



**Aetna Medicare FIDE
(HMO D-SNP)**

2026 Provider Orientation



Agenda

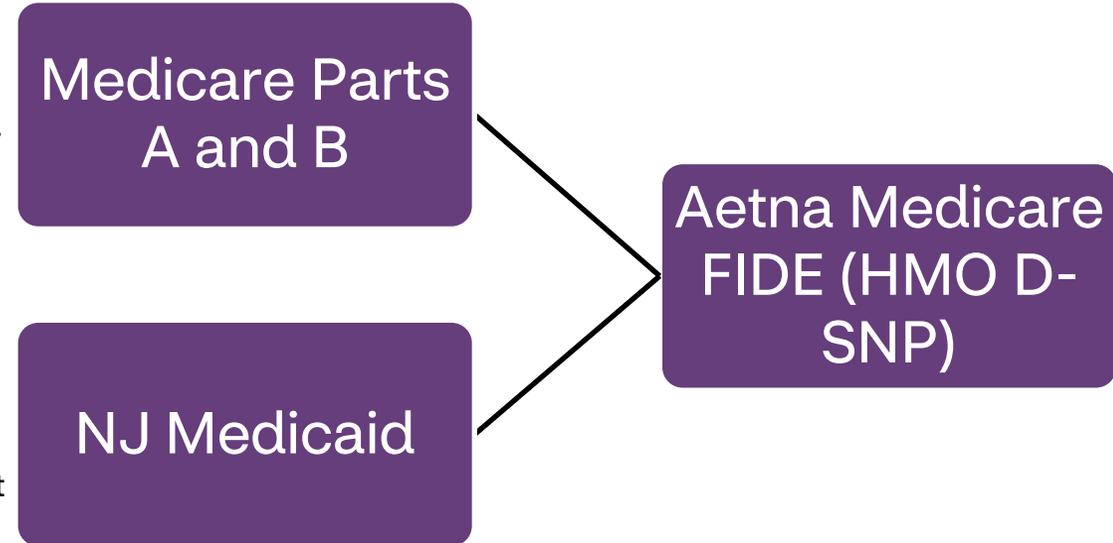
- **Overview**
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Aetna Medicare FIDE (HMO D-SNP) Overview

Aetna Medicare FIDE (HMO D-SNP) is a Fully Integrated Dual Eligible plan. It is a Medicare Advantage plan which serves dual eligible members in New Jersey. It covers all Medicare and Medicaid services including prescriptions drugs, behavioral health, Managed Long Term Services and Supports (MLTSS) (if applicable) and additional supplemental benefits at \$0 cost sharing for all members. This plan serves all counties in NJ.

Plan Features

- Coverage of all Medicare and Medicaid benefits including prescription drugs, behavioral health and Managed Long-Term Care Services and Supports (if applicable)
- Additional enhanced benefits including an Extra Benefits Card with a \$255/monthly benefit for members with a qualifying chronic condition to be used for over-the-counter items, healthy foods, transportation (including gas at the pump and ride share services such as Lyft/Uber), personal care supplies, and utilities. Members without a qualifying chronic condition can use the monthly allowance to purchase only over-the-counter (OTC) items.
- SilverSneakers® gives members access to a large network of fitness centers, community classes, on-demand videos, Apple Fitness+ subscription, and at-home fitness kits.
- Personal emergency response system (PERS) LifeStation® is a medical alert system that provides users with 24/7 access to help in the event of a fall or other emergency. Includes GPS and fall detection at no additional cost.
- Members can receive 14 meals over 7 days after an inpatient hospital discharge or skilled nursing stay.
- Annual allowance of up to \$400 each calendar year to support the cost of wigs due to chemotherapy-related hair loss.





Member Eligibility to join Aetna Medicare FIDE (HMO D-SNP)

To join Aetna Medicare FIDE (HMO D-SNP), the member must:

- Have Medicare Parts A and B
- Eligible for NJ FamilyCare (Medicaid)
- Live in the state of New Jersey
- Eligible for:
- QMB+
- FBDE

When a member enrolls in an HMO D-SNP, they will be automatically disenrolled from original Medicare or any Medicare Advantage plan in which they may be enrolled. Their NJ Family Care (Medicaid) plan, their Part D prescription drug plan, and all their Medicare and Medicaid benefits will be covered by the plan.



