Consumer Disclosure and Member Handbook – Texas

Dental Maintenance Organization (DMO°) plans from Aetna Dental Inc.°

° Aetna Dental Inc. is licensed by the Texas Department of Insurance to operate as a Dental Maintenance Organization (DMO) within an approved service area.

www.aetna.com

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Understanding your plan of benefits

Aetna dental benefit plans cover a variety of dental care, but they do not cover everything. Your “plan documents” list all the details for the plan you chose. Such as, what’s covered, what’s not covered and the specific amounts you will pay for services.

Note: Specific plan documents take the place of general information contained in this document, as applicable. Plan document names vary. They may include a Schedule of Benefits, Evidence of Coverage, Group Agreement and/or any riders and updates that come with them.

You’ll find a plan design overview and summary of benefits in your pre-enrollment packet. These documents are a brief description of the services and benefits covered under your particular plan. They also list services and benefits that are not covered. After enrollment, you can refer to your plan documents for a more complete description of your plan benefits and exclusions.

If you can’t find your plan documents or want information on whether a specific service is covered or excluded, call Member Services at 1-877-238-6200 to ask for a copy. You can also get a copy from your employer.

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. 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. Si usted es sordo o tiene problemas de audición, use su TTY y marque 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.

If you have a disability affecting your ability to communicate or read

You can ask us to send information and materials about how to file a complaint or appeal in the appropriate format. Our information formats include Braille, large print and audio tape.

Get plan information online and by phone

If you’re already enrolled in an Aetna dental plan

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

1. Register and log in to your secure Aetna Navigator® 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.

Visit www.aetna.com and click “Log In/Register.” Follow the prompts to create a user name and password.

Then you can log in any time to:

• Print your Aetna Dental ID card.
• Verify who’s covered and what’s covered.
• Access your “plan documents.”
• Track claims or view past copies of Explanation of Benefits statements.
• Use the DocFind® search tool to find network care.

2. Call Customer Service at the toll-free number on your Aetna ID card or toll free at 1-877-238-6200.

You can speak with a representative to:

• Understand how your plan works or what you will pay.
• Notify us of changes in your name, address or telephone number.
• Change your primary care dentist or office.
• Find emergency care outside your area.
• File a complaint or appeal.
• Get copies of your plan documents.
• Find dental health information.

Call your primary care dentist’s office directly with questions about appointments, hours of service or dental matters.

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.
Covered benefits
This plan does not cover all dental care expenses and includes exclusions and limitations. Benefits exclusions and limitations are outlined in your plan documents. Read your plan documents carefully to determine which health care services are covered benefits and to what extent.
You’ll also find a summary of exclusions and limitations within this document. To find out before you enroll whether your plan documents contain exclusions and limitations different from those listed in this document, contact your employer’s benefits manager. You may also request a sample copy of the Aetna Evidence of Coverage from your employer.
If you’re already a member, you may call us toll-free at 1-877-238-6200.
In order for benefits to be covered, they must be “medically necessary” and, in some cases, must also be preauthorized by Aetna. Refer to the “Preauthorization” section of this document to learn more.
For the purpose of coverage, except for an emergency situation outside the service area, you must access the following benefits through your primary care dentist (PCD) either directly or with a PCD referral. You are responsible for cost sharing as outlined in your Evidence of Coverage.
• Visits and exams
• X-rays and pathology
• Endodontics
• Restorations and repairs
• Periodontics
• Oral surgery
• Space maintainers
• Nutritional counseling and tobacco counseling
• External bleaching

Emergency and urgent care
Emergency care is the dental services administered in a dentist’s office, dental clinic or other facility. The dentist evaluates and stabilizes urgent dental conditions. To be considered an emergency, the condition must be sudden and severe and may include excessive bleeding, severe pain or acute infection that leads an average person with average knowledge of dentistry to believe immediate care is needed.
If you need emergency care:
1. Whenever possible, call your PCD to arrange an emergency appointment or contact Aetna Member Services
2. If it is not possible to contact the PCD, call your closest dental provider

