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altus dental™
Altus Dental Insurance Company, Inc.

Altus Dental
P.O. Box 1557
Providence, RI 02901-1557

Group Name: TOWN OF CLINTON-HIGH PLAN **Group ID:** 6989-0002
Product Name: Altus Dental Plus with Connection Dental

Maximums

Below is a summary of all maximums associated with your group and policy.

Annual Maximum	$1,500.00
Elective Orthodontic Lifetime Maximum	$1,000.00
Maximum Lifetime Cap	Unlimited

Benefits Summary

All Services are subject to the provisions described in the Certificate of Coverage. Claims must be received within 180 days of the date of service. Altus Dental covers the following services rendered by or under the supervision of a dentist in a dental office. If applicable, services subject to a deductible and/or coinsurance/copayment are indicated. Services are covered up to the allowance if the dentist is participating. If the dentist is non-participating, we will pay the coverage level for that type of service, based on the reasonable and customary charge for the dentist's area, less any deductible(s) or coinsurance/copays that are your responsibility. You are responsible for any difference between our payment and the non-participating dentist's charge. The information listed here is not a guarantee of payment. To be covered, services must be in accordance with Altus Dental's utilization review guidelines. All services must be completed to qualify for benefits (e.g. permanent crowns cemented, bridge or denture inserted).

Please note: Unless otherwise indicated, the Annual Maximum applies to all services/procedures listed below.

In Network		Out of Network	
Individual Deductible:	$50.00	**Individual Deductible**	$50.00
Family Deductible:	$150.00	**Family Deductible:**	$150.00

P Indicates Pre-Treatment Estimate recommended.

D Indicates Deductible Applies for this procedure.

Procedure	In Network	Out Of Network	Waiting Period	Frequency/Limitations *
Diagnostic				
Oral exam	100%	100%	None	Twice per calendar year
Bitewing x-rays	100%	100%	None	One set per calendar year
Complete x-ray series or panoramic film	100%	100%	None	Once every 36 months
Single x-rays	100%	100%	None	As required
Preventive				
Cleaning	100%	100%	None	Twice per calendar year
Fluoride treatment	100%	100%	None	For children under age 19 twice per calendar year

	Sealants	100%	100%	None	For children under age 16, once every 36 months on unrestored permanent molars
	Space maintainers	100% D	80% D	None	Once every 60 months for lost deciduous (baby) teeth
	Restorative				
	Amalgam (silver) fillings	100% D	80% D	None	Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
P	Crowns over natural teeth, build ups, posts and cores	60% D	50% D	None	Replacement limited to once every 60 months
	Recementing crowns or bridges	100% D	80% D	None	Once every 60 months
	Endodontics				
	Root canal therapy on permanent teeth	100% D	80% D	None	One procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
	Periodontics				
P	Root planing and scaling	100% D	80% D	None	Once per quadrant every 24 months
P	Osseous (bone) surgery	100% D	80% D	None	Once per quadrant every 24 months (bone grafts are not covered)
P	Gingivectomies	100% D	80% D	None	Once per site every 24 months
P	Soft tissue grafts	100% D	80% D	None	Once per site every 60 months
P	Crown lengthening	100% D	80% D	None	Once per site every 60 months
	Periodontal maintenance following active therapy	100% D	80% D	None	Two per year
	Prosthodontics				
P	Bridges and crowns over implants	60% D	50% D	None	Replacement limited to once every 60 months
P	Partial and complete dentures	60% D	50% D	None	Replacement limited to once every 60 months
	Repairs to existing partial or complete dentures	100% D	80% D	None	Once per calendar year
	Rebasing or relining of partial or complete dentures	100% D	80% D	None	Once every 60 months
	Implant Services				
P	Surgical placement of endosteal implant and abutment	60% D	50% D	None	Replacement limited to once every 60 months
	Extractions and Oral Surgery				
	Extractions and other routine oral surgery when not covered by a patient's medical plan	100% D	80% D	None	
	Orthodontics - Subject to applicable lifetime maximum				
	Elective braces and related services	50%	50%	None	For dependent children under the age of 19. Subject to a lifetime maximum. No pre-approval required.
	Other Services				

Palliative treatment (minor procedures necessary to relieve acute pain)	100% D	80% D	None	Twice per calendar year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	100% D	80% D	None	

Dependent children are covered up until the end of the month that they turn age 26.

*Coverage for benefits with time limitations (e.g. 6, 12, 24, 36 or 60 months) is calculated to the exact day. Benefits will then be available the following day. For example, when a procedure is covered once every 12 months, if the procedure was performed on July 1, 2009, it will not be covered again until July 2, 2010.

The voluntary disenrollment rate among insureds of Altus Dental is 0%. The involuntary disenrollment rate among insureds of Altus Dental is 0%.

Exclusions & Limitations

Unless otherwise specified in the Benefits Summary, the following are not covered:

- When those services do not qualify for payment according to our dental treatment guidelines. These guidelines assist us in making determinations as to whether services are covered and whether a particular service is the least costly, clinically acceptable method of prevention, diagnosis or treatment. A service may not qualify for coverage under these guidelines even though it was furnished or recommended by a dentist.
- Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- An illness or injury that we determine is employment-related.
- Services you would not be required to pay for if you did not have this Certificate or for which no charge would have been made in the absence of this Certificate.
- Services or supplies which are deemed experimental in terms of generally accepted dental standards.
- Services provided by a dentist who is a member of your immediate family.
- An illness, injury or dental condition for which benefits are or would have been available through a government program if you did not have this Altus Dental coverage.
- Services rendered by someone other than a licensed dentist or a licensed hygienist operating as authorized by applicable law.
- Exams by specialists except for periodic oral exams.
- Consultations.
- Disorders related to the temporomandibular joints –(TMJ), including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations required because of erosion, abrasion, or attrition. Services meant primarily to change or to improve your appearance.
- Orthodontics.
- Occlusal guards.
- Implants.
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Services related to congenital anomalies.
- Prescription drugs.
- General anesthesia or intravenous sedation when rendered by anyone other than a dentist.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.

Altus Dental also reserves the right to adopt and to apply from time to time such administrative policies as Altus Dental, in the exercise of its judgment, deems reasonable in approving the eligibility of subscribers and the appropriateness of treatment plans and related charges.