The Member Rights and Responsibilities



1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides
6. A right to make recommendations regarding the organizations member rights and responsibilities policy
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Shared decision-making aids offer healthcare providers the opportunity to leverage best practice tools tailored to their specific medical specialties. These aids cover a diverse array of medical scenarios, providing specialized information on topics such as diabetes, cardiovascular, wellness screening, flu prevention and more. By incorporating these decision aids into their practice, healthcare providers can enhance the collaborative decision-making process.

The Member Rights and Responsibilities can be found in the provider manual available [here](#)

Member ID Card

The Aetna Medicare FIDE (HMO D-SNP) member card represents coverage for both Medicare and NJ Medicaid, which may include MLTSS (if applicable)

Front:

Aetna Medicare FIDE (HMO D-SNP) 

Member Name: 
Prescription Drug Coverage

Member ID: **RxBin** 610502
RxPCN MEDDAET
RxGrp RXAETD

PCP Group/Name:

PCP Phone:

MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: \$0 ER: \$0 Rx: \$0 Dental: \$0

H6399-001 Issue Date:

Back:

2025/12/01 B05 Sh: 0 Bin 1
J6AC Env [81] Csets 1 of 1



In case of an emergency, call 911 or go to the nearest emergency room (ER). Prior authorization is not required for emergency services.

Member Services: 1-844-362-0934 (TTY: 711)
Behavioral Health: 1-844-362-0934 (TTY: 711)
Pharmacy Help Desk: 1-800-238-6279 (TTY: 711)
Dental Services: 1-855-225-1727 (TTY: 711)
Vision Services: 1-844-362-0934 (TTY: 711)
Provider Services: 1-844-362-0934 (TTY: 711)
24-Hour Nurse Advice: 1-844-362-0934 (TTY: 711)
Care Management: 1-844-362-0934 (TTY: 711)
Website: AetnaMedicare.com/NJDSNP

Send Claims To: Aetna Medicare FIDE (HMO D-SNP)
P.O. Box 982967, El Paso, TX 79998-9267

Claim Inquiry: 1-844-362-0934 (TTY: 711)

Use the member ID number on the Aetna Medicare FIDE (HMO D-SNP) when submitting claims for reimbursement. One phone number for member services, care management, provider services and other key plan contacts.



