CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Explanation of Benefits

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

**********ALL FOR AADC 956
PB-0MA-38-ENV 21314 62
TUSHAR GANDHI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Customer Service

Questions? Contact us at
800-971-4153

Enrollee:	TUSHAR GANDHI
Member ID:	0720943CC
Group:	CONNECTED CARE CALIFORNIA
Group#:	INTELCCC
Location:	CA01
Location Name:	CA01-ACTIVE INTEL CA

January Monthly Statement

Dear TUSHAR GANDHI ,

The information below is a summary of the healthcare claims you incurred for the period 12/21/2023 through 12/21/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$371.00

This is the total amount billed for the dates of service of 12/21/2023 through 12/21/2023.

Total Amount Paid By Plan

$295.02

This is the amount the plan paid in total for services rendered from 12/21/2023 through 12/21/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$63.21

This is the amount the provider(s) of service ***may*** bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
51562055-01	TUSHAR GANDHI	$371.00	$0.00	$12.77	$358.23	$47.68	$0.00	$310.55	$295.02
	Totals	$371.00	$0.00	$12.77	$358.23	$47.68	$0.00	$310.55	$295.02

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Forwarding Service Requested

**********ALL FOR AADC 956
PB-0MA-38-ENV 13176 34
RAJVEE MODI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Customer Service

Questions? Contact us at
800-971-4153

Enrollee:	TUSHAR GANDHI
Member ID:	0720943CC
Group:	CONNECTED CARE CALIFORNIA
Group#:	INTELCCC
Location:	CA01
Location Name:	CA01-ACTIVE INTEL CA

April Monthly Statement

Dear RAJVEE MODI ,

The information below is a summary of the healthcare claims you incurred for the period 03/23/2023 through 03/23/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$709.97

This is the total amount billed for the dates of service of 03/23/2023 through 03/23/2023.

Total Amount Paid By Plan

$57.76

This is the amount the plan paid in total for services rendered from 03/23/2023 through 03/23/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$502.79

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
49864899-01	RAJVEE MODI	$503.00	$0.00	$0.21	$502.79	$502.79	$0.00	$0.00	$0.00
49897514-01	RAJVEE MODI	$206.97	$0.00	$149.21	$57.76	$0.00	$0.00	$57.76	$57.76
Totals		$709.97	$0.00	$149.42	$560.55	$502.79	$0.00	$57.76	$57.76

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********ALL FOR AADC 956
PB-0MA-38-ENV 10858 27
TUSHAR GANDHI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Customer Service

Questions? Contact us at
800-971-4153

Enrollee: TUSHAR GANDHI
Member ID: 0720943CC
Group: CONNECTED CARE CALIFORNIA
Group#: INTELCCC
Location: CA01
Location Name: CA01-ACTIVE INTEL CA

May Monthly Statement

Dear TUSHAR GANDHI ,

The information below is a summary of the healthcare claims you incurred for the period 05/03/2023 through 05/03/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$693.73

This is the total amount billed for the dates of service of 05/03/2023 through 05/03/2023.

Total Amount Paid By Plan

$61.36

This is the amount the plan paid in total for services rendered from 05/03/2023 through 05/03/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$0.00

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
50167590-01	TUSHAR GANDHI	$515.66	$0.00	$465.93	$49.73	$0.00	$0.00	$49.73	$49.73
50167857-01	TUSHAR GANDHI	$178.07	$0.00	$166.44	$11.63	$0.00	$0.00	$11.63	$11.63
	Totals	$693.73	$0.00	$632.37	$61.36	$0.00	$0.00	$61.36	$61.36

Claim#: 50167590-01
Patient: TUSHAR GANDHI

Patient#: 5964388742R
Provider: QUEST DIAGNOSTICS
Paid Date: 05/23/23

Dates of Service	Service Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Eligible Expense	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
05/03-05/03/2023	55	$154.85	$0.00	BX	$143.83	$11.02	$0.00	$0.00	$11.02	100%	$11.02
05/03-05/03/2023	55	$22.50	$0.00	BX	$20.70	$1.80	$0.00	$0.00	$1.80	100%	$1.80
05/03-05/03/2023	55	$74.25	$0.00	BX	$66.26	$7.99	$0.00	$0.00	$7.99	100%	$7.99

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********ALL FOR AADC 956
PB-OMA-38-ENV 14694 38
RAJVEE MODI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Customer Service

Questions? Contact us at
800-971-4153

Enrollee: TUSHAR GANDHI
Member ID: 0720943CC
Group: CONNECTED CARE CALIFORNIA
Group#: INTELCCC
Location: CA01
Location Name: CA01-ACTIVE INTEL CA

June Monthly Statement

Dear RAJVEE MODI ,

The information below is a summary of the healthcare claims you incurred for the period 05/22/2023 through 05/22/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$4,940.00

This is the total amount billed for the dates of service of 05/22/2023 through 05/22/2023.

