ExxonMobil Dental Plan Claim Form

- Complete Sections 2 - 6.
- Sign Section 7 to have benefits paid to the dentist.
- Attach itemized bills. The bills must include:
  - patient's name, date of birth and relationship to participant
  - date of service
  - procedure codes
  - cost of each service or supply
  - provider's name, address and tax identification number (TIN)

If this information is missing, write it on the bill and sign your name.

- You may submit a request for a pre-treatment estimate of benefits if you anticipate extensive dental work. Actual payment may differ from the estimate.
- If you are covered by other dental coverage, attach a copy of the bills you have submitted to the other plan and the explanation of benefits you received from the other plan.
- Incomplete forms will delay payment.
- Send the completed claim form and the bills to:

  Aetna
  P.O. Box 14094
  Lexington, KY 40512-4094
- If you have questions, call Aetna at **800-255-2386**
  Overseas, call collect **210-366-2416.**

This form is for:

☐ Request for pre-treatment estimate ☐ Statement of services rendered

1. Employer Information

Name: **EXXONMOBIL**

Policy/Group Number: **721001**

2. Participant Information

Member ID Number or Social Security Number | Name | Birthdate

☐ Employee ☐ Retiree ☐ Survivor ☐ COBRA

Address (include zip code)

Daytime Telephone Number ( )

3. Patient Information

Member ID Number or Social Security Number | Name | Birthdate

Relationship to Participant: ☐ Self ☐ Spouse ☐ Child ☐ Other

Address (if different from participant)

Marital Status: ☐ Married ☐ Single

Sex: ☐ Male ☐ Female

Full-Time Student: ☐ No ☐ Yes

Is patient employed? ☐ No ☐ Yes

Name/Address of Employer

4. Other Coverage Information

Is patient covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no-fault auto insurance, Medicare or any federal, state or local government plan? ☐ No ☐ Yes

If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator

Insured's Social Security Number - – | Insured's Name | Insured's Birthdate

5. Claim Information

Is claim related to an accident? ☐ No ☐ Yes If yes, date _____ time _____ ☐ a.m. ☐ p.m.

Is claim related to employment? ☐ No ☐ Yes

Description of Accident

6. Release

To all dental care providers:
You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with benefit calculation information used in payment of this claim for the purpose of reviewing the experience and operation of the plan. This authorization is valid for the term of the plan under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patient's or Authorized Person's Signature _____ Date _____

7. Assignment

Use of PPO Provider is an automatic assignment of benefits to the provider

I authorize payment of dental benefits to the dentist or supplier of service.

Patient's or Authorized Person's Signature _____ Date _____

Any person who knowingly and with intent to defraud or deceive the ExxonMobil Dental Plan files a statement of claim containing any materially false, incomplete or misleading information must repay any funds improperly received and may lose eligibility to participate in the ExxonMobil Dental Plan.

999-0237B (04/04)

(F49) 06/05

Information on Filing ExxonMobil Dental Plan Claims

When to File a Claim

With your ExxonMobil Dental Plan, you have the option of using *network* or *non-network* dentists. When you use *network* dentists, they will file claims for you. When you use *non-network* dentists, you are responsible for filing your own claims.

How to File a Claim

Here's what to remember when you file a claim:

- Complete a claim form for each covered family member who has received dental treatment. Provide all the information requested.
- Attach the Explanation of Benefits from another plan if it paid benefits first.
- Remember to sign the form. Also sign if you are filing a claim on behalf of your child.
- Sign the Assignment section if you want benefits to be paid directly to your *non-network* dentist. When you use a *network* dentist, benefits are automatically assigned to him or her.
- Attach an itemized bill to your claim form. Make sure that it includes:
  - Patient's name.
  - Patient's relationship to the participant (for example, self, husband, daughter). If this isn't shown, write it on the bill.
  - Patient's date of birth. If this isn't shown, write it on the bill.
  - Date of services.
  - Procedure codes.
  - Cost of each service or supply.
  - Dentist's name, address and tax identification number (TIN).
- ***Mail*** your completed claim form, with itemized bill(s) attached, to:

  Aetna
  P.O. Box 14094
  Lexington, KY 40512-4094

Visit Us On-Line at www.aetna.com

When you visit the Aetna website, you'll find fast, up-to-date information about our company and wellness programs through:

- DocFind®, for help finding network providers in your area;
- InteliHealth®, for information on a variety of health topics, along with wellness and fitness tips.