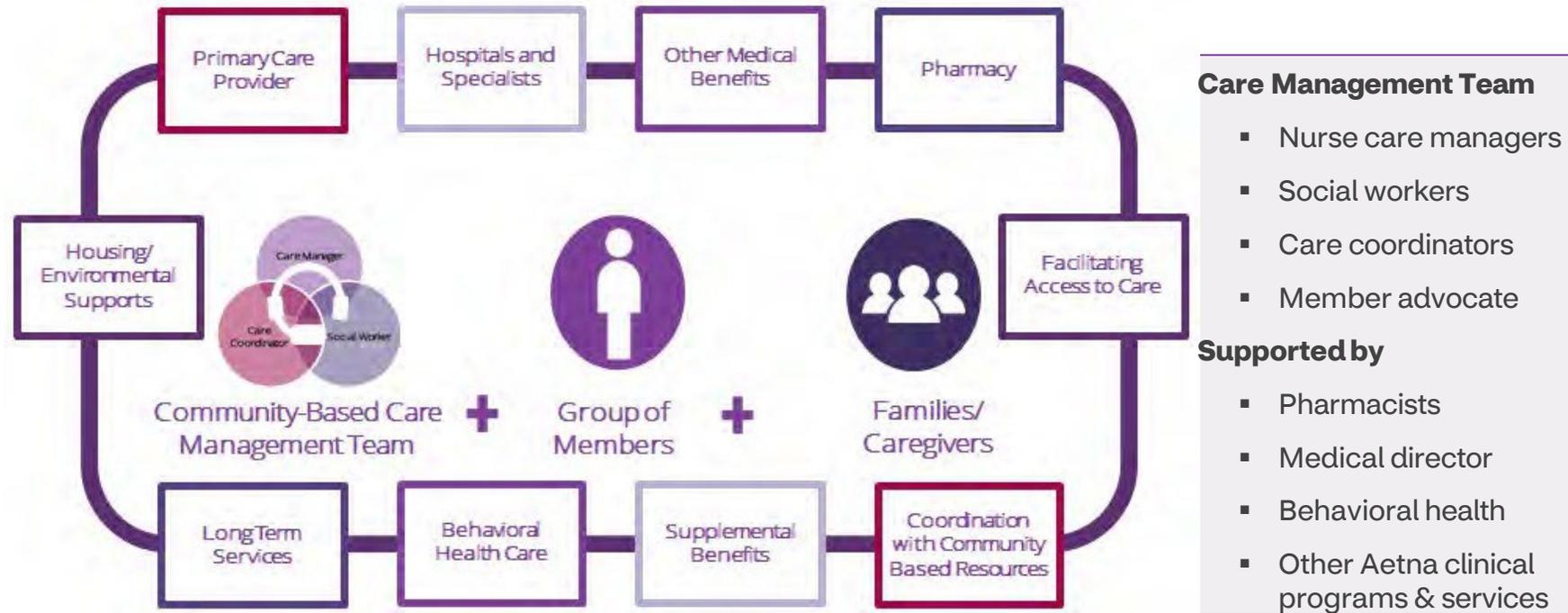
Large and Trusted Network

- Aetna Medicare FIDE (HMO D-SNP) Network leverages the Aetna Medicare Network. Members can utilize the plan-specific [provider directory](#).
- Network consists of Aetna Medicare and Medicaid providers statewide.
- Dental Network through Liberty Dental network available throughout New Jersey.
- Lab Corp and Quest Labs, as well as other independent labs, are in-network.

Care Management Program

Aetna Care Management Program extends beyond traditional case and disease management programs, offering personal, comprehensive support for 100 percent of members.

- Integrated team-based care management model with a personal touch
- Balanced clinical approach that integrates medical, functional, environmental, behavioral health and psycho-social needs through a core care management team



Member Care Team

Our personalized, holistic and local care management strategy

Every member is supported by a dedicated Care Team

- Comprehensive health risk assessment
- Individualized and personalized care plan
- Transitional care if discharged from the hospital
- Assistance with accessing community resources and support
- Help navigating the health care system
- Provide Long Term Services and Supports to members that qualify

Our care team



Registered nurse

Assesses member's needs and risk levels; develops and oversees care plan



Social worker

Identifies and addresses social determinants of health



Care coordinator

Completes initial outreach, Health Risk Assessment and assists with benefit navigation and appointment scheduling



Member advocate

Assists member with Medicaid recertification and accessing benefits

Provider Role In The Care Management Program



- Communicate with care managers, ICT members, members and caregivers
- Collaborate with our organization on the ICP
- Review and respond to patient-specific communication
- Maintain ICP in member's medical record
- Participate in the ICT
- Remind member of the importance of the HRA, which is essential in the development of the ICP
- Encourage the member to work with their care management team



One Plan, One Card, Complete Coverage

Aetna Medicare FIDE (HMO D-SNP) members show one card to receive all services covered by the plan

Medicare Parts A, B and D	Aetna Medicare FIDE Medicare Supplemental Benefits	NJ FamilyCare/ Medicaid	Medicaid MLTSS (if applicable)
<ul style="list-style-type: none"> • Primary care provider (PCP) visits • Specialist visits • Inpatient/outpatient hospital • Emergency and urgent care • X-rays and diagnostic radiology • Lab services • Ambulance • Therapy: physical therapy (PT)/occupational therapy (OT)/speech therapy (ST) • Prescription coverage 	<ul style="list-style-type: none"> • For members with a qualifying chronic condition, \$255 monthly allowance for Over-the-Counter (OTC) items, healthy food, utilities, transportation, and personal care supplies. Members without a qualifying chronic condition can use the monthly allowance to purchase only OTC items. • \$400 annual allowance for wigs for chemotherapy-related hair loss. • Virtual medical visits — members have the option to schedule a telehealth visit 24 hours a day, seven days a week via Teladoc or MinuteClinic® video visit. • Fitness program • Personal Emergency Response System • Meals at home (seven days/14 meals) • 24-hour Nurse Line • Annual routine physical exam • Worldwide emergency and urgent care coverage (\$250,00 annual maximum benefit) 	<ul style="list-style-type: none"> • Medicare cost share covered for all members, including Part D copays • Additional coverage beyond Medicare limits • Preventive and comprehensive dental • Hearing services • Vision services • Podiatry (routine) • Chiropractic care • Behavioral health services • Acupuncture • Transportation • Medical day care • Personal care assistance • Additional pharmacy-covered items, including OTC products • Housing support 	<ul style="list-style-type: none"> • Assisted living services and programs • Caregiver/participant training • Chore services • Community residential services • Community transition services • Home-based supportive care • Home-delivered meals • Medication dispensing device • Residential modifications • Respite care • Social adult day care • Structured day program • Supported day services • Traumatic brain injury (TBI) behavioral management • Non-medical transportation • Vehicle modifications • Nutrition support

