Aetna Life Insurance Company
PO BOX 14079
LEXINGTON, KY 40512-4079

Statement date: December 19, 2024

Member: [redacted]
Member ID: [redacted]
Group #: 0169696-18-029 QA PF+F?0
Group name: RIPPLING PEO 1, INC.

QUESTIONS? Contact us at aetna.com
1-800-704-7287
Or write to the address shown above.

[redacted]

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

This statement is called your EOB. It shows the amount that was billed, your member rate, and your cost share. 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). You can change your delivery preference, view, print or download your EOBs online anytime.

Track your health care costs

$16,702.17
Amount you saved

Going to a provider in the network saves you money. That's because we have arranged discounted rates with these providers. To find a doctor or other health care professional, go to **www.aetna.com**.

$0.00 (In-network)
Amount you have left to meet deductible

Annual deductible	$2,000.00
Deductible used	- $2,000.00
Deductible remaining	$0.00

Your payment summary

		Plan's share			Your share
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
[redacted]	Beth R Hochman	$0.00			$244.84
[redacted]	David C Ianacone	$22.32	David C Ianacone	1/2/25	$71.76
[redacted]	Elie S Al Kazzi	$0.00			$660.97
[redacted]	Elie S Al Kazzi	$1,934.20	Elie S Al Kazzi	12/19/24	$60.00
[redacted]	Gordon E Sims III	$1,013.95	Gordon E Sims III	12/19/24	$60.00
[redacted]	Jessica N Simon	$0.00			$165.21
[redacted]	Leonard Penacerrada	$524.05	Leonard Penacerrada	12/19/24	$0.00
[redacted]	Manuel E Morlote	$0.00			$27.94
[redacted]	Margaret Y Cho	$99.46	Margaret Y Cho	1/2/25	$24.86
[redacted]	Matthew N Suberlak	$261.26	Matthew N Suberlak	12/19/24	$0.00

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		Plan's share			Your share
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
[redacted]	NYU Langone Hospitals Tisch	$0.00			$573.60
[redacted]	Vinay Prabhu	$0.00			$261.26
Total:		$3,855.24			**$2,150.44**

A guide to key terms

	Term	This means	Your totals
	Amount billed:	The amount your provider charged for services.	**$26,677.29**
	Member rate/ Allowed amount:	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.	**$5,302.12**
!	**Pending or not payable:**	Charges that are either not covered or need more review by us. Read 'Your Claim Remarks' to learn more.	**$3,969.44**
	Deductible:	A cost share amount you pay for covered services before your plan starts to pay.	**$2,000.00**
	Coinsurance:	When you pay part of the bill and we pay part of the bill. It is a cost share out-of-pocket amount.	**$30.44**
	Copay:	The fixed cost share amount you pay when you visit a doctor or health care provider.	**$120.00**
	Your share:	The amount you're responsible for after your plan paid its share. You may have already paid your provider.	

Your claims up close

Claim for [redacted]

Provider: Beth R Hochman (In-Network)

Claim ID: E737G87PR00 Received on 11/25/24	**Amount billed**	**Member rate**	**Pending or not payable (Remarks)** !	**Applied to deductible**	**Your copay**	**Amount remaining**	**Plan's share**	**Your coinsurance**	**Your share C+D+E+H=I**
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
INPATIENT PHYSICIAN SERVICE 99221 on **11/22/24**	576.00	244.84		244.84					244.84
Refer to Remarks Section			(1)						
Totals:	576.00	244.84		244.84	0.00			0.00	**$244.84**

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

Continued on next page

Claim for [redacted]

Provider: Matthew N Suberlak (In-Network)

Claim ID: EBPDJ1SVK00 Received on 11/26/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
CT ABD&PELV W/CONTRAST 74177 on **11/22/24**	650.00	261.26				261.26	261.26 (100%)		
Refer to Remarks Section			(1)						
Totals:	650.00	261.26		0.00	0.00	261.26	261.26	0.00	**$0.00**

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

Claim for [redacted]

Provider: Vinay Prabhu (In-Network)

Claim ID: EPPDJ0VD200 Received on 11/26/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
CT ABD&PELV W/CONTRAST 74177 on **11/23/24**	650.00	261.26		261.26					261.26
Refer to Remarks Section			(1)						
Totals:	650.00	261.26		261.26	0.00			0.00	**$261.26**

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

Claim for [redacted]

Provider: Elie S Al Kazzi (In-Network)

Claim ID: EGTYJ4ZQW00 Received on 11/27/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
INPATIENT PHYSICIAN SERVICE 99223 on **11/22/24**	1,416.00	486.54		486.54					486.54
INPATIENT PHYSICIAN SERVICE 99232 on **11/23/24**	540.00	174.43		174.43					174.43
Refer to Remarks Section			(1)						
Totals:	1,956.00	660.97		660.97	0.00			0.00	**$660.97**

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

Continued on next page

Claim for [redacted]

