



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  
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**THIS IS NOT A BILL**

**JOHN DOE**  
**1000 MIDDLE STREET**  
**MIDDLETOWN CT 06457**

**2 QUESTIONS?** Contact us at [aetnavigators.com](http://aetnavigators.com)  
1-800-999-9999  
Or write to the address shown above.

**3 Notes:**

Member: John T. Doe  
Group Name: ABC Company

Member ID: W0698569857  
Group Number: 660379-10-001 AB DAMG7D  
**All Remarks Appear After Final Claim**

**7 Claim Activity for JOHN T DOE (Self)**

**9 Patient Responsibility (shaded columns)**

DATE AND TYPE OF SERVICE	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED	PENDING OR NOT PAYABLE	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
This is the claim detail for the bills received on 01/11/05. Claim ID: PID589W400											
Ellen Smith 01/08/05 Office Visit	110.00	90.00			20.00		70.00	90%	63.00	7.00	27.00
<b>Column Totals</b>	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											
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
<i>Refer to Remarks Section</i>				2							
<b>Column Totals</b>	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											
Rhonda Parker 01/08/05 Office Visit	110.00	90.00			20.00		70.00	90%	63.00	7.00	27.00
<b>Column Totals</b>	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. Claim ID: PID589W400											
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	PENDING OR NOT PAYABLE	SEE REMARKS	YOUR COPAY	Patient Responsibility (shaded columns)					Total Patient Responsibility
						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.						Claim ID: PID589W400					
01/08/05 Office Visit	110.00	90.00			20.00		70.00	90%	63.00	7.00	27.00
<b>Column Totals</b>	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	PENDING OR NOT PAYABLE	SEE REMARKS	YOUR COPAY	Patient Responsibility (shaded columns)					Total Patient Responsibility
						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.						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
<b>Column Totals</b>	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	PENDING OR NOT PAYABLE	SEE REMARKS	YOUR COPAY	Patient Responsibility (shaded columns)					Total Patient Responsibility
						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. <b>23</b>						Claim ID : EKLGI9W400 <b>24</b>					
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
<b>Column Totals</b>	62.00		10.00				52.00		46.80	5.20	15.20



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## Claim Activity for SCOTT DOE (Son)

DATE AND TYPE OF SERVICE	Patient Responsibility (shaded columns)										Total Patient Responsibility
	SUBMITTED CHARGES	NEGOTIATED OR ALLOWED	PENDING OR NOT PAYABLE	SEE REMARKS	YOUR COPY	YOUR DEDUCTIBLE	AMOUNT REMAINING	PAID AT	PLAN PAYS	YOUR SHARE OF AMOUNT REMAINING	
	A	B	C		D	E	F		G	H	
This is the claim detail for the bills received on 01/15/05. <b>23</b> Claim ID: PFG689W400 <b>24</b>											
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
<b>Column Totals</b>	110.00	90.00			<b>20.00</b>		70.00		63.00	<b>7.00</b>	<b>27.00</b>

<b>26</b>	<b>Randy Jackson May Bill You:</b>	<b>\$15.20</b>
	<b>Latoya London May Bill You:</b>	<b>\$27.00</b>
<b>27</b>	<b>C + D + E + H =</b>	<b>I</b>

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**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	Annual Limit	Year To Date	Remainder
<b>Individual Limits</b>			
<b>John (Self)</b>			
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
<b>Janice (Spouse)</b>			
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
<b>Scott (Son)</b>			
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
<b>Family Limits</b>			
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

**Payment Summary:** **30**

<b>Sent To:</b> Ellen Smith <b>Date Sent:</b> 01/17/2005 <b>Amount:</b> \$63.00
<b>Date Sent:</b> 01/16/2005 <b>Amount:</b> \$63.00
<b>Sent To:</b> Jim Michaels <b>Date Sent:</b> 01/13/2005 <b>Amount:</b> \$54.69
<b>Sent To:</b> Rhonda Parker <b>Date Sent:</b> 01/17/2005 <b>Amount:</b> \$63.00
<b>Sent To:</b> Hartford Hospital <b>Date Sent:</b> 01/17/2005 <b>Amount:</b> \$378.00
<b>Sent To:</b> Randy Jackson <b>Date Sent:</b> 01/16/2005 <b>Amount:</b> \$46.80
<b>Sent To:</b> Latoya London <b>Date Sent:</b> 01/14/2005 <b>Amount:</b> \$63.00

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