

Understanding Your Health Statement

Medical / Pharmacy Health Statement

HEALTH CARE PROVIDER
PO BOX 00000
ANYWHERE, US 00000-0000
PHONE: (000) 000-0000

HEALTH STATEMENT

Member Number: 000000000
Statement Period: 01/01/2007 - 01/31/2007

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SAMPLE STATEMENT
100 MAIN ST
ANYWHERE, US 00000

Visit www.WEBSITE.COM
for more detail on account
balances and activity

Size Up Your Risk

40% of Americans think they're overweight, but in reality, it's 66%. One way to tell you're overweight is to check your clothing size. A study in the Journal of Human Nutrition and Dietetics found men with pants waist size 38+ have a 3.5% greater risk of developing diabetes, heart disease and hypertension. For women, risk increases to 7% in those dress size 18+. Check the tags in your closet to size up your risk!

See last page for more helpful information

2007 Network Deductible	Annual	Applied	Remaining
Family	\$2,400.00	\$39.95	2,360.05
INDIVIDUAL	\$1,200.00	\$39.95	1,160.05

2007 Network Out-Of-Pocket	Annual	Applied	Remaining
Family	\$2,500.00	\$39.95	2,460.05
INDIVIDUAL	\$1,500.00	\$39.95	1,460.05

Balances may not match what is on your nearest website.

Claim Details	Amount Billed	Discount	Cost Of Care	Health Plan Paid	Amount You Owe	Remark Code
INDIVIDUAL on 01/04/07 #000000001101 FINANCIAL ACCOUNT PAYMENT S PROVIDER MEDICAL	28.00	8.05	19.95	0.00 19.95	0.00	D1
INDIVIDUAL on 01/05/07 #000000001102 FINANCIAL ACCOUNT PAYMENT PRESCRIPTION NAME STRENGTH PHARMACY NAME PHARMACY	20.00		20.00	0.00 20.00	0.00	

All of your Explanation of Benefit forms (EOB) are available online at www.website.com.
* Some claim detail may not appear on this Statement to maintain the privacy of our members.
** This is the amount you owe the physician, health care professional or facility. This may include amounts already paid to your provider/pharmacy at the time of service. This may include amounts that will be paid out of your HRA/FSA.

2007 Network Deductible	Annual	Applied	Remaining
Family	\$2,400.00	\$19.95	2,380.05
INDIVIDUAL	\$1,200.00	\$19.95	1,180.05

2007 Network Out-Of-Pocket	Annual	Applied	Remaining
Family	\$2,500.00	\$19.95	2,480.05
INDIVIDUAL	\$1,500.00	\$19.95	1,480.05

Network Deductible

(1) Annual: Your deductible is the fixed dollar amount that you must pay each year toward covered medical expenses before your plan benefits are payable.

(2) Applied: Amount applied toward your network deductible.

(3) Remaining: Amount you have remaining to meet your total deductible.

Network Out of Pocket

(4) Annual: The amount you pay in the plan year before the plan pays 100% of your covered expenses.

(5) Applied: Amount applied toward your out-of-pocket deductible.

(6) Remaining: Total you still have to pay out of pocket before the plan covers 100% of covered expenses.

	A	B	C	D	E	F
	Claim Details *					
	Amount Billed	Discount	Cost Of Care	Health Plan Paid	Amount You Owe	Remark Code
G	INDIVIDUAL on 01/04/07 #000000001101 FINANCIAL ACCOUNT PAYMENT S PROVIDER MEDICAL	28.00	8.05	19.95 0.00 19.95	0.00	D1
H	INDIVIDUAL on 01/05/07 #000000001102 FINANCIAL ACCOUNT PAYMENT PRESCRIPTION NAME STRENGTH PHARMACY NAME PHARMACY	20.00	20.00	0.00 20.00	0.00	

(A) Amount Billed: Total amount billed by physician, health care professional, or facility before any network discounts are applied.

(B) Discount: Participating provider/facility discounts or other program discounts.

(C) Cost of Care: Net Cost after all discounts have been applied.

(D) Health Plan Paid: Amount paid by your plan for covered expenses.

(E) You Owe: Amount you owe the physician, health care professional, or facility. This may include amounts already paid at the time you received service.

(F) Notes: Identifies any associated remarks regarding the claim.

(G) Financial Account Payment: Payment made from member financial account for example Flexible Spending Account.

