Consumer's Right to Know About Health Plans in Rhode Island

Aetna Life Insurance Company (Aetna)
January, 2012

Consumer Disclosure

Single Service Plan Edition

Safe and Healthy Lives In Safe and Healthy Communities

2012_DentalPPO

Consumer Disclosure

Aetna Life Insurance Company
Dental PPO
RI Certificate #154

CONSUMER'S RIGHT TO KNOW ABOUT HEALTH PLANS
THE HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

Knowing how Health Plans work helps you to be a better consumer. This Health Plan is regulated by the Rhode Island Department of Health and is required by law to disclose the information contained in this document, routinely, to all prospective subscribers and to current subscribers upon request. Official Plan Documents give complete information about this Health Plan, in sample or final form, and are available upon request. Health Plans must also provide a comprehensive list of all participating providers, updated annually.

This Consumer Disclosure has been reviewed and approved by the Rhode Island Department of Health in accordance with R23-17.13 (Rules and Regulations for Certifying Health Plans). Requests for more information about Health Plan certification or consumer rights may be addressed to:

> Rhode Island Department of Health, Division of Health Services Regulation, 3 Capitol Hill, Providence, RI 02908-5097, Phone: 401 222-6015.

Q **Who can I contact at the Health Plan for information?** Representatives of this Health Plan are available to help you get the information you need. You can contact a Health Plan representative at:

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Member Services Representative
151 Farmington Avenue, Hartford, Connecticut 06156
Toll-Free: 1-800-872-3862
Para Contactar a un representante que hable Espanol, llame a:
Nombre del Representante del Plan: 1-800-533-6615

Q **How does the Health Plan Review and approve covered services?** A Health Plan may review covered services that are recommended by providers to decide if the services are medically necessary. If the plan decides the services is not medically necessary, it will not pay. You and your provider can appeal the Health Plan's decision.

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This plan only pays for covered dental expenses that are medically necessary and are not considered experimental or investigational. Charges for treatment of $150 or more will require advance claim review by Aetna before they will be considered covered dental expenses. All expenses not requiring predetermination are reviewed retrospectively, (post-service review). Written policies and criteria for medical necessity determinations of a service or supply are available from the Member Services Representative.

Q What if I have an emergency? An emergency is a problem that needs to be seen by a provider "right-away" to prevent permanent damage or death. Here's what this Health Plan wants you to do when you have an emergency health care problem, at home or out of state.

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In an emergency situation seek treatment immediately. Emergency care for dental services is defined as palliative treatment only.

Q Does the Health Plan require that I get a second opinion for any services? What if I want a second opinion? In some cases the Health Plan may require a second opinion before it will pay for a covered service. Or you may just want a second opinion on a plan for diagnosis or treatment.

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This plan does not require that you obtain a second opinion before it will pay for covered services. However, if you elect to obtain a second opinion, this plan will pay a portion of the charge for the dentist services as well as any x-ray and laboratory tests, but only if the dental procedure is covered under the plan.

Q How does the Health Plan make sure that my personal health information is protected and kept confidential? In general, personal health information must be kept confidential (private) by a Health Plan, its employees and agencies it contracts with. Here's how the Health Plan makes sure that personal health information is protected.

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This information cannot be disclosed without your consent. Subject to any applicable state or federal law, disclosure may be made without consent where necessary for the conduct of Aetna's business, to regulators of Aetna's business, or to law enforcement authorities to prevent or prosecute fraud or other illegal activities. Aetna employees are governed by these laws and the requirements in Aetna's Code of Conduct. Providers must agree to comply with all applicable state and federal laws.

Q How am I protected from discrimination? You have the right to be treated fairly and equally. Health Plans may not discriminate against you due to age, sex, religion, race or ethnic origin, disability, occupational status or any other characteristics protected by law.

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This plan does not discriminate against members or prospective members due to age, sex, religion, race, ethnic origin, disability, occupational status, or any other characteristic protected by state or federal law.

Q If I refuse treatment, will it affect my future treatment? A Health Plan must tell you what effect it will have on future coverage if you refuse to be treated for any condition.

