West Virginia — Aetna Dental® Network Access Plan

This manual will help you understand your dental plan's provider network and related topics.

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Aetna Dental
Network Access Plan

1. Introduction

The West Virginia Office of Insurance Commissioner (OIC) has licensed Aetna Life Insurance Company as a life, accident and health and disability insurance company.

The OIC requires us to provide you with this Aetna Dental Network Access® Plan for your Aetna dental network (DMO or PPO). It has important information about your dental plan's provider network and related topics. This material is for information only. It is neither an offer of coverage nor medical advice. It is not a contract of insurance.

This Aetna Dental Network Access Plan is for the DMO and PPO products.

Why use in-network providers?
You pay less out of pocket when you use providers in our network. Some plans do not cover out-of-network services, while others require you to pay a larger share of out-of-network costs. We negotiate discounted rates for covered health care services. This means when you get covered dental services from an in-network provider, they won't bill you for costs above their contracted rates.

Also, we strive to build our network with high quality providers. This improves the health care experience for all. And members find it easy to get the care they need.

To learn more about your network, just visit **Aetna.com**. You may also call us at **1-877-238-6200**. (TTY: 711)

You can get a printed copy of this access plan. Just call us at **1-877-238-6200**. (TTY: 711)

2. Your provider network

Provider directories
Aetna provides you with an online provider search tool. We update it whenever changes occur. You can also get a printed provider directory upon request. Just call us at **1-877-238-6200**. (TTY: 711)

How we build your network
We make sure there is a broad range of qualified providers in the network. This helps ensure you can safely and easily get the care you need.

Before we accept dental providers, they must meet our high standards, accept our reimbursement rates and agree to your plan's policies and procedures. Each provider goes through a thorough credentialing process, which includes reviewing the provider's:

- Licensure
- Drug Enforcement Agency certification
- Academic background and training
- Certifications
- Sanction history and malpractice claims history
- Malpractice insurance
- Access and availability
- Cost efficiency

All of this information is rechecked every three years. And we're always monitoring other quality indicators such as:

- State licensure board sanctions
- Loss of license
- Office of personnel management/office of inspector general reports
- Medicare opt outs
- Potential quality of care concerns (member complaints and internally identified events)

3. Monitoring network adequacy

We strive to make sure your provider network has enough licensed dentists (primary care and specialty care). The network must conveniently and safely meet members' needs. It must also meet West Virginia Office of Insurance Commissioner standards. We are always assessing network adequacy. We will add more providers when needed. We assess the:

- Ratio of providers to members — there are enough providers for the number of members in the plan
- Geographic distribution — participating providers are reasonably close to members
- Appointment availability — service and wait times are reasonable

As of June 2020, the Aetna Dental West Virginia networks include:

- DMO: 16 primary care dentists
  3 specialty care dentists
- PPO: 358 primary care dentists,
  48 specialty care dentists

Standards for distance and wait time
We routinely measure the adequacy of your provider network. We compare it to Aetna and state standards for acceptable driving distances and appointment wait times. When you cannot get an in-network appointment within the distance or wait time standards, we will cover an out-of-network provider at your in-network benefit levels. See the section titled "Referrals for out-of-network care", on page 3.

Tele-dentistry
For tele-dentistry services, we provide the same benefit as if you went to the provider's office. This helps to meet the needs of members and provide access to health care services.

4. Monitoring network quality

The quality program monitors the quality and safety of clinical care and services to members.

We continue to monitor and improve access to providers. Every year, we measure and analyze:

- Geographic distribution of providers
- Member-to-practitioner ratios
- Member complaints and surveys
- Provider surveys
- Tracking and trending of data relating to the network

We review counties where members don't have easy access to care. And we try to identify other providers for recruitment.

5. Referrals for in-network specialist care

Specialist referrals within the provider network
In some of our dental plans, you need a referral from your primary dentist to get care from a specialist in the network. Refer to your plan documents to see:

- If you need to select a primary care dentist (PCD)
- Whether a PCD referral for specialist care is required

If you need a referral, contact your PCD before you get services from a dental specialist.

You can find network specialists by using our **online provider search tool**. It has the most up-to-date list of network dental providers. Members and providers can search the tool at **Aetna.com**. Or you can log in to your Aetna member website. If you don't have access to a computer, just call us at **1-877-238-6200 (TTY: 711)** for help. That's also the number to call for a printed provider directory.

6. Referrals for out-of-network care

Sometimes your plan might not have a provider for a covered benefit. Or perhaps no network dentist can provide the service you need within a reasonable timeframe. In such cases, your primary care Dentist (PCD) can ask for approval so you can get the service from a non-participating provider. Your cost will be the same as if you received services from a network provider.

If you use an out-of-network provider, you must get approval from us first. If you don't, we may reduce your benefits, or we may not pay any benefits.

