Important information about your dental benefits

Dental Maintenance Organization (DMO)†

† In Illinois, DMO plans provide limited out-of-network benefits. In order to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. Illinois DMO is not an HMO.
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 to ask for a copy. Use the toll-free number on your Aetna Dental ID card. You can also get a copy of the Certificate of Coverage by contacting your employer directly.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

This managed care plan may not cover all of your health care expenses. Read your contract carefully to determine which health care services are covered. To contact the plan, members may call the number on their ID card; all others, call 1-877-238-6200.

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

Do you need help in another language? Member Services can connect you to a special line where you can talk to someone in your own language. You can also get help with a complaint or appeal.

Language hotline – 1-888-982-3862 (140 languages are available, ask for an interpreter.)
TDD 1-800-628-3323 (hearing impaired only)

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

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa – 1-888-982-3862 (Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)
TDD 1-800-628-3323 (solo para personas con impedimentos auditivos)
Getting help

Contact Member Services with questions

Call the toll-free number on your Dental ID card. Or, call 1-800-US-Aetna (1-800-872-3862) Monday through Friday, 7 a.m. to 7 p.m. ET. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at www.aetna.com. Click on “Contact Us” after you log in.

Member Services can help you:
- 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 specific dental health information

Your state may have different 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
  P.O. 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
  P.O. Box 14080
  Lexington, KY 40512-4080
  Telephone: 1-877-238-6200
- Health Education and Advocacy Unit
  Office of the Attorney General
  16th Floor 200 Saint Paul Place
  Baltimore, MD 21202
  Telephone: 410-528-1840
  Fax: 410-576-7040

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
P.O. 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
P.O. Box 1157
Richmond, Virginia 23218-1157
Call: 804-371-9741 or 1-800-552-7945 (VA Only)

The Office of the Managed Care Ombudsman
Office of the Managed Care Ombudsman, Bureau of Insurance
P.O. 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
Virginia Department of Health
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

It’s important to know which dentists are in our network. That’s because this dental plan only cover services provided by dentists who are in our network.

Here’s how you can find out if your dentist is in our network:
- Log in to www.aetna.com. Follow the path to find a doctor, and enter your dentist’s name in the search field.
- Call us at the toll-free number on your Aetna Dental ID card. If you don’t have your card, you can call us 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 telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursemements, 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 of any dental practice, please contact either the selected dentist or Member Services at the number on your ID card. You can get more information about the network, participating providers or our grievance procedures through the DocFind® directory at www.aetna.com or by calling 1-877-238-6200.

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 Urgently 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 517-373-0220 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 Provider Leaves the Network
Our contracts are designed to provide transition of care for covered persons should the treating dental care provider contract terminate.

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 non-participating 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:

• Copay – A set amount (for example, $15) you pay for a covered dental care service. For example, 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%) 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.

Your costs when you go outside the network
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.

When you have no choice, we will pay the bill as if you got care in network. For example, you’re covered if you have a dental emergency while on vacation. You pay your plan’s copayments, coinsurance and deductibles as you normally do. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule. Contact us if your dentist asks you to pay more. We will help you determine if you need to pay that bill.

North Carolina members can request approval for in-network level of benefits when care for covered services is not available within the network.
Call Member Services if you cannot find a dentist in the network for your needs. Member Services will find a participating dentist for you, or authorize you to receive services from a dentist outside the network. Your out-of-pocket costs will be the same as if you received services in the network.

Choose a primary care dentist (PCD)
You must 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.

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 name of the PCD you have chosen on your enrollment form. Or call Member Services after you enroll to tell us your selection. The name of your PCD will appear on your Aetna Dental ID card. You may change your selected PCD at any time. If you change your PCD, you will receive a new ID card.

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 required, you may have to pay the bill yourself.
• 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 PCP for those services.
• Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issuance date.
• You can get a special referral to go outside the network if a network specialist is not available.

Emergency and urgent care
In the event of an emergency, call 911 or go to the nearest emergency room. If a delay would not risk your health, call your dentist or PCD. You are covered for emergency treatment outside your service area. Examples of an emergency include severe pain, bleeding or infection. Pay the charges to the dentist and submit a claim to the plan for reimbursement.

If the dentist was more than a specified distance away from your PCD, then you will receive emergency benefits coverage up to a maximum of $100**.

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* State laws vary with regard to out-of-network benefits. 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.

** Refer to your plan documents. 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
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, call the number on your Aetna Dental ID card.

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. The phone number is on your Aetna Dental ID card. You can also send us an e-mail through our secure member website, www.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 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
  P.O. 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
  P.O. 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
  P.O. 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 (5) 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
    P.O. 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

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 health 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.

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 requests within a reasonable amount of time. If we don’t agree with the change, you can file an appeal.

If you’d like a copy of our privacy policy, call the toll-free number on your ID card or visit us at www.aetna.com.

Member Rights

We publish a list of rights and responsibilities on our website. Visit www.aetna.com/individuals-families-healthinsurance/member-guidelines/member-rights.html to view the list. You can also call Member Services at the number on your ID card 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.
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 1-800-323-9930. Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.