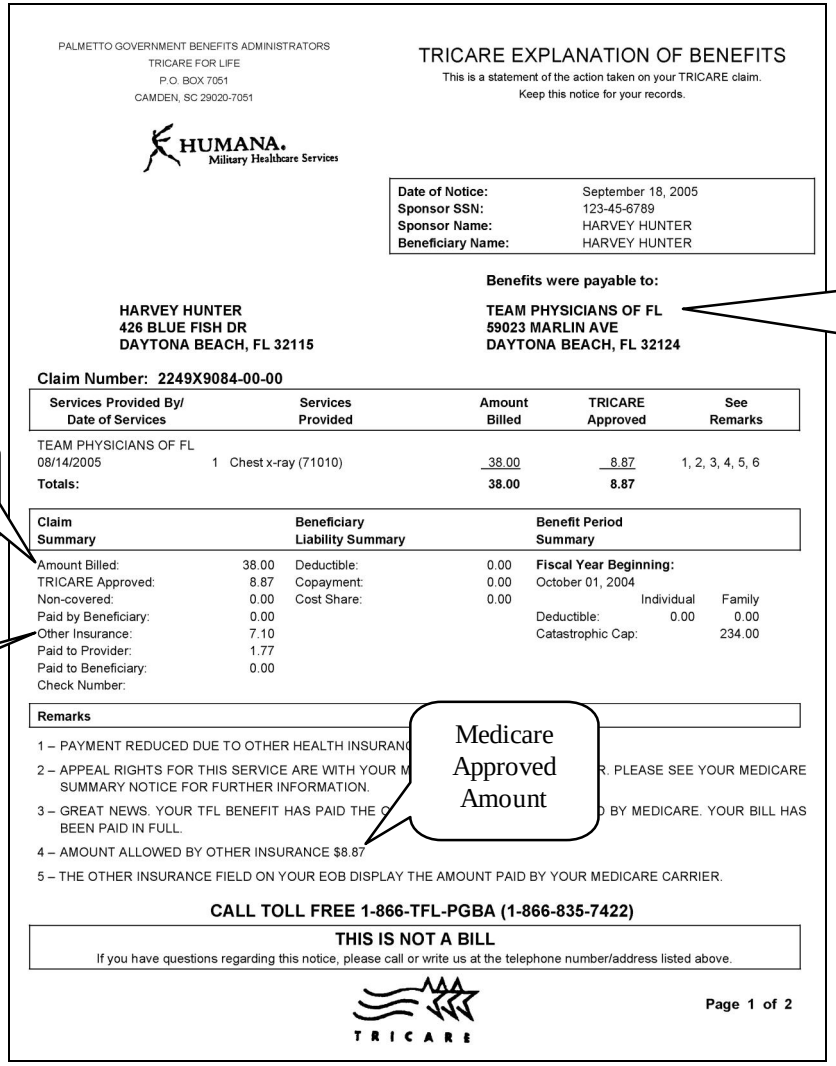
ST2

TRICARE STATEMENT EXAMPLES

Example 1: Palmetto Government Benefits Administrators



PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
TRICARE FOR LIFE
P.O. BOX 7051
CAMDEN, SC 29020-7051

HUMANA. Military Healthcare Services

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

Date of Notice:	September 18, 2005
Sponsor SSN:	123-45-6789
Sponsor Name:	HARVEY HUNTER
Beneficiary Name:	HARVEY HUNTER

HARVEY HUNTER
426 BLUE FISH DR
DAYTONA BEACH, FL 32115

Benefits were payable to:
TEAM PHYSICIANS OF FL
59023 MARLIN AVE
DAYTONA BEACH, FL 32124

If information appears here the "Provider Accepted Assignment".

