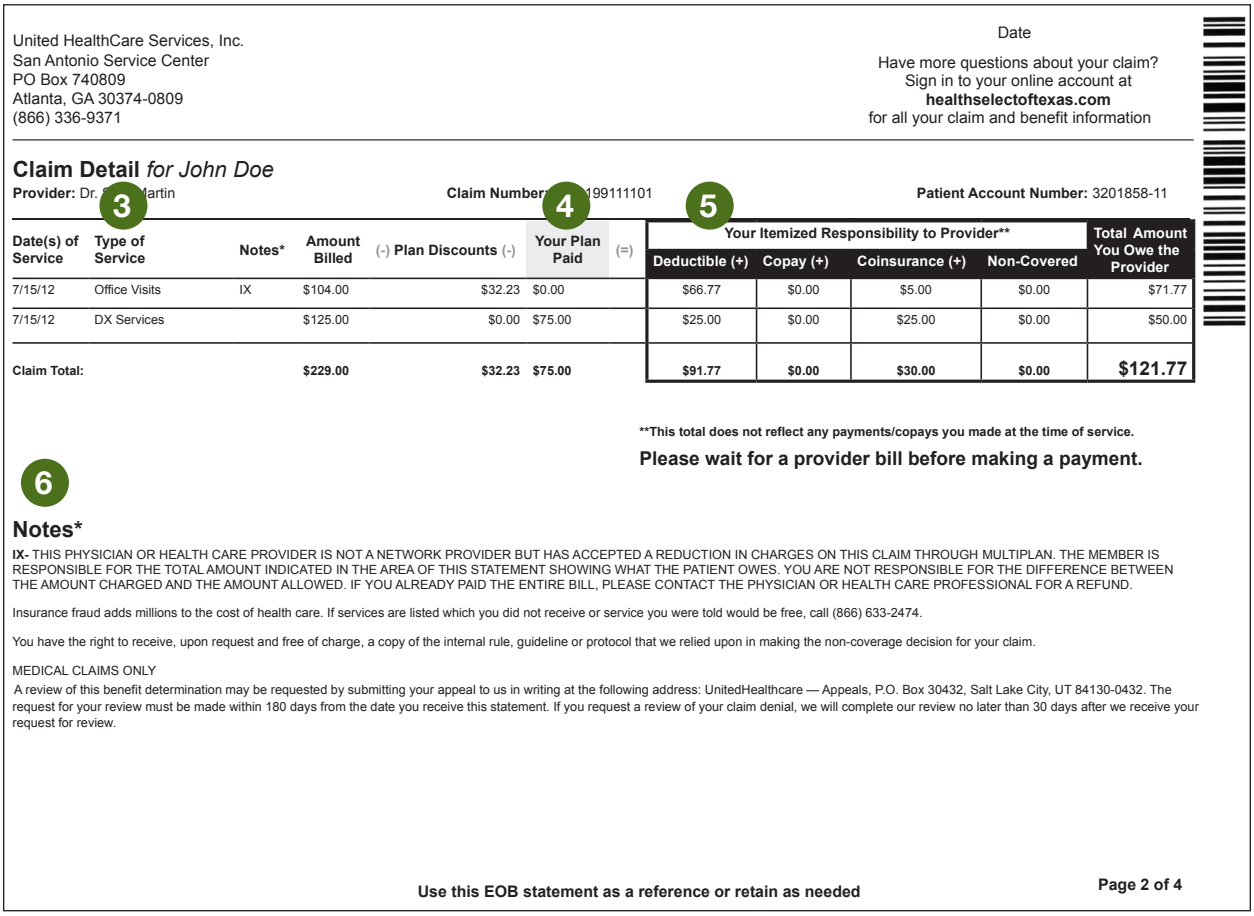
1. Patient

The name of the person who received the medical care.

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 Detail *for John Doe*

Provider: Dr. [illegible] Martin **Claim Number:** [illegible]199111101 **Patient Account Number:** 3201858-11

Date(s) of Service	Type of Service (3)	Notes*	Amount Billed	(-) Plan Discounts (-)	Your Plan Paid (4) (=)	Your Itemized Responsibility to Provider** (5) Deductible (+)	Copay (+)	Coinsurance (+)	Non-Covered	Total Amount You Owe the Provider
7/15/12	Office Visits	IX	$104.00	$32.23	$0.00	$66.77	$0.00	$5.00	$0.00	$71.77
7/15/12	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.

(6)

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.

Use this EOB statement as a reference or retain as needed

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3. Types of Service
Description of service 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
Itemized Responsibility — This section shows your responsibility for the services provided.

6. Notes
Section with more details on why claim was paid or not paid. This section also shows your appeals options and other helpful information.

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).

