Important disclosure information

Dental Preferred Provider Organization (PPO)

Participating Dental Network (PDN)†

†Texas

In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN). Please refer to the plan design overview and summary of benefits contained in your pre-enrollment packet for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at **1-877-238-6200**.

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Understanding your plan of benefits

Aetna Dental® PPO plans cover many dental services. However, they do not cover everything. Your "plan documents" list all the details for the plan you choose. This includes what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. They may include a Booklet-Certificate and/or any riders and updates that are included. If you can't find your plan documents, call Member Services at **1-877-238-6200** to ask for a copy.

Covered services may include dental care provided by general dentists and specialist dentists. However, certain limitations may apply. For example, the dental plan excludes or limits coverage for some services including, but not limited to, cosmetic and experimental procedures.

The information that follows provides general information about Aetna dental PPO/PDN plans. Members should consult their plan documents for a complete description of what dental services are covered and any applicable exclusions and limitations.

Not all of the information in this booklet applies to your specific plan

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator or call Aetna Member Services.

Colorado

This policy does not include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a standalone plan or as a covered benefit in another health plan. Please contact your insurance carrier, agent or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an exchange-qualified standalone dental plan that includes pediatric dental coverage.

Help for those who speak another language and for the hearing impaired

If you require language assistance, please call Member Services at **1-877-238-6200**. An Aetna representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you're deaf or hard of hearing, use your TTY and dial **711** for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

Si usted necesita asistencia lingüística, por favor llame a Servicios al Miembro al **1-877-238-6200**. Un representante de Aetna le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, use su TTY y marcar **711** para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

Get plan information online and by phone

If you're already enrolled in an Aetna dental plan

You have two convenient ways to get plan information anytime, day or night:

(1) **Register and log in to your secure member website.**

You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

Have your Aetna ID card handy to register. Then visit **aetna.com** and click "Log In." Follow the prompts to complete the one-time registration.

Then you can log in any time to:

- View and print your Aetna Dental ID card.
- Verify who's covered and what's covered.
- Access your "plan documents."
- Track claims or view past copies of Explanation of Benefits statements.
- Use the online provider search tool to find in-network care.

(2) **Call Member Services at the toll-free number on your Aetna ID card or toll free at 1-877-238-6200.**

You can speak with a representative to:

- Understand how your plan works or what you will pay.
- Get information about how to file a claim.
- Get a referral.
- Find care outside your area.
- File a complaint or appeal.
- Get copies of your plan documents.
- Find dental health information.

Not yet a member?

For help understanding how a particular dental plan works, you should review your plan documents or contact your employer or benefits administrator.

Your state may have additional contact information

Hawaii Insurance Division telephone number

You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at **1-808-586-2790**.

Maryland

For quality of care issues and life and health care insurance complaints, you may contact:

Aetna Dental Grievance and Appeals Unit
PO Box 14080
Lexington, KY 40512-4080
Toll-free phone: **1-877-238-6200**

Maryland Insurance Administration of
Life and Health Insurance Complaints
200 Saint Paul Place, Suite 2700
Baltimore, MD 21202
Toll-free phone: **1-800-492-6116**
Local phone: **410-468-2244**
Fax: **410-468-2243**

For help resolving a billing or payment dispute with the dental plan or your dental care provider you may contact:

Aetna Dental Grievance and Appeals Unit
PO Box 14080
Lexington, KY 40512-4080
Telephone: **1-877-238-6200**

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 Saint Paul Place, 16th Floor
Baltimore, MD 21202
Telephone: **410-528-1840**
Fax: **410-576-7040**
Email address: **heau@oag.state.md.us**
http://www.oag.state.md.us/Consumer/HEAU.htm

Nothing herein shall be construed to require the plan to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

Virginia contact information

If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance or if you have questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Aetna Life Insurance Company
PO Box 14080
Lexington, KY 40512-4597
Toll-free phone: **1-877-238-6200**

