Important information about your dental benefits

For the Dental Preferred Provider Organization (PPO) and Participating Dental Network (PDN) plans.

Understanding your plan of benefits

Your plan of benefits will be determined by your employer and underwritten and/or administered by Aetna Life Insurance Company (Aetna*), 151 Farmington Avenue, Hartford, CT 06156.

Aetna dental benefits plans cover a variety of dental services. 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.

Plan document names vary. They may include a Schedule of Benefits, Booklet, Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna Dental ID card. You may also get a copy of your Booklet-certificate by contacting your employer directly.

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

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator or call Aetna Member Services.

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

Texas

In Texas, the Preferred Provider Organization (PPO) plan is known as the Participating Dental Network (PDN). Please refer to the plan design overview and summary of benefits contained in your pre-enrollment packet for a brief description of the services and benefits covered under your particular plan, as well as those services and benefits that are excluded. After enrollment, you can refer to your plan documents for a more complete description of your covered services and benefits and the exclusions under your plan. For information on whether a specific service is covered or excluded, please contact Member Services at the toll-free number on your ID card.

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your Aetna Dental ID card. You can also send Member Services an e-mail. Just go to your secure member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Member Services can help you:

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- File a complaint or appeal
- Get copies of your plan documents
- Find specific dental health information
- And more

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Dental benefits and dental insurance plans are underwritten and/or administered by Aetna Life Insurance Company.

www.aetna.com

Hawaii
Insurance Division Telephone Number:
You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at: **1-808-586-2790.**

Maryland
For quality of care issues and life and health care insurance complaints, you may contact:

Aetna Dental Grievance and Appeals Unit
P.O. Box 14080
Lexington, KY 40512-4080
Toll-free phone: **1-877-238-6200**

or

Maryland Insurance Administration of Life and Health Insurance Complaints
200 Saint Paul Place, Suite 2700
Baltimore, MD 21202
Toll-free phone: **1-800-492-6116**
Local phone: **410-468-2244**
Fax: **410-468-2243**

For help resolving a billing or payment dispute with the dental plan or your dental care provider you may contact:

Aetna Dental Grievance and Appeals Unit
P.O. Box 14080
Lexington, KY 40512-4080
Telephone: **1-877-238-6200**

or

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
16th Floor 200 Saint Paul Place
Baltimore, MD 21202
Telephone: **410-528-1840**
Fax: **410-576-7040**

Nothing herein shall be construed to require the plan to pay counsel fees or any other fees or costs incurred by a member in pursuing a complaint or appeal.

Virginia
Important information about your insurance
If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

Aetna Life Insurance Company
P.O. Box 14080
Lexington, KY 40512-4597
Toll-free phone: **1-877-238-6200**

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Local Phone: **804-371-9691**
Fax: **804-371-9944**

The contact information, with the new name for the Center for Quality Health Care Services and Consumer Protection;

Office of Licensure and Certification
9600 Mayland Drive, Suite 401
Richmond, VA 23233-1463
Toll-free Phone: **1-800-955-1819**
Richmond Metropolitan Area: **804-367-2106**
Website: **www.vdh.virginia.gov/OLC/Complaints**

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company is regulated as a Managed Care Health Insurance Plan (MCHIP) and as such, is subject to regulation by both the Virginia State Corporation Commission Bureau of Insurance and the Virginia Department of Health.

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

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

Language hotline: **1-877-238-6200** *(140 languages are available. You must ask for an interpreter.)*

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: ***1-877-238-6200*** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

The Aetna network of dental care providers

You can choose to visit a dentist that participates in the Aetna Dental PPO/PDN network. Or you may visit any licensed dental care provider. The choice is yours. To find dental care providers in our network, visit **www.aetna.com** and click on Find a Doctor.

Georgia
Members can call **1-877-238-6200** (toll free) to confirm whether a dental provider is in the network and/or accepting new patients.