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If you refuse treatment it will not affect coverage for any future treatment you may receive.

Q How does the health plan pay providers? Your Health Plan must tell you about the kinds of financial arrangements it has with providers.

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Participating dentists are compensated on a negotiated fee-for-service basis.

Q How is coverage renewed or canceled?

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Aetna, the policyholder or a member employer may cancel the policy, in whole or in part, at any time. Among other reasons, Aetna may also cancel the policy, in whole or in part, for failure by your employer to pay premiums. Your coverage will renew on the anniversary date of your employer's plan unless you choose another plan offered by your employer. Provisions of the plan, such as out-of-pocket costs, may change upon renewal. Your coverage may also cancel when your employment ceases, you are no longer in an eligible class, or you fail to make required contributions.

Q If I am covered by two or more health plans, what should I do? If you or a family member are covered by two or more Health Plans, you may have to give information on your coverage to each Health Plan. This helps the Health Plans to arrange payments between the plans when you or a family member receive a service. Here's what this plan will ask you to tell them.

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This plan contains a coordination of benefits provision. As a result, if you are covered by two or more health plans, benefits under the other plans may be taken into consideration when determining the benefits payable under this plan. This may mean a reduction in benefits under this plan. You must inform Aetna of the other coverage(s) that you have so that it can be determined whether or not, and to what extent this plan can coordinate benefits with the other plan(s).

Covered Services:

Single Service Health Plans (example: dental care, vision care) must provide you with standardized and easy-to-understand information about covered services – including out-of-pocket costs, service limitations and other things you need to know. Health Plans can do this through general information materials or by using a special insert summary called "Covered Services at a Glance." For more complete information, read the Official Plan Documents or contact a Health Plan Representative.

Dental PPO

COVERED SERVICES AT-A-GLANCE

Annual Deductible: **In-Network:** $25 - $200 (increments of $25) Applies to Type B Basic and Type C Major services.
Out-of-Network: $25 - $200 (increments of $25) Applies to Type B Basic and Type C Major services
Family Deductible Limit (In and Out of Network): 2x, 3x individual deductible

Type of Service (Not All Services are Listed Call plan or check Official Plan Documents for Details	Is Pre-Determination Required *(Yes/No)	What Out-of-Pocket Expenses Will I Have to Pay?	What Other Limitations Apply?	If I Choose a Non-Participating Provider Will the Service be Covered?
Preventive Services (Type A)	Yes, for treatment costing over $150.	Zero to 30% coinsurance	Routine exams two per calendar year; problem-focused exams two per calendar year. Two cleanings per calendar year. Two bitewing x-rays per calendar year. Calendar Year Maximum for Types A, B and C services: $750, $1000, $1500, $2000, $2500 (does not apply to Orthodontic Benefit).	Yes, Zero to 30% of the usual and prevailing charge after the deductible. -OR- Up to PPO negotiated fee(s) after the deductible.
Basic Services (Type B)	Yes, for treatment costing over $150.	Zero to 70% coinsurance	Calendar Year Maximum for Types A, B and C services: $750, $1000, $1500, $2000, $2500 (does not apply to Orthodontic Benefit).	Yes, Zero to 70% of the reasonable and customary charge after the deductible.
Major Services (Type C)	Yes, for treatment costing over $150.	40% to 70% coinsurance	Calendar Year Maximum for Types A, B and C services: $750, $1000, $1500, $2000, $2500 (does not apply to Orthodontic Benefit).	Yes, 40% to 70% of the usual and prevailing charge after the deductible.
Orthodontic Treatment	Yes	40% to 60% coinsurance	Lifetime maximums of $750, $1,000, $1500, $2000, $2,500.	Yes, 40% to 60% of the usual and prevailing charge after the deductible; lifetime maximums of $500, $750, $1,000, $1500, $2,000.
Emergency Services	No	N/A	Charges covered for initial visit for a Dental Emergency. Any subsequent visit related to the Dental Emergency will be covered	Out of Network expenses are covered at the In-Network coinsurance rates up to a maximum $75.

			the same as any other visit.	

Summary for consumer information only. This is not a contract.