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-