Aetna Medicare Extra Benefits Card

(Continued)

Extra Benefits Card

For members with a qualifying chronic condition, the plan provides a monthly allowance of \$255/month to help pay for every day expenses including: healthy food, over-the-counter (OTC) items, transportation (including gas at the pump and ride share services), utilities, and personal care items. Any unused amounts will not roll-over into the next month.

- Members with a chronic condition who qualify for SSBCI through claims will not need to take action. They will be able to spend their allowance on healthy food, utilities, personal care supplies and transportation costs (such as gas at the pump or Uber/Lyft) in addition to OTC products.
- Members who do NOT have a claim on file for a qualifying chronic condition, will be able to call into Member Services to let us know which qualifying condition they have or schedule an appointment with their PCP or Specialist for care of their qualifying condition. Once we confirm they qualify, the member will be able to use the new Extra Benefits Card for OTC products, plus healthy food, utilities, transportation and personal care items.



Aetna Medicare FIDE(HMO D-SNP) Benefits

(Continued)

Additional benefits for Aetna Medicare FIDE (HMO D-SNP) enrollees:

Virtual medical visits

Members can schedule a Teladoc appointment at [Teladoc.com/Aetna](https://www.teladoc.com/Aetna) or by calling **1- 855-TELADOC (1- 855-835-2362) (TTY: 711)** or MinuteClinic® Video Visit which is available 24/7 via the CVS app or at by visiting the [Minute Clinic Website](#).*

Personal Emergency Response System (PERS)

Members pay \$0 copay for each item. Personal emergency response system is provided by LifeStation.

Meals at Home

Members can receive 14 meals over 7 days after an inpatient hospital discharge or skilled nursing stay.

Aetna 24-Hour Nurse Line

Member can get guidance and support on your basic health care questions, 24 hours a day, 7 days a week.

Fitness programs

SilverSneakers® gives members access to a large network of fitness centers, community classes, on-demand videos, at-home fitness kits, and Apple Fitness+ subscription.

Worldwide urgent and emergency coverage

There is a \$250,000 combined maximum benefit amount for worldwide emergency care, emergency transportation and urgently needed care.

Aetna Medicare FIDE(HMO D-SNP) Benefits

(Continued)

Additional benefits for Aetna Medicare FIDE (HMO D-SNP) enrollees:

Housing-Related Services

This benefit is intended to ensure that members can live in a safe, healthy and affordable home.

- To be eligible for Housing Supports, a member must meet at least one social-risk criterion (including but not limited to: homelessness; being at-risk of homelessness; transitioning from an institution; or having been recently released from a correctional facility).
- The member must also meet at least one clinical-risk criterion (including but not limited to: a chronic health condition; a mental health condition; substance misuse; pregnancy; complex medical health due to disability; sexual/domestic violence; assisted living needs; or repeated hospitalization).

Durable Medical Equipment - Wigs

Annual allowance of up to \$400 each calendar year to support the cost of wigs due to chemotherapy-related hair loss.

Nutrition Support

A program intended to help members in MLTSS assess their dietary needs and nutritional options and also includes services to provide pantry items and/or groceries to members under certain circumstances to ensure they have adequate access to food. The health plan will conduct an assessment via a standardized tool to determine eligibility for the benefit.

Verifying Member Enrollment

To see if the patient is enrolled and to check their eligibility dates you may do one of the following:

Verify by Phone

Call our Provider Services team at **1-844-362-0934**. Please provide the following information:

- Your National Provider Identifier (NPI) or Tax ID number
- Name of care provider practice or facility
- Member ID number, if you have it
- Member name
- Member date of birth

Verifying through Availity

Register for our Availity (our secure portal) which features an eligibility lookup tool. Providers will need to fill out and submit the [portal registration form](#).