Provider: Manuel E Morlote (In-Network)

Claim ID: ETJNHHWC000 Received on 11/27/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
ELECTROCARDIOGRAM REPORT 93010 on **11/22/24**	55.00	27.94		27.94					27.94
Refer to Remarks Section			(1)						
Totals:	55.00	27.94		27.94	0.00			0.00	**$27.94**

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

Claim for [redacted]

Provider: Elie S Al Kazzi (In-Network)

Claim ID: ECADJ5Q4F00 Received on 11/28/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
UPPER GI ENDOSCOPY BIOPSY 43239 on **11/26/24**	4,673.00		3,969.44 (2)		60.00	643.56	643.56 (100%)		60.00
Refer to Remarks Section			(1)						
Totals:	4,673.00		3,969.44	0.00	60.00	643.56	643.56	0.00	**$60.00**

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

Claim for [redacted]

Provider: Elie S Al Kazzi (In-Network)

Claim ID: ECJNJ5W6Z00 Received on 11/28/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
COLONOSCOPY AND BIOPSY 45380 on **11/26/24**	5,813.00	1,290.64				1,290.64	1,290.64 (100%)		
Refer to Remarks Section			(1)						
Totals:	5,813.00	1,290.64		0.00	0.00	1,290.64	1,290.64	0.00	**$0.00**

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

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Claim for [redacted]

Provider: Leonard Penacerrada (In-Network)

Claim ID: ENFDJ3DKD00 Received on 11/29/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
EMERGENCY SERVICES 99285 on **11/21/24** Refer to Remarks Section	1,107.00	524.05	(1)			524.05	524.05 (100%)		
Totals:	1,107.00	524.05		0.00	0.00	524.05	524.05	0.00	**$0.00**

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

Claim for [redacted]

Provider: Jessica N Simon (In-Network)

Claim ID: E6Y2HHL2C00 Received on 11/29/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
INPATIENT PHYSICIAN SERVICE 99238 on **11/23/24** Refer to Remarks Section	463.00	165.21	(1)	165.21					165.21
Totals:	463.00	165.21		165.21	0.00			0.00	**$165.21**

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

Claim for [redacted]

Provider: Gordon E Sims III (In-Network)

Claim ID: EPPDJ2S0S00 Received on 11/30/24	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
ANES LWR INTST NDSC NOS 00811 on **11/26/24** Refer to Remarks Section	1,420.00	1,073.95	(1)		60.00	1,013.95	1,013.95 (100%)		60.00
Totals:	1,420.00	1,073.95		0.00	60.00	1,013.95	1,013.95	0.00	**$60.00**

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

Continued on next page

Claim for [redacted]

Provider: NYU Langone Hospitals Tisc (In-Network)

Claim ID: ET37HL2Z500 Received on 12/12/24	Amount billed	Member rate	Pending or not payable (Remarks) !	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
MEDICAL SERVICES 88305 on **11/26/24**	8,262.29	573.60	(3)	573.60					573.60
Refer to Remarks Section			(4) (1)						
Totals:	8,262.29	573.60		573.60	0.00			0.00	**$573.60**

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

Claim for [redacted]

Provider: David C Ianacone (In-Network)

Claim ID: E3ADHRMW600 Received on 12/13/24	Amount billed	Member rate	Pending or not payable (Remarks) !	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
INPATIENT PHYSICIAN SERVICE 99231 on **11/23/24**	257.00	94.08		66.18		27.90	22.32 (80%)	5.58 (20%)	71.76
Refer to Remarks Section			(1)						
Totals:	257.00	94.08		66.18	0.00	27.90	22.32	5.58	**$71.76**

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

Claim for [redacted]

Provider: Margaret Y Cho (In-Network)

Claim ID: EPFDKJTVL00 Received on 12/16/24	Amount billed	Member rate	Pending or not payable (Remarks) !	Applied to deductible	Your copay	Amount remaining	Plan's share	Your coinsurance	Your share C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
MEDICAL SERVICES 88305 on **11/26/24**	795.00	124.32				124.32	99.46 (80%)	24.86 (20%)	24.86
Refer to Remarks Section			(1)						
Totals:	795.00	124.32		0.00	0.00	124.32	99.46	24.86	**$24.86**

! **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) **You do not have to pay this. When more than one procedure is done on the same date, the main service is considered at 100% of the negotiated rate. We consider other procedures at 50% of the negotiated rate. [U66]**

(3) **The Submitted Charges and Negotiated Network Amount have been adjusted to reflect addition of the New York HCRA surcharge.**

(4) **Our portion of the New York HCRA surcharge is included in this payment. [997]**

Your benefit balances to date for 1/1/24 to 12/31/24

Individual Balances	Annual limit	Amount used	Amount remaining
[redacted]			
Medical In Network Deductible	$2,000.00	$2,000.00	$0.00
Medical In Network Out of Pocket Maximum*	$6,850.00	$2,166.10	$4,683.90
Medical Out of Network Deductible	$6,000.00	$0.00	$6,000.00
Medical Out of Network Out of Pocket Maximum*	$14,000.00	$0.00	$14,000.00

*Limit includes both Medical and Pharmacy

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

A flu shot can protect you and those you love

It's flu season again - and there's no better way to prevent the flu than to get your annual flu shot. Everyone in your family six months and older should get one, with rare exceptions. That's according to the Centers for Disease Control and Prevention (CDC). Check with your local pharmacy, visit a retail clinic or walk-in clinic, or ask your doctor if they'll be offering flu shots this year. There are lots of convenient ways to get one. It's your best shot at keeping you and your family healthy.