Claim Number: 2249X9084-00-00

Services Provided By/ Date of Services	Services Provided	Amount Billed	TRICARE Approved	See Remarks
TEAM PHYSICIANS OF FL				
08/14/2005	1 Chest x-ray (71010)	38.00	8.87	1, 2, 3, 4, 5, 6
Totals:		**38.00**	**8.87**	

Total Charge

Claim Summary		Beneficiary Liability Summary		Benefit Period Summary		
Amount Billed:	38.00	Deductible:	0.00	**Fiscal Year Beginning:**		
TRICARE Approved:	8.87	Copayment:	0.00	October 01, 2004		
Non-covered:	0.00	Cost Share:	0.00		Individual	Family
Paid by Beneficiary:	0.00			Deductible:	0.00	0.00
Other Insurance:	7.10			Catastrophic Cap:		234.00
Paid to Provider:	1.77					
Paid to Beneficiary:	0.00					
Check Number:						

Medicare Payment

Remarks

1 – PAYMENT REDUCED DUE TO OTHER HEALTH INSURANC

2 – APPEAL RIGHTS FOR THIS SERVICE ARE WITH YOUR M R. PLEASE SEE YOUR MEDICARE SUMMARY NOTICE FOR FURTHER INFORMATION.

3 – GREAT NEWS. YOUR TFL BENEFIT HAS PAID THE C D BY MEDICARE. YOUR BILL HAS BEEN PAID IN FULL.

4 – AMOUNT ALLOWED BY OTHER INSURANCE $8.87

5 – THE OTHER INSURANCE FIELD ON YOUR EOB DISPLAY THE AMOUNT PAID BY YOUR MEDICARE CARRIER.

Medicare Approved Amount

CALL TOLL FREE 1-866-TFL-PGBA (1-866-835-7422)

THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at the telephone number/address listed above.

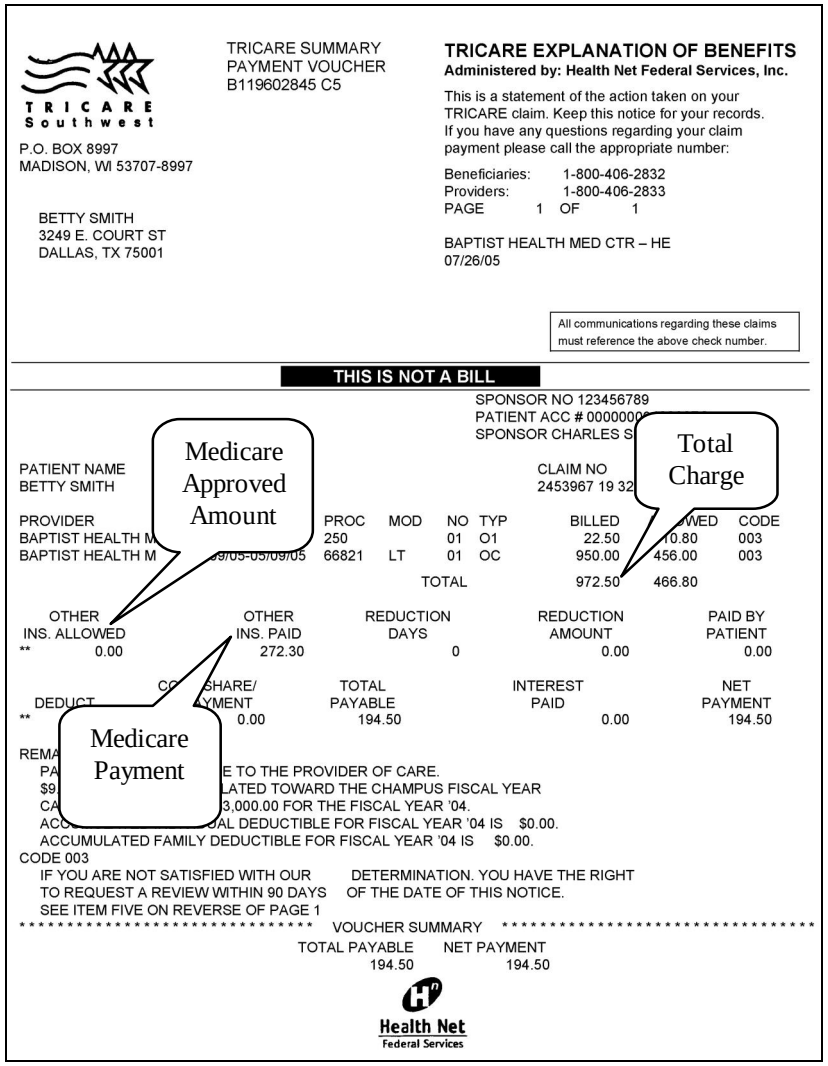
TRICARE

Page 1 of 2

ST2

TRICARE STATEMENT EXAMPLES
(continued)