A link to Availity is also located on our at [Provider Portal Website](#).



Claims Submission

Aetna Medicare FIDE (HMO D-SNP) members should NOT be balanced billed for any covered benefit.



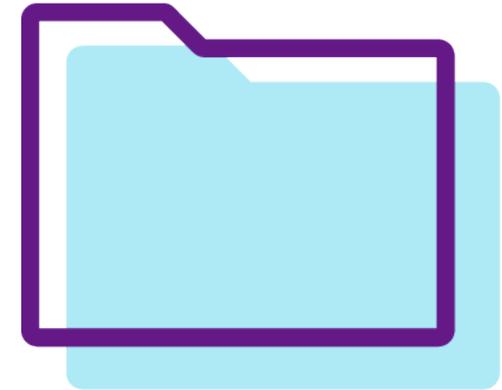
We have an automated system for processing claims for members enrolled in Aetna Medicare FIDE (HMO D-SNP).

- Using the member's ID number from the plan ID card, you'll only need to submit **one claim**. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits.
- You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to resubmit a secondary claim to Aetna.
- We encourage participating providers to electronically submit claims through ECHO. Use submitter ID **#46320** when submitting claims Aetna Medicare FIDE (HMO D-SNP).

Claim Submission

Electronic claims can be submitted through three ways:

- Your own claim clearinghouse
 - Ensure that your clearinghouse is compatible with ECHO using the 837 file format.
 - Please use Submitter ID **#46320** when submitting electronic claims
- Availity
 - Information on Availity can be found at the [Provider Portal Website](#)
- Paper Claims
 - Please use Submitter ID **#46320** when submitting paper claims



Aetna Medicare FIDE (HMO D-SNP)

PO Box 982967

El Paso, TX 79998-2970

Tips for Submitting Claims

- Confirm member's eligibility before rendering services.
- To best ensure timely and accurate payment of your claim, submit a “clean claim”
- A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party
 - It does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity
- Clean claims are processed according to the following timeframes:
 - 90% of clean EDI claims adjudicated within 30 days of receipt
 - 90% of clean paper claims adjudicated within 90 days of receipt
- If providers have an approved authorization for a claim, include the authorization number on all claim lines pertaining to the authorization.

Timely Filing

In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:

New claim submissions –

Claims must be filed on a valid claim form within your contracted timely filing timeframe. This is from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.

Claim Resubmission –

Claim resubmissions must be filed within your contracted timely filing period. The only exception to this is if a claim is recouped, the provider is given an additional contracted days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.



EFT and ERA Setup

Aetna Medicare FIDE (HMO D-SNP) is partnering with ECHO to introduce the new EFT/ERA Registration Services (EERS), a streamlined way for our providers to access payment services.

What is EERS?

EERS offers providers a standardized method of electronic payment and remittance. Providers will be able to use the ECHO tool to manage EFT and ERA enrollments with multiple payers on a single platform.

How does it work?

Please complete the ERA/EFT [enrollment form](#). Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup. ECHO Health supports both NPI and TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process.

If you need assistance, contact ECHO Health at allpayer@echohealthinc.com or 1-888-834-3511.

To validate your account, please make sure you have an ECHO Health draft number and payment amount so they can validate your enrollment request. A draft number is listed as the EPC draft # on ECHO Health explanation of payments. If you do not have an ECHO draft number available please dial 1-888-834-3511.

How do I enroll?

To enroll in EERS, please visit [ECHO portal guide](#).

Prior Authorizations

In certain instances, an authorization may be necessary before care or services are covered. When prior authorizations are required, providers may send the corresponding authorizations and supporting evidence to the following addresses:

Pharmacy

Address: Aetna Medicare FIDE
Part D Coverage Determinations
Dept. 4750 S. 44th Place, Suite 150
Phoenix, AZ 85040 -4015

Phone: 1-844-362-0934

Fax Number: 1-844-814-2260

[Part D Authorization Form](#)

Medical Authorization

Phone: 1-844-362-0934

Fax Number: 1-833-322-0034

[Medical Authorization Form](#)

Home Health Authorization

Phone: 1-844-362-0934

Fax Number: 1-844-814-2260

[Home Health Authorization Form](#)

Provider Disputes

If you are a Contracted Provider, you may use the [Dispute Form](#) found online to have your claim reconsidered.

Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

Aetna Medicare FIDE (HMO D-SNP)

PO Box 982967

El Paso, TX 79998-2974

Incomplete or missing information may cause the decision to be upheld or returned to Provider. Common mistakes include:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

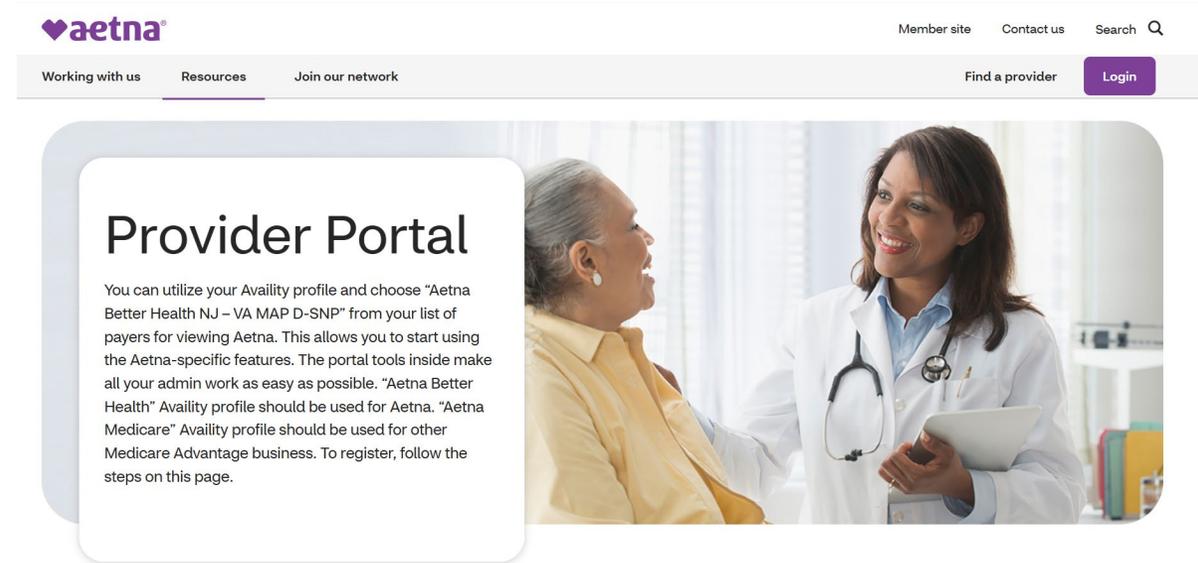
- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed

Provider Portal

If you are already registered in Availity, you will simply select **Aetna Better Health All Plans NJ-VA MAPD-DSNP** for Aetna Medicare FIDE (HMO D-SNP) from your list of payers to begin accessing the portal and all of the features.

[Find out more at the Aetna Medicare FIDE \(HMO D-SNP\) Provider Portal Website](#)

If you are not registered, we recommend that you do so immediately by going to the above portal location.