A summary of any agreement or contract between Aetna and any dental care provider will be made available upon request by calling the Member Services telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of provider under contract with Aetna.

Illinois
Not every participating dental provider listed will be accepting new patients. Although we have identified those providers who were not accepting patients as known to us at the time the Dental Directory was created, the status of the dental practice may have changed. For the most current information about the status change of any dental practice, please contact either the selected dentist or Member Services at the number on your ID card. You may get more information about the network, participating providers or our grievance procedures through the DocFind® directory at **www.aetna.com** or by calling **1-877-238-6200**.

Kentucky
Any dental care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Michigan
Contact the Michigan Department of Consumer and Industry Services at **517-373-0220** to verify participating providers' licenses or to access information on formal complaints and disciplinary actions filed or taken against participating providers.

Transition of Care When a Provider Leaves the Network
Our contracts are designed to provide transition of care for covered persons should the treating dental care provider contract terminate.

1. Participating dental care providers are contractually obligated for continued treatment of certain members after termination for any reason as outlined below:

   "Provider shall remain obligated at company's sole discretion to provide covered services to: (a) any member receiving active treatment from provider at the time of termination until the course of treatment is completed to company's satisfaction or the orderly transition of such member's care to another provider by the applicable affiliate of company; and (b) any member, upon request of such member or the applicable payor, until the anniversary date of such member's respective plan or for one (1) calendar year, whichever is less. The terms of this agreement shall apply to such services."
2. In cases of provider termination, in order to allow for the transition of members with minimal disruption to participating providers, Aetna may permit a member who has met certain requirements to continue an "Active Course of Treatment" for covered benefits with a non-participating provider for a transitional period of time without penalty subject to any out-of-pocket expenses outlined in the member's plan design.

Costs and rules for using your plan

What you pay

You will share in the cost of your dental care. These are called "out-of-pocket" costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- Copay – A 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's office visit may be different than a specialist's office visit.
- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount.

- Deductible – Some plans include a deductible. This is the amount you owe for dental care services before your dental plan begins to pay. For example, if your deductible is $100, your plan won't pay anything until you have paid $100 for any covered dental care services that are subject to the deductible.

Your costs when you go outside the network
You may choose a dentist in our network. You may choose to visit an out-of-network dentist. We cover the cost of care based on if 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.

"In network" – This means we have a contract with that dentist. He agrees to how much he will charge you for covered services. That amount is often less than what he would charge if he was not in our network. Most of the time it costs you less to use doctors in our network. Many plans pay a higher percentage of the bill if you stay in network. The dentist agrees he won't bill you for any amount over his contract rate. All you have to pay is your coinsurance or copayments, along with any deductible.

"Out of network" means that we do not have a contract for discounted rates with that dentist. 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 that 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 that you are fully responsible for paying everything above the amount that 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, Aetna pays for your health care using "prevailing or reasonable" charge that we get from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used. 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.

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.

To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

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.

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 — just by calling the toll-free number on your Aetna Dental ID card.

* Refer to your plan documents. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

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 the number on your Aetna Dental ID card.

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

Call Member Services to file a verbal complaint or to ask for the appropriate address to mail a written complaint. The phone number is on your Aetna Dental ID card. You can also e-mail Member Services through the secure member website.

If you're not satisfied after talking to a Member Services representative, you can ask that your issue be sent to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, write to us at the address that applies to where you live:

- Northeast Territory – includes Mid-Atlantic and North-Eastern states (CT, DE, DC, IL, IN, KY, ME, MD, MA, MI, NH, NJ, NY, OH, PA, RI, VA, VT, WV, WI)

  Aetna Dental Grievance and Appeals Unit
  P.O. Box 14080
  Lexington, KY 40512-4080

- South Territory – (AL, AR, FL, GA, LA, MS, NC, OK, SC, TN, TX)
  Aetna Dental Grievance and Appeals Unit
  P.O. Box 14597
  Lexington, KY 40512-4597

- West Territory – (AK, AZ, CA, CO, HI, IA, ID, KS, MN, MO, MT, ND, NE, NV, NM, OR, SD, UT, WA, WY)

  Aetna Dental Grievance and Appeals Unit
  P.O. Box 10462
  Van Nuys, CA 91410

Link to your state insurance department website
Visit the National Association of Insurance Commissioners (NAIC) at **www.naic.org**.