If we receive a claim for an emergency condition from a dental provider other than your PCD, we will pay the benefit based on the reasonable charge for such care. You will be responsible for the copay indicated in your Dental Care Schedule.
We will pay the claim only if the care given is intended to stabilize the emergency condition and to provide palliative relief until you can see your PCD. The itemized bill must describe the care involved.
You may have to pay for the emergency treatment at the time the services are done. You or the treating provider may then submit the bill to Aetna.
What you 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 provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network dentist, unless you have Aetna approval before the services are performed, you will have to pay all of the costs for the services.

Your financial responsibility

You are responsible for all applicable copayments, percentage copayments and premiums under your particular plan. This information is included, with specific amounts, in your enrollment kit. You are also financially responsible for all noncovered services.

• Copayment – A fixed amount (for example, $15) you pay for a covered dental care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary dentist may be different than a specialist’s office visit.

• Percentage copayment – Your share of the costs for a covered service. This is calculated as a percentage (for example, 20 percent) of the allowed amount for the service.

How we pay your dentist and how we calculate your coinsurance

This does not apply to fixed “copayments.”

Primary care services – A percentage copayment applies to covered primary care services rendered by your PCD. Subject to any applicable state laws, the percentage copayment for most PCDs is a percentage of the PCD’s usual fee for that service as reviewed by us. The “usual fee” means the fee the PCD charges to his/her patients in general. You can ask your PCD for a copy of their usual fee schedule. This usual fee schedule may change from time to time. It is used only for the purpose of calculating a percentage copayment and is not the basis for compensation to the PCD. We compensate PCDs based on separate negotiated agreements that may be less than or unrelated to the PCD’s usual and customary charges. (These agreements may vary among PCDs and may include per member per month payments; chair hour rates; discounted fee-for-service arrangements and/or other payment mechanisms).

Specialty services – Percentage copayment may also apply when you see a specialist. Your percentage copayment is a percentage of the participating specialist dentist’s fee for that service. The “fee” may be a fee negotiated with the participating specialist dentist and approved by the plan. In that case, your percentage copayment will be based on the actual, negotiated fee.

We pay participating specialist dentists based on separate, negotiated agreements that may be less than or unrelated to the dentist’s usual and customary charges. These agreements may vary among participating specialist dentists.
Exclusions and limitations

The following are not covered benefits except as described in rider(s) or amendments(s) attached to your plan documents:

1. Services or supplies that are covered in whole or in part by any part of your plan documents, or by any other plan of group benefits that is provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not: a non-occupational disease; or a non-occupational injury.

3. Services not listed in the Dental Care Schedule that applies; unless otherwise specified in the plan documents.

4. Replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.

5. Plastic, reconstructive, or cosmetic surgery, or other dental services or supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons are not covered, except (a) to the extent needed to repair an injury which occurs while the person is covered under the contract, and (b) for dental services or supplies provided in connection with a congenital defect. Facings on molar crowns and pontics will always be considered cosmetic.

6. Services, procedures, drugs, or other supplies that are determined by Aetna to be experimental, or still under clinical investigation by health professionals.

7. Any appliances or services that are used only for the purpose of splinting (stabilization or immobilization of periodontally involved teeth), altering vertical dimension (the degree of jaw separation when the teeth are in contact), restoring occlusion (the contact relationship of the teeth in the upper and lower jaw), or correcting attrition; abrasion, or erosion (grinding or wearing away of teeth by mechanical or chemical means. his would include the use of dentures, crowns, inlays, onlays, bridgework, or any other appliance or service if they are used only for the purposes mentioned above.