Total Amount Paid By Plan

$0.00

This is the amount the plan paid in total for services rendered from 05/22/2023 through 05/22/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$1,927.51

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
50268419-01	RAJVEE MODI	$4,940.00	$0.00	$3,012.49	$1,927.51	$1,927.51	$0.00	$0.00	$0.00
	Totals	$4,940.00	$0.00	$3,012.49	$1,927.51	$1,927.51	$0.00	$0.00	$0.00

Claim#: 50268419-01
Patient: RAJVEE MODI

Patient#: AB10946305-3
Provider: ABDULMALIK S DREDAR
Paid Date: 06/06/23

Dates of Service	Service Code	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Eligible Expense	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
05/22-05/22/2023	49	$4,790.00	$0.00	BX	$2,878.29	$1,911.71	$1,911.71	$0.00	$0.00	100%	$0.00

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Explanation of Benefits

RETAIN FOR TAX PURPOSES

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**********ALL FOR AADC 956
PB-OMA-38-ENV 14693 38
TUSHAR GANDHI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Customer Service

Questions? Contact us at
800-971-4153

Enrollee:	TUSHAR GANDHI
Member ID:	0720943CC
Group:	CONNECTED CARE CALIFORNIA
Group#:	INTELCCC
Location:	CA01
Location Name:	CA01-ACTIVE INTEL CA

June Monthly Statement

Dear TUSHAR GANDHI ,

The information below is a summary of the healthcare claims you incurred for the period 05/09/2023 through 05/09/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$525.00

This is the total amount billed for the dates of service of 05/09/2023 through 05/09/2023.

Total Amount Paid By Plan

$0.00

This is the amount the plan paid in total for services rendered from 05/09/2023 through 05/09/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$519.32

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
50225712-01	TUSHAR GANDHI	$525.00	$0.00	$5.68	$519.32	$519.32	$0.00	$0.00	$0.00
	Totals	$525.00	$0.00	$5.68	$519.32	$519.32	$0.00	$0.00	$0.00

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Forwarding Service Requested

**********ALL FOR AADC 956
PB-OMA-38-ENV 14739 40
TUSHAR GANDHI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Customer Service

Questions? Contact us at
800-971-4153

Enrollee:	TUSHAR GANDHI
Member ID:	0720943CC
Group:	CONNECTED CARE CALIFORNIA
Group#:	INTELCCC
Location:	CA01
Location Name:	CA01-ACTIVE INTEL CA

July Monthly Statement

Dear TUSHAR GANDHI ,

The information below is a summary of the healthcare claims you incurred for the period 06/23/2023 through 06/23/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$371.00

This is the total amount billed for the dates of service of 06/23/2023 through 06/23/2023.

Total Amount Paid By Plan

$0.00

This is the amount the plan paid in total for services rendered from 06/23/2023 through 06/23/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$304.49

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
50473116-01	TUSHAR GANDHI	$371.00	$0.00	$66.51	$304.49	$304.49	$0.00	$0.00	$0.00
Totals		$371.00	$0.00	$66.51	$304.49	$304.49	$0.00	$0.00	$0.00

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

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Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********ALL FOR AADC 956
PB-STL_UNSORTED-MACH-ENV 5066 12
TUSHAR GANDHI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Customer Service

Questions? Contact us at
800-971-4153

Enrollee:	TUSHAR GANDHI
Member ID:	0720943CC
Group:	CONNECTED CARE CALIFORNIA
Group#:	INTELCCC
Location:	CA01
Location Name:	CA01-ACTIVE INTEL CA

September Monthly Statement

Dear TUSHAR GANDHI ,

The information below is a summary of the healthcare claims you incurred for the period 07/17/2023 through 07/17/2023. This information is commonly referred to as an *"Explanation of Benefits" (EOB).* This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$561.00

This is the total amount billed for the dates of service of 07/17/2023 through 07/17/2023.

Total Amount Paid By Plan

$561.00

This is the amount the plan paid in total for services rendered from 07/17/2023 through 07/17/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$0.00

This is the amount the provider(s) of service *may* bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
50629027-01	TUSHAR GANDHI	$561.00	$0.00	$0.00	$561.00	$0.00	$0.00	$561.00	$561.00
	Totals	$561.00	$0.00	$0.00	$561.00	$0.00	$0.00	$561.00	$561.00

CONNECTED CARE / CA
18861 90TH AVENUE, #1A
MOKENA IL 60448

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********ALL FOR AADC 956
PB-OMA-3B-ENV 20415 56
RAJVEE MODI
4041 SALT POINT WAY
RANCHO CORDOVA CA 95742-6640

Customer Service

Questions? Contact us at
800-971-4153

Enrollee:	TUSHAR GANDHI
Member ID:	0720943CC
Group:	CONNECTED CARE CALIFORNIA
Group#:	INTELCCC
Location:	CA01
Location Name:	CA01-ACTIVE INTEL CA

November Monthly Statement

Dear RAJVEE MODI ,

The information below is a summary of the healthcare claims you incurred for the period 10/19/2023 through 10/25/2023. This information is commonly referred to as an ***"Explanation of Benefits" (EOB).*** This is not a bill. It is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the provider(s) of service. Use this EOB to verify the accuracy of any bill you may receive from the provider(s) listed below. If you did not receive service from the provider(s) listed below or suspect fraudulent charges please contact the customer service department at the number listed above.

Total Amount Billed

$502.88

This is the total amount billed for the dates of service of 10/19/2023 through 10/25/2023.

Total Amount Paid By Plan

$10.52

This is the amount the plan paid in total for services rendered from 10/19/2023 through 10/25/2023. Please see the "Claim Detail" section of this document for more information.

Your Financial Responsibility

$358.23

This is the amount the provider(s) of service ***may*** bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim Summary

Claim Number	Patient Name	Total Charge	Ineligible Amount	Discount Amount	Eligible Expenses	Deductible Amount	Co-pay Amount	Balance	Payment Amount
51155785-01	RAJVEE MODI	$371.00	$0.00	$12.77	$358.23	$358.23	$0.00	$0.00	$0.00
51219481-01	RAJVEE MODI	$131.88	$0.00	$121.36	$10.52	$0.00	$0.00	$10.52	$10.52
Totals		$502.88	$0.00	$134.13	$368.75	$358.23	$0.00	$10.52	$10.52