Member handbook and consumer disclosure

Important information about your health benefits

For Individual 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.

Important disclosure information

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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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 choose. 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, Contract and/or any riders and updates that come with them. You'll find a summary of plan benefits and exclusions when you enroll. 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 (TTY: 711)** to ask for a copy.

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:

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 marcar **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.

(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.

Visit Aetna.com and click "Log In." Follow the prompts to create a username and password.

Then you can log in anytime 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 (EOB) statements
- Use the online provider search tool to find network care

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(2) Call Customer Service at the toll-free number on your Aetna 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
- 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
- You can also write to: PO Box 14094
  Lexington, KY
  40512-4094

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 visit Aetna.com.

Covered benefits

This plan does not cover all dental care expenses and includes exclusions and limitations. If you're unable to undergo dental treatment in a dental office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by your physician or by the dentist providing the dental care, you may be covered under your health benefits plan.

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.

If you're already a member, you may call us toll-free at 1-877-238-6200 (TTY: 711).

For the purpose of coverage, except for an emergency situation, 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 document.

- 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.

Though not required to receive coverage, helpful steps to take should you need emergency care are as follows:

(1) If possible, try calling 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 usual and customary rate or an agreed rate. 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.

You can ask for approval to get the in-network level of benefits when a network dentist is not available within 75 miles for covered services. Call Member Services for help finding an available dentist in the network. If none are available, Member Services can authorize you to receive services from a dentist outside the network. Your out-of-pocket costs will be the same as if you received services in the network.

In addition, please note that when you receive services from an out-of-network facility-based provider in a network facility, you will be held harmless. In this circumstance, we will reimburse the out-of-network facility-based provider at the usual and customary rate, and you will not owe any amounts beyond the copayment or other out-of-pocket amounts you would have paid had facility-based provider also been in-network.

Your financial responsibility

You are responsible for all applicable 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 differ from that for a specialist's office visit.

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. If you receive a balance bill, please contact us by calling the number on the back of your ID card.

After determining that a claim from a non-network physician or provider for services provided is payable, we must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by Aetna and the non-network physician or provider. If the rate was not agreed to by the physician or provider, Aetna must provide an explanation of benefits to you that includes a statement that our payment is at least equal to the usual and customary rate for the service.

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 not covered in whole or in part by any part of your plan documents.

(2) Services and supplies to diagnose or treat a disease or injury that is not a nonoccupational disease or a nonoccupational injury.

(3) Services not listed in the Dental Care Schedule, unless otherwise specified in the plan documents.

(4) Replacement of a lost, missing or stolen appliance, or the 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) 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). This includes the use of dentures, crowns, inlays, onlays, bridgework or any other appliance or service if they are used only for the purposes mentioned above.

(7) 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 planning in a single office visit, unless necessary due to the need for premedication, 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

iv. Prosthetic replacement dependent on severely compromised abutment teeth

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

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

(10) Orthodontic treatment, unless otherwise specified in your plan documents.

(11) 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.

(12) Treatment by someone 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.

(13) 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

ii. The tooth is an abutment to a covered partial denture or fixed bridge

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

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

(16) Services needed solely in connection with noncovered services.

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

(18) 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, covered services include those for services and supplies that are:

- 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.
- Furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.)

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.

- Regarding a denture: impressions have been taken from which the denture will be prepared.
- Regarding a root canal: the pulp chamber was opened.
- Regarding 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; 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.

Visit **Treasury.gov/resource-center/sanctions/Pages/default.aspx** for more information on U.S. trade sanctions.

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 document or call **1-877-238-6200 (TTY: 711)**.

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.

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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 dentists. 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 member website at **Aetna.com**.

The complaints and appeals process is described below:

Definitions

Aetna Member Services: You or your authorized representative may obtain assistance or additional information by contacting Member Services at **1-877-238-6200** (TTY: **711**).

Authorized representative: You may authorize another person to act as your representative in the complaint process

Benefits 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 benefits exclusions or limitations, not related to medical necessity and/or experimental and investigational procedures.

Complaint: Any dissatisfaction expressed orally or in writing by a complainant to Aetna regarding any aspect of our 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.

How to file a complaint

Written complaints: You may mail your concerns or inquiries to:

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 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 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 Complaint 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 Complaint Appeal Panel

You may appear in person, by phone or 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, and the response 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 dental specialist may interview the member or the member's representative and shall decide the appeal. They will not have been involved in reviewing and making decisions regarding the case at any prior level of determination and will have the same or similar specialty as the provider who would typically manage the dental 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 12030
Austin, Texas 78711-2030
Phone: **1-800-252-3439**
Fax: **512-490-1007**
Web: 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** (TTY: **711**).

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 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 website home page, select "Find Care" from the top menu bar and start your search.

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
- Specialty
- 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)**.

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at **http://www.tdi.texas.gov"www.tdi.texas.gov** or by calling **800-252-3439**.

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List of doctors

You can get a directory of health care providers that are in your plan's network.

