



Aetna Life Insurance Company
 PO BOX 981106
 EL PASO, TX 79998-1106

Statement date: November 15, 2020

Member: KEVIN BISHOP
 Member ID: W256809465
 Group #: 0719982-14-003 RC P1&N50
 Group name: IBM MEDICAL PLAN

QUESTIONS? Contact us at aetna.com
 1-888-725-1841
 Or write to the address shown above.

KEVIN BISHOP
 21 OLD STONE HIGHWAY
 EAST HAMPTON NY 11937

Explanation of Benefits (EOB) - This is not a bill

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preference, view, print or download your EOBs online anytime.

Track your health care costs

\$5,974.98

Amount you saved

Going to a doctor or hospital in the network saves you money. That's because we have arranged discounted rates with these providers. The online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.

\$0.00 (In-network)

Amount you have left to meet deductible

Annual deductible	\$3,550.00
Deductible used	- \$3,550.00
Deductible remaining	\$0.00

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your provider charged for services.	\$9,787.49
Member rate:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	\$3,076.08
ⓘ Pending or not payable:	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	\$623.75
Deductible:	The amount you pay for covered services before your plan starts to pay.	\$0.00
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is the out-of-pocket amount that you may owe.	\$956.63
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	\$0.00

Your payment summary

Patient	Provider	Your plan paid			You may owe or already paid
		Amount	Sent to	Send date	Amount
Kevin (self)	Massimiliano Spaliviero	\$148.61	Massimiliano Spaliviero	11/26/20	\$63.69
Kevin (self)	Shahid M Hussain	\$56.04	Shahid M Hussain	11/19/20	\$24.02
Kevin (self)	Stony Brook Southampton Hospital	\$324.13	Stony Brook Southampton Hospital	10/29/20	\$152.28

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Patient	Provider	Your plan paid			You may owe or already paid
		Amount	Sent to	Send date	Amount
Kevin (self)	Stony Brook Southampton Hospital	\$1,525.27	Stony Brook Southampton Hospital	11/19/20	\$716.64
Total:		\$2,054.05			\$956.63

Your claims up close

Claim for Kevin (self) Provider: Stony Brook Southampton Ho (In-Network)

Claim ID: E9JCK5YD200 Received on 10/22/20	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
MEDICAL SERVICES 76857 on 10/15/20	666.88		554.20 (1) (2)			112.68	78.88 (70%)	33.80 (30%)	33.80
US EXAM ABDO BACK WALL, COMP 76770 on 10/15/20	1,186.01	394.94	(2)			394.94	276.46 (70%)	118.48 (30%)	118.48
Refer to Remarks Section			(3) (4)						
Totals:	1,852.89	394.94	554.20	0.00	0.00	507.62	355.34	152.28	\$152.28
								NY HCRA Surcharge Paid to the State	\$31.21

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for Kevin (self) Provider: Shahid M Hussain (In-Network)

Claim ID: ETACLMSJ300 Received on 10/29/20	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
MEDICAL SERVICES 76857 on 10/15/20	134.00	28.10				28.10	19.67 (70%)	8.43 (30%)	8.43
US EXAM ABDO BACK WALL, COMP 76770 on 10/15/20	176.00	51.96				51.96	36.37 (70%)	15.59 (30%)	15.59
Refer to Remarks Section			(4)						
Totals:	310.00	80.06		0.00	0.00	80.06	56.04	24.02	\$24.02

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for Kevin (self) Provider: Massimiliano Spaliviero (In-Network)

Claim ID: EGACMW48300 Received on 11/3/20	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
OFFICE VISIT 99214 on 10/23/20	300.00	212.30				212.30	148.61 (70%)	63.69 (30%)	63.69
Refer to Remarks Section			(4)						
Totals:	300.00	212.30		0.00	0.00	212.30	148.61	63.69	\$63.69

You can find all numbered claim remarks in 'Your Claim Remarks' section.



Claim for Kevin (self) Provider: Stony Brook Southampton Ho (In-Network)

Claim ID: E7ACLNDQC00 Received on 11/5/20	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
COLLECTION OF VENOUS BLOOD 36415 on 10/30/20	69.55		69.55 (5)						
METABOLIC PANEL TOTAL CA 80048 on 10/30/20	187.29	56.82	(2)			56.82	39.77 (70%)	17.05 (30%)	17.05
PSA TOTAL 84153 on 10/30/20	253.05	76.77	(2)			76.77	53.74 (70%)	23.03 (30%)	23.03
PSA FREE 84154 on 10/30/20	136.21	41.32	(2)			41.32	28.92 (70%)	12.40 (30%)	12.40
URINALYSIS, AUTO. W/SCOPE 81001 on 10/30/20	95.64	29.02	(2)			29.02	20.31 (70%)	8.71 (30%)	8.71
CYTOPATH, CONCENTRATE TECH 88108 on 10/30/20	243.87	73.98	(2)			73.98	51.79 (70%)	22.19 (30%)	22.19
Refer to Remarks Section			(4)						
Totals:	985.61	277.91	69.55	0.00	0.00	277.91	194.53	83.38	\$83.38
									NY HCRA Surcharge Paid to the State \$17.08

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for Kevin (self) Provider: Stony Brook Southampton Ho (In-Network)