8. Services that do not meet broadly accepted national standards of care, including but not limited to:

   (i) more than two quadrants of scaling and root planing in a single office visit, unless necessary due to the need for pre-medication, significant travel distance or patient management difficulty;
   (ii) services where diagnostic information does not support the proposed treatment;
   (iii) services that will inadequately treat the Member’s condition; and
   (iv) prosthetic replacement dependent on severely compromised abutment teeth.

9. Services intended for medically necessary medical or surgical diagnosis or treatment of any jaw joint disorder.

10. Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

11. Orthodontic Treatment, unless otherwise specified in your plan documents.

12. General anesthesia and intravenous sedation; unless otherwise specified in your plan documents and used in conjunction with another covered necessary service or supply that is listed on the applicable Dental Care Schedule.

13. Treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

14. A crown, cast, or processed restoration unless:

   (i) it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
   (ii) the tooth is an abutment to a covered partial denture or fixed bridge.

15. Pontics, crowns, cast or processed restorations made with high noble metals, unless otherwise specified in your plan documents.

16. Surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in your plan documents.

17. Services needed solely in connection with non-covered services.

18. Services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

19. Services given by a nonparticipating dental provider, except if provided as out-of-area emergency dental care.

Any exclusion above will not apply to the extent that coverage is required under any law that applies to the coverage.

To the extent allowed by Texas, those for services and supplies:

Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any individual in the armed forces of a government.

Benefits payable under Medicare will not have any effect on benefits payable under this plan.
Benefits after termination of coverage

Dental services given after the member’s coverage terminates are not covered. However, ordered inlays, onlays, crowns, removable bridges, cast or processed restorations, dentures; fixed bridgework, and root canals will be covered when ordered, if the item is installed or delivered no later than 30 days after coverage terminates.

Ordered means prior to the date coverage ends:

As to a denture: impressions have been taken from which the denture will be prepared.

As to a root canal: the pulp chamber was opened.

As to any other item listed above: the teeth which will serve as retainers or support; or which are being restored; have been fully prepared to receive the item; and impressions have been taken from which the item will be prepared.

If a member’s primary care dentist’s contract with Aetna terminates, the member will be notified. The provider will continue to provide treatment to any member who is receiving active treatment on the date of termination until the covered member can either select another primary care dentist or be assigned by Aetna to another primary care dentist, and be accepted by another primary care dentist.

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.

Preauthorization: Getting approvals for services

For those services that do not allow direct access, you must first obtain a referral from your primary care dentist (PCD). Your dentist may be required to obtain prior approval of coverage for certain services. This is called “precertification.” Network providers are responsible for obtaining preauthorization from the plan for certain services. You should ask your PCD or Member Services to find out if precertification is necessary for any covered services.

If you do not obtain precertification where required you may have to pay for those services. We also review certain services at the time of delivery (concurrent review) or after the service has concluded (retrospective review). This function is the responsibility of the dental plan and the provider.

What happens if your dentist leaves the dental plan

If your participating general or specialty dentist discontinues participation in the DMO and you are currently under active dental treatment, you may be able to continue to see that provider until the treatment in progress is completed. For information on continuing your care in these situations, please refer to your Evidence of Coverage or call 1-877-238-6200.

If orthodontic treatment began before the participating orthodontic or specialty dentist left the network, the dentist may continue to provide care throughout the course of active orthodontic treatment.
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. (See “Emergency and urgent care” for more information.)
• 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 PCD 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 issue date.
• If a network specialist is not available in your service area, you can get a specialty referral to go outside the network. This referral must be approved by Aetna before you see the specialist dentist.

What to do if you disagree with us

We are interested in hearing all comments, questions, complaints or appeals from customers, members and doctors. We do not retaliate against any of those individuals or groups for making a complaint or appeal.

To file a complaint or appeal, you may call Member Services to file a verbal complaint or ask for the appropriate address to mail a written complaint. You can also email Member Services through your secure Aetna Navigator member website at www.aetna.com.