You can get the directory online at **http://www.aetna.com"www.aetna.com** or by calling the toll-free number on your ID card.

If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at **tdi.texas.gov**.

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Aetna Dental DMO plan service area

In order to be eligible to receive benefits covered by the DMO, you must live or work within the service area. To view the most recent access filing information, go to **Aetna.com/dsepublicContent/assets/html/content.html?resource=texas-network-adequacy.** The following Texas counties are in the service area.

Anderson
Andrews
Angelina
Aransas
Archer
Atascosa
Austin
Bandera
Bastrop
Bee
Bell
Bexar
Blanco
Bosque
Bowie
Brazoria
Brazos
Brooks
Burleson
Burnet
Caldwell
Calhoun
Cameron
Camp
Cass
Chambers
Cherokee
Clay
Coke
Collin
Colorado
Comal
Cooke
Coryell
Crosby
Dallas
Delta
Denton
DeWitt
Dickens
Dimmit
Donley
Duval
Eastland
Ector
El Paso
Ellis
Erath
Falls
Fannin
Fayette
Floyd
Fort Bend
Franklin
Freestone
Gaines
Galveston
Gillespie
Goliad
Gonzales
Grayson
Gregg
Grimes
Guadalupe
Hale
Hardin
Harris
Harrison
Hays
Henderson
Hidalgo
Hill
Hockley
Hood
Hopkins
Houston
Howard
Hunt
Hutchinson
Jack
Jackson
Jasper
Jeff Davis
Jefferson
Jim Wells
Johnson
Jones
Karnes
Kaufman
Kendall
Kenedy
Kerr
Kimble
Kleberg
Lamar
Lamb
Lampasas
Lee
Leon
Liberty
Limestone
Live Oak
Llano
Lubbock
Madison
Martin
Mason
Matagorda
Maverick
Mcculloch
Mclennan
Medina
Midland
Milam
Mitchell
Montague
Montgomery
Morris
Nacogdoches
Navarro
Newton
Robertson
Rockwall
Runnels
Swisher
Tarrant
Taylor
Waller
Washington
Webb
Nueces
Ochiltree

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Oldham
Orange
Palo Pinto
Panola
Parker
Polk
Potter
Rains
Randall
Red River
Refugio
Rusk
Sabine
San Jacinto
San Patricio
San Saba
Shelby
Smith
Somervell
Starr
Stephens
Sterling
Terry
Titus
Tom Green
Travis
Trinity
Tyler
Upshur
Uvalde
Van Zandt
Victoria
Walker
Wharton
Wichita
Willacy
Williamson
Wilson
Wise
Wood
Young
Zavala

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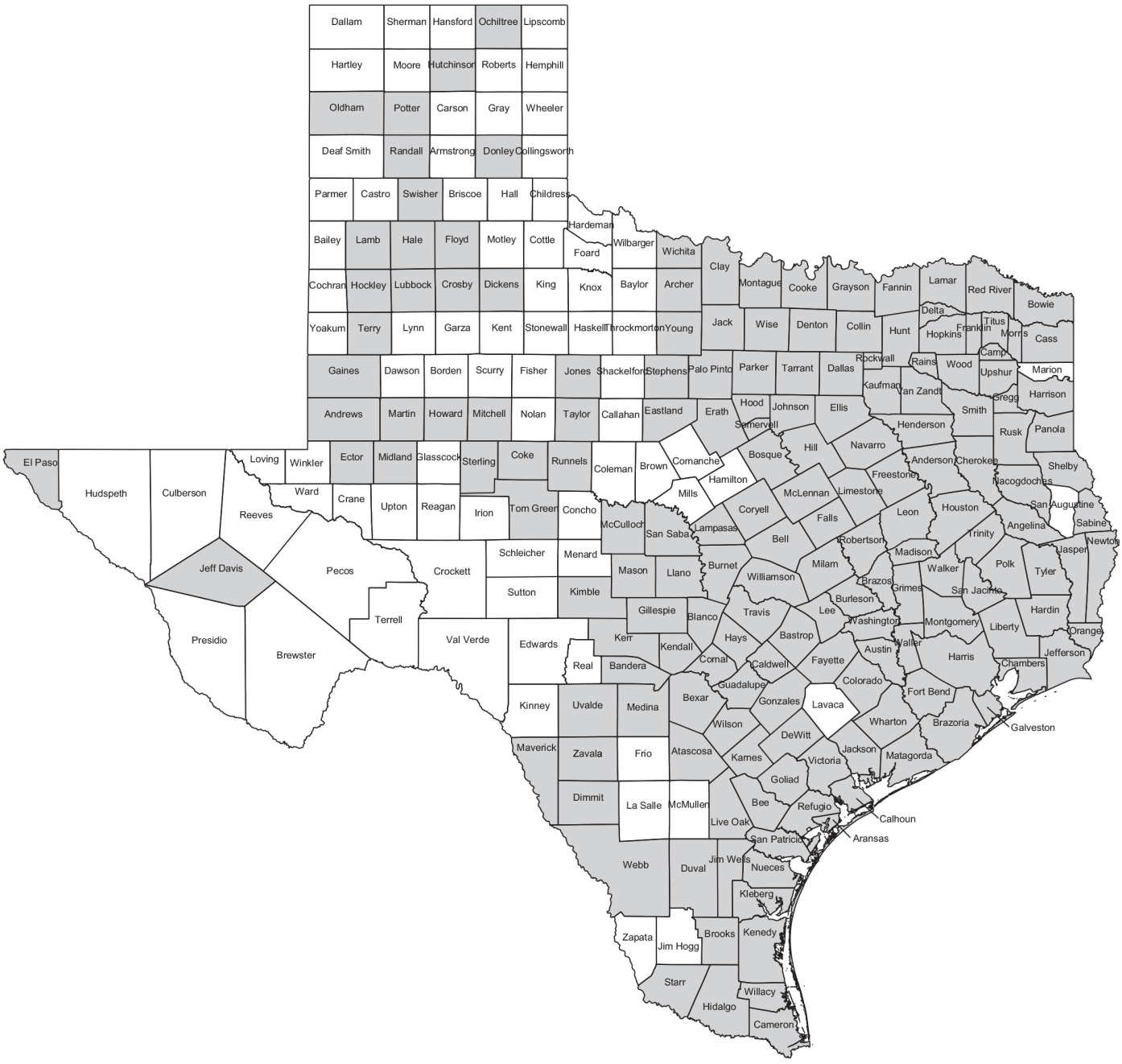
Aetna Dental DMO plan service area



