Gundersen Lutheran®

HOW TO READ YOUR COST SHARED FUND STATEMENT

1. The name of the member who received medical services and their billing address.

2. Your member and employer group identification numbers.

3. The medical practitioner's name who provided the service to you.

4. Your patient account number assigned to your claim by your provider.

5. The number assigned to your claim when received by the Health Plan.

6. Each service provided to you is submitted to the Health Plan with a procedure code that identifies the service you received.

7. Procedure description states what service you received.

8. Is the amount billed by your medical provider for the service you received.

9. This amount shows the rolling balance of your Cost Share Fund. It is the total amount available for you to use if you have single coverage or the total amount for your family to use if you have family coverage.

10. The amount shown in this column is the amount applied toward your deductible and is eligible for 50% payment from your Cost Share Fund.

11. The amount shown in this column is the amount of co-insurance you are responsible for and is eligible for 50% payment from your Cost Share Fund.

12. The amount paid to your medical provider out of your Cost Share Fund for each eligible service.

13. Contact information to reach Gundersen Lutheran Health Plan in the event you have questions regarding your Cost Share Fund Statement.

Gundersen Lutheran Administrative Services
1836 South Ave
Mail Stop NCA2-01
La Crosse, WI 54601

P656702800M

Gundersen Luthearn Health Plan
1836 South Avenue
Mail Stop NCA2-01
La Crosse, WI 54601

Return Service Requested

GUNDERSEN LUTHERAN COST SHARE STATEMENT

ENV 1264

SINGLE PIECE
1264 0.3584 SP 0.440

1

JANE DOE
847 ORANGE ST APT A
ONALASKA, WI 54650

28

2

Member Name:	JANE DOE
Member Number:	000000073
Group Number:	590000
Group Name:	GUNDERSEN LUTHERAN ADMIN
Date Printed:	2/1/2011
Page Number:	1

Services below were previously processed by your Gundersen Lutheran MEDICAL PLAN. Amounts not eligible under the Employee HRA will not appear on this statement.

3 4 5

Provider: KEVIN MILLER **Account #:** 004900000WWWL **Claim #:** 000000E01191

Serv	Date of Service	Procedure	Procedure Description	Billed Amount	Deductible Amount	Co-Ins Amount	Paid by Cost Share Fund
0100	1/15/11	99213	PROF VISIT	99.90	79.92	0.00	39.96

Provider: KEVIN MILLER **Account #:** 004900000WWWL **Claim #:** 000000E01199

6 7 8

Serv	Date of Service	Procedure	Procedure Description	Billed Amount	Deductible Amount	Co-Ins Amount	Paid by Cost Share Fund
0100	1/15/11	82105	PATH/LAB	32.90	26.32	0.00	13.16

AMOUNT REMAINING IN FAMILY COST SHARE FUND: $946.88

10 11 12

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If You Have Questions Regarding Your Cost Share Fund Statement Contact:
608-775-8007 or 800-897-1923
TTY: 800-947-3529
www.glhealthplan.org/costshare

VOID