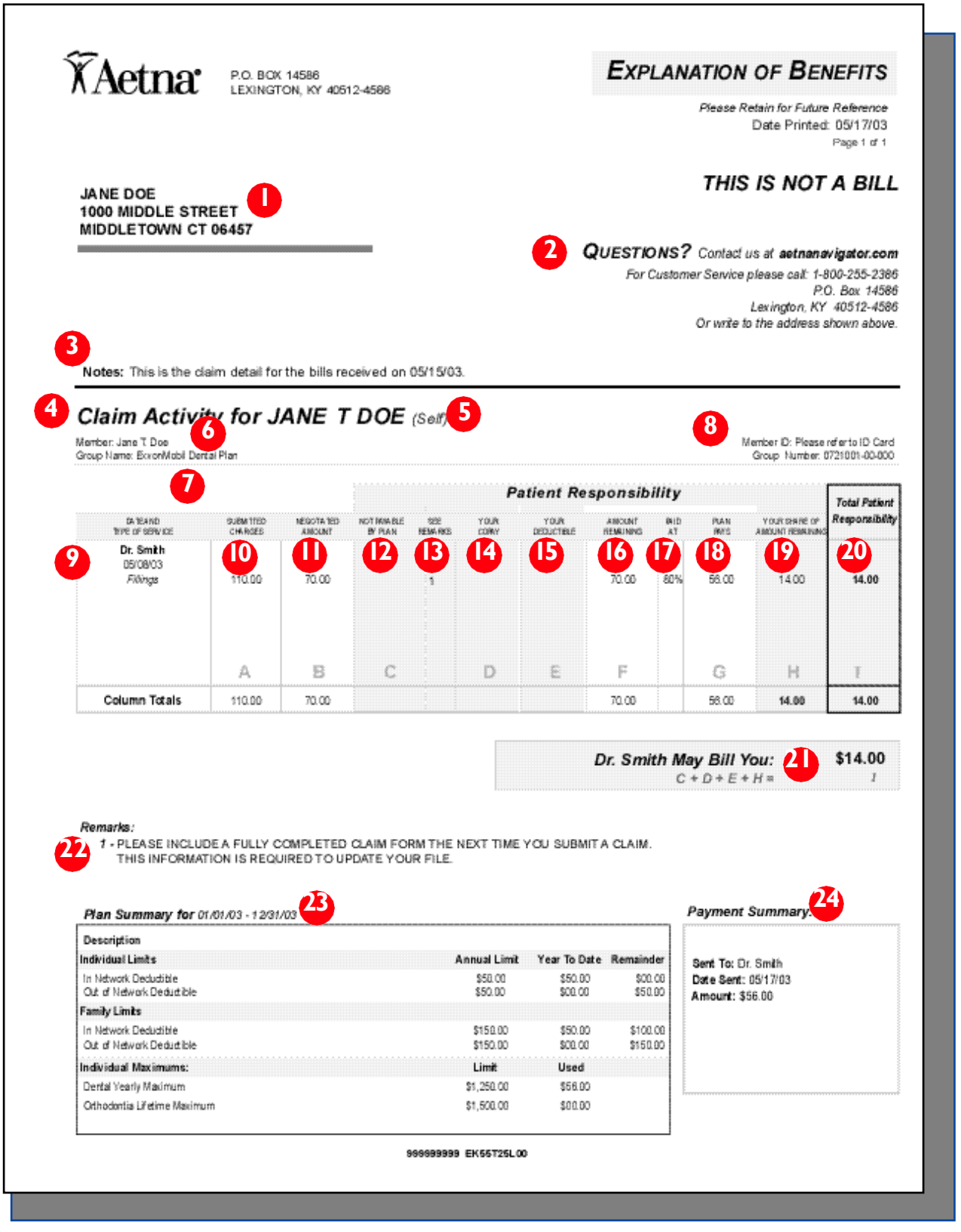
With www.aetna.com, you have convenient access to help, information and services from the comfort of your home, day or night.