Example 2: TRICARE Southwest



TRICARE Southwest

P.O. BOX 8997
MADISON, WI 53707-8997

TRICARE SUMMARY
PAYMENT VOUCHER
B119602845 C5

TRICARE EXPLANATION OF BENEFITS
Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice for your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-406-2832
Providers: 1-800-406-2833
PAGE 1 OF 1

BETTY SMITH
3249 E. COURT ST
DALLAS, TX 75001

BAPTIST HEALTH MED CTR – HE
07/26/05

All communications regarding these claims must reference the above check number.

THIS IS NOT A BILL

SPONSOR NO 123456789
PATIENT ACC # 0000000
SPONSOR CHARLES S

PATIENT NAME
BETTY SMITH

CLAIM NO
2453967 19 32

PROVIDER		PROC	MOD	NO	TYP	BILLED	ALLOWED	CODE
BAPTIST HEALTH M		250		01	O1	22.50	10.80	003
BAPTIST HEALTH M	09/05-05/09/05	66821	LT	01	OC	950.00	456.00	003
					TOTAL	972.50	466.80	

OTHER INS. ALLOWED	OTHER INS. PAID	REDUCTION DAYS	REDUCTION AMOUNT	PAID BY PATIENT
** 0.00	272.30	0	0.00	0.00

DEDUCT	CO SHARE/ YMENT	TOTAL PAYABLE	INTEREST PAID	NET PAYMENT
**	0.00	194.50	0.00	194.50

REMA
PA E TO THE PROVIDER OF CARE.
$9 LATED TOWARD THE CHAMPUS FISCAL YEAR
CA 3,000.00 FOR THE FISCAL YEAR '04.
ACC AL DEDUCTIBLE FOR FISCAL YEAR '04 IS $0.00.
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '04 IS $0.00.
CODE 003
IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION. YOU HAVE THE RIGHT TO REQUEST A REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.
SEE ITEM FIVE ON REVERSE OF PAGE 1

