

| Service Date & Type | Amount Billed | Amount Not Covered | Covered Amount | CoPay/Deductible | What your plan paid | Coinsurance | What I Owe |
|---------------------|---------------|--------------------|----------------|------------------|---------------------|-------------|------------|
|                     |               |                    |                |                  |                     |             |            |
|                     |               |                    |                |                  |                     |             |            |
| Total               | \$214.50      | \$0.00             | \$126.00       | \$15.00/\$0.00   | \$111.00            | \$0.00      | \$15.00    |

Amount Billed

Amount Not Covered-

Covered Amount-

CoPay/Deductible-

What your plan paid-

Coinsurance-

\*Other insurance-

What I Owe-