Claim ID: E5JMLSS8500 Received on 11/11/20	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
CT ABD & PELV 1+ REGNS 74178 on 11/2/20	6,338.99	2,110.87	(2)			2,110.87	1,477.61 (70%)	633.26 (30%)	633.26
Refer to Remarks Section			(4)						
Totals:	6,338.99	2,110.87		0.00	0.00	2,110.87	1,477.61	633.26	\$633.26
									NY HCRA Surcharge Paid to the State \$129.79

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Your Claim Remarks

General Remarks:

- (1) You do not have to pay this. When more than one of these services is done on the same day, we reduce the allowed amount. We allowed 50% of the contracted rate for this service. [Q22]
- (2) The Submitted Charges and Negotiated Network Amount have been adjusted to reflect addition of the New York HCRA surcharge.
- (3) Our portion of the New York HCRA surcharge is included in this payment. [997]
- (4) Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page. We will also provide your treatment codes and their meanings, if they do not appear on this statement. If you have questions about your diagnosis or your treatment, please contact your provider. [H63]
- (5) You do not owe this amount. We consider payment for this service to be part of the payment for other services. It is not paid separately. [780]



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Your benefit balances to date for 1/1/20 to 12/31/20

Individual Balances	Annual limit	Amount used	Amount remaining
Kevin (self)			
Medical In Network Deductible	\$3,550.00	\$3,550.00	\$0.00
Medical In Network Out of Pocket Maximum	\$6,850.00	\$4,548.95	\$2,301.05
Medical Out of Network Deductible	\$4,250.00	\$0.00	\$4,250.00
Medical Out of Network Out of Pocket Maximum	\$10,550.00	\$0.00	\$10,550.00

Individual lifetime benefits	Amount	Amount used	Amount remaining
Kevin (self)			
Medical Out of Network Lifetime	\$1,000,000.00	\$0.00	\$1,000,000.00

A complete list of your benefit balances and plan limits can be found on your secure member website.

The accumulated amounts towards your medical plan may have been adjusted due to claims not paid by us.

More Information

Do you have questions? Call us free of charge at the toll-free number on the first page of this statement or on your member ID card.

Appeals

Please send your written appeal along with a copy of this entire EOB to this address:

Appeals Resolution Team
PO Box 14463
Lexington, KY 40512

If you disagree with a claim decision, you can ask us to review it. The process is called an appeal. You or someone you name to act for you, your authorized representative, can ask for this review. Call our Member Services Department using the telephone number displayed on the member ID card or send your written request to the above address.

Your request should include:

- . Name, date of birth, and address
- . Member ID number
- . Group ID and name of your group, usually your employer
- . Any other claim documents or records or other facts you would like us to consider. This could be new details that you did not give us the first time.

You have the right to look at the relevant documents we used to make our decision on your claim. A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You can ask for these (free of charge) by calling or writing us. You have 180 days from the time you get this explanation to appeal. You might even have more time if your plan brochure or Summary Plan Description says so.

When to expect a decision

- . If your plan allows for one appeal we'll let you know our decision 60 days after we get your appeal request. Some states might require a different time period.
- . Your plan may allow two appeals. In that case, we will let you know our first decision 30 days from the date we receive your appeal request, unless your state gives us a different amount of time. If you don't agree with that first decision, you have a second chance to appeal.

What happens next

If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Employer sponsored plans

If you don't agree with our final decision, you may have the right to bring a lawsuit under Section 502(a) of a law called ERISA. Check with your employee benefits coordinator to see which appeals process your plan allows and if your plan is governed by ERISA.

Coordination of benefits

If you are covered by more than one health benefit plan, you should file all your claims with each plan.

Your privacy

Your health information is confidential. Any information you give us will be kept private. When contacting us about this notice or for help with other questions, please be prepared to provide your member name, member ID, and date of birth.

Prevent fraud

If you suspect fraud or abuse involving these services or would like to report other healthcare fraud-related issues, please call the toll-free hotline at 1-800-338-6361 or e-mail us at aetnasiu@aetna.com.

Resources available to help you

Need help understanding this notice or our decision? **Call us free of charge at the toll-free number on your medical ID card.** There are also other resources available to help you. Most plans are now subject to health care reform law. Call us or ask your employer if your plan is subject to the law. If it is, you can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) for help, if your health plan is provided by your employer. In addition, a Consumer Assistance Program may be able to assist you.

Community Health Advocates, Community Service Society of New York, 633 Third Avenue 10th Floor, New York, NY 10017
Tel: 888-614-5400, Web: <http://www.communityhealthadvocates.org/>

Aetna Life Insurance Company complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna Life Insurance Company provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), Tel: 800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), E-Mail: CRCoordinator@aetna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 800-368-1019, 800-537-7697 (TDD).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Për asistencë në gjuhën shqipe telefononi falas në numrin e regjistruar në kartën tuaj të identitetit (ID). (Albanian)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

বাংলায় ভাষা সহায়তার জন্য আপনার আইডি কার্ডে যে নম্বরটি তালিকাভুক্ত রয়েছে বিনামূল্যে তাতে কল করুন। (Bengali-Bangala)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε χωρίς χρέωση τον αριθμό που αναγράφεται στην κάρτα αναγνώρισης. (Greek)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

اردو میں لسانی معاونت کے لیے اپنے ID کارڈ پر درج نمبر پر مفت کال کریں۔ (Urdu)

פאר שפראך הילף אין אידיש רופט דעם נומער וואס שטייט אויף אייער אידענטיטעט קארטל פון אפצאל. (Yiddish)