Insurance Company
Administrative Concepts, Inc.
994 Old Eagle School Rd Ste 1005
Wayne PA 19087-1802

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

An explanation of each bullet point can be found on the following page.

1 PROVIDER 123
123 YOUR STREET
YOUR CITY, NA 12345

Customer Service Information

Questions? Please contact Customer Service at (610)293-9229
Or visit us online at www.visit-aci.com
or email us at aciclaims@visit-aci.com

Enrollee: MEMBER NAME (2)
Date: 11/01/2014 (3)
Group Name: GROUP NAME (4)

5 **Claim#: 12345678-00**
Patient: PATIENT NAME

Patient #: 1310500xcv900095700917
Provider: MEDICAL CENTER

6 Dates of Service	7 Service Code	8 Total Charge	9 Ineligible Amount	10 Reason Code	11 Discount Amount	12 Covered By Plan	13 Other Insurance	14 Deductible Amount	15 Co-Pay Amount	16 Covered After Deductions	17 Paid At	Payment Amount
10/17-10/17/2014	08	$426.00	$340.80	PN	$85.20	$0.00	$0.00	$0.00	$0.00	$0.00	100%	$0.00
10/17-10/17/2014	08	$404.00	$323.20	PN	$80.80	$0.00	$0.00	$0.00	$0.00	$0.00	100%	$0.00
10/17-10/17/2014	WE	$291.00	$0.00	PN	$58.20	$232.80	$0.00	$0.00	$0.00	$232.80	100%	$232.80
10/17-10/17/2014	WE	$191.00	$0.00	PN	$38.20	$152.80	$0.00	$0.00	$0.00	$152.80	100%	$152.80
10/17-10/17/2014	SC	$385.60	$348.47	SN	$0.00	$37.13	$0.00	$0.00	$0.00	$37.13	100%	$37.13
Column Totals		$1,697.60	$1,012.47		$262.40	$422.73	$0.00	$0.00	$0.00	$422.73		$422.73

Patient's Responsibility: **$1,012.47** (18)

Total Payment Amount (19) $422.73

Service Code Description

08	DIAGNOSTIC LAB
SC	NY SURCHARGE 9.63%
WE	WELLNESS SERVICES

Reason Code Description

PN	PHCS DISCOUNT. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.
PY	THE PREVENTATIVE SERVICE IS NOT A COVERED SERVICE UNDER THE AFFORDABLE CARE ACT AND IS NOT ELIGIBLE FOR BENEFITS UNDER THIS PLAN.
SN	THIS REFLECTS THE 9.63% NY SURCHARGE ELECT STATUS

Payment Details

Paid To	Check No.	Amount
MEDICAL CENTER	000010052	$385.60

Additional Information

*** Administrative Concepts, Inc. does not share private health information except as required by law. We are committed to guarding the private information entrusted to us.

UNDERSTANDING YOUR EXPLANATION OF BENEFIT STATEMENT (EOB)

At ACI, it is important to us that you understand what, when and why & how your claim was processed. Each time a claim is processed, an Explanation of Benefit Statement (EOB) is mailed to you and the Physician or Hospital to provide claims and payment information on a single statement for you regarding those services. To follow is an overview of that information and what it means.

If you have questions regarding your EOB statement, please call our Customer Service Team at (888) 293-9229.

1	Address	Provider Name and Mailing Address, or Insureds' Name and Mailing Address
2	Enrollee Name	The *Enrollee* name may not always be the *patient* name. The Enrollee name is the policyholder. The patient can be a covered dependent.
3	Date	The *Date* is when the EOB was issued
4	Group Name	The *Group Name* is the Employer Group, Organization, School or University.
5	Claim#	The *Claim Number* identifies specific information for a single claim. Immediate below is the *Patient Name*.
6	Dates of Service	The date or span of dates that your were treated by a physician or hospital
7	Service Code	A number or letter code for the description noted below
8	Total Charge	Amount charged by health care provider for each service submitted on the claim
9	Ineligible Amount	The amount that will not be considered for benefits
10	Reason Code	The reason code why the previous amount will not be considered for benefits. You will find the description of the reason code below
11	Discount Amount	The negotiated reduction in cost by the Preferred Provider Organization
12	Covered by Plan	The plan allowance is the amount we use to determine our payment and your coinsurance for covered services.
13	Other Insurance	The amount paid by your Primary Insurance Carrier
14	Deductible Amount	A *Deductible* is a fixed amount of covered expenses you must incur for your coinsurance for covered services.
15	Copay Amount	A copayment is a fixed amount of money you pay to the physician, facility, pharmacy, etc., when you receive certain services.
16	Covered After Deductions	The total allowable amount
17	Paid At	The percentage that the total allowable amount will be paid
18	Patient Responsibility	This is the remaining amount after your benefits have been applied. It is your responsibility to pay the patient responsibility to the billing physician or hospital.
19	Total Paid	The total, exact amount of the payment