********** VOUCHER SUMMARY **********

TOTAL PAYABLE	NET PAYMENT
194.50	194.50

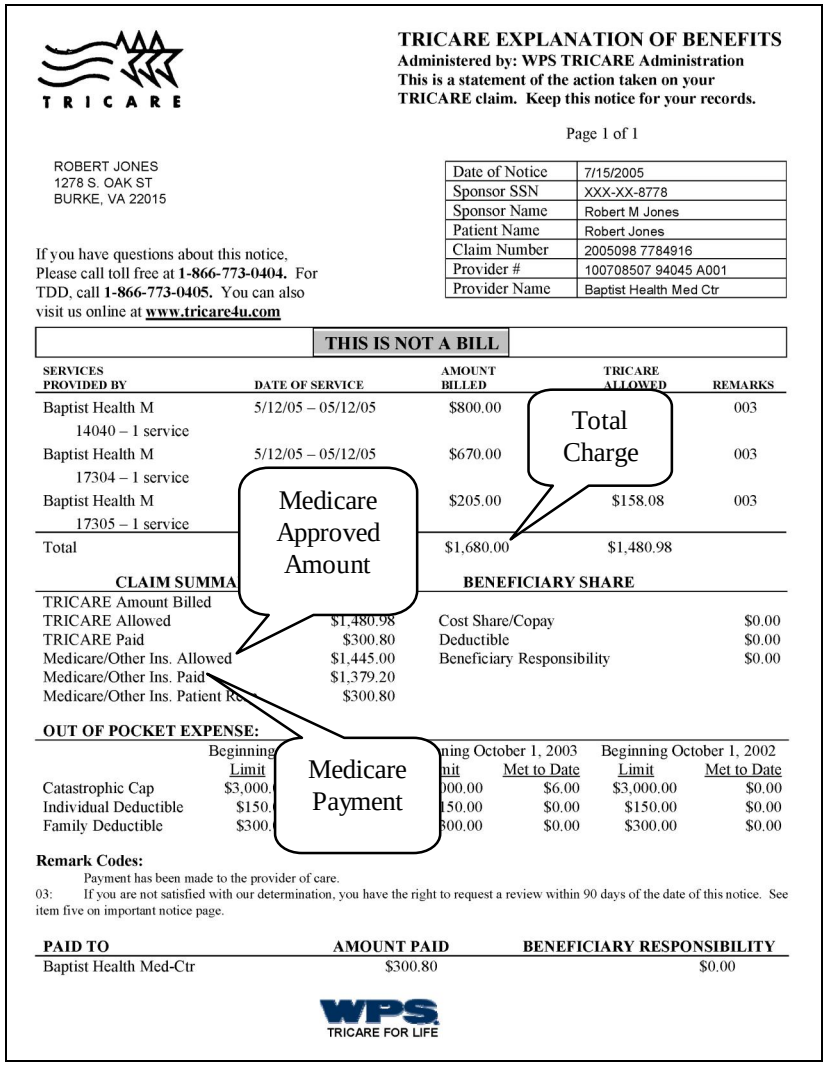
Health Net Federal Services

Medicare Approved Amount

Total Charge

Medicare Payment

Example 3: WPS TRICARE Administration



TRICARE

TRICARE EXPLANATION OF BENEFITS
Administered by: WPS TRICARE Administration
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

Page 1 of 1

ROBERT JONES
1278 S. OAK ST
BURKE, VA 22015

Date of Notice	7/15/2005
Sponsor SSN	XXX-XX-8778
Sponsor Name	Robert M Jones
Patient Name	Robert Jones
Claim Number	2005098 7784916
Provider #	100708507 94045 A001
Provider Name	Baptist Health Med Ctr

If you have questions about this notice, Please call toll free at **1-866-773-0404.** For TDD, call **1-866-773-0405.** You can also visit us online at **www.tricare4u.com**

THIS IS NOT A BILL

SERVICES PROVIDED BY	DATE OF SERVICE	AMOUNT BILLED	TRICARE ALLOWED	REMARKS
Baptist Health M	5/12/05 – 05/12/05	$800.00		003
14040 – 1 service				
Baptist Health M	5/12/05 – 05/12/05	$670.00		003
17304 – 1 service				
Baptist Health M		$205.00	$158.08	003
17305 – 1 service				
Total		$1,680.00	$1,480.98	

CLAIM SUMMA

		BENEFICIARY SHARE	
TRICARE Amount Billed			
TRICARE Allowed	$1,480.98	Cost Share/Copay	$0.00
TRICARE Paid	$300.80	Deductible	$0.00
Medicare/Other Ins. Allowed	$1,445.00	Beneficiary Responsibility	$0.00
Medicare/Other Ins. Paid	$1,379.20		
Medicare/Other Ins. Patient Re	$300.80		

OUT OF POCKET EXPENSE:

	Beginning Limit	ning October 1, 2003 nit	Met to Date	Beginning October 1, 2002 Limit	Met to Date
Catastrophic Cap	$3,000.	000.00	$6.00	$3,000.00	$0.00
Individual Deductible	$150.	150.00	$0.00	$150.00	$0.00
Family Deductible	$300.	300.00	$0.00	$300.00	$0.00

Remark Codes:
Payment has been made to the provider of care.
03: If you are not satisfied with our determination, you have the right to request a review within 90 days of the date of this notice. See item five on important notice page.

PAID TO	AMOUNT PAID	BENEFICIARY RESPONSIBILITY
Baptist Health Med-Ctr	$300.80	$0.00

WPS TRICARE FOR LIFE

Total Charge

Medicare Approved Amount

Medicare Payment