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

Total	\$214.50	\$0.00	\$126.00	\$15.00/\$0.00	\$111.00	\$0.00	\$15.00					
Amoı	unt Billed											
Amou	unt Not Covered	d-										
Cover	Covered Amount-											
CoPa	y/Deductible-											
What	t your plan paid	-										
Coins	surance-											
*Oth	er insurance-											
What	I Owe-											