Understanding the Explanation of Benefits

You'll receive an Explanation of Benefits (EOB) each time a claim is processed. The EOB contains important information about how your claim was processed and what benefits were paid.

The circled numbers on the sample EOB correspond to the numbers in the following explanation:

1. Name and mailing address for the member.
2. Contact information to use for any questions.
3. Displays date Aetna received the claim.
4. First and last name of patient with middle initial.
5. Relationship of patient to the member.
6. First and last name of member.
7. The name of the plan sponsor.
8. The control, suffix, account, plan summary and unique plan identifiers.
9. The provider name, month, day and year the service was provided, and brief description of the service.
10. The amount billed for this service.
11. The special fee that has been negotiated with the provider for this service (when the provider participates in the network).
12. The amount being pended (i.e., placed on hold until additional information requested from the provider and/or member has been received and reviewed) or denied.
13. Remarks column displays a remark code that corresponds to the remark text shown in field 22.
14. Patient copayment for the services.
15. Amount applied to deductible for the charges submitted.
16. The amount of the submitted bill, less any discount, amounts not covered or pending, copays and deductibles.
17. The percentage the plan will pay on the amount remaining of the submitted bill.
18. The amount the plan will pay for this service.
19. Also known as "Coinsurance". The portion of the allowable charges for which the member is responsible.
20. Indicates the total amount for which the patient is responsible. This includes copays, deductibles, coinsurance and not covered amounts.
21. Total for which the member is responsible.
22. Remarks section explains why a charge was not covered or a claim was pended.
23. Summary of plan financial limits for the benefit year such as deductible and lifetime maximum.
24. Payment Summary identifies who received payment.



Aetna

P.O. BOX 14586
LEXINGTON, KY 40512-4586

EXPLANATION OF BENEFITS

Please Retain for Future Reference
Date Printed: 05/17/03
Page 1 of 1

THIS IS NOT A BILL

JANE DOE
1000 MIDDLE STREET
MIDDLETOWN CT 06457

1

2 **QUESTIONS?** *Contact us at* ***aetnanavigator.com***
For Customer Service please call: 1-800-255-2386
P.O. Box 14586
Lexington, KY 40512-4586
Or write to the address shown above.

3 **Notes:** This is the claim detail for the bills received on 05/15/03.

4 ***Claim Activity for JANE T DOE*** *(Self)* 5

6 Member: Jane T Doe
Group Name: ExxonMobil Dental Plan

8 Member ID: Please refer to ID Card
Group Number: 0721001-00-000

7

					Patient Responsibility							Total Patient Responsibility
	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	
9	Dr. Smith 05/08/03 *Fillings*	10 110.00	11 70.00	12	13 1	14	15	16 70.00	17 80%	18 56.00	19 14.00	20 **14.00**
		A	B	C		D	E	F		G	H	I
	Column Totals	110.00	70.00					70.00		56.00	**14.00**	**14.00**

Dr. Smith May Bill You: 21 **$14.00**
C + D + E + H = *I*

Remarks:
22 *1* - PLEASE INCLUDE A FULLY COMPLETED CLAIM FORM THE NEXT TIME YOU SUBMIT A CLAIM. THIS INFORMATION IS REQUIRED TO UPDATE YOUR FILE.

Plan Summary for *01/01/03 - 12/31/03* 23

Description			
Individual Limits	**Annual Limit**	**Year To Date**	**Remainder**
In Network Deductible	$50.00	$50.00	$00.00
Out of Network Deductible	$50.00	$00.00	$50.00
Family Limits			
In Network Deductible	$150.00	$50.00	$100.00
Out of Network Deductible	$150.00	$00.00	$150.00
Individual Maximums:	**Limit**	**Used**	
Dental Yearly Maximum	$1,250.00	$56.00	
Orthodontia Lifetime Maximum	$1,500.00	$00.00	

Payment Summary 24

Sent To: Dr. Smith
Date Sent: 05/17/03
Amount: $56.00

999999999 EK55T25L00

If You Have Questions or Need More Claim Forms

Call Aetna Member Services at 800-255-2386. Overseas, call collect 210-366-2416.