(H) Prescription Claim: Identifies a prescription claim including Prescription Name, Strength, and Issuing Pharmacy.

Understanding Your Health Statement

Financial Account Statement

Member Number: 000000000 Statement Period: 01/01/2007 - 01/31/2007 Page 2 Of 2

Account	Coverage Amount	Amount Paid YTD	Amount Available
Financial Account 2007	\$2,000.00	\$139.95	1,860.05

Balances may vary slightly from what is on your personal checks. *The coverage amount includes any prior year carryover, if applicable.

Claim Details *	Amount Considered	Amount Pended	Plan Paid	Health Plan Ref #	Remark
01/04/07 #000000009102 FINANCIAL TRANSACTION	100.00	0.00	0.00	000000007501	910001

Claim Details *	Transaction Date	Settlement Date	Debit	Credit	CAC Ref #
FINANCIAL CAC TRANSACTION MEDICAL	01/04/07	01/05/07	19.95		0000000210
FINANCIAL CAC TRANSACTION PHARMACY	01/05/07	01/05/07	20.00		0000000811

All of your Explanation of Benefit forms (EOB) are available online at www.website.com.
* Some claim detail may not appear on this Statement to maintain the privacy of our members.

Remark Code **Explanation**

D1 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.

910001 YOU ARE NOT FINANCIALLY RESPONSIBLE FOR THIS CHARGE, THEREFORE, NO BENEFITS ARE PAYABLE. THANK YOU.

Appeals and Privacy Information

MEDICAL CLAIMS ONLY
A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: YOU HEALTHCARE APPEALS, P.O. BOX 00000, ANYWHERE CITY, US 00000-0000. 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.

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

Meet Your Needs Online
At almost anytime 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 visit www.website.com

Website Registration
You can register and begin using myweb in the same session. Navigate to www.website.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).

Consumer Alerts

Heart Disease: A Family Affair **Know the Signs of Heart Attack** **We're Here for You**

Do your parents have heart disease? American Journal of Preventive Medicine found women's risk is 41% greater if their mother has heart disease and 17% greater if their father has it.

Do you know the signs of heart attack? The most common sign is chest pain, but pain in your arms, back, neck, jaw or stomach can also be signs of an attack.

At United Health, we're committed to helping you easily navigate the health care system. If you're confused about your benefits or where to find a network provider, help is a phone call away.

1	2	3	4
Account	Coverage Amount	Amount Paid YTD	Amount Available
Financial Account 2007	\$2,000.00	\$139.95	1,860.05

- (1) **Account:** Identifies the financial account name.
- (2) **Starting Coverage Amount:** Total dollar amount in your account at the start of the plan. (Includes any prior year carry over.)
- (3) **Amount Paid YTD:** Total dollar amount paid year-to-date from your account for covered expenses.
- (4) **Remaining Balance:** Total dollar amount remaining in your account.

Remark Codes: Identifies additional information regarding your claim. Some remarks will identify additional action that may need to be taken by the member or the service provider.

A	B	C	D	E	F
Claim Details *	Amount Considered	Amount Pended	Plan Paid	Health Plan Ref #	Notes
01/04/07 #000000009102 FINANCIAL TRANSACTION	100.00	0.00	0.00	000000007501	910001

1	2	3	4	5	6
Claim Details *	Transaction Date	Settlement Date	Debit	Credit	CAC Ref #
FINANCIAL CAC TRANSACTION MEDICAL	01/04/07	01/05/07	19.95		0000000210
FINANCIAL CAC TRANSACTION PHARMACY	01/05/07	01/05/07	20.00		0000000811

- (1) **Claim Details:** Financial Account source and type of transaction.
- (2) **Transaction Date:** Date you received service.
- (3) **Settlement Date:** Date claim was settled.
- (4) **Debit:** Amount paid from your account.
- (5) **Credit:** Amount paid to your account.
- (6) **Consumer Account Card Ref #:** CAC transaction identification number.

- (A) **Claim Details:** Date of the financial transaction, claim reference number, and type of transaction.
- (B) **Amount Considered:** Submitted for reimbursement from your financial account.
- (C) **Amount Pended:** Amount to be paid from your account, pending additional contributions to your plan.
- (D) **Plan Paid:** Amount paid from your account.
- (E) **Health Plan Ref #:** Claim's identification number.
- (F) **Notes:** Identifies any associated remarks to the claim.