

**1** PGBA, LLC  
TRICARE Claims Administrator For Your Region

**TRICARE EXPLANATION OF BENEFITS**  
This is a statement of the action taken on your TRICARE claim.  
Keep this notice for your records.

**2** **HUMANA MILITARY**  
HEALTHCARE SERVICES  
★★★★★

**3** Date of Notice: August 02, 1999  
**4** Sponsor SSN: 000-00-0000  
**5** Sponsor Name: NAME OF SPONSOR  
**5** Beneficiary Name: NAME OF BENEFICIARY

**6** PATIENT, PARENT/GUARDIAN  
ADDRESS  
CITY, STATE ZIP CODE

**7** Benefits were payable to:  
PROVIDER OF MEDICAL CARE  
ADDRESS  
CITY, STATE ZIP CODE

**8** Claim Number: 919535695-00-00


Services Provided By/ Date of Services <b>9</b>	Services Provided <b>10</b>	Amount Billed <b>11</b>	TRICARE Approved <b>12</b>	See Remarks <b>13</b>
PROVIDER OF MEDICAL CARE				
07/08/1999	1 Office/outpatient visit, est (99213)	\$45.00	\$38.92	1
07/08/1999	1 Comprehen metabolic panel (88054)	\$20.00	\$19.33	1
07/08/1999	1 Automated hemogram (85025)	\$12.00	\$12.00	1
<b>Totals</b>		<b>\$77.00</b>	<b>\$70.25</b>	

Claim Summary <b>14</b>	Beneficiary Liability Summary <b>15</b>	Benefit Period Summary <b>16</b>
Amount Billed: 77.00	Deductible: 0.00	<b>Fiscal Year Beginning:</b>
TRICARE Approved: 70.25	Copayment: 0.00	October 1, 1998
Non-Covered: 6.75	Cost Share: 17.56	Individual Family
Paid by Beneficiary: 0.00		Deductible: 150.00 150.00
Other Insurance: 0.00		Catastrophic Cap: 856.32
Paid to Provider: 52.69		<b>Enrollment Year Beginning:</b>
Paid to Beneficiary: 0.00		December 01, 1998
Check Number:		Individual Family
		POS Deductible: 300.00 600.00
		Prime Cap: 856.32

**17** Remarks

1 – CHARGES ARE MORE THAN ALLOWABLE AMOUNT

**18**  
1-800-XXX-XXXX  
**THIS IS NOT A BILL**  
If you have questions regarding this notice, please call or write us at the telephone number/address listed above.



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