If you have been unable to contact or obtain satisfaction from the company or the agent, you may also contact:

The Virginia State Corporation Commission
Bureau of Insurance
PO Box 1157
Richmond, Virginia 23218-1157
Call: **804-371-9741** or **1-800-552-7945** (VA Only)

The Office of the Managed Care
Ombudsman Bureau of Insurance
PO Box 1157
Richmond, Virginia 23218
Toll-free phone: **1-877-310-6560**, select option **1**
Fax: **804-371-9944**
Email: **mombudsman@scc.virginia.gov**

Virginia Department of Health
Complaint Intake
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1463
Toll-free: **1-800-955-1819**
Metro Richmond area: **804-367-2106**
Fax: **804-527-4503**
Email: **OLC-Complaints@vdh.virginia.gov**

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

Search our network for dental care providers

Use our online provider search tool for the most up-to-date list of dental care professionals. You can get a list of available dentists by ZIP code, or enter a specific dentist's name in the search field.

Existing members: Visit **aetna.com** and log in. From your secure member website home page, select "Find Care" from the top menu bar and start your search.

Considering enrollment: Visit **aetna.com** and select "Find a doctor" on top of the home page. Then follow the steps under "Not a member yet?" to search for providers.

Our online search tool is more than just a list of dentists' names and addresses. It also includes information about:

- Where the dentist attended school
- Board certification status
- Language spoken
- Gender
- Driving directions

Get a free printed directory

To get a free printed list of dental care providers, call the toll-free number at **1-877-238-6200**.

Georgia

Members can call **1-877-238-6200** (toll-free) to confirm whether a dental provider is in the network and/or accepting new patients. A summary of any agreement or contract between Aetna and any dental care provider will be made available upon request by calling the Member Services. The summary will not include financial agreements as to actual rates, reimbursements, charges or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of provider under contract with Aetna.

Illinois
While every primary care dentist listed in the dental directory contracts with Aetna to provide primary care services, not every provider listed will be accepting new patients. Although we have identified those providers who were not accepting patients as known to us at the time the dental directory was created, the status of the dental practice may have changed. For the most current information about the status change of any dental practice, please contact either the selected dentist or Member Services at **1-877-238-6200**. You can get more information about the network, participating providers or our grievance procedures through the online provider search tool directory at **aetna.com** or by calling Member Services.

Kentucky
Any dental care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Customary waiting times:

- Emergency/Immediately urgent care – Within 24 hours
- Routine care – Within 5 weeks
- Routine hygiene visit – Within 8 weeks

Michigan
Contact the Michigan Department of Consumer and Industry Services at **517-284-8800** to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Transition of care: When a dentist leaves the network

Our contracts are designed to provide transition of care if your treating dental care provider contract terminates.

(1) Participating dental care providers are contractually obligated for continued treatment of certain members after termination for any reason as outlined below:

"Provider shall remain obligated at company's sole discretion to provide covered services to: (a) any member receiving active treatment from provider at the time of termination until the course of treatment is completed to company's satisfaction or the orderly transition of such member's care to another provider by the applicable affiliate of company; and (b) any member, upon request of such member or the applicable payor, until the anniversary date of such member's respective plan or for one (1) calendar year, whichever is less. The terms of this agreement shall apply to such services."

(2) In cases of provider termination, in order to allow for the transition of members with minimal disruption to participating providers, Aetna may permit a member who has met certain requirements to continue an "Active Course of Treatment" for covered benefits with a nonparticipating provider for a transitional period of time without penalty subject to any out-of-pocket expenses outlined in the member's plan design.

Costs and rules for using your plan

What you pay

You will share in the cost of your dental care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- **Coinsurance –** Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) of the allowed amount for the service.
- **Deductible –** This is the amount you owe for dental care services before your dental plan begins to pay.

Notice: You must personally bear all costs if you use health care not authorized by this plan or purchase drugs that are not authorized by this plan.