We cannot deny or change a referral that we have approved once you get care, except for fraud or abuse.

7. Understanding your plan of benefits

Aetna DMO plans cover many dental services. However, they do not cover everything. Your plan documents list all the details for the plan you choose. This includes 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, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy 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. You can also get a copy of the Certificate of Coverage by contacting your employer directly.

8. Grievances and appeals

Aetna has many licensed dentists on staff. If we deny coverage, one of our dentists must review the decision. When Aetna issues a clinical denial, we send a detailed letter to you and your provider.

If you or your provider disagree with a clinical denial, you have the right to send us a grievance or appeal. You can

also do this if you have a complaint about any other aspect of your coverage. Details on how to do this are in your plan documents. You may also refer to your individual policy, group member certificate and your Summary of Benefits and Coverage. Grievance and appeal information is also on our website, and on the Explanation of Benefits (EOB) you get after we process your claims.

9. Coordination and continuity of care

Keeping the provider you go to now (continuity of care)

You may have to find a new provider when you:

- Join our plan and your current provider is not in our network
- Are already a member and your provider leaves our network

In these situations, you might have the right to continue with the same provider. For example, you might need to:

- Continue a course of treatment already underway
- Continue with a new course of treatment already scheduled

New members continuing treatment with an out-of- network provider

When you join an Aetna plan, you may already be in an active course of treatment with a provider who is not in your Aetna network. In such cases, we may provide "transition of care" benefits. This will give you temporary coverage with the out-of-network provider. During this transition, we will help you transfer to a network specialty provider (if you want ongoing in-network coverage).

Current members seeing a provider who is leaving the network

Sometimes a provider leaves your network. In such cases, providers will continue to care for you for a limited time after they leave. When this happens, we send affected members a letter to let them know the provider is leaving. We also help members select a new PCD or practice site. If the provider is a specialist, the letter will ask you to have your PCD contact Aetna for more help.

If you are already an Aetna member in an active course of treatment with a network provider who is leaving, we provide coverage for continuation of care, up to and including:

- For an active course of treatment that includes a member having undergone treatment, or having been seen at least once in the last 12 months as long as the member has not been released from treatment.

Once approved for continuation of care coverage, the care period ends when:

- You or the treating provider stop your treatment
- You reach 90 days from the date your original provider leaves (unless our dental director feels a longer period is necessary)
- Care is successfully transitioned to a new network provider
- You meet or exceed your benefits for that type of care
- Care is no longer necessary

Whichever occurs first.

Changing your PCD

You can change your PCD at any time. Just call us at **1-877-238-6200 (TTY: 711)**. Or visit your secure member website at **Aetna.com**.

Hold harmless

Our contracts have a "hold harmless" provision. It prevents network providers from balance billing you if the insurer is insolvent or can't continue operations.

10. Members with special communication needs

Access and accessibility of services of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds and with physical or mental disabilities

Members with limited English proficiency, physical or mental disabilities: Aetna uses Language Line, an interpretation service, to address the needs of enrollees with limited English proficiency. Language Line offers 24/7 over-the-phone interpretation in over 200 languages. EOB statements and other correspondence generated through the claims and appeal process provide notice that translation services are available. And Aetna's member disclosure information (available to members on our public website as well as in enrollment packets) includes a notice that language services are available for members who speak another language or are hearing impaired.

For hearing-impaired or speech-disabled individuals, Aetna uses a relay service. The relay service acts as an intermediary for telecommunications between hearing individuals and individuals who are deaf, hard of hearing, deaf-blind and/or have speech disabilities. We have specially trained communication assistants who complete the calls and stay online to relay messages either:

- Electronically over a teletypewriter (TTY) or telecommunications device for the deaf (TDD) or
- Verbally to hearing parties

Aetna doesn't consider the member's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when providing access to care. Aetna and network providers must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

If a member chooses to provide certain information about race, ethnicity and languages spoken, it may help to improve access to health care and better serve a member. All information that a member provides is private. The member disclosure document addresses privacy and access to health care in more detail.

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, sexual orientation, 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 the number on your ID card.

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: P.O. Box 24030 Fresno, CA 93779), **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, 1-800-537-7697 (TDD)**.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Aetna Health Inc. and their affiliates (Aetna). Each insurer has sole financial responsibility for its own products.

TTY:711

English	To access language services at no cost to you, call the number on your ID card.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة الهوية الخاصة بك.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
Nepali	भाषासम्बन्धी सेवाहरूमाथि नि:शुल्क पहुँच राख् आफ्नो कार्डमा रहेको म्बरमा कल गनुहोस्।
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره ذکر شده روی کارت شناسایی خود تماس بگیرید.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Yoruba	Láti ráyèsí àwọn iṣẹ́ èdè fún ọ lọ́fẹ̀ẹ́, pe nọ́mbà tó wà lórí káàdì ìdánimọ̀ rẹ.