The complaints and appeals process is described below:

Definitions

Complaint: A complaint means any dissatisfaction expressed orally or in writing by a complainant to Aetna regarding any aspect of the HMOs operations. The term includes dissatisfaction relating to plan administration procedures related to review or appeal of an adverse determination, the denial, reduction or termination of a service for reasons not related to medical necessity, the manner in which a service is provided or a disenrollment decision.

The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or a provider’s or enrollee’s oral or written expression of dissatisfaction or disagreement with an adverse determination.

Benefit or Coverage Decision: Aetna provides benefits for covered services in accordance with your dental benefits plan. A decision to reduce or deny a service is based on specific plan benefit exclusions or limitations not related to medical necessity and/or experimental and investigational procedures.
Authorized Representative: You may authorize another person to act as your representative in the complaint process.

Aetna Member Services: You or your authorized representative may obtain assistance or additional information by contacting Member Services at 1-877-238-6200.

How to file a complaint

Written complaints: You may mail your concerns or inquiries to the address as directed by your employer. If you do not have the information readily available to you, Member Services can assist you or you may use the address below and we will redirect to the appropriate area as necessary.

    Aetna Dental Inc. (DMO)
    PO Box 14597
    Lexington, KY 40512

STEP 1:
When you file a written or oral complaint, you will receive an acknowledgement letter within five business days. An Aetna representative will review, investigate and respond to your complaint, in writing, within thirty calendar days from the receipt of your complaint.

Complaints involving emergencies, urgent care, hospitalized members or life-threatening conditions are completed as soon as possible considering the medical or dental immediacy of the condition, procedure or treatment under review. An Aetna representative will investigate and complete the review not later than one business day after Aetna receives the complaint. The decision will be communicated verbally or electronically immediately after making the decision. A resolution letter will be sent within three days of the decision.

Note: Reviews are not expedited for services that have already been provided.

STEP 2:
If you are not satisfied with the response to the complaint, you may request in writing the right to a Complaint Appeal Panel meeting. You will receive an acknowledgment letter within five business days of Aetna’s receipt of your request. No later than the fifth business day before the date the complaint Appeal Panel is scheduled to meet, you will be provided with:

• Documentation to be presented to the Appeal Panel
• The specialization of the physicians or providers consulted during the investigation of the appeal
• The name/title and affiliation of each HMO representative on the appeal panel.

You may appear in person, by phone, through an authorized representative or you may address a written appeal to the Complaint Appeal Panel. The panel meeting will be held in the county where you normally receive health care services or at an agreed site. During this meeting you have the right to:

• Present alternative expert testimony to the Complaint Appeal Panel
• Request the presence of and question any person making the prior determination that resulted in the appeal.

Individuals involved in reviewing and making decisions regarding a complaint appeal will not have been involved at any prior level of the issue or determination. If the case is based in whole or in part on a medical judgment, a health care professional with appropriate training and expertise in the field of medicine involved will be consulted.

The Appeals Process will be completed no later than the 30th calendar day after the date the written request for the appeal is received. A representative will provide a written response with the Complaint Appeal Panel’s decision that will include the toll-free number and address for the Texas Department of Insurance.
**Emergency conditions and options**

If the complaint involves an ongoing emergency, emergent care, urgent care or a life-threatening condition, the process will be completed in accordance with the medical or dental immediacy of the case not later than one business day after Aetna receives the request for appeal. Upon request, Aetna will provide a same or similar specialty review in lieu of a Complaint Appeal Panel meeting. The physician specialist may interview the member or the member’s representative and shall decide the appeal. He/she will not have been involved in reviewing and making decisions regarding the case at any prior level of determination, and will be of the same or similar specialty as the physician or provider who would typically manage the medical condition, procedure or treatment under consideration for review.

**Additional member rights**

If you do not agree with the final plan determination, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

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 local U.S. Department of Labor Office and your state insurance regulatory agency.

