

AETNA U.S. HEALTHCARE OF GEORGIA, INC.
(GEORGIA)

DENTAL SCHEDULE OF BENEFITS

Emory University

Contract Holder Group Agreement Effective Date: January 1, 2008

Contract Holder Number: 811221

Applies to Covered Services Provided by Participating Dental Providers:

This coverage pays benefits for **Covered Dental Services**. **HMO** pays the benefits to **PCD's** and **Par Specialist Dentists** as mutually agreed with them. Other benefits are payable to you.

Covered Dental Services shown below must be given by **Participating Dental Providers**; at the dental office location; except for **Referral Care** when approved by **HMO**; or for **Out-Of-Area Emergency Dental Care**.

Copayment for Services Provided by Participating Dental Providers:

Each **Member** must pay part of the cost of the services or supplies for which coverage is provided under the **Dental Care Plan**. This is a **Copayment**.

A **Copayment** is separate from **HMO's** compensation to **Participating Dental Providers**. For certain dental services, the **Copayment** may represent the full payment to the **Participating Dental Provider**.

This Dental Schedule of Benefits shows:

Those services for which a **Copayment** is required; and

The amount of each **Copayment**; except that no **Copayment** is shown for the Alternate Treatment Rule described in the "limitations" section. If the Alternate Treatment Rule is applied to a service; an added **Copayment** may apply.

The next sentence applies if:

- (1) An unlisted service is provided for the dental care of a specific condition; and
- (2) The list includes one or more services that; under standard practices; are separately suitable for the dental care of that condition.

In that case; the service provided will be considered to have been a service in the list that **HMO** determines would have produced a professionally acceptable result.

Primary Care Dentist Services

	Copayment Amount
<i>VISITS AND EXAMS</i>	
• Oral examination (limited to total of 4 visits per year)	\$ 0.00
• Emergency palliative treatment	10.00
• Prophylaxis (cleaning), (limited to 2 treatments per year)	
Adult	0.00
Child	0.00
• Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)	0.00
• Oral hygiene instruction	0.00
• Sealants, per tooth (limited to 1 application every 3 years for permanent molars and to covered persons under age 16)	10.00
• Pulp vitality test	0.00
• Consultation	0.00
• Diagnostic casts	0.00
<i>X-RAYS AND PATHOLOGY</i>	
• Bitewing X-rays (limited to 1 set per year)	0.00
• Entire series, including bitewings, or panoramic film, (limited to 1 set every 3 years)	0.00
• Vertical bitewing X-rays (limited to 1 set every 3 years)	0.00
• Periapical X-ray	0.00
• Intraoral, occlusal view, maxillary or mandibular	0.00
• Extraoral upper or lower jaw	0.00
• Biopsy and histopathologic examination of oral tissue	80.00
<i>SPACE MAINTAINERS - Includes all adjustments within six months after installation.</i>	
• Fixed	65.00
• Removable	80.00
• Recement space maintainer	15.00
• Removal of fixed space maintainer (by dentist who did not place appliance)	15.00
<i>ENDODONTICS</i>	
• Pulp cap	0.00
• Pulpotomy	35.00
• Root canal therapy, including necessary X-rays	
Anterior	120.00
Bicuspid	140.00
<i>RESTORATIONS AND REPAIRS - (Copayments for crowns and pontics are per unit.) There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown with an asterisk.</i>	
• Amalgam restoration - primary or permanent	
1 surface	0.00
2 surfaces	0.00
3 surfaces	0.00
4 or more surfaces	0.00
• Resin-based composite restoration (other than for molars)	
1 surface	0.00
2 surfaces	0.00
3 surfaces	0.00
4 or more surfaces or incisal angle	0.00
• Retention pins	6.00
• Stainless steel crowns, prefabricated, primary tooth	45.00
• Stainless steel crowns, prefabricated, permanent tooth	60.00

