AETNA LIFE INSURANCE COMPANY
P.O. BOX 150431
HARTFORD, CT 06115-0431

EXPLANATION OF BENEFITS

Please Retain for Future Reference
Date Printed: 01/17/05

THIS IS NOT A BILL

JOHN DOE
1000 MIDDLE STREET
MIDDLETOWN CT 06457 [1]

[2] **QUESTIONS?** *Contact us at* ***aetnanavigator.com***
For Customer Service please call: 1-800-999-9999
Or write to the address shown above.

[3] **Notes:**

Member: John T. Doe [4]
Group Name: ABC Company [5]

[6] Member ID: Please refer to ID Card
Group Number: 660379-10-001 AB DAMG7D

All Remarks Appear After Final Claim

[7] *Claim Activity for JOHN T DOE* *(Self)* [8]

DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED	[9] ***Patient Responsibility*** *(shaded columns)* NOT PAYABLE BY PLAN	SEE REMARKS	YOUR COPAY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	***Total Patient Responsibility***
	A	B	C		D	E	F		G	H	I
[10]	[11]	[12]	[13]	[14]	[15]	[16]	[17]	[18]	[19]	[20]	[21]

This is the claim detail for the bills **received on 01/11/05**. Claim ID: PID589W400

DATE AND TYPE OF SERVICE	A	B	C	SEE REMARKS	D	E	F	PAID AT	G	H	I
Ellen Smith 01/08/05 *Office Visit*	110.00	90.00			**20.00**		70.00	90%	63.00	**7.00**	**27.00**
Column Totals	110.00	90.00			**20.00**		70.00		63.00	**7.00**	**27.00**

This is the claim detail for the bills **received on 01/12/05**. Claim ID: PKLGI9W400

DATE AND TYPE OF SERVICE	A	B	C	SEE REMARKS	D	E	F	PAID AT	G	H	I
Jim Michaels 01/10/05 *Medical Services*	31.00		**5.00**				26.00	90%	23.40	**2.60**	**7.60**
01/10/05 *Medical Services*	31.00		**5.00**	1			26.00	90%	23.40	**2.60**	**7.60**
Refer to Remarks Section				2							
Column Totals	62.00		**10.00**				52.00		46.80	**5.20**	**15.20**

[22] *Late Claim Interest* $7.89

This is the claim detail for the bills **received on 01/12/05**. Claim ID: EPO589W400

DATE AND TYPE OF SERVICE	A	B	C	SEE REMARKS	D	E	F	PAID AT	G	H	I
Rhonda Parker 01/08/05 *Office Visit*	110.00	90.00			**20.00**		70.00	90%	63.00	**7.00**	**27.00**
Column Totals	110.00	90.00			**20.00**		70.00		63.00	**7.00**	**27.00**

This is the claim detail for the bills **received on 01/15/05**. [23] Claim ID: PID589W400 [24]

DATE AND TYPE OF SERVICE	A	B	C	SEE REMARKS	D	E	F	PAID AT	G	H	I
Hartford Hospital 01/08/05 *Office Visit*	110.00	90.00	**25.00**	3			65.00	90%	58.50	**6.50**	**31.50**
01/10/05 *Diag*	75.00	75.00					75.00	90%	67.50	**7.50**	**7.50**
X-ray	50.00	50.00					50.00	90%	45.00	**5.00**	**5.00**
X-ray	20.00	20.00					20.00	90%	18.00	**2.00**	**2.00**
X-ray	50.00	20.00					70.00	90%	63.00	**7.00**	**7.00**
Lab	150.00	150.00					70.00	90%	63.00	**7.00**	**7.00**

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Claim Activity for JOHN T DOE *(Self)*

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DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED	NOT PAYABLE BY PLAN	SEE REMARKS	YOUR COPAY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	Total Patient Responsibility
			Patient Responsibility (shaded columns)								
	A	B	C		D	E	F		G	H	I
This is the claim detail for the bills **received on 01/15/05**.					Claim ID: PID589W400						
01/08/05 *Office Visit*	110.00	90.00			20.00		70.00	90%	63.00	7.00	**27.00**
Column Totals	565.00	495.00	**25.00**		**20.00**		420.00		378.00	**42.00**	**87.00**