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights or complaints at:

- **PO Box 149091**
- **Austin, Texas 78714-9091**
- **Phone:** 1-800-252-3439
- **Fax:** 512-490-1007
- **Web:** [http://www.tdi.texas.gov](http://www.tdi.texas.gov)
- **Email:** ConsumerProtection@tdi.texas.gov

**How we determine what’s covered**

You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if a service is a covered benefit before you receive care. For more information about coverage and benefits, please call **1-877-238-6200**.

Sometimes we may perform a dental clinical review after you receive treatment. This helps us determine what dental services are covered under the dental plan and the extent of that coverage.

How we determine what’s covered

You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if a service is a covered benefit before you receive care. For more information about coverage and benefits, please call **1-877-238-6200**.

Sometimes we may perform a dental clinical review after you receive treatment. This helps us determine what dental services are covered under the dental plan and the extent of that coverage.
Search our network for dental care providers

Use our DocFind® 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 www.aetna.com and log in. From your secure member website home page, select “Find a Doctor” from the top menu bar and start your search.

Considering enrollment: Visit www.aetna.com and scroll down to “Find a doctor, dentist, facility or vision provider” from the home page. You’ll need to select the plan you’re interested in from the drop-down box.

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
• Specialty
• Language spoken
• Gender
• Driving directions

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. 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. You may change your selected PCD one time per month. Your request must be received by the 15th day of the current month to be effective on the first day of the next month.

Get a FREE printed directory

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

In order to be eligible to receive benefits covered by the DMO you must live or work within the service area. The following partial counties with the specific Zip codes listed are within the service area:

Brewster County – ZIP code 79830, 79831, 79832 and 79842
Jeff Davis County – ZIP code 79734

The following full counties in the state of Texas are within the service area:

Anderson
Andrews
Angelina
Aransas
Archer
Armstrong
Atascosa
Austin
Bailey
Bandera
Bastrop
Baylor
Bee
Bell
Bexar
Blanco
Borden
Bosque
Bowie
Brazoria
Brazos
Briscoe
Brooks
Brown
Burleson
Burnet
Caldwell
Calhoun
Callahan
Cameron
Camp
Carson
Cass
Castro
Chambers
Cherokee
Childress

Howard
Hudspeth
Hunt
Hutchinson
Irion
Jackson
Jefferson
Jim Hogg
Jim Wells
Johnson
Jones
Karnes
Kaufman
Kendall
Kenedy
Kerr
Kimble
King
Kleberg
Knox
La Salle
Lamar
Lampasas
Lavaca
Lee
Leon
Liberty
Limestone
Lipscomb
Live Oak
Llano
Loving
Lubbock
Lynn
Madison
Marion
Martin
Mason
Matagorda
Maverick
McCulloch
McLennan
McMullen
Medina
Menard
Midland
Milam
Mills
Mitchell
Montague
Montgomery
Moore
Morris
Motley
Nacogdoches
Navarro
Newton
Nolan
Nueces
Ochiltree
Oldham
Orange
Palo Pinto
Panola
Parker
Parmer
Pecos
Polk
Potter
Rains
Randall
Reagan
Real
Red River
Reeves
Refugio
Roberts
Robertson
Rockwall
Runnels
Rusk
Sabine
San Augustine
San Jacinto
San Patricio
San Saba
Schleicher
Scurry
Shackelford
Shelby
Sherman
Smith
Somervell
Starr
Stephens
Sterling
Stonewall
Sutton
Swisher
Tarrant
Taylor
Terry
Throckmorton
Titus
Tom Green
Travis
Trinity
Tyler
Upshur
Upton
Uvalde
Van Zandt
Victoria
Walker
Waller
Ward
Washington
Webb
Wharton
Wheeler
Wichita
Wilbarger
Willacy
Williamson
Wilson
Winkler
Wise
Wood
Yoakum
Young
Zapata
Zavala
Member Rights

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

We protect your privacy

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

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

Summary of the Aetna Privacy Policy

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

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

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 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 www.aetna.com.
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.