

Important disclosure information

Dental Maintenance Organization (DMO®) (in Virginia, DNO†)

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†DNO (Dental Network Only) in Virginia is not an HMO. To receive maximum benefits, members must choose a participating primary care dentist to coordinate their care with in-network providers.



Understanding your plan of benefits

Aetna DMO 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 Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy 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 (TTY: 711)** to ask for a copy. You can also get a copy of the Certificate of Coverage by contacting your employer directly.

This managed care plan may not cover all of your dental care expenses. Read your contract carefully to determine which dental care services are covered. To contact the plan, call 1-877-238-6200 (TTY: 711).

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 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.

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 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 member ID card handy to register. Then visit **aetna.com** and click on "Log In." Then select "Register" to follow the prompts to complete the one-time registration.

Then you can log in anytime to:

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

(2) Call Customer Service at the toll-free number on your member ID card or toll-free at **1-877-238-6200 (TTY: 711)**.

You can speak with a representative to:

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Dental benefits and dental insurance plans are underwritten by Aetna Dental Inc., Aetna Dental of California, Inc., Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.



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 (TTY: 711)**

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 (TTY: 711)**

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>

The plan is not required to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

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.

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 (TTY: 711)**

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: **ombudsman@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**

The state prefers written correspondence so it can maintain a record of your inquiry. 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 member 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 us toll-free at **1-877-238-6200 (TTY: 711)**.

Georgia

You can call Member Services at **1-877-238-6200 (TTY: 711)** (toll-free) to confirm whether a dental provider is in the network and/or accepting new patients. You can also ask them for a summary of any agreement or contract between Aetna and any dental care provider. 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 (TTY: 711)**. 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 Insurance and Financial 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.

*Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by nonparticipating providers are available for plan contracts written in: CT, IL, KY and OH and for members residing in MA and OK (regardless of contract situs state). In Illinois, DMO plans provide limited out-of-network benefits. However, to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. In Illinois, the DMO plan is not an HMO.

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:

- **Copay** – A set amount (for example, \$25) you pay for a covered dental care service. The copay for your primary care dentist's office visit may be different than a specialist's office visit.
- **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.

Aetna DMO is a network-only plan.* That means, the plan covers dental care services only when you see a dentist who participates in the Aetna network. When you see an out-of-network dentist, you will have to pay all of the costs for the services.

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.

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 you are unable to find a participating general dentist (within 75 miles), or a specialty* dentist (within a 40 mile radius), or if there is an unreasonable appointment delay, you can call Member Services. They will find a participating dentist for you (within the accessibility and appointment wait guidelines), or authorize that you can receive services from a dentist outside the network. Your out-of-pocket cost will be the same as if you 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 if the first available appointment is longer than these reasonable times:

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

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.

Emergency and urgent care

If you are covered under the DMO plan and need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your primary care dentist (PCD) to receive treatment. If you are unable to contact your PCD, contact Member Services at **1-877-238-6200 (TTY: 711)** for assistance in locating a dentist. Refer to your plan documents for details. 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.

Choose a primary care dentist (PCD)

You should pick a primary care dentist, or PCD, who can get to know your dental care needs and help you better manage your dental care. You can designate any primary care dentist who participates in the Aetna DMO network and who is available to accept you or your family members. If you do not pick a PCD, your benefits may be limited or we may select a PCD for you.

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

A PCD is the dentist you go to for checkups, cleanings and when you need dental care. If it's an emergency, you don't have to call your PCD first. This one dentist can coordinate all your care. Your PCD will refer you to a specialist when needed.

Tell us who you choose to be your PCD

You may choose a different PCD from the Aetna DMO network for each member of your family. Enter the primary dentist office ID number on your enrollment form. You can find this office ID number in the online directory at **aetna.com**. Or call Member Services at **1-877-238-6200 (TTY: 711)** after you enroll to tell us your selection. You may change your selected PCD at any time.

Referrals: Your PCD will refer you to a specialty dentist when needed

If you need specialty dental care, your PCD will give you a referral to a specialist who participates in the Aetna network. A referral is a written request for you to see another dentist. Some dentists can send the referral electronically to your specialist. There's no paper involved. Talk to your dentist to understand why you need to see a specialist.

Remember these points about referrals:

- Always get the referral before you receive the care.
- You do not need a referral for emergency care.
- If you do not get a referral when it's required, you may have to pay for the full cost of the care.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCD for those services.
- Referrals are valid for one year from date of issue. During that one-year period, no additional referrals to that same specialist are required.
- You can get a special referral to go outside the network if a network specialist is not available.

Knowing what is covered

Our dental clinical review program helps 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 receive the care. Only licensed dentists make clinical determinations. We will notify you and your dentist if we deny coverage for any reason. We will state the reason when we notify you of the coverage denial. For more information about clinical reviews, you can call Member Services at **1-877-238-6200 (TTY: 711)**.

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**.

You can avoid unexpected bills

Just call Member Services at **1-877-238-6200 (TTY: 711)** to find out what's covered before you receive the care.

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 at **1-877-238-6200 (TTY: 711)** to file a verbal complaint or to ask for the address to mail a written complaint. You can also send us an email through your member website at **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:

Dental Appeals Resolution Team
PO Box 14597
Lexington, KY 40512

Link to your state insurance department website

Visit the National Association of Insurance Commissioners (NAIC) at **www.naic.org**. Select "Members: then select the "Insurance Dept Directory (PDF)" to locate your state's insurance department website link.

Kentucky appeals process

(1) As an Aetna member, 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 **1-877-238-6200 (TTY: 711)**.
- (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 a 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 at **1-877-238-6200 (TTY: 711)**. 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, or 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 the toll-free number on your ID card 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](https://www.aetna.com/individuals-families/member-rights-resources.html) to view the list. You can also call Member Services at **1-877-238-6200 (TTY: 711)** 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 nontreatment. 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 nontreatment.

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 listing 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 Maintenance Organization (DMO) Disclosure

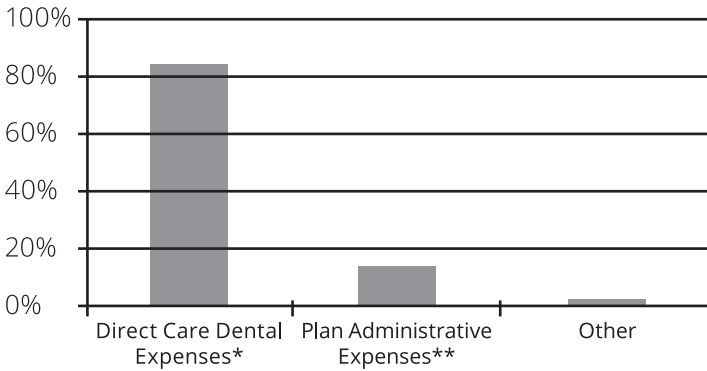
How we pay providers

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	<p>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.</p> <p>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.</p>	0%
Capitation	<p>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.</p>	48%
Fee-for-service	<p>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.</p>	1%
Discounted fee-for-service	<p>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.</p>	51%



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),

Phone: **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).



TTY: 711

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'éhjí bee níká a'doowoł doo búáh ílínígóó koji' hólne' 1-888-982-3862 . (Navajo)

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

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

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

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

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862 . (Ibo)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

M̄ dyi wuḍu-dù kà kò dò bĕ dyi móuń ni Pídyi ní, níí, dá nòbà nià kɛ:1-888-982-3862. (Kru-Bassa)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862 پر بات کریں۔ (Urdu)

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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