UnitedHealthcare
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United HealthCare Services, Inc.
GREENSBORO 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.

September 07, 2012

251EOBSV2A0800001
GUANGXU ZHOU
102 KANIS CREEK LN
LITTLE ROCK AR 72223

Member/Patient Information

Member/Patient: GUANGXU ZHOU
Member ID: A874105363
Relationship: EE
Group Name: ICF CONSULTING GROUP, INC
Group #: 0717461

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).

Dollar Amount	Description
$290.00	**Amount Billed** This is the total amount that your provider billed for the services that were provided to you.
$153.98	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$111.02	**Your Plan Paid** This is the portion of the amount billed that was paid by your plan.
$25.00	**Total amount you owe the provider(s)** 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 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.

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Claim Detail for GUANGXU ZHOU

Provider: W RILEY JR **Claim Number:** 384076168101 **Patient Account Number:** 0297202SVC8800329

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-)	Plan Discounts	(-)	Your Plan Paid	(=)	Your Itemized Responsibility to Provider** Deductible	(+)	Copay	(+)	Coinsurance	(+)	Non Covered	(=)	Amount You Owe
08/29/2012	LABORATORY SERVICES	D1	$36.00		$27.11		$8.89		$0.00		$0.00		$0.00		$0.00		$0.00
Claim Total:			**$36.00**		**$27.11**		**$8.89**		**$0.00**		**$0.00**		**$0.00**		**$0.00**		**$0.00**

**This total does not reflect any payments / copays you made at the time of service.
Please wait for a provider bill before making a payment.

Claim Detail for GUANGXU ZHOU

Provider: W RILEY JR **Claim Number:** 384076168201 **Patient Account Number:** 0297202SVC8800330

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-)	Plan Discounts	(-)	Your Plan Paid	(=)	Your Itemized Responsibility to Provider** Deductible	(+)	Copay	(+)	Coinsurance	(+)	Non Covered	(=)	Amount You Owe
08/29/2012	LABORATORY SERVICES	D1	$47.00		$35.26		$11.74		$0.00		$0.00		$0.00		$0.00		$0.00
Claim Total:			**$47.00**		**$35.26**		**$11.74**		**$0.00**		**$0.00**		**$0.00**		**$0.00**		**$0.00**

**This total does not reflect any payments / copays you made at the time of service.
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Claim Detail for GUANGXU ZHOU

Provider: W RILEY JR **Claim Number:** 384076168301 **Patient Account Number:** 0297202SVC8800331

Date(s) of Service	Type of Service	Notes*	Amount Billed	(-)	Plan Discounts	(-)	Your Plan Paid	(=)	Your Itemized Responsibility to Provider** Deductible (+)	Copay (+)	Coinsurance (+)	Non Covered (=)	Amount You Owe
08/29/2012	OFFICE VISITS	D1	$193.00		$85.98		$82.02		$0.00	$25.00	$0.00	$0.00	$25.00
08/29/2012	LABORATORY SERVICES	D1	$6.00		$2.06		$3.94		$0.00	$0.00	$0.00	$0.00	$0.00
08/29/2012	LABORATORY SERVICES	D1	$8.00		$3.57		$4.43		$0.00	$0.00	$0.00	$0.00	$0.00
Claim Total:			**$207.00**		**$91.61**		**$90.39**		**$0.00**	**$25.00**	**$0.00**	**$0.00**	**$25.00**

**This total does not reflect any payments / copays you made at the time of service.
Please wait for a provider bill before making a payment.

Notes*

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.

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: UnitedHealthcare Appeals, P.O. Box 30432, Salt Lake City, UT 84130-0432. 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.

You or your authorized representative, such as a family member or physician, may appeal the decision by submitting comments, documents or other relevant information to the appeal address referenced above.

You may request copies (free of charge) of information relevant to your claim by contacting us at the above address.

Availability of Consumer Assistance/Ombudsman Services
There may be other resources available to help you understand the appeals process. For more questions about your appeal rights, an adverse benefit determination, or for

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assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).
Your state consumer assistance program may also be able to assist you at:
Arkansas Insurance Department, Consumer Services Division
1200 West Third St.
Little Rock, AR 72201
Toll-free telephone: 1-855-332-2227
Web site: Insurance.consumers@arkansas.gov

If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Insurance fraud adds millions to the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-888-697-8323.

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, obtain more information on EOB content and more! For immediate, secure self-service visit www.myuhc.com.

Myuhc Registration

You can register and begin using myuhc in the same session. Navigate to www.myuhc.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).

Maintaining the privacy and security of individuals' personal information is very important to us at UnitedHealthcare. To protect your privacy, we implemented strict confidentiality practices. These practices include the ability to use a unique individual identifier. You may see the unique individual identifier on UnitedHealthcare correspondence, including medical ID cards (if applicable), letters, explanation of benefits (EOBs), and provider remittance advices (PRAs). If you have any questions about the unique individual identifier or its use, please contact your customer care professional at the number shown at the top of this Statement.

Please call the number included in this document or on the back of your ID card if you need diagnosis and/or treatment code information regarding the services referenced in this communication.

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Account Summary

Summary of Deductible and Out of Pocket
Plan Year: 2012

GUANGXU **Relationship: EE**	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$500.00	$0.00	$500.00
Out of Pocket	$3,000.00	$0.00	$3,000.00
OUT OF NETWORK			
Deductible	$1,500.00	$0.00	$1,500.00
Out of Pocket	$6,000.00	$0.00	$6,000.00

FAMILY	Annual Amount	(-) Applied to Date	(=) Remaining Balance
IN NETWORK			
Deductible	$1,500.00	$0.00	$1,500.00
Out of Pocket	$6,000.00	$0.00	$6,000.00
OUT OF NETWORK			
Deductible	$4,500.00	$0.00	$4,500.00
Out of Pocket	$12,000.00	$0.00	$12,000.00

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.

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 your plan documents for specific information regarding what services apply to the deductible.

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

Copay: A fee you pay each time you see a provider, receive a service, or fill a prescription.

Out of Pocket: The out of pocket maximum is the dollar amount you pay before your plan benefit starts paying at 100% for eligible health care services. Please refer to your plan documents for specific information on what costs apply to the maximum amount.