26

Ellen Smith May Bill You:	**$27.00**
Jim Michaels May Bill You:	**$15.20**
Rhonda Parker May Bill You:	**$27.00**
Hartford Hospital May Bill You:	**$87.00**

Claim Activity for JANICE DOE *(Spouse)*

DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED	NOT PAYABLE BY PLAN	SEE REMARKS	YOUR COPAY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	Total Patient Responsibility
			Patient Responsibility (shaded columns)								
	A	B	C		D	E	F		G	H	I
This is the claim detail for the bills **received on 01/15/05**.					Claim ID: EID589W400						
Ellen Smith 01/08/05 *Office Visit*	110.00	90.00			20.00		70.00	90%	63.00	**7.00**	**27.00**
Column Totals	110.00	90.00			**20.00**		70.00		63.00	**7.007**	**27.00**

26

Ellen Smith May Bill You:	**$27.00**
27 C + D + E + H =	I

Claim Activity for SCOTT R DOE *(Son)*

DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED AMOUNT	NOT PAYABLE BY PLAN	SEE REMARKS	YOUR COPAY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	Total Patient Responsibility
			Patient Responsibility (shaded columns)								
	A	B	C		D	E	F		G	H	I
This is the claim detail for the bills **received on 01/15/05**. 23					Claim ID : EKLGI9W400 24						
Randy Jackson 01/10/05 *Medical Services*	31.00		**5.00**				26.00	90%	23.40	**2.60**	**7.60**
01/10/05 *Medical Services*	31.00		**5.00**	**1**			26.00	90%	23.40	**2.60**	**7.60**
Column Totals	62.00		**10.00**				52.00		46.80	**5.20**	**15.20**

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Claim Activity for SCOTT DOE *(Son)*

			Patient Responsibility (shaded columns)								Total Patient Responsibility
DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED	NOT PAYABLE BY PLAN	SEE REMARKS	YOUR COPAY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	
	A	B	C		D	E	F		G	H	I
This is the claim detail for the bills **received on 01/15/05**. 23					Claim ID: PFG689W400 24						
Latoya London 01/08/05 *Office Visit* ***Refer to Remarks Section***	110.00	90.00		4	20.00		70.00	90%	63.00	**7.00**	**27.00**
Column Totals	110.00	90.00			**20.00**		70.00		63.00	**7.00**	**27.00**

26

Randy Jackson May Bill You:	**$15.20**
Latoya London May Bill You:	**$27.00**
27 *C + D + E + H =*	*I*

28

Aetna Health Fund Remarks: ***Suppress if no AHF RMKS***

Flexible Spending Account Remarks: ***Suppress if no FSA RMKS***

General Remarks: ***Suppress if no Line or Claim Level RMKS***

1 - We have paid the maximum allowed by your plan of benefits for this service.
2 - The late claim interest/penalty charge is required by state regulations. A late claim interest/penalty charge has been applied and is included in the payment. The charge has been paid by Aetna. It does not come from member funds, and is not applied to plan limits.
3 - This claim could not be considered at this time.
4 - This claim was previously processed on Scott in error and denied as a duplicate. All records have been adjusted.

Plan Summary for *01/01/05- 12/31/05* 29

Description			
Family Limits	**Annual Limit**	**Year To Date**	**Remainder**
In Network Deductible	$600.00	$600.00	$00.00
In Network Share of Amount Remaining (Coinsurance)	$1,500.00	$225.00	$1275.00
Out of Network Deductible	$600.00	$525.00	$75.00
Out of Network Share of Amount Remaining (Coinsurance)	$1,500.00	$00.00	$1,500.00
Individual Limits	**Annual Limit**	**Year To Date**	**Remainder**
John (Self)			
In Network Deductible	$200.00	$200.00	$00.00
In Network Share of Amount Remaining (Coinsurance)	$500.00	$75.00	$425.00
Out of Network Deductible	$250.00	$175.00	$75.00
Out of Network Share of Amount Remaining (Coinsurance)	$750.00	$00.00	$750.00
Janice (Spouse)			
In Network Deductible	$200.00	$200.00	$00.00
In Network Share of Amount Remaining (Coinsurance)	$500.00	$75.00	$425.00
Out of Network Deductible	$250.00	$175.00	$75.00
Out of Network Share of Amount Remaining (Coinsurance)	$750.00	$00.00	$750.00
Scott (Son)			
In Network Deductible	$200.00	$200.00	$00.00
In Network Share of Amount Remaining (Coinsurance)	$500.00	$75.00	$425.00
Out of Network Deductible	$250.00	$175.00	$75.00
Out of Network Share of Amount Remaining (Coinsurance)	$750.00	$00.00	$750.00

