Your Explanation of Benefits (EOB)

Company Name & Address

THE PERFECTHEALTH INSURANCE COMPANY
55 WATER STREET 5TH FLOOR
NEW YORK, NY 10041

Forwarding Service Requested

BRIAN XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXX
PORT JEFFERSON, NY 11776-4488

Explanation of Benefits
Please Retain for Your Records

Group Number:	100001	← Group Plan Number
Claim No:	XXXXXXX	← Claim Number Assigned
Insured Name:	BRIAN XXXXXXXXXX	← Subsrciber Name
ID No:	555-55-5555	← ID Number
Claimant:	BRIAN	← Patient's Name
Check Date:	10/05/2006	← Date Claim was Processed
Provider:	ABC OCCUPATIONAL THERAPY	
Account No:	000	← Patient Account Number
PPO Name:		← PPO Vendor

Procedure Code — Date of Service — Total Charges — Reason Why Not Covered — Eligible Amount

CLAIM DETAIL

Procedure Code	Dates of Services	Charges Submitted	PerfectHealth Contract Rate	Amount Not Covered	Remark Codes*	Covered Charges	Charges Paid at 70% OUT	
97530	05/03/06	67.50	52.00		*	52.00	52.00	
97530	05/10/06	67.50	52.00		*	52.00	52.00	
97530	05/24/06	67.50	52.00		*	52.00	52.00	
97530	05/31/06	67.50	52.00		*	52.00	52.00	
97530	06/07/06	67.50	52.00		*	52.00	52.00	
97530	06/14/06	67.50	52.00		*	52.00	52.00	

CLAIM SUMMARY

Charges Submitted	Total Provider Discount (if applicable)	Amount Not Covered Plan Limit / Patient Responsibility	Total Covered Charges	Amount Applied to Deductible	Patient Portion (coinsurance)	Total Patient Responsibility (see below for explanation)	PerfectHealth Payment (coinsurance)
405.00			312.00		93.60	186.60	218.40

Amount Paid (→ 218.40) — Patient Liability (→ 186.60)

Remark Codes

* THE AMOUNT ALLOWED IS IN ACCORDANCE WITH THE FEE SCHEDULE APPLICABLE TO YOUR PLAN.
BENEFITS ARE ASSIGNED TO THE EMPLOYEE.
YOU HAVE MET $ 5051.00 OF THE CURRENT YEAR DEDUCTIBLE. YOU HAVE MET $ 2205.00 OF THE CURRENT YEAR COINSURANCE(IN OR OUT OF NETWORK). AN ADDITIONAL IN OR OUT OF NETWORK COINSURANCE MAY APPLY. SEE YOUR CERTIFICATE OF COVERAGE.

*** If you have any questions, please call our Customer Service Department at (646)447-7077. If you suspect fraud, please contact our FRAUD HOTLINE at (877)835-5447.
For Non Participating providers, the patient's responsibility is the amount charged, less PerfectHealth's payment if any. For Participating providers, the patient's responsibility is the PPO contracted amount, less PerfectHealth's payment, if any.
If you disagree with the decision of your claim:
1) Call our Customer Service Dept. at (646)447-7077, or submit a written appeal to the address above.
2) Appeals must be submitted within 180 days of receipt of initial determination to avoid forfeiture of your rights to an appeal.

THE PERFECTHEALTH INSURANCE COMPANY
55 WATER STREET 5TH FLOOR
NEW YORK, NY 10041

FLEET MAINE N.A.(00802 51407)
SOUTH PORTLAND,ME

52-153/112

CHECK DATE	CHECK NO
10/05/2006	5000023186

AMOUNT
$*****218.40

CHECKS VOID AFTER 90 DAYS

PAY Two Hundred Eighteen & 40/100 Dollars

TO THE ORDER OF Brian XXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXX
Port Jefferson, NY 11776-4488