

Small Business Solutions

Dental Benefits and Insurance Plan Options

Georgia



We want you to knowSM



AETNA SMALL GROUP DENTAL PLANS

DMO®/PPO PLAN OPTIONS

| Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees Available Without an Aetna Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees | Plan Option 1 DMO Fixed Copay Plan 64 | Plan Option 2 Freedom-of-Choice — Monthly selection between the DMO and the PPO Max | | Plan Option 3 Freedom-of-Choice — Monthly selection between the DMO and the PPO | | |
|--|---|--|---------------------------|--|-------------------------|--------------------|
| | MEMBER BENEFITS | DMO Fixed Copay Plan 64** | DMO Fixed Copay Plan 64** | PPO Max Plan 100/70/40 | DMO Plan 100/90/60 | PPO Plan 100/70/40 |
| Office Visit Copay | \$5 | \$5 | N/A | \$5** | N/A | |
| Annual Deductible per Member (does not apply to Diagnostic & Preventive Services) | None | None | \$50; 3x Family Maximum | None | \$50; 3x Family Maximum | |
| Annual Maximum Benefit | Unlimited | Unlimited | \$1,000 | Unlimited | \$1,000 | |
| DIAGNOSTIC SERVICES | | | | | | |
| Oral Exams | | | | | | |
| Periodic oral exam | No Charge | No Charge | 100% | 100% | 100% | |
| Comprehensive oral exam | No Charge | No Charge | 100% | 100% | 100% | |
| Problem-focused oral exam | No Charge | No Charge | 100% | 100% | 100% | |
| X-rays | | | | | | |
| Bitewing — single film | No Charge | No Charge | 100% | 100% | 100% | |
| Complete series | No Charge | No Charge | 100% | 100% | 100% | |
| PREVENTIVE SERVICES | | | | | | |
| Adult cleaning | No Charge | No Charge | 100% | 100% | 100% | |
| Child cleaning | No Charge | No Charge | 100% | 100% | 100% | |
| Sealants — per tooth | No Charge | No Charge | 100% | 100% | 100% | |
| Fluoride application — with cleaning | No Charge | No Charge | 100% | 100% | 100% | |
| Space maintainers — fixed | \$75 | \$75 | 100% | 100% | 100% | |
| BASIC SERVICES | | | | | | |
| Amalgam filling — 2 surfaces | \$12 | \$12 | 70% | 90% | 70% | |
| Resin filling — 2 surfaces, anterior | \$21 | \$21 | 70% | 90% | 70% | |
| Oral Surgery | | | | | | |
| Extraction — exposed root or erupted tooth | \$11 | \$11 | 70% | 90% | 70% | |
| Extraction of impacted tooth — soft tissue | \$46 | \$46 | 70% | 90% | 70% | |
| MAJOR SERVICES* | | | | | | |
| Complete upper denture | \$275 | \$275 | 40% | 60% | 40% | |
| Partial upper denture | \$275 | \$275 | 40% | 60% | 40% | |
| Crown — Porcelain with noble metal | \$255 | \$255 | 40% | 60% | 40% | |
| Pontic — Porcelain with noble metal | \$255 | \$255 | 40% | 60% | 40% | |
| Inlay — Metallic (3 or more surfaces) | \$195 | \$195 | 40% | 60% | 40% | |
| Oral Surgery | | | | | | |
| Removal of impacted tooth — partially bony | \$58 | \$58 | 40% | 60% | 40% | |
| Endodontic Services | | | | | | |
| Bicuspid root canal therapy | \$109 | \$109 | 40% | 90% | 40% | |
| Molar root canal therapy | \$280 | \$280 | 40% | 60% | 40% | |
| Periodontic Services | | | | | | |
| Scaling & root planing — per quadrant | \$51 | \$51 | 40% | 90% | 40% | |
| Osseous surgery — per quadrant | \$300 | \$300 | 40% | 60% | 40% | |
| ORTHODONTIC SERVICES* | | | | | | |
| Orthodontic Lifetime Maximum | Does not apply | Does not apply | Does not apply | Does not apply | Does not apply | |

* Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1, 2 & 3.

** Dollar amounts indicated are member responsibility.

Access to negotiated discounts: On the PPO plans in Plan Options 2-6, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1, 2 & 3.

Plan Options 2 & 4; PPO Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

The DMO in Plan Option 1 can be offered with any one of the PPO plans in Plan Options 4-6 in a Dual Option package.

Options 1 & 2 DMO Copay Plan 64 amounts listed are the total patient responsibility for the services indicated. The \$5 Office Visit Copay is additional.

Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only in Plan Options 1, 2, 3 & 5 or adults and children in Plan Option 6.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

For a summary list of Limitations and Exclusions, refer to page 5.

