[redacted]

Your Health Statement

THIS IS NOT A BILL

[redacted]

Statement Period: 07/29/2020 - 08/19/2020

Claim Activity for [redacted]

[redacted]

DIAGNOSIS CODE: [redacted]
DESCRIPTION: [redacted]

MEMBER RESPONSIBILITY

From - To Date of Service	Procedure Code	Description of Service	Amount Billed	Amount Allowed	Amount Paid	Deductible Amount	Copayment Amount	Coinsurance Amount	You Owe	Remarks
10/15/2019 - 10/15/2019	99203	OFFICE OR OTHR OUTPATIEN	$750.00	$274.80	$137.40	$0.00	$0.00	$137.40	$612.60	1,2
		TOTALS	**$750.00**	**$274.80**	**$137.40**	**$0.00**	**$0.00**	**$137.40**	**$612.60**	

Remarks	Explanation - Amounts shown below were not paid based on the terms of your policy.	Amount
1	Coinsurance Required for Out-of-Network Provider	$137.40
2	Patient Liability Non Network Provider	$475.20
	TOTAL	$612.60

[redacted]

DIAGNOSIS CODE: [redacted]
DESCRIPTION: [redacted]

MEMBER RESPONSIBILITY

From - To Date of Service	Procedure Code	Description of Service	Amount Billed	Amount Allowed	Amount Paid	Deductible Amount	Copayment Amount	Coinsurance Amount	You Owe	Remarks
10/15/2019 - 10/15/2019	99243	OFFICE CONSULTATION FOR	$750.00	$266.05	$133.03	$0.00	$0.00	$133.02	$616.97	1,2
		TOTALS	**$750.00**	**$266.05**	**$133.03**	**$0.00**	**$0.00**	**$133.02**	**$616.97**	

Remarks	Explanation - Amounts shown below were not paid based on the terms of your policy.	Amount
1	Coinsurance Required for Out-of-Network Provider	$133.02