Your costs when you go outside the network

You may choose a dentist in our network. You may choose to visit an out-of-network dentist. We cover the cost of care based on if the dentist is "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

If you choose a dentist who is out of network, your Aetna dental plan may pay some of that dentist's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network dentist.

"In network" means we have a contract with that dentist. He agrees to how much he will charge you for covered services. That amount is often less than what he would charge if he was not in our network. Most of the time, it costs you less to use dentists in our network. Many plans pay a higher percentage of the bill if you stay in network. The dentist agrees he won't bill you for any amount over his contract rate. All you have to pay is your coinsurance or copayments, along with any deductible.

"Out of network" means we do not have a contract for discounted rates with that dentist. We don't know exactly what an out-of-network dentist will charge you. If you choose a dentist who is out of network, your Aetna dental plan may pay some of that dentist's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network dentist. Your out-of-network dentist sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your dentist may bill you for the dollar amount Aetna doesn't "recognize."

You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount Aetna allows for a service or procedure.

Authorization for in-network level of benefits when covered dental services are provided by a nonparticipating dentist

North Carolina dental PPO plan members you may be eligible to receive authorization for the in-network level of benefits when covered dental services are performed by a nonparticipating dentist. If a member is unable to find a participating general dentist (within 75 miles) or a specialty* dentist (within a 40 mile radius) or there is an unreasonable appointment delay, he/she should call Member Services.

Member Services will find a participating dentist for the member (within the accessibility and appointment wait guidelines) or authorize the member to receive services from a dentist outside the network. The member's out-of-pocket cost will be the same as if he/she received services from a participating dentist.

Connecticut dental PPO plan members - You can ask for approval to get in-network level of benefits when a network dentist is not available within 40 miles for covered services or the first available appointment is longer than these reasonable times:

- Emergency care – Within 24 hours
- Routine care – Within 5 weeks
- Hygiene – Within 8 weeks

How we pay dentists who are not in our network

PPO/PDN:

When you choose to see an out-of-network dentist, Aetna pays for your health care using "prevailing" or "reasonable" charge we get from an industry database. This way of paying out-of-network dentists applies when you choose to get care out of network.

PPO MAX/PDN MAX plans:

We use a fee schedule to pay both in-network and out-of-network dentists. In-network dentists have agreed to accept this fee. When you choose to see an out-of-network dentist, your coinsurance share of the bill is calculated based on the fee schedule (allowed amount) instead of the dentist's actual charge. Dentists will charge you the difference between what the plan allows and the actual charge for the service. You would owe this in addition to your normal share of the costs.

Going in network just makes sense

- We have negotiated discounted rates for you.
- In-network dentists won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

*Specialty dentists include endodontists, periodontists, pedodontists, oral surgeons and orthodontists.

Emergency and urgent care

If you need emergency dental care, you are covered 24 hours a day, 7 days a week, anywhere in the world. When emergency services are provided by a participating PPO/PDN dentist, your copayment/coinsurance amount will be based on a negotiated fee schedule.

Refer to your plan documents. This care is subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Knowing what is covered

You can avoid unexpected bills with a simple call to Member Services, at **1-877-238-6200**, to find out what's covered before you receive the care.

We have developed a dental clinical review program to help us determine what dental services are covered under the dental plan and the extent of that coverage. Some services may be subject to a review after you received the care. Only dental consultants who are licensed dentists make clinical determinations. We will notify you and your dentist if we deny coverage for any reason. The reason is stated on our notification. For more information about clinical reviews or any other topic, please call Member Services.

No coverage based on U.S. Sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. Trade sanctions, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx.**

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

The complaint and appeal processes can be different depending on your plan and where you live. Some states have laws that include their own appeal processes. So it's best to check your plan documents or talk to someone in Member Services to see how it works for you.

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also send us an email through our secure member website, **aetna.com**.

