Aetna Dental of California Inc.
P.O. BOX 14094
LEXINGTON, KY 40512-4094

Statement date: August 26, 2022

Member: ANDREW SHARP
Member ID: W272991909
Group #: 0863140-56-002 EB LAN9Z0
Group name: KFORCE FA & TECH FLEX KFS

QUESTIONS? Contact us at aetna.com
1-877-238-6200
Or write to the address shown above.

ANDREW SHARP
212 THOMPSON SQ
MOUNTAIN VIEW CA 94043

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

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preference, view, print or download your EOBs online anytime.

Your payment summary

		Your plan paid			You may owe or already paid
Patient	**Provider**	**Amount**	**Sent to**	**Send date**	**Amount**
Andrew (self)	Joseph O Paraiso	$245.00	Joseph O Paraiso	8/26/22	$350.00
Total:		$245.00			**$350.00**

Your claims up close

Claim for Andrew (self) Provider: Joseph O Paraiso (Out-of-Network)

Claim ID: ECAC00KTD01 Received on 8/23/22	Amount billed	Member rate	Not payable by plan (Remarks) !	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
Service type and date	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
FLUORIDE GEL CARRIER D5986 on **8/4/22**	350.00		350.00 (1)						350.00
PROPHYLAXIS - ADULT D1110 on **8/4/22**	165.00		(2)			165.00	165.00 (100%)		
PERIODIC ORAL EVALUATION D0120 on **8/4/22**	80.00					80.00	80.00 (100%)		
Totals:	595.00		350.00	0.00	0.00	245.00	245.00	0.00	**$350.00**

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

Your Claim Remarks

General Remarks:

*** - In certain. states, PPO dentists are not required to accept PPO discounted rates for non-covered services.**

(1) This procedure is not covered under your dental plan. Your plan provides benefits for a specific list of services. These can be found in your Dental Benefits Plan. Look under the "List of Covered Dental Expenses". [018]

(2) We took another look at your claim. This is your adjusted claim. [RWRK - C38]

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

A Message about Teladoc

Board certified physicians are available 24/7 to quickly diagnose and treat your routine illnesses. Call 1-855-TELADOC (1-855-835-2362) or log onto www.Teladoc.com/Aetna to request a consult.

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

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:

Dental Appeals Resolution Team
PO Box 14597
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, you 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 California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 888-466-2219and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 888-466-2219 and a TYY line (877-688-9891) for the hearing and speech impaired. The department's Internet Web site (www.HealthHelp.ca.gov) has complaint forms, IMR application forms and instructions online.

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.

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)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) Զանգահարեք թիվը նշված է ձեր ID քարտի առանց գնով: (Armenian)

(Hindi) हिन्दी में भाषा सहायता के लिए, अपने आईडी कार्ड पर दिये गये नम्बर पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau tus xov tooj ntawm koj daim npav. (Hmong)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ
សូមទូរស័ព្ទតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នកដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

(Persian) برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

สำหรับความช่วยเหลือทางด้านภาษาเป็น (ภาษาไทย) โทรหมายเลขที่แสดงไว้บนบัตรประจำตัวของท่าน ฟรีไม่มีค่าใช้จ่าย (Thai)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)