Payment Summary: 30

Sent To: Ellen Smith
Date Sent: 01/17/2005
Amount: $63.00
Date Sent: 01/16/2005
Amount: $63.00

Sent To: Jim Michaels
Date Sent: 01/13/2005
Amount: $54.69

Sent To: Rhonda Parker
Date Sent: 01/17/2005
Amount: $63.00

Sent To: Hartford Hospital
Date Sent: 01/17/2005
Amount: $378.00

Sent To: Randy Jackson
Date Sent: 01/16/2005
Amount: $46.80

Sent To: Latoya London
Date Sent: 01/14/2005
Amount: $63.00

Field Descriptions for the Consolidated Family Statement

1 – [Mailing address]. Name and mailing address for the member.

2 – Questions? Customer specific contact information (website and/or telephone number) to use for any questions.

3 – Notes. Displays optional messages.

4 – Member. First and last name of member.

5 – Group Name. The name of the plan sponsor.

6 – Group Number. The control, suffix, account, plan summary and PI record.

7 – Claim Activity for [Name]. First and last name of patient with middle initial.

8 – [Relationship]. Relationship of patient to the member.

9 – Patient Responsibility. The shaded columns (C, D, E, H) are amounts for which patient is responsible. See fields #21, 26, 27.

10 – Date and Type of Service. The provider name, month, day and year the service was provided, and brief description of the service.

11 – Submitted Charges. The amount billed for this service.

12 – "Negotiated" or "Allowed". Negotiated = the special fee for this service negotiated with a provider who participates in the network. Allowed = the amount allowed for a provider not participating in the network.

13 – Pending or Not Payable by Plan. The amount being pended or denied. The next field (#14) points to the reason. *Note: this amount is excluded from the total in field #21 if no patient responsibility applies.*

14 – See Remarks. Corresponds to the remark with this number in field #28.

15 – Your Copay. Patient copayment for the services rendered.

16 – Your Deductible. Patient deductible applied to the difference between fields #12 and 13 (or #11 and 13 if out of network).

17 – Amount Remaining. The amount on which the benefit is calculated.

18 – Paid At. The percentage used to calculate benefits.

19 –Plan Pays. The amount your plan will pay for this service in absence of any adjustments in field #22.

20 – Your Share of Amount Remaining. Also known as "coinsurance". The portion of the allowable charges for which the member is responsible.

21 – Total Patient Responsibility. Indicates the total amount for which the patient is responsible. This includes not covered, copay, deductible and coinsurance amounts.

22 – [Claim Adjustments]. An amount that may impact the benefit Aetna will pay, such as the amount paid by another health plan, or a late claim interest amount (shown here on one claim only). *Note: when field #22 exists, then field #27 is suppressed.*

23 –[Received Date]. Date this specific claim was received by the claim office, with a unique date displayed for each claim.

24 – Claim ID. For internal Aetna use: Claim ID number, with a unique number displayed for each claim.

25 – Customer Member ID. The Customer Member ID (for internal Aetna use) that may match your ID card.

26 – [Provider Name] May Bill You. Totals for which the member is responsible. See field #27.

27 – C+D+E+H=I. These "shadow" letters identify columns and demonstrate how patient responsibility (amount provider may bill you) was calculated in field #26. *Note: this is suppressed if field #22 (claim adjustment) displays, since the formula is then invalid.*

28 – Remarks. Explain denied or pended charges, or provide additional information. Correspond to expense lines above with the same number in field #14.

29 – Plan Summary for [benefit year]. Summary of plan financial limits for the benefit year listed.

30 – Payment Summary. Payee, date sent and payment amount.