

UnitedHealthcare **Student**Resources (UHCSR)
 Student Injury and Sickness Insurance Plan
 Understanding your Explanations of Benefits (EOB)

COLUMNS EXPLANATION:

- The **“Service”** column is a descriptive term for the submitted medical service or procedure as determined by the American Medical Association’s published CPT® (Current Procedural Codes). The description used here is the descriptive category used by UHCSR versus the actual descriptive term for the specific service/procedure.
- The **“Dates of Service”** column is the actual date that the medical service/procedure was performed by the Medical Provider. This is NOT the date it was billed or processed.
- The **“Proc Code”** includes the actual AMA CPT® that was submitted by the Medical Provider for the particular service/procedure.
- The **“Amount Claimed”** is the actual amount that the Medical Provider charged for the service/procedure.
- The **“Ineligible”** column includes the required Coinsurance (if a PPO provider is used) OR any amount that exceeds the Usual and Customary (if an Out-of-Network Provider is used) and is therefore not covered under the policy. The Ineligible amount will be included in the Patient Balance.
- The **“Discount”** column includes any applicable PPO discount that varies depending on the Providers contract with UnitedHealthcare.
- The **“Total Covered”** column includes the Amount Claimed minus any Discount or Ineligible amounts.
- The **“Copay”** is the stated amount per visit that is applicable to that particular service. This is in addition to the Deductible. This amount is subtracted from the Total Covered and will be included in the Patient Balance.
- The **“Deductible”** column includes any amounts that still needs to be applied to the Insured’s Policy Deductible or any amount specified in the policy as the required per visit copay or deductible for a particular service/procedure. This amount is subtracted from the Total Covered before any Coinsurance is calculated.
- The **“Total Benefits”** is the amount paid by the Insurance Company, this amount should match the Check Amount above unless the EOB is a correction and a previous amount had already been paid.
- The **“Patient Balance”** is the amount the Insurance Company estimates you will be required to pay for Medical Services. This will include any amounts listed in Ineligible and Deductible columns.
- The **“Remark Code”** includes remarks explaining in further detail how the Insurance Company processed a particular charge. The full remark can be found under the “Remarks:” heading. Match the Code to the appropriate Remarks text below. There may be multiple remarks per line item.

IMPORTANT NOTES:

- The Policy Deductible is \$200 per policy year and if the insured hasn’t paid anything towards the deductible, the entire Covered amount may be applied; if the insured has paid some but has not satisfied all of the deductible, the unsatisfied amount will be subtracted from the “Total Covered” before any coinsurance is calculated. Please see the example below:

EXAMPLE: Laboratory charge of \$47 is submitted.

Service	Dates of Service From To	Proc Code	Amount Claimed	Ineligible	Discount	Total Covered	Co-Pay	Deductible	Total Benefits	Patient Balance	Remark Code
Laboratory	02/20/07-02/20	83550	47.00	4.64	24.80	37.66		19.10	18.56	23.74	

\$47.00 (Amount Claimed) - \$4.70 (PPO Discount) = \$42.30 (Adjusted Amount Claimed)

\$42.30 (Adjusted Amt Claimed) - \$19.10 (Deductible Balance) = \$23.20

\$23.20 x 20% coinsurance = \$4.64 (Ineligible-Required Coinsurance)

\$19.10 (Deductible Balance) + \$4.64 (Required Coinsurance) = \$23.74 (Patient Balance)

- If a particular service/procedure requires a copay or deductible per visit, this copay is in addition to the policy Deductible. Please see the example below:

EXAMPLE: Doctors Visit charge of \$110 is submitted.

Service	Dates of Service From To	Proc Code	Amount Claimed	Ineligible	Discount	Total Covered	Co-Pay	Deductible	Total Benefits	Patient Balance	Remark Code
Doctor Visit	10/09/07-10/09	90806	110.00		33.00	77.00	\$30.00	47.00	0.00	77.00	

\$110 (Amount Claimed) - \$33.00 (PPO Discount) = \$77.00 (Total Covered)

\$77.00 (Total Covered) - \$30.00 (Copay) = \$47.00 (Applied towards Deductible); the Patient Balance includes both the Copay and Deductible

\$200 (Policy Deductible) - \$47.00 (Deductible Applied) = \$153 (Balance of Deductible to satisfy); even though patient paid \$77.00

- It is possible for the insured to see no Discount applied if the Provider’s charge for a particular service/procedure is less than the Preferred Allowance.
- It is possible that an Out-of-Network provider may adjust off any amount that exceeds the Usual and Customary charges if you request it but they are NOT required to do so therefore you should not expect such an adjustment.