Aetna Life Insurance Company
P.O. BOX 14079
LEXINGTON, KY 40512-4079

Statement date: July 2, 2022

Member: ANDREW SHARP
Member ID: W272991909
Group #: 0863140-52-009 JA P1(340
Group name: KFORCE FA & TECH FLEX KFS

QUESTIONS? Contact us at aetna.com
1-888-463-6265
Or write to the address shown above.

ANDREW SHARP
212 THOMPSON SQ
MOUNTAIN VIEW CA 94043

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

$287.19
Amount you saved

Going to a provider 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.**

$950.00 (In-network)
Amount you have left to meet deductible

Annual deductible	$950.00
Deductible used	- $0.00
Deductible remaining	$950.00

A guide to key terms

	Term	This means	Your totals
	Amount billed:	The amount your provider charged for services.	**$2,494.00**
	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.	**$716.81**
!	**Pending or not payable:**	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	**$880.76**
	Deductible:	A cost share 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 cost share out-of-pocket amount that you may owe.	**$0.00**
	Copay:	The fixed cost share amount you pay when you visit a doctor or health care provider.	**$275.00**

Your payment summary

		Your plan paid			You may owe or already paid
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
Andrew (self)	Alison G Chang	$82.00	Alison G Chang	7/20/22	$55.00
Andrew (self)	Amanda J Murphy	$153.00	Amanda J Murphy	6/29/22	$55.00

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		Your plan paid			You may owe or already paid
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
Andrew (self)	Beth Beadle	$661.81	Beth Beadle	7/6/22	$55.00
Andrew (self)	HMS Santa Clara Family Health Plan	$154.24	HMS Santa Clara Family Health Plan	7/4/22	$110.00
Total:		$1,051.05			**$275.00**

Your claims up close

Claim for Andrew (self) Provider: Beth Beadle (In-Network)

Claim ID: EPACZWVZP00 Received on 6/17/22	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
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
OFFICE VISIT 99205 on **6/13/22**	1,004.00	716.81			55.00	661.81	661.81 (100%)		55.00
Refer to Remarks Section			(1)						
Totals:	1,004.00	716.81		0.00	55.00	661.81	661.81	0.00	**$55.00**

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

Claim for Andrew (self) Provider: HMS Santa Clara Family Hea (Out-of-Network)

Claim ID: EJACZ0J6G00 Received on 6/22/22	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
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
OFFICE VISIT 99205 on **5/12/22**	670.00		523.82 (2) (3)		55.00	91.18	91.18 (100%)		55.00
Refer to Remarks Section			(1)						
Totals:	670.00		523.82	0.00	55.00	91.18	91.18	0.00	**$55.00**

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

Claim for Andrew (self) Provider: HMS Santa Clara Family Hea (Out-of-Network)

Claim ID: EJPCZZ9MD00 Received on 6/22/22	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
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
OFFICE VISIT 99215 on **5/17/22**	475.00		356.94 (2) (3)		55.00	63.06	63.06 (100%)		55.00
Refer to Remarks Section			(1)						
Totals:	475.00		356.94	0.00	55.00	63.06	63.06	0.00	**$55.00**

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

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Claim for Andrew (self) Provider: Alison G Chang (In-Network)

Claim ID: EKJMZ131200 Received on 6/27/22	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
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
PHONE E/M PHYS/QHP 21-30 MIN 99443 on **6/24/22**	137.00				55.00	82.00	82.00 (100%)		55.00
Refer to Remarks Section			(1)						
Totals:	137.00			0.00	55.00	82.00	82.00	0.00	**$55.00**

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

Claim for Andrew (self) Provider: Amanda J Murphy (In-Network)

Claim ID: E2FCYM3J200 Received on 6/27/22	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
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
TYMPANOMETRY-IMPEDANCE TEST 92567 on **6/24/22**	59.00					59.00	59.00 (100%)		
COMPREHENSIVE AUDIOMETRY 92557 on **6/24/22**	149.00				55.00	94.00	94.00 (100%)		55.00
Refer to Remarks Section			(1)						
Totals:	208.00			0.00	55.00	153.00	153.00	0.00	**$55.00**

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

Your Claim Remarks

General Remarks:

(1) 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]

(2) The amount shown is the amount above what Medicaid requested. You will not be billed for this amount. [K88]

(3) Medicaid paid these services in error. We are paying them back. [X73]

Your benefit balances to date for 1/1/22 to 12/31/22

Individual Balances	Annual limit	Amount used	Amount remaining
Andrew (self)			
Medical In Network Deductible	$950.00	$0.00	$950.00
Medical In Network Out of Pocket Maximum	$4,000.00	$275.00	$3,725.00
Medical Out of Network Deductible	$1,900.00	$0.00	$1,900.00
Medical Out of Network Out of Pocket Maximum	$8,000.00	$275.00	$7,725.00

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.

Si necesita asistencia lingüística en español, llámenos al número que figura en su tarjeta de identificación (ID) médica.

若需要中文协助，请拨打您医疗身分证上的电话联系我们。

Para sa tulong sa wikang Tagalog, tawagan kami sa numero na nasa iyong Medikal na ID card.

Ya'áti' t'áá dinék'ehjí bee aká'a'áyeed biniiyé, nihich'į' hodíílnihjį' éí azee' ál'įįdi naaltsoos bee néé ho'dílzinígíí number bikáá' yisdzoh.

Do you need this in another language? Call 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.