Go to: https://www.myuhc.com

1. You will need your United Health Care ID card to register

2. Please remember Username & Password for future use

Continue to next page
This is the Home Page

1. Click on Manage My Claims

Continue to Next Page
YOUR CLAIM SUMMARY

1. Click on the down menu on Dates Visited. Select one of the options below:
   - Last 30 Days
   - Last 60 Days
   - Last 6 Months
   - Current Calendar Year
   - Previous Calendar Year
   - Last 18 Monts
   - Custom Date Range

2. Click on the Family Member
3. Click on Medical
4. Click on Search
5. Click on View Claim on the most recent or the largest amount billed
CLICK ON EXPLANATION OF BENEFITS
UnitedHealthcare Insurance Company
SPRINGFIELD SERVICE CENTER
P.O. BOX 740800
ATLANTA, GA 30374-0800

Have more questions about your claim?
Visit www.myuhc.com
for all your claim and benefit information.

December 07, 2015

Member/Patient Information
Member/Patient ID:
Relationship:
Group Name:
Group #:

Explanation of Benefits Statement
This is not a bill. Do not pay. This is to notify you that we processed your claim.

Claims Summary
Detailed claim information is located on the following page(s).

<table>
<thead>
<tr>
<th>Dollar Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,700.00</td>
<td>Amount Billed</td>
</tr>
<tr>
<td>$2,470.11</td>
<td>Plan Discounts</td>
</tr>
<tr>
<td>$1,229.89</td>
<td>Your Plan Paid</td>
</tr>
<tr>
<td>$0.00</td>
<td>Total amount you owe the provider(s)</td>
</tr>
</tbody>
</table>

This is the total amount that your provider billed for the services that were provided to you. Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay. This is the portion of the amount billed that was paid by your plan.

The portion of the Amount Billed you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, co-pay, coinsurance and/or non-covered charges. This amount does not include any payments made directly to the subscriber. If a payment was made directly to the subscriber, you, the subscriber is responsible for paying the physician, facility or other health care professional.

If any claims are denied, you will receive notice. You may be required to pay the charges before you can receive further care from this provider.

If you are not satisfied with the processing of your claim, please contact your provider. If there is still a problem, you may request that your claim be reviewed.

Please keep for your records.

Print this page and turn in with a GAP claim form.
**ACCOUNT SUMMARY**

THIS IS YOUR EXPLANATION OF BENEFITS (EOB)

THIS PAGE WILL SHOW HOW MUCH HAS BEEN APPLIED TO YOUR IN-NETWORK DEDUCTIBLE

ONE MEMBER OF THE FAMILY HAS MET THE $2,000 HIGH DEDUCTIBLE

PRINT THIS PAGE AND TURN IN WITH GAP CLAIM FORM

GAP CLAIM FORM WEBSITE

CONTINUE TO NEXT PAGE

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**Summary of Deductible and Out of Pocket**

**Plan Year:** 2016

**Relationship:** CH

<table>
<thead>
<tr>
<th></th>
<th>Annual Amount</th>
<th>(-) Applied to Date</th>
<th>(=) Remaining Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN NETWORK MEDICAL/RX COMBINED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$5,550.00</td>
<td>$2,000.00</td>
<td>$3,550.00</td>
</tr>
<tr>
<td><strong>OUT OF NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$5,000.00</td>
<td>$0.00</td>
<td>$5,000.00</td>
</tr>
</tbody>
</table>

**FAMILY**

<table>
<thead>
<tr>
<th></th>
<th>Annual Amount</th>
<th>(-) Applied to Date</th>
<th>(=) Remaining Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IN NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$8,000.00</td>
<td>$2,000.00</td>
<td>$6,000.00</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$8,000.00</td>
<td>$2,000.00</td>
<td>$6,000.00</td>
</tr>
<tr>
<td><strong>OUT OF NETWORK</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$8,000.00</td>
<td>$0.00</td>
<td>$8,000.00</td>
</tr>
<tr>
<td>Out of Pocket</td>
<td>$18,000.00</td>
<td>$0.00</td>
<td>$18,000.00</td>
</tr>
</tbody>
</table>

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**Definitions of Key Terms**

**Applied to Date:** The total amount of money applied to your deductible or out of pocket as of this EOB statement.

**Out of Pocket:** This is the amount you pay before your plan benefit starts paying 100% for eligible health care services. Please refer to your plan documents for more information.

**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. Please refer to plan documents for specific information regarding what services apply to the deductible.

**Plan Year:** The dates your plan benefit maximums are applicable.
VERY IMPORTANT:

After Human Resources processes your Gap Claim, we pass it on to Accounts Payable to pay you.

Accounts Payable will direct deposit your reimbursement into your checking/savings account.

If you have NOT set up a direct deposit with Accounts Payable, please do so now. The website for the Direct Deposit form is: http://uca.edu/financialaccounting/accountspayable/