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-877-287-0117. For more help call the CA Dept. of Insurance at 1-800-927-4357 English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-877-287-0117. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務，用中文把文件唸給您聽。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-877-287-0117 與我們聯絡。欲取得其他協助，請致電1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-877-287-0117 . Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese.

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-877-287-0117번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-877-287-0117. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-877-287-0117. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-877-287-0117までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-877-287-0117 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-877-287-0117 'ਤ ਸਾਨ ਫ਼ਨ ਕਰੋ। ਵਧੇਰ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-877-287-0117 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-877-287-0117 . للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-877-287-0117. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

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

You are entitled to a review (appeal) of this benefit determination if you have questions or do not agree.

To obtain a review, you or your authorized representative should call our Member Services Department using the telephone number displayed on the member ID card or submit a request in writing to the Appeals Resolution Team address shown above. Your request should include the group name (e.g., your employer), your name, member ID, address and date of birth and other identifying information shown on this notice, and any comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim. You may also request (free of charge) documents relevant to your claim. Verbal or written requests for review of the adverse determination must be communicated, mailed or delivered within 180 days following receipt of this explanation or such longer period as may be specified in your plan brochure or Summary Plan Description.

Notice of a determination will be sent within 15 days following receipt of your request, unless otherwise required by state law. If you do not agree with such determination, you have the right to file a second request for review.

If you do not agree with the final determination on review, and if you are a member of a group plan, you may have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

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.

The Consumer Communications Bureau with the California Department of Insurance is available to assist customers with claims they feel have been wrongfully denied or rejected. Consumers may call or write the Bureau to have claims reviewed. Callers outside California and those in California (area codes 213 or 310) may contact the Consumer Communications Bureau at 213-897-8921. The number for the rest of California is 800-927-4357. The mailing address is: Consumer Communications Bureau, California Department of Insurance, 300 South Spring Street, South Tower, Los Angeles, CA 90013. The Department's Internet website (www.insurance.ca.gov) has complaint forms and instructions online.

The California Department of Insurance is responsible for regulating health insurance plans. Before you file a complaint with the California Department of Insurance, you should first contact the insurance company in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete the department's Request for Assistance form. Occasionally, the issue may be of such a nature that attempting to contact the insurance company first may not be appropriate. In these situations, it would be appropriate to contact the Department first.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov, or by calling the department's consumer information line at 800-927-4357. You may also obtain a copy of this law and these regulations free of charge from this insurer.

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.

Independent Medical Review of Grievances Involving a Disputed Health Care Service
You may request an independent medical review (IMR) of disputed health care services from the California Department of Insurance (Department) if you believe that health care services have been improperly denied, modified, or delayed by the insurance company or one of its contracted providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified or delayed by the insurance company or one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. The IMR process is in addition to any other procedures or remedies that maybe available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We provide an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the insurance company regarding a disputed health care service.

Eligibility
Your application for IMR will be reviewed by the Department to confirm that: (1)(A) Your provider has recommended a health care service as medically necessary, or (B) You have received urgent care or emergency services that a provider determined was medically necessary, or (C)You have been seen by a contracting provider for the diagnosis or treatment of the medical condition for which you seek independent review; (2) The disputed health care service has been denied, modified, or delayed by the insurance

company or one of its contracted providers, based in whole or in part on a decision that the health care service is not medically necessary; and (3) You have filed a grievance with the insurance company or its contracted providers and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the Department's attention. In addition, the Department may waive the requirement that you follow the insurance company's grievance process for any period of time in extraordinary and compelling cases. For urgent care, you may not be required to participate in the insurance company's grievance process for more than 3 days before accessing IMR.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, the insurance company will provide the health care service.

For non-urgent cases, the IMR organization designated by the Department must provide its determination in 30 days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb or major bodily function, the IMR organization must provide its determination within 3 business days.

Please note: when filing a request for an Independent Medical Review, you will be required to authorize release of any medical records that may be needed for the purpose of reaching a decision.

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. You may contact the Department of Insurance for questions about appeal rights or this notice.

California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower
Los Angeles, CA 90013, Tel: 800-927-Help (4357), TTY: 800-482-4833, Web: www.insurance.ca.gov

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)

اُردو 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 פריי פון אפצאל. (Yiddish)