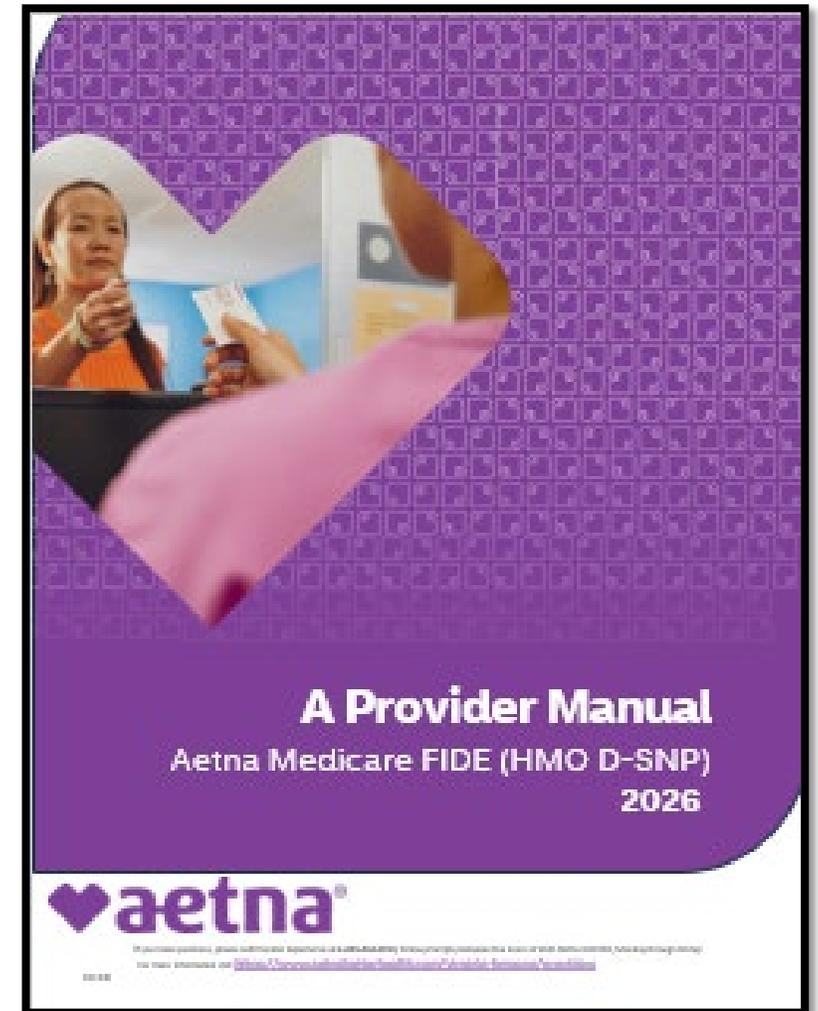
Provider Manual

The provider manual contains plan policies, procedures and benefits.

You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available on our [Forms and Resources Page](#).

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department at **1-844-362-0934** or by email at COEProviderServices@Aetna.com.



Provider Responsibilities

- Enrollee Privacy Rights
- Enrollee Privacy Requests
- Advanced Directives
- Provider Marketing
- Cultural Competency
- Health Literacy
- Alternative Formats
- Americans with Disabilities Act
- Abuse and Neglect
- Fraud, Waste, and Abuse

Provider Responsibilities (continued)

Enrollee Privacy Rights and Requests

- Uphold the privacy requirements of HIPAA when members exercise privacy requests.
- Make information available about Aetna Medicare FIDE (HMO D-SNP) practices regarding their PHI.
- Maintain a process to request access, change, or restrict disclosure of PHI.
- Consistently respond to privacy requests within required time standards.
- Document requests and actions taken.

Advanced Directives

The advance directive must be prominently displayed in medical records. Must include:

- Providing written information on individual's rights under state law to make medical decisions.
- Written policies about advance directives (including conscientious objections).
- Documenting whether member's advance directive has been executed.
- Members may not be discriminated against due to advance directive decisions and providing unconditional care.

Provider Responsibilities (continued)

Provider Marketing

- Aetna may not conduct sales activities in healthcare settings.
- Providers may discuss NJ Medicaid plans in response to an inquiry.
- Providers are encouraged to display enrollee materials of participating plans.

Providers may:

- Educate on plan benefits and policies
- Refer to sources within Aetna
- Discuss participating status

Providers may not:

- Accept applications
- Induce enrollments
- Accept direct marketing compensation



Provider Responsibilities (continued)

Enhancing Patient Safety Through Language Access

“I Speak” cards are important because they help quickly identify a patient’s preferred language, ensuring timely access to interpreter services and improving communication for safe, effective care. They support compliance with language access requirements and enhance patient experience. Please review the [language identification guide](#) with your patients and distribute “I Speak” [cards](#) to help ease the patients experience with healthcare.

Cultural Competency and Health Literacy

- Care without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or medical history, ability to pay or ability to speak English.
- Treat all enrollees with dignity and respect.
- Participating providers are required to identify language needs and provide translation, oral or sign language interpretation.
- Aetna makes its language interpretation and sign language services available for free. Contact **1-844-362-0934** to access those services.
- Culturally and Linguistically Appropriate Services (CLAS) available at the [Think Cultural Health](#) site

Alternative Formats

- Large print, Braille, and alternative media for plan materials
- Contact Provider Services at **1-844-362-0934** or by email at COEProviderServices@AETNA.COM