AETNA SMALL GROUP DENTAL PLANS

DMO®/PPO PLAN OPTIONS

| <p>Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees</p> <p>Available Without an Aetna Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees</p> | <p>Plan Option 4 PPO Max</p> | <p>Plan Option 5 Passive PPO 1500</p> | <p>Plan Option 6 Passive PPO 2000</p> |
|---|---|--|--|
| MEMBER BENEFITS | PPO Max Plan 100/80/50 | PPO Plan 100/80/50 | PPO Plan 100/80/50 |
| Office Visit Copay | N/A | N/A | N/A |
| Annual Deductible per Member (does not apply to Diagnostic & Preventive Services) | \$50; 3x Family Maximum | \$50; 3x Family Maximum | \$50; 3x Family Maximum |
| Annual Maximum Benefit | \$1,500 | \$1,500 | \$2,000 |
| DIAGNOSTIC SERVICES | | | |
| Oral Exams | | | |
| Periodic oral exam | 100% | 100% | 100% |
| Comprehensive oral exam | 100% | 100% | 100% |
| Problem-focused oral exam | 100% | 100% | 100% |
| X-rays | | | |
| Bitewing — single film | 100% | 100% | 100% |
| Complete series | 100% | 100% | 100% |
| PREVENTIVE SERVICES | | | |
| Adult cleaning | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | 100% |
| Sealants — per tooth | 100% | 100% | 100% |
| Fluoride application — with cleaning | 100% | 100% | 100% |
| Space maintainers — fixed | 100% | 100% | 100% |
| BASIC SERVICES | | | |
| Amalgam filling — 2 surfaces | 80% | 80% | 80% |
| Resin filling — 2 surfaces, anterior | 80% | 80% | 80% |
| Oral Surgery | | | |
| Extraction — exposed root or erupted tooth | 80% | 80% | 80% |
| Extraction of impacted tooth — soft tissue | 80% | 80% | 80% |
| MAJOR SERVICES* | | | |
| Complete upper denture | 50% | 50% | 50% |
| Partial upper denture | 50% | 50% | 50% |
| Crown — Porcelain with noble metal | 50% | 50% | 50% |
| Pontic — Porcelain with noble metal | 50% | 50% | 50% |
| Inlay — Metallic (3 or more surfaces) | 50% | 50% | 50% |
| Oral Surgery | | | |
| Removal of impacted tooth — partially bony | 50% | 50% | 50% |
| Endodontic Services | | | |
| Bicuspid root canal therapy | 50% | 50% | 50% |
| Molar root canal therapy | 50% | 50% | 50% |
| Periodontic Services | | | |
| Scaling & root planing — per quadrant | 50% | 50% | 50% |
| Osseous surgery — per quadrant | 50% | 50% | 50% |
| ORTHODONTIC SERVICES* | | | |
| Orthodontic Lifetime Maximum | Does not apply | \$1,000 | \$1,000 |

* Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to the DMO in Plan Options 1, 2 & 3.

** Dollar amounts indicated are member responsibility.

Access to negotiated discounts: On the PPO plans in Plan Options 2-6, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the DMO in Options 1, 2 & 3.

Plan Options 2 & 4; PPO Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

The DMO in Plan Option 1 can be offered with any one of the PPO plans in Plan Options 4-6 in a Dual Option package.

Options 1 & 2 DMO Copay Plan 64 amounts listed are the total patient responsibility for the services indicated. The \$5 Office Visit Copay is additional.

Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only in Plan Options 1, 2, 3 & 5 or adults and children in Plan Option 6.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

For a summary list of Limitations and Exclusions, refer to page 5.