If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate complaint department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, write to us at the appropriate address as follows:

Northeast Territory – includes Mid-Atlantic and Northeastern states (CT, DE, DC, IL, IN, KY, ME, MD, MA, MI, NH, NJ, NY, OH, PA, RI, VA, VT, WV, WI)

Aetna Dental Grievance and Appeals Unit
PO Box 14080
Lexington, KY 40512-4080

South Territory – (AL, AR, FL, GA, LA, MS, NC, OK, SC, TN, TX)

Aetna Dental Grievance and Appeals Unit
PO Box 14597
Lexington, KY 40512-4597

West Territory – (AK, AZ, CA, CO, HI, IA, ID, KS, MN, MO, MT, ND, NE, NV, NM, OR, SD, UT, WA, WY)

Aetna Dental Grievance and Appeals Unit
PO Box 10462
Van Nuys, CA 91410

Link to your state insurance department website
Visit the National Association of Insurance Commissioners (NAIC) at **www.naic.org**.

Kentucky appeals process

(1) As a member of Aetna, you have the right to file an appeal about service(s) you have received from your dental care provider or Aetna when you are not satisfied with the outcome of the initial determination, and the request is regarding a change in the decision for:

- Certification of health care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

(2) You or your authorized representative may file an appeal within 180 days of an initial determination. You may contact Member Services at the number listed on your identification card.

(3) A Customer Resolution Consultant will acknowledge the appeal within five business days of receipt. A Customer Resolution Consultant may call you or your dental care provider for dental records and/or other pertinent information.

(4) Our goal is to complete the appeal process within 30 days of receipt of your appeal. An appeal file is reviewed by an individual who was neither involved in any prior coverage determinations related to the appeal nor a subordinate of the person who rendered a prior coverage determination. A dentist or other appropriate clinical peer will review clinical appeals. A letter of resolution will be sent to you upon completion of the appeal. It is important to note that it is a covered member's right to submit new clinical information at any time during the appeal of an adverse determination or coverage denial to an insurer or provider.

(5) If the appeal is for a decision not to certify urgent or ongoing services, it should be requested as an expedited appeal. An example of an expedited appeal is a case where a delay in making a decision might seriously jeopardize the life or health of the member or jeopardizes the member's ability to regain maximum function. An expedited appeal will be resolved within 72 hours. If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

(6) If you are dissatisfied with the outcome of a clinical appeal and the amount of the treatment or service would cost the covered individual at least $100.00 if they had no insurance, you may request a review by an external review organization (ERO). The request must be made within 60 days of the final internal review. A request form will be included in your final determination letter. It can also be obtained by calling Member Services. A decision will be rendered by the ERO within 21 calendar days of your request. An expedited process is available to address clinical urgency. If you disagree with the decision regarding your right to an external review, you may file a complaint with the Kentucky Department of Insurance.

(7) As a member, you may, at any time, contact your local state agency that regulates health care service plans for complaint and appeal issues, which Aetna has not resolved or has not resolved to your satisfaction. Requests may be submitted to:

Kentucky Department of Insurance
PO Box 517
Frankfort, KY 40602-0517

(8) You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your plan administrator, your local U.S. Department of Labor Office and your state insurance regulatory agency.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna Privacy Policy

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs), (this includes plan sponsors and/or employers)

We obtain information from many different sources — particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

For more information about our privacy notice or if you'd like a copy, call **1-877-238-6200** or visit us at **aetna.com.**

Member Rights

We publish a list of rights and responsibilities on our website. Visit **aetna.com/individuals-families/member-rights-resources.html** to view the list. You can also call Member Services at **1-877-238-6200** to ask for a printed copy.

Hawaii

Informed Consent: Members have the right to be fully informed when making any decision about any treatment, benefit or non-treatment. Your dental provider will:

- Discuss all treatment options, including the option of no treatment at all.
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan.
- Discuss all risks, benefits and consequences to treatment and non-treatment.

