

# Important disclosure information — New Hampshire

Dental Preferred Provider  
Organization (PPO)

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## Understanding your plan of benefits

Aetna Dental® PPO plans cover many dental services. However, they do not cover everything. Your plan documents list all the details for the plan you choose, including what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. Plan documents may include a Booklet-Certificate and/or any riders and updates that are included. If you can't find your plan documents, call Member Services at **1-877-238-6200 (TTY: 711)** to ask for a copy.

Covered services may include dental care provided by general dentists and specialist dentists. However, certain limitations may apply. For example, the dental plan excludes or limits coverage for some services including, but not limited to, cosmetic and experimental procedures.

The information that follows provides general information about Aetna Dental PPO/PDN plans. Members should consult their plan documents for a complete description of what dental services are covered and any applicable exclusions and limitations.

### **Not all of the information in this booklet applies to your specific plan**

Review your plan documents, ask your benefits administrator or call Aetna Member Services.

## 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 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. Just register once to create a user name and password.

Have your member ID card handy to register. Then visit **Aetna.com** and click on "Login." Then select "Register" and follow the prompts to complete the one-time registration.

Then you can log in anytime to:

- View and print your dental member ID card
- Verify who's covered and what's covered
- Access your plan documents
- Track claims or view past copies of your Explanation of Benefits statements
- Use the online provider search tool to find in-network care

#### **(2) Call Member Services at the toll-free number on your member ID card or toll free at 1-877-238-6200 (TTY: 711).**

You can speak with a representative to:

- 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 dental health information

#### **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.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. Dental benefits and dental insurance plans are underwritten by Aetna Dental Inc., Aetna Dental of California, Inc., Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.**

## Search our network for dental care providers

Use our online provider 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 **Aetna.com** and log in. From your member home page, select "Find Care" from the top menu bar and start your search.

**Those considering enrollment:** Visit **Aetna.com** and select "Find a doctor" on top of the home page. Then follow the steps under "Not a member yet?" to search for providers.

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
- Language spoken
- Gender
- Driving directions

### 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 (TTY: 711)**.

## Transition of care: when a dentist leaves the network

Our contracts are designed to provide transition of care if your treating dental care provider contract terminates.

- (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 nonparticipating 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:

- **Coinsurance** — Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) 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.

**Notice:** You must personally bear all costs if you use health care not authorized by this plan or purchase drugs that are not authorized by this plan.

## Your costs when you go outside the network

You may choose a dentist in our network. Or you may choose to visit an out-of-network dentist. We cover the cost of care based on whether the dentist is in network or out of network. We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

If you choose a dentist who is out of network, your Aetna dental plan may pay some of that dentist's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network dentist.

An **in-network** dentist is one with whom we have a contract. The dentist agrees to charge certain amounts for covered services. Those amounts are often less than they would be if the dentist was not in our network. Most of the time, it costs you less to use dentists in our network. Many plans pay a higher percentage of the bill if you stay in network. The dentist agrees not to bill you for any amount over the dentist's contract rate. All you have to pay is your coinsurance or copayments, along with any deductible.

## Going in network just makes sense

- We have negotiated discounted rates for you.
- In-network dentists won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

An **out-of-network** dentist is one with whom we do not have a contract. We don't know exactly what an out-of-network dentist will charge you. If you choose a dentist who is out of network, your Aetna dental plan may pay some of that dentist's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network dentist. Your out-of-network dentist sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes or allows. Your dentist may bill you for the dollar amount Aetna doesn't recognize.

You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount Aetna allows for a service or procedure.

## How we pay dentists who are not in our network

### PPO/PDN:

When you choose to see an out-of-network dentist, we pay for your health care using the prevailing or reasonable charge that we get from an industry database. This way of paying out-of-network dentists applies when you choose to get care out of network.

### PPO MAX/PDN MAX plans:

We use a fee schedule to pay both in-network and out-of-network dentists. In-network dentists have agreed to accept this fee. When you choose to see an out-of-network dentist, your coinsurance share of the bill is calculated based on the fee schedule (allowed amount) instead of the dentist's actual charge. Dentists will charge you the difference between what the plan allows and the actual charge for the service. You would owe this in addition to your normal share of the costs.

## Emergency and urgent care

If you need emergency dental care, you are covered 24 hours a day, 7 days a week, anywhere in the world. When emergency services are provided by a participating PPO/PDN dentist, your copayment/coinsurance amount will be based on a negotiated fee schedule.

Refer to your plan documents. This care is 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

You can avoid unexpected bills with a simple call to Member Services at **1-877-238-6200 (TTY: 711)** to find out what's covered before you receive the care.

We have developed a dental clinical review program to help 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 received the care. Only dental consultants who are licensed dentists make clinical determinations. We will notify you and your dentist if we deny coverage for any reason. The reason is stated on our notification. For more information about clinical reviews or any other topic, please call Member Services.

## 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 [Treasury.gov/resource-center/sanctions/pages/default.aspx](https://www.treasury.gov/resource-center/sanctions/pages/default.aspx).

## 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.

We will notify you in writing of the reason for claim denial.