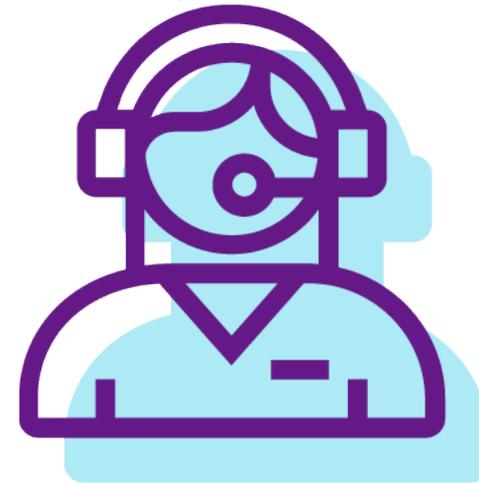
Provider Responsibilities (continued)

Stay Up-to-Date

Don't miss the quarterly [provider newsletter](#)—it includes key updates and resources that support compliance and improve member care.

Americans with Disabilities Act

- Obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities
- Waiting room and exam room furniture meets needs of all enrollees, including those with disabilities.
- Accessibility by public transportation routes
- Clear signage
- Appropriate accommodations such as large print materials
- Additional Resources at the [Americans With Disability](#) website



Provider Appointment & Access Standards

Provider Appointment Standards

- Aetna Medicare FIDE (HMO D-SNP) monitors provider compliance to appointment availability standards
- Routine, preventive care available within 28 days for most providers from request
- Dental Care – initial appointment within 21 days
- Urgent care appointments, not deemed an emergency medical condition, triaged, and if deemed necessary, provided within 24 hours
- Urgent Dental Care – 48 hours
- Appointment not deemed serious (non-urgent complaints) within 72 hours
- Post-hospitalization or emergency department visits within 7 days of discharge

Provider Access

- Aetna Medicare FIDE (HMO D-SNP) members require access to their medical home/PCP, including after hours and on weekends (“live person” and no answering machines). Provider voicemail messages should direct members to the emergency room in cases of emergency
- Aetna Medicare FIDE (HMO D-SNP) will monitor the availability of 24/7 access and the processes that support after hours availability and response
- Providers are encouraged to use alternative options for communication, such as scheduling appointments via the web, communicating via secure email and expanded office hours or open access scheduling
- This membership necessitates that providers make their practices accessible to accommodate the full range of disabilities that may exist with the population

	Primary Care	Specialist	OB/GYN	Behavioral Health
Emergency	Immediate	Immediate	Immediate	Immediate
Urgent	24 Hours	24 Hours	24 Hours	24 Hours
Non-Urgent (Non-life threatening)	72 Hours	72 Hours	72 Hours	6 Hours
Routine	28 Days	28 Days	28 Days (non-perinatal)	28 Days
Perinatal	N/A	N/A	1 st Trimester: 3 Weeks 2 nd Trimester: 7 Days 3 rd Trimester: 3 Days High Risk: 3 Days Routine: 3 Weeks Postpartum: 6 weeks	N/A
Wait Time	No more than 45 minutes	No more than 45 minutes	No more than 45 minutes	No more than 45 minutes

In addition to the standards above, Behavioral Health providers are contractually required to offer:

- Follow-up Behavioral Health **Medication Management** within 3 months of the first appointment
- Follow-up Behavioral Health **Therapy** within 10 business days of the first appointment
- Next Follow-up Behavioral Health **Therapy** within 30 business days of the first appointment

Key Contacts

For member services, provider services and prior authorization for Aetna Medicare FIDE (HMO D-SNP) call **1-844-362-0934**

[Aetna Medicare FIDE \(HMO D-SNP\) Home Page](#)

[Aetna Medicare FIDE \(HMO D-SNP\) Provider Site](#)

[Aetna Medicare FIDE \(HMO D-SNP\) Provider Manual](#)

[Provider Relations Email](#)

Take a moment to check out the [quarterly provider newsletter](#)—it's packed with helpful tips and updates to make your work easier.

An elderly couple is shown in a close-up, intimate moment. The man, on the left, has short grey hair, wears glasses, and a light blue polo shirt. The woman, on the right, has short white hair and is wearing a white textured cardigan. They are holding hands, looking down at each other with a gentle expression. In the background, an American flag is visible, partially obscured by a semi-transparent yellow banner. The setting appears to be an outdoor area with a building and some greenery.

Thank You

**♥ aetna[®]**

Aetna Policy Statement

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