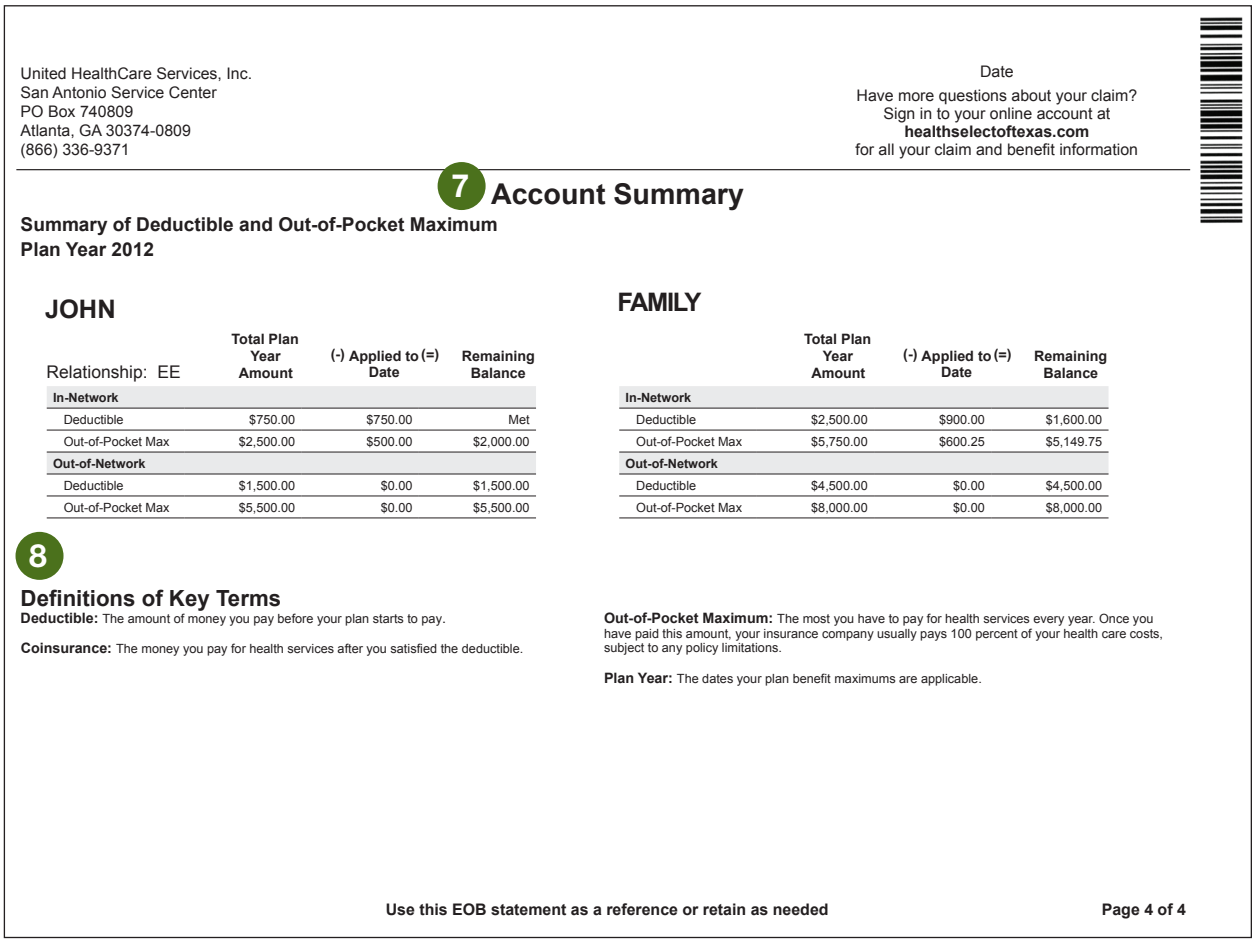
Maintaining the privacy and security of an individual's personal information is very important to us at your Health Plan. To protect your privacy we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier on your Health Plan correspondence,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

6. Notes

Section with more details on why claim was paid or not paid. This section also shows your appeals options and other helpful information.

Claim detail page

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



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7 **Account Summary**

Summary of Deductible and Out-of-Pocket Maximum
Plan Year 2012

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

8

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.

Use this EOB statement as a reference or retain as needed

Page 4 of 4

7. Account Summary

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

Please note: You have separate in-network and out-of-network deductibles.

8. Definitions

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

UnitedHealthcare Services, Inc., on behalf of itself and its affiliated companies, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

UnitedHealthcare provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters
- Information written in other languages

If you need these services, please call toll-free (866) 336-9371 (TTY 711), Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in writing by mail or email. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Civil Rights Coordinator
P.O. Box 30608
Salt Lake City, UT 84130
UHC_Civil_Rights@UHC.com

If you need help filing a grievance, please call toll-free **(866) 336-9371** (TTY **711**), Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**
Phone: Toll-free **(800) 868-1019**, **(800) 537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

You have the right to get help and information in your language at no cost. To request an interpreter, please call toll-free **(866) 336-9371** (TTY **711**), Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

This letter is also available in other formats like large print. To request the document in another format, please call toll-free **(866) 336-9371** (TTY **711**), Monday through Friday, 8 a.m. to 7 p.m. CT and Saturday, 7 a.m. to 3 p.m. CT.

Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione **(866) 336-9371** TTY **711**

Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số **(866) 336-9371** TTY **711**

您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 **(866) 336-9371**。聽力語言殘障服務專線 **711**

귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 **(866) 336-9371** 번을 누르십시오. TTY **711**

لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على**(866) 336-9371**. الهاتف النصي (TTY) **711**

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئیے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، **(866) 336-9371** دبائیں۔ TTY **711**

May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang **(866) 336-9371** TTY **711**

Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche **(866) 336-9371** ATS **711**.

आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, **(866) 336-9371** दबाएं। TTY **711**

شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و **(866) 336-9371** را فشار دهید. TTY **711**

Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die **(866) 336-9371** TTY **711**

તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, **(866) 336-9371** દબાવો. TTY **711**

Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите **(866) 336-9371** Линия TTY **711**

ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、**(866) 336-9371**を押してください。TTY専用番号は **711**です。

ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາໝາຍເລກໂທລະສັບສຳລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ **(866) 336-9371 TTY 711**

UnitedHealthcare®

ERS
Employees Retirement System of Texas

12/16