• Recementing inlays or crowns	15.00
• Recementing bridges	20.00
• Sedative filling	8.00
• Inlays and Onlays, Metallic*	220.00
• Crowns	
Porcelain	260.00
Porcelain with metal (includes abutments)*	260.00
Metallic (full cast) (includes abutments)*	260.00
Metallic (3/4 cast)*	250.00
Cast post and core*	80.00
Prefabricated post and core	71.00
Core buildup including pins	45.00
• Pontics	
Metallic (full cast)*	260.00
Porcelain with metal*	260.00
• Full mouth rehabilitation, per unit (<i>This means 6 or more covered units of crowns and/or pontics under one treatment plan.</i>)	125.00
• Dentures and Partials - (<i>Includes relines, rebases and adjustments within six months after installation. Adjustments within first six months are limited to four.</i>)	
Complete, upper or lower	320.00
Partial, upper or lower	
Resin base	300.00
Cast metal base	400.00
Immediate, upper or lower (does not include charge for reline)	330.00
Adjust complete denture, upper or lower	10.00
Adjust partial denture, upper or lower	10.00
Repair broken acrylic, complete denture, upper or lower	30.00
Replace one tooth on complete denture	25.00
Repair acrylic, cast frame, broken clasp	35.00
Replace broken tooth, partial	35.00
Add tooth to existing partial denture	35.00
Add clasp to existing partial	45.00
Rebase, complete denture, upper or lower	86.00
Rebase, partial denture, upper or lower	86.00
Reline, complete denture, upper or lower (chairside)	50.00
Reline, partial denture, upper or lower (chairside)	50.00
Reline, complete denture, upper or lower (laboratory)	95.00
Reline, partial denture, upper or lower (laboratory)	95.00
Interim partial denture, upper or lower (stayplate), anterior only	95.00
Tissue conditioning for dentures	25.00
PERIODONTICS	
• Scaling and root planing, per quadrant (limited to 4 separate quadrants every 2 years)	60.00
• Scaling and root planing, 1 to 3 teeth (limited to once per site every 2 years)	36.00
• Periodontal maintenance procedures following surgical therapy (limited to 2 per year)	40.00
• Occlusal guard (for bruxism only), limited to 1 every 3 years	70.00
ORAL SURGERY - <i>Includes local anesthetics and routine post-operative care.</i>	
• Extractions, exposed tooth or erupted tooth	0.00
• Extractions, coronal remnants	0.00
• Surgical removal of erupted tooth	36.00
• Surgical removal of impacted tooth (soft tissue)	60.00
• Incision and drainage of intraoral abscess	30.00
• Surgical exposure of impacted or unerupted tooth to aid eruption	70.00

Specialty Services

**Copayment
Amount**

ENDODONTICS - Includes local anesthetics where necessary.

• Apicoectomy/periradicular surgery	\$ 130.00
Anterior	130.00
Bicuspid, first root	150.00
Molar, first root	90.00
Each additional root	65.00
Retrograde filling, per root	80.00
Root amputation, per root	280.00
Molar root canal therapy	220.00
Retreatment of previous root canal therapy	240.00
Anterior	380.00
Bicuspid	
Molar	

ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.

• Surgical removal or root tip, root recovery	35.00
• Frenectomy	90.00
• Alveoplasty in conjunction with extractions - per quadrant	35.00
• Alveoplasty not in conjunction with extractions - per quadrant	60.00
• Surgical removal of impacted tooth	
Partially bony	72.00
Completely bony	110.00
Completely bony with unusual surgical complications	110.00

PERIODONTICS

• Gingivectomy or gingivoplasty - per quadrant, limited to 1 per quadrant, every 3 years	120.00
• Gingivectomy or gingivoplasty - 1 to 3 teeth, limited to once per site, every 3 years	40.00
• Gingival flap procedure - per quadrant	140.00
• Gingival flap procedure, including root planing - 1 to 3 teeth	84.00
• Occlusal adjustment (other than with an appliance or by restoration)	
Limited	10.00
Complete	60.00
• Osseous surgery (including flap entry and closure) - per quadrant, limited to 1 per quadrant, every 3 years	325.00
• Osseous surgery (including flap entry and closure) - 1 to 3 teeth, limited to once per site every 3 years	195.00
• Surgical revision procedure, per tooth	130.00
• Pedicle soft tissue graft	250.00
• Free soft tissue graft (including donor site surgery)	265.00
• Subepithelial connective tissue graft	300.00
• Soft tissue allograft	300.00
• Combined connective tissue and double pedicle graft	330.00
• Clinical crown lengthening - hard tissue	195.00

ORTHODONTICS

• Orthodontic screening exam	30.00
• Orthodontic diagnostic records	150.00
• Comprehensive orthodontic treatment of adolescent or adult dentition	1545.00
• Orthodontic retention	275.00

- Subscriber Eligibility:** All active full-time employees of the **Contract Holder** who regularly work at least the minimum number of hours per week as defined by the **Contract Holder** and agreed to by **HMO**.
- Eligible for benefits on the date of commencement of work.
- Dependent Eligibility:** A dependent unmarried child as described in the Eligibility and Enrollment section of the **Certificate** who is:
- i. under 19 years of age, and will be covered until the end of the month after they have reached the age specified above; or
 - ii. under 25 years of age, dependent on a parent or guardian **Member**, and attending a recognized college or university, trade or secondary school on a full-time basis, and will be covered until the end of the month after they have reached the age specified above; or
 - iii. chiefly dependent upon the **Subscriber** for support and maintenance, and is 19 years of age or older but incapable of self-support due to mental or physical incapacity, either of which commenced prior to: 19, or if a student, 25.
- Termination of Coverage:** Coverage of the **Subscriber** and the **Subscriber's** dependents who are **Members**, if any, will terminate on the next **Premium** due date following the date on which the **Subscriber** ceased to meet the eligibility requirements.
- Coverage of **Covered Dependents** will cease on the next **Premium** due date following the date on which the dependent ceased to meet the eligibility requirements.
- In no case will adjustments in coverage or rates be made effective more than 2 **Premium** due dates prior to the date **HMO** is notified in writing, on a form satisfactory to **HMO**, of the requested deletion.