You can call Member Services at **1-877-238-6200 (TTY: 711)** for further assistance. You can also send us an email through your member website at **Aetna.com**.

We will, of course, be available to you to discuss the position we have taken. The New Hampshire insurance department maintains a service division to investigate complaints at 21 South Fruit Street, Suite 14, Concord, New Hampshire 03301. You can call that division at **1-800-852-3416**.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, write to us at:

Dental Appeals Resolution Team  
PO Box 14597  
Lexington, KY 40512

We will notify you in writing of our decision on an expedited review within two business days.

### External review

An external review is a review done by people in an organization outside of Aetna. An outside organization is referred to as an external review organization (ERO). Sometimes, it's called an independent review organization (IRO).

You have a right to external review only if:

- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided that the service or supply is experimental or investigational
- You have received an adverse determination

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefits determination or final adverse benefits determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review form to the:

New Hampshire Department of Insurance  
Attn: Commissioner, External Review Unit  
21 Fruit Street, Suite 14  
Concord, New Hampshire 03301-7317

**1-800-852-3416** or **603-271-2261**

TDD Access: Relay **NH 1-800-735-2964**

### **NH.gov/insurance**

You must submit the form within 180 calendar days of the date you receive the decision from us, and you must include a copy of the notice from us and all other important information that supports your request.

The notice will include:

- Information about your right to request external review
- The New Hampshire “Consumer Guide to External Appeal” form
- The New Hampshire “Independent External Review” form

You may also submit a request for an external review if you have not received a decision from Aetna within the established time frames for:

- A first or second level appeal review
- A standard review of adverse benefits determinations
- An expedited appeal review

We will promptly provide you with a statement of your right to file an external review by:

- The expiration date of the time period for issuing the decision if Aetna does not render a decision within the established time frames
- The date you and Aetna agree to submit the adverse benefits determination to external review prior to completion of the internal review process

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The New Hampshire Department of Insurance will contact the ERO that will conduct the review of your claim.

## 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. Personal information also does not include reports that do not identify you.

### **Summary of the Aetna Privacy Policy**

When necessary for your care or treatment, or 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)

We obtain information from many different sources — particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

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 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. It also explains when we need your permission to use or 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 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 Member Services at **1-877-238-6200 (TTY: 711)**, or visit us at **Aetna.com**.

## Member rights

We publish a list of rights and responsibilities on our website. Visit **[Aetna.com/individuals-families/member-rights-resources.html](https://www.aetna.com/individuals-families/member-rights-resources.html)** to view the list. You can also call Member Services at **1-877-238-6200 (TTY: 711)** to ask for a printed copy.

### Patients' Bill of Rights

- I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b. Know your rights and responsibilities. Hospital staff must tell you or list them in writing before or when you are admitted. This does not include emergencies. You or someone on your behalf must acknowledge in writing that you received the information.
- II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments, the signing must be by the person legally responsible for the patient. Understand your medical condition, health care needs and any test results. Your doctor should tell you how and when you'll receive this information. You may help plan your total care and medical treatment. You can refuse treatment. You may give your consent to and be involved in experimental research.
- III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

- IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph, "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
- V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
- VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
- VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
- VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
- IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
- X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed \$15 for the first 30 pages or \$.50 per page, whichever is greater, provided that copies of filmed records such as radiograms, X-rays, and sonograms shall be copied at a reasonable cost.
- XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
- XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.



- XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients. Not perform services for the facility. They can give you tasks to perform as therapy or as a diversion if included in the plan for your care and treatment.
- XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients. The patient may participate in social, religious and community activities, as long as it does not violate the rights of other patients.
- XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
- XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, gender identity, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.
- XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
- XVIII. The patient shall be entitled to have the patient's parents, if a minor, or a spouse, next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
- XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
- XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
- XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network, and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

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 (TTY: 711). Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-877-238-6200 (TTY: 711).**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call **1-877-238-6200**.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

Phone: **1-800-648-7817, TTY: 711,**

Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 800-537-7697 (TDD)**.



TTY: 711

To access language services at no cost to you, call 888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 888-982-3862 . (Spanish)

Afin d'accéder aux services langagiers sans frais, composez le 888-982-3862 . (French)

如欲使用免費語言服務，請致電 888-982-3862 。（Chinese）

नःशुल्क भाषा सेवा प्राप्त ग 888-982-3862 मा टेलिफो ग् होस् । (Nepali)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 888-982-3862 . (Vietnamese)

Para acessar os serviços de idiomas sem custo para você, ligue para 888-982-3862 . (Portuguese)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 888-982-3862 . (Greek)

للحصول على الخدمات اللغوية دون تكلفة، الرجاء الاتصال على الرقم 888-982-3862 . (Arabic)

Za besplatne prevodilačke usluge pozovite 888-982-3862 . (Serbo-Croatian)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 888-982-3862 . (Indonesian)

무료 언어 서비스를 이용하려면 888-982-3862 번으로 전화해 주십시오. (Korean)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 888-982-3862 . (Russian)

Pou jwenn sèvis lang gratis, rele 888-982-3862 . (French Creole-Haitian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 888-982-3862 . (Bantu)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 888-982-3862 . (Polish)