Choose a primary care dentist (PCD)

You should 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.

Member rights

We publish a list of rights and responsibilities on our website. Visit **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)**.

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)

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.

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Call the toll-free number on your ID card or visit us at **Aetna.com** for more information about our privacy notice or if you'd like a copy of it.

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.

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aetna®

TTY: **711**

English	**To access language services at no cost to you, call** (888) 982-3862 .
Amharic	እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ ወደ (888) 982-3862 ይደውሉ።
Arabic	للحصول على خدمات اللغة مجانًا، اتصل على (888) 982-3862
Armenian	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք հեռախոսահամարով: (888) 982-3862
Carolinian (Kapasal Falawasch)	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye (888) 982-3862 .
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang (888) 982-3862 .
Chinese Traditional	如欲使用免費語言服務，請致電 (888) 982-3862 .
Cushitic-Oromo	Tajaajila afaanii bilisaan argachuuf, (888) 982-3862 irratti bilbilaa.
French	Afin d'accéder aux services langagiers sans frais, composez le (888) 982-3862 .
French Creole (Haitian)	Pou w jwenn aksè ak sèvis lang gratis pou ou, rele (888) 982-3862 .
German	Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie (888) 982-3862 an.
Greek	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό (888) 982-3862 .
Gujarati	તમારે કોઇ તના ખર્ચ વના ભાષાની સેવાઓની પહચ માટે, કોલ કરો (888) 982-3862 .
Hindi	आपके लए बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, (888) 982-3862 पर कॉल करे।
Hmong	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu (888) 982-3862 .
Italian	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (888) 982-3862 .
Japanese	無料の言語サービスをご利用いただくには、(888) 982-3862 にお電話ください。
Karen	လၢကမၤန့ၢ် ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၢတလိၣ်လၢာ်ဘူၣ်လၢာ်စ့ၤ လၢနဂီၢ်အဂီၢ်, (888) 982-3862 .
Korean	무료로 언어 서비스를 이용하려면 (888) 982-3862 번으로 전화하세요
Laotian	ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ, ໃຫ້ໂທຫາ (888) 982-3862 .
Mon-Khmer, Cambodian	ដើម្បីទទួលនេសវាផ្នែកភាសាដោយមិនគិតថ្លៃពីអ្នកសូមទូរសព្ទទេលខ (888) 982-3862 ។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojį' hólne' (888) 982-3862 .
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff (888) 982-3862 .
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره (888) 982-3862 تماس بگیرید.
Polish	Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer (888) 982-3862 .
Portuguese	Ligue para (888) 982-3862 para receber assistência linguística gratuita.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, (888) 982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Чтобы получить бесплатные языковые услуги, позвоните по номеру (888) 982-3862 .
Samoan	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le (888) 982-3862 .
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite (888) 982-3862 .
Spanish	Para acceder a los servicios de idiomas sin costo, llame al (888) 982-3862 .
Syriac-Assyrian	ܡܛܠ ܚܠܝܐ ܐܬܘܪܝܐ ܕܡܫܬܡܫܬ ܠܐ ܡܓܢܐ ܚܠܘܦ ܟܠ ܡܘܪܢܐ: ܩܪܝ ܒܗܘ (888) 982-3862 .
Tagalog	Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tumawag sa (888) 982-3862 .
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร (888) 982-3862 .
Ukrainian	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером (888) 982-3862 .
Vietnamese	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số (888) 982-3862 .