altus dental™
Altus Dental Insurance Company, Inc.

ALTUS DENTAL - HIGH PLAN BENEFITS SUMMARY

MASSACHUSETTS HEALTH CONNECTOR

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms.
The Certificate includes any limitations or exclusions not seen here. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

UNDER AGE 19

MAXIMUMS

Annual Maximum	None
Medically Necessary Orthodontic Lifetime Maximum	None
Maximum Lifetime Cap	Unlimited
In Network Out-of-Pocket Maximum (per member)	$350 for one individual under age 19 / $700 for two or more individuals under age 19
Out-of-Network Out-of-Pocket Maximum (per member)	None

DEDUCTIBLES
Apply to certain services

Individual Deductible: $50
Family Deductible: $150

(P) **Indicates Pre-treatment Estimate recommended.**
(A) **Indicates Prior Authorization required.**
(D) **Indicates Deductible applies.**

Procedure	In Network	Out of Network*	Frequency / Limitations †
Diagnostic			
Oral Exam	100%	80%	Twice per policy year. In addition, comprehensive exams are covered once per lifetime per dentist location.
Bitewing x-rays	100%	80%	Two sets per policy year
Complete x-ray series and panoramic film	100%	80%	Once every 36 months
Single x-rays	100%	80%	As required
Preventive			
Cleaning	100%	80%	Twice per policy year
Fluoride treatment	100%	80%	Once every 3 months
Sealants	100%	80%	Once every 36 months on unrestored molars
Space maintainers	100%	80%	
Minor Restorative			
Amalgam (silver) and composite (white) fillings	75% (D)	55% (D)	Once per 12 months per tooth surface
Stainless steel crowns	75% (D)	55% (D)	
Rebasing or relining of partial or complete dentures	75% (D)	55% (D)	Once every 24 months
Recementing crowns and onlays	75% (D)	55% (D)	

AGE 19 & OVER

MAXIMUMS

Annual Maximum	$1,250
Maximum Lifetime Cap	Unlimited

DEDUCTIBLES
Apply to certain services

Individual Deductible: $50
Family Deductible: $150

(P) **Indicates Pre-treatment Estimate recommended.**
(D) **Indicates Deductible applies.**

Procedure	In Network	Out of Network*	Frequency / Limitations †
Diagnostic			
Oral Exam	100%	80%	Twice per policy year. In addition, comprehensive exams are covered once every 60 months per dentist location.
Bitewing x-rays	100%	80%	Two sets per policy year
Complete x-ray series or panoramic film	100%	80%	Once every 60 months
Single x-rays	100%	80%	As required
Preventive			
Cleaning	100%	80%	Twice per policy year
Periodontal maintenance following active therapy	100%	80%	Once every 3 months
Minor Restorative			
Amalgam (silver) fillings	75% (D)	55% (D)	Once per 24 months per tooth surface. Composite (white) fillings covered on front teeth and on one surface for back teeth. Multi-surface white fillings on back teeth are paid up to a silver filling. Temporary fillings covered once per tooth.
Repairs to existing partial or complete dentures	75% (D)	55% (D)	Once every 12 months, same repair
Rebasing or relining of partial or complete dentures	75% (D)	55% (D)	Once every 36 months
Recementing crowns and onlays	75% (D)	55% (D)	Once every 60 months

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ALTUS DENTAL – HIGH PLAN BENEFITS SUMMARY (Continued)

UNDER AGE 19

Procedure	In Network	Out of Network*	Frequency / Limitations †
Major Restorative			
(P) Crowns, build ups, posts and cores	50% (D)	30% (D)	Covered over natural teeth when teeth cannot be restored with regular fillings. Replacement limited to once every 60 months. Stainless steel crowns are covered at a different coinsurance amount.
Endodontics			
Root canal therapy on permanent teeth	75% (D)	55% (D)	One procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
Periodontics			
(P) Root planing and scaling	75% (D)	55% (D)	Once per quadrant every 36 months
Prosthodontics			
(P) Partial and complete dentures	50% (D)	30% (D)	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	75% (D)	55% (D)	Includes simple extractions not requiring surgery and surgical extractions. One procedure per tooth per lifetime.
Orthodontics			
(A) Medically necessary braces and related services	50%	30%	**Requires prior authorization.** No payment will be made if not obtained. Covered only when medically necessary. Patient must have severe and handicapping malocclusion as defined by our guidelines. Once per lifetime.
Other Services			
Palliative treatment (minor procedures necessary to relieve acute pain)	75% (D)	55% (D)	
General anesthesia or intravenous (I.V.) sedation	75% (D)	55% (D)	
Dependent children are covered under these benefits up until the end of the policy year that they turn age 19.			

AGE 19 & OVER

Procedure	In Network	Out of Network*	Frequency / Limitations †
Major Restorative (6 month waiting period)			
(P) Crowns, build ups, posts and cores	50% (D)	30% (D)	Covered over natural teeth when teeth cannot be restored with regular fillings. Replacement limited to once every 84 months.
Endodontics			
Root canal therapy on permanent teeth	75% (D)	55% (D)	One procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
Periodontics			
(P) Root planing and scaling	75% (D)	55% (D)	Once per quadrant every 24 months
(P) Osseous (bone) surgery	75% (D)	55% (D)	Once per quadrant every 36 months
Prosthodontics (6 month waiting period)			
(P) Fixed bridges and crowns (when part of a bridge)	50% (D)	30% (D)	Replacement limited to once every 84 months
(P) Partial and complete dentures	50% (D)	30% (D)	Replacement limited to once every 84 months
Extractions and Oral Surgery			
Extractions and other routine oral surgery when not covered by a patient's medical plan	75% (D)	55% (D)	Includes simple extractions not requiring surgery and surgical extractions. One procedure per tooth per lifetime.
Other Services			
Palliative treatment (minor procedures necessary to relieve acute pain)	75% (D)	55% (D)	Twice per policy year
General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures	75% (D)	55% (D)	
Dependent children covered under a family plan are covered under these benefits from age 19 up until the end of the policy year that they turn age 26. Children under age 19 have different coverage.			

***Out-of-network care**: This is the amount Altus Dental pays. For services received out-of-network, your costs will be greater. Non-participating dentists are paid at a reduced level. Please refer to your Certificate of Coverage for further details.

†**Time limits** on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Altus Dental Insurance Co. does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.