Important information about your dental benefits – Texas

Dental Maintenance Organization (DMO®)†

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, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy 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
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 (sólo para personas con impedimentos auditivos)

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.
Getting help

Contact Member Services with questions

Call 1-877-238-6200 Monday through Friday, 7 a.m. to 8 p.m. CT. 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
• And more...

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

Search our network for dental care providers

It’s important to know which dentists are in our network.

Here’s how you can find out if your dentist is in our network.

• Log on to your secure member website at www.aetna.com.
• Follow the path to find a participating dentist. Search options include zip, city or county where the provider is located. You can also narrow your search by name, specialty, languages spoken, male/female and/or other criteria.
• You can call us 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 79734
Jeff Davis County - Zip Code 79734

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

Anderson Borden Cass Coryell
Andrews Bosque Castro Cottle
Angelina Bowie Chambers Crane
Aransas Brazoria Cherokee Crockett
Archer Brazos Childress Crosby
Armstrong Briscoe Clay Dallam
Atascosa Brooks Cochran Dallas
Austin Brown Coke Dawson
Bailey Burleson Coleman DeWitt
Bandera Burnet Collin Deaf Smith
Bastrop Caldwell Collingsworth Delta
Bay City Calhoun Colorado Denton
Bee Callahan Comal Dickens
Bell Cameron Comanche Dimmit
Bexar Camp Concho Donley
Blanco Carson Cooke Duval

Eastland Ector Howard McLennan
El Paso Hudspeth Medina
Ellis Hunt Menard
Erath Hutchinson Midland
Falls Irion Milam
Fannin Jack Mills Mitchell
Fayette Jasper Montague
Fisher Jefferson Montgomery
Floyd Jim Hogg Moore
Foard Jim Wells Morris
Fort Bend Johnson Motley
Franklin Jones Nacogdoches
Freestone Karnes Navarro
Frio Kaufman Newton
Gaines Kendall Nolan
Galveston Kenedy Nueces
Garza Kent Ochiltree
Gillespie Kerr Oldham
Glasscock Kimble Orange
Goliad King Palo Pinto
Gonzales Kleberg Panola
Gray Knox Parker
Grayson La Salle Parmer
Greene Lamar Pecos
Grimes Lamb Polk
Guadalupe Lampasas Potter
Hale Lavaca Raines
Hall Lee Randall
Hamilton Leon Reagan
Hansford Liberty Real
Hardeman Limestone Red River
Hardin Lipscomb Reeves
Harrington Harris Refugio
Hartley Harrison Llano
Haskell Loving Lubbock
Hays Lynn Madison
Henderson Hemphill Marion
Hidalgo Hill Martin
Hockley Mason McCulloch
Hood Matagorda Schleicher
Hopkins Maverick Scurry

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
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.

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.

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:

• 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.
• Coinsurance – Your share of the costs for a covered service. Coinsurance is calculated as a percent (for example, 20%) 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” as described above.

Primary Care Services – A coinsurance applies to covered primary care services rendered by your PCD. Subject to any applicable state laws, your coinsurance for most PCDs is a percent of the PCD’s usual fee for that service as reviewed by us. The “usual fee” means the fee that 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 be changed from time to time. It is used only for the purpose of calculating a coinsurance 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 – Coinsurance may also apply when you see a specialist. Your coinsurance is a percent 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 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.

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 preformed, you will have to pay all of the costs for the services.

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 that 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.

Knowing what is 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.

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 Certificate 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.
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 e-mail Member Services through your secure Aetna Navigator member website at www.aetna.com.

The complaints and appeals process is described below and begins with helpful definitions.

Complaint Definition: A complaint means any dissatisfaction expressed orally or in writing by a complainant to Aetna regarding any aspect of the HMO’s 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: A member may authorize another person to act as his/her representative in the complaint process.

Aetna Member Services: A member or his/her authorized representative may obtain assistance or additional information by contacting member services at 1-877-238-6200.

Written complaints: Concerns or inquiries should be mailed to the address as directed by your employer. If you do not know 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 (5) business days. An Aetna representative will review, investigate and respond to your complaint, in writing, within thirty (30) 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 (5) 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, telephonically, 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 not 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 a member does not agree with the final Plan determination, the member has 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:

P.O. 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

**We protect your privacy**

We consider your personal information to be private. Our policies help us protect your privacy. By “personal information,” we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to www.aetna.com. You’ll find the “Privacy Notices” link at the bottom of the page. You can also write to:

Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

**Summary of the Aetna privacy policy**

We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we may disclose it to:

• Your doctors, dentists, pharmacies, hospitals and other caregivers
• Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs.
• Other insurers
• Third-party administrators
• Vendors
• Consultants
• Government authorities and their respective agents

These parties must also keep your information private. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

• Paying claims
• Making decisions about what to cover
• Coordinating payments with other insurers
• Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health and dental plans. We usually will not ask if it’s okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies include how to handle requests for your information if you are unable to give consent.

**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](http://www.aetna.com/individuals-families-healthinsurance/member-guidelines/member-rights.html) to view the list. You can also call Member Services at 1-877-238-6200.
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.

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09.28.301.1-TX I (6/14)