The complaint and appeal processes can be different depending on your plan and where you live. Some states have laws that include their own processes. So it's best to check your plan documents or talk to someone in Member Services to see how it works for you.

Kentucky appeals process

1. As a member of Aetna, you have the right to file an appeal about service(s) you have received from your dental care provider or Aetna, when you are not satisfied with the outcome of the initial determination and the request is about a change in the decision for:
   - Certification of health care services
   - Claim payment
   - Plan interpretation
   - Benefit determination
   - Eligibility
2. You or your authorized representative may file an appeal within 180 days of an initial determination. You may contact Member Services at the number listed on your identification card.
3. A Customer Resolution Consultant will acknowledge the appeal within five (5) business days of receipt. A Customer Resolution Consultant may call you or your dental care provider for dental records and/or other pertinent information.
4. Our goal is to complete the appeal process within 30 days of receipt of your appeal. An appeal file is reviewed by an individual who was neither involved in any prior coverage determinations related to the appeal nor a subordinate of the person who rendered a prior coverage determination. A dentist or other appropriate clinical peer will review clinical appeals. A letter of resolution will be sent to you upon completion of the appeal. It is important to note that it is a covered member's right to submit new clinical information at any time during the appeal of an adverse determination or coverage denial to an insurer or provider.
5. If the appeal is for a decision not to certify urgent or ongoing services, it should be requested as an expedited appeal. An example of an expedited appeal is a case where a delay in making a decision might seriously jeopardize the life or health of the member or jeopardizes the member's ability to regain maximum function. An expedited appeal will be resolved within 72 hours. If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

6. If you are dissatisfied with the outcome of a clinical appeal and the amount of the treatment or service would cost the covered individual at least $100.00 if they had no insurance, you may request a review by an external review organization (ERO). The request must be made within 60 days of the final internal review. A request form will be included in your final determination letter. It can also be obtained by calling Member Services. A decision will be rendered by the ERO within 21 calendar days of your request. An expedited process is available to address clinical urgency. If you disagree with the decision regarding your right to an external review, you may file a complaint with the Kentucky Department of Insurance.
7. As a member, you may, at any time, contact your local state agency that regulates health care service plans for complaint and appeal issues, which Aetna has not resolved or has not resolved to your satisfaction. Requests may be submitted to:

   Kentucky Department of Insurance
   P.O. Box 517
   Frankfort, KY 40602-0517
8. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your plan administrator, your local U.S. Department of Labor Office and your state insurance regulatory agency.

We protect your privacy

We consider 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 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** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Hawaii

Informed Consent:

Members have the right to be fully informed when making any decision about any treatment, benefit or nontreatment. Your dental provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits and consequences to treatment and nontreatment

Kansas

Kansas law permits you to have the following information upon request:

- A complete description of the dental care services, items and other benefits to which the insured is entitled in the particular dental plan that is covering or being offered to such person
- A description of any limitations, exceptions or exclusions to coverage in the dental benefit plan, including prior authorization policies or other provisions that restrict access to covered services or items by the insured
- A listing of the plan's participating dental care providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider
- Notification in advance of any changes in the dental benefit plan that either reduces the coverage or benefits or increases the cost, to such person
- A description of the grievance and appeal procedures available under the dental benefit plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

Washington State

The following materials are available: any documents referred to in the enrollment agreement; any applicable preauthorization procedures; dentist compensation arrangements and descriptions of and justification for provider compensation programs; circumstances under which the plan may retrospectively deny coverage previously authorized.

Notes