MONTHLY
claims statement

The information in this statement is current as of

Your Family's Medical Claims

You can see further details about your claims listed below by going to .

Member Name Date of Service Claim Number Provider Name	Total Charge	Network Savings	Paid Provider Processed Date	HRA Paid (If Applicable)		Amount You Owed Provider
	$438.00	$135.78	$302.22	$0.00	COPAY	$0.00
					DEDUCTIBLE	$0.00
					COINSURANCE	$0.00
Acute Care Hospital					NON-COVERED	$0.00
NON-COVERED CODES:					OTHER INSURANCE	$0.00
Provider Network					YOU OWED PROVIDER	$0.00
Dr Visit	$120.00	$41.81	$78.19	$0.00	COPAY	$0.00
			08/25/2016		DEDUCTIBLE	$0.00
					COINSURANCE	$0.00
					NON-COVERED	$0.00
					OTHER INSURANCE	$0.00
					YOU OWED PROVIDER	$0.00
	$2,730.00	$2,490.67	$239.33	$0.00	COPAY	$0.00
					DEDUCTIBLE	$0.00
Laboratory					COINSURANCE	$0.00
Independent Laboratory					NON-COVERED	$0.00
					OTHER INSURANCE	$0.00
					YOU OWED PROVIDER	$0.00
Dr visit with Labs	$390.00	$193.98	$196.02	$0.00	COPAY	$0.00
					DEDUCTIBLE	$0.00
					COINSURANCE	$0.00
Family Medicine					NON-COVERED	$0.00
NON-COVERED CODES:					OTHER INSURANCE	$0.00
Provider Network					YOU OWED PROVIDER	$0.00