


# How to read your EOB



A UnitedHealthcare Company

Page 1



PO Box 30541 Salt Lake City, UT 84130-0541  
1-800-826-9781  
www.umar.com

**CUSTOMER LOGO**

**1** Employee Joe Patient  
Employee Address 1234 W SUNSHINE BLVD  
STE 100A  
BEST CITY US 12345-9876  
Member ID 999999999  
Patient Joe Patient  
Notice Date 02-15-15  
Employer Name Customer Inc.  
Group Number 76-999999

**2** **EXPLANATION OF BENEFITS NOTICE – THIS IS NOT A BILL**

**2** Provider: Physician, Joe, MD     
 **3** Patient Account: 1234567890     
 **4** Claim Control Number: 9999999999

Service Description	Dates of Service From: To:	Amount Billed	Amount Not Payable	See Note Section	Less Deductible	Co-Pay Amount	Allowable Amount	%	Plan Benefit Amount	Amount Paid	Provider May Bill You
<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>
Emergency Care	02-01-15 02-01-15	\$500.00	\$100.00	908	\$50.00	\$25.00	\$325.00	80	\$260.00	\$260.00	\$140.00
<b>Totals</b>		<b>\$500.00</b>	<b>\$100.00</b>		<b>\$50.00</b>	<b>\$25.00</b>	<b>\$325.00</b>		<b>\$260.00</b>	<b>\$260.00</b>	<b>\$140.00</b>

**17** Note Section  
908 Provider negotiated discount. You are not responsible for this amount.

**18** Payment To: XYZ Clinic      Payment Date: 02-15-15      Payment Amount: \$260.00

Benefit	Benefit Level	Applied To Date
01-01-15	\$200 Out Net Ind Cal Yr Deductible	\$200.00Met
01-01-15	\$400 Out Net Fam Cal Yr Deductible	\$300.00
01-01-15	\$400 In Net Ind Cal Yr Deductible	\$205.00
01-01-15	\$800 In Net Fam Cal Yr Deductible	\$305.00

- 1** Fields include member information under which the claim was processed.
- 2** Hospital, physician or other health care provider that performed the services.
- 3** Account number assigned by the hospital, physician or other health care provider.
- 4** UMR assigns a unique claim control number to each claim received.
- 5** Services and/or procedures that were performed by the hospital, physician or other health care provider.
- 6** Dates(s) services were performed by the hospital, physician or other health care provider.
- 7** Amount charged for the services by the hospital, physician or other health care provider.
- 8** Charges not allowed according to the Plan – see comment code.
- 9** Refers to codes used to explain charges that were not allowed – see Notes Section.
- 10** Amount applied to the deductible.
- 11** Co-pay amount paid at office visit
- 12** Charges allowed for payment – this is the difference between the “Amount Billed” and the “Amount Not Payable” and/or “Less Deductible” columns.
- 13** Percentage at which the Allowable charges are paid.
- 14** Amount actually payable by the Plan.
- 15** Amount that UMR paid to the provider.
- 16** Only amount you are responsible to pay to the hospital, physician or other health care provider, if applicable.
- 17** Explains codes provided in the “See Notes Section” column. Lists the specific code and its definition.
- 18** List of individuals or organizations to whom checks were issued.
- 19** Provides benefit period and benefit levels, amounts applied to individual/family deductibles, out-of-pocket and lifetime maximums, if applicable.

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## Cover Page Explanations:

- 20 UMR toll-free telephone number for members to call with questions regarding the Explanation of Benefits.
- 21 Website address for members to access regarding eligibility and claim information.
- 22 Indicates the specific time frame for members to file appeals. This information is provided in the members' SPD (Summary Plan Description). Also indicates the members' right to file civil action.
- 23 Indicates the telephone number for members to call with questions regarding appeal rights.
- 24 Indicates the toll-free telephone number for members to call if they suspect illegal activity regarding claims.



PO Box 30541  
Salt Lake City UT 84130-0541

SAMPLE

JOE PATIENT  
1234 W SUNSHINE BLVD  
STE 100A  
BEST CITY US 12345-9876

- 20 **QUESTIONS / CONCERNS** Contact 1-800-826-9787.
- 21 **INTERNET:** Online services are available 24 hours a day at [www.umar.com](http://www.umar.com).
- 22 **APPEAL:** You may file an appeal of the claim decision by sending a written request and pertinent information within 180 days from the date of this Notice to "**Claims Appeal Unit, P.O. Box 30546, Salt Lake City, UT 84130-0546**". Refer to your current benefit booklet for information on the appeal process. After you have exhausted the mandatory appeal levels that are described in your benefit booklet, you have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act(ERISA).
- 23 **OTHER RESOURCES TO HELP YOU** For questions about your appeal rights, this notice, or for assistance you can contact the Employee Benefits Security Administration at 866-444-EBSA (3272). Additionally, you can contact your consumer assistance program at the Office of the Governor Consumer Health Assistance 1-888-333-1597.
- 24 **HELP STOP FRAUD!** If you know or suspect any illegal activity concerning claims, contact our anti-fraud unit by calling 1-800-356-5803. You do not need to identify yourself. Refer to your benefit booklet for more details on Claim determination.



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