Kansas

Kansas law permits you to have the following information upon request:

- A complete description of the dental care services, items and other benefits to which the insured is entitled in the particular dental plan that is covering or being offered to such person
- A description of any limitations, exceptions or exclusions to coverage in the dental benefit plan, including prior authorization policies or other provisions that restrict access to covered services or items by the insured
- A list of the plan's participating dental care providers, their business addresses and telephone numbers, their availability and any limitation on an insured's choice of provider
- Notification in advance of any changes in the dental benefit plan that either reduces the coverage or benefits or increases the cost, to such person
- A description of the grievance and appeal procedures available under the dental benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

Washington State

The following materials are available: any documents referred to in the enrollment agreement; any applicable preauthorization procedures; dentist compensation arrangements and descriptions of and justification for provider compensation programs; circumstances under which the plan may retrospectively deny coverage previously authorized.

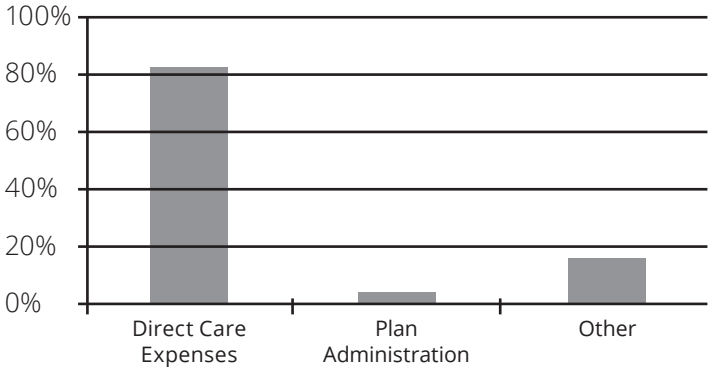
Maryland Dental Indemnity Plan Disclosure

How we pay providers

Terms	These examples show how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percentage of dentists paid by each method
Salary	A physician is an employee of Aetna and is paid compensation (monetary wages) for providing specific health care services. Since Dr. Jones is an employee of Aetna, she receives her usual biweekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing prenatal care to Mrs. Smith, who is a member of Aetna, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have any effect upon Dr. Jones' salary.	0%
Capitation	A physician (or group of physicians) is paid a fixed amount of money per month by Aetna for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an Aetna network. She is not employed by Aetna. Her contract with Aetna stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of Aetna, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.	0%
Fee-for-service	A physician charges a fee for each patient visit, medical procedure or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder. Dr. Jones' contract with the insurer or Aetna states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for some portion of the bill.	100%
Discounted fee-for-service	Payment is less than the rate usually received by the physician for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician, who usually gets an increased volume of patients. Like fee-for-service, this type of contractual arrangement involves Aetna paying Dr. Jones for each patient visit and each delivery; but, under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure she performs, Aetna will pay Dr. Jones a discounted rate.	0%

Terms	These examples show how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.	Percentage of dentists paid by each method
Bonus	A physician is paid an additional amount over what he or she is paid under salary, capitation, fee-for- service or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services. Aetna rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.	0%
Case rate	Aetna and the physician agree in advance that payment will cover a combination of services provided by both the physician and hospital for an episode of care. This type of arrangement stipulates how much Aetna will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from Aetna for the care provided to Mrs. Smith.	0%

Premium dollar distribution



The cost of providing dental services in the State of Maryland did not exceed the premium revenue per $100.

*Dental Expenses includes the costs of dental services, other professional services, referrals, emergency room visits, hospitalization and pharmacy

**Administrative Expenses include, but may not be limited to: occupancy, depreciation and amortization, marketing, salaries, interest expense and accounting and corporate expenses.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. While this information is believed to be accurate as of the publication date, it is subject to change.

If you need this material translated into another language, please call Member Services at 1-877-238-6200.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-877-238-6200.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide 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 **1-877-238-6200**.

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,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, **TTY: 711**,
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **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 **1-800-368-1019**, **800-537-7697** (TDD).

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To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862 . (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-888-982-3862 . (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

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للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862 . (Arabic)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-982-3862 । (Bengali)

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Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe 1-888-982-3862 . (Yoruba)

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