OUT-OF-STATE PLAN OPTIONS

| Available With an Aetna Medical Plan to Groups with 2 – 50 Eligible Employees Available Without an Aetna Medical Plan (Dental Standalone) to Groups with 10 – 50 Eligible Employees | Low Option No Ortho | Low Option Ortho | Medium Option No Ortho | Medium Option Ortho | High Option No Ortho | High Option Ortho |
|--|-------------------------|-------------------------|---------------------------|-------------------------|-------------------------|-------------------------|
| MEMBER BENEFITS | PPO Max Plan 100/80/50 | PPO Max Plan 100/80/50 | PPO Max Plan 100/80/50 | PPO Max Plan 100/80/50 | PPO Max Plan 100/80/50 | PPO Max Plan 100/80/50 |
| Office Visit Copay | N/A | N/A | N/A | N/A | N/A | N/A |
| Annual Deductible per Member (does not apply to Diagnostic & Preventive Services) | \$50; 3x Family Maximum | \$50; 3x Family Maximum | \$50; 3x Family Maximum | \$50; 3x Family Maximum | \$50; 3x Family Maximum | \$50; 3x Family Maximum |
| Annual Maximum Benefit | \$1,000 | \$1,000 | \$1,500 | \$1,500 | \$2,000 | \$2,000 |
| DIAGNOSTIC SERVICES | | | | | | |
| Oral Exams | | | | | | |
| Periodic oral exam | 100% | 100% | 100% | 100% | 100% | 100% |
| Comprehensive oral exam | 100% | 100% | 100% | 100% | 100% | 100% |
| Problem-focused oral exam | 100% | 100% | 100% | 100% | 100% | 100% |
| X-rays | | | | | | |
| Bitewing — single film | 100% | 100% | 100% | 100% | 100% | 100% |
| Complete series | 100% | 100% | 100% | 100% | 100% | 100% |
| PREVENTIVE SERVICES | | | | | | |
| Adult cleaning | 100% | 100% | 100% | 100% | 100% | 100% |
| Child cleaning | 100% | 100% | 100% | 100% | 100% | 100% |
| Sealants — per tooth | 100% | 100% | 100% | 100% | 100% | 100% |
| Fluoride application — with cleaning | 100% | 100% | 100% | 100% | 100% | 100% |
| Space maintainers — fixed | 100% | 100% | 100% | 100% | 100% | 100% |
| BASIC SERVICES | | | | | | |
| Amalgam filling — 2 surfaces | 80% | 80% | 80% | 80% | 80% | 80% |
| Resin filling — 2 surfaces, anterior | 80% | 80% | 80% | 80% | 80% | 80% |
| Oral Surgery | | | | | | |
| Extraction — exposed root or erupted tooth | 80% | 80% | 80% | 80% | 80% | 80% |
| Extraction of impacted tooth — soft tissue | 80% | 80% | 80% | 80% | 80% | 80% |
| MAJOR SERVICES* | | | | | | |
| Complete upper denture | 50% | 50% | 50% | 50% | 50% | 50% |
| Partial upper denture | 50% | 50% | 50% | 50% | 50% | 50% |
| Crown — Porcelain with noble metal | 50% | 50% | 50% | 50% | 50% | 50% |
| Pontic — Porcelain with noble metal | 50% | 50% | 50% | 50% | 50% | 50% |
| Inlay — Metallic (3 or more surfaces) | 50% | 50% | 50% | 50% | 50% | 50% |
| Oral Surgery | | | | | | |
| Removal of impacted tooth — partially bony | 50% | 50% | 50% | 50% | 50% | 50% |
| Endodontic Services | | | | | | |
| Bicuspid root canal therapy | 50% | 50% | 50% | 50% | 50% | 50% |
| Molar root canal therapy | 50% | 50% | 50% | 50% | 50% | 50% |
| Periodontic Services | | | | | | |
| Scaling & root planing — per quadrant | 50% | 50% | 50% | 50% | 50% | 50% |
| Osseous surgery — per quadrant | 50% | 50% | 50% | 50% | 50% | 50% |
| ORTHODONTIC SERVICES* | Not covered | 50% | Not covered | 50% | Not covered | 50% |
| Orthodontic Lifetime Maximum | Does not apply | \$1,000 | Does not apply | \$1,000 | Does not apply | \$1,000 |

* Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services.

Access to negotiated discounts; On all PPO Max plans, members are eligible to receive non-covered services at the PPO negotiated rate when visiting a participating PPO dentist at any time, including during the Coverage Waiting Period.

PPO Max Non-Preferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Orthodontic coverage is available only to groups with 10 or more eligibles and for dependent children only. Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate. For a summary list of Limitations and Exclusions, refer to page 5.

For out-of-state employees in all states except: Arkansas, Alaska, Hawaii, Idaho, Maine, Montana, North Dakota, New Hampshire, New Mexico, South Dakota and Wyoming.

Limitations and Exclusions

Listed below are some of the charges and services for which these dental plans do not provide coverage. For a complete list of exclusions and limitations, refer to the plan documents.

- Dental services or supplies that are primarily used to alter, improve or enhance appearance.
 - Experimental services, supplies or procedures.
 - Treatment of any jaw joint disorder, such as temporomandibular joint disorder.
 - Replacement of lost, missing or stolen appliances and certain damaged appliances.
 - Those services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved.
- Specific service limitations**
- DMO Plans: Oral exams (4 per year)
 - PPO Plans: Oral exams (2 routine and 2 problem-focused per year)
 - All Plans:
 - > Bitewing X-rays (1 set per year)
 - > Complete series X-rays (1 set every 3 years)
 - > Cleanings (2 per year)
 - > Fluoride (1 per year; children under 16)
 - > Sealants (1 treatment per tooth, every 3 years on permanent molars; children under 16)
 - > Scaling & root planing (4 quadrants every 2 years)
 - > Osseous surgery (1 per quadrant every 3 years)
 - All other limitations and exclusions in the plan documents.

Notes

Notes

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefit coverage include Aetna Health Inc. and Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna arranges for the provision of dental services. However, Aetna itself is not a provider of dental services and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area and by plan design. With the exception of Aetna Rx Home Delivery® service, all participating physicians, hospitals and other health care providers are independent contractors and are neither employees nor agents of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet member's medical needs, member may request to have services provided by non-system or non-group providers. Member's request will be reviewed and will require prior authorization from the system or group and/or Aetna to be a covered benefit.

Health benefit and insurance plans contain exclusions and some benefits are subject to limitations or visit maximums. Members or Providers may be required to precertify, or obtain prior approval of coverage for certain services such as non-emergency inpatient hospital care. You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services.

While this material is believed to be accurate as of the print date, it is subject to change.