UnitedHealthcare Insurance Company
HealthSmart Benefit Solutions Inc.
3320 West Market St.
Suite 100
Fairlawn, OH 44333

HealthSmart®

Questions? Contact us at:1-800-331-1096
Customer Svc Hrs: 8:00 A.M - 5:00 P.M EST

SAMPLE

1 Your Name Here
123 Main Street
Anywhere, USA 12345

2 ABC Company
3 Group Number: Group 123
4 Issue Date: January 1, 2016
5 Member Number: 123456789

Monthly Explanation of Benefits

This is not a Bill

1 Your Name Here Page 1 of 2

6 Patient's Name / 7 Type of Service	Service Date(s)	Amount Claimed	Discount	Other Adjustments	Other Plan Payment	14 Patient Responsibility After Payments: Ineligible	Co-Pay	Deductible	Out of Pocket	Total Benefits	Paid At	Remark Codes
Sample Patient # 1												
Claim Number: 15012750-01	8	10	11	12	13	15	16	17	18	20	21	22
	9 Provider: Doctor #124								Finalized: 19	1/26/15		
MEDICAL SUPPLY	12/20/14	451.52	0.00	0.00	0.00	0.00	0.00	50.00	120.46	281.06	70%	
Totals:		451.52	0.00	0.00	0.00	0.00	0.00	50.00	120.46	281.06		
								23 Patient Responsibility		451.52		
Claim Number: 15012750-02	Provider: Doctor #125								Finalized:	1/26/15		
MEDICAL SUPPLY	12/18/14	190.83	0.00	0.00	0.00	0.00	0.00	0.00	57.25	133.58	70%	
Totals:		190.83	0.00	0.00	0.00	0.00	0.00	0.00	57.25	133.58		
								Patient Responsibility		190.83		
Claim Number: 15012750-03	Provider: Doctor #126								Finalized:	1/26/15		
MEDICAL SUPPLY	12/17/14	184.50	0.00	0.00	0.00	0.00	0.00	0.00	55.35	129.15	70%	
Totals:		184.50	0.00	0.00	0.00	0.00	0.00	0.00	55.35	129.15		
								Patient Responsibility		184.50		

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This claim and all other claims shall remain subject to all Policy provisions and Exclusions/Limitations. We reserve the right to investigate for Pre-Existing Conditions and applicable Exclusions/Limitations.

Explanation:

1. Insured Member's full name and address
2. Employer's company name
3. Health plan Group Number
4. Date this EOB was issued
5. Insured Member's number
6. Patient *(Insured or covered family member receiving healthcare services)*
7. Type of service received
8. Date service was received
9. Physician *(or other)* rendering healthcare service
10. Claim amount charged for the service provided
11. Discount to amount charged *(if applcable)*
12. Other adjustment to amount charged *(if applicable)*
13. Payment made by a plan that is not the ABC Company health plan
14. Over-and-above payments made by the health plan, amount that patient must pay
15. Amount of "Patient Responsibility" 14 that is not covered by the health plan
16. Patient Responsibility: co-pay amount
17. Patient Responsibility: deductible amount
18. Patient Responsibility: out-of-pocket amount
19. Date on which the claim was completed
20. Total benefits paid after discount, adjustment, other plan payment and patient responsibllity amounts
21. The "Total Benefits" paid as a percentage of the "Amount Claimed" less co-pay, deductible and ineligible amounts
22. Codes that provide additional explanation for adjustments to amounts paid
23. Total amount for which the patient is responsible
24. Services received by that patient form additional healthcre service providers during this statement period