

This Summary, together with the accompanying Certificate of Coverage, describes the Plan selected for you and your covered dependents (if any) by your plan sponsor. Your group number is **7322-0001 & 0003**.

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 (illustrated under "Plan pays" below) for that type of service, based on the reasonable and customary charge for the dentist's area, less any deductible(s) or coinsurance/copayments 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.)

The annual maximum is: \$750.00 per member per calendar year
The annual deductible is: \$0.00
The maximum lifetime cap: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Oral exam - twice per calendar year
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 twice per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars

Plan pays 50%; Member Coinsurance 50%

- Simple extractions not requiring surgery
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. 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.
- Root canal therapy for permanent front teeth
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasement or relining of partial or complete dentures once every 60 months

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

Monthly Premium:
Individual: \$28.19
Family: \$72.17

This Summary, together with the accompanying Certificate of Coverage, describes the Plan selected for you and your covered dependents (if any) by your plan sponsor. Your group number is **7322-0002 & 0004**.

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 (illustrated under "Plan pays" below) for that type of service, based on the reasonable and customary charge for the dentist's area, less any deductible(s) or coinsurance/copayments 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.)

The annual maximum is: \$1,000.00 per member per calendar year
The annual deductible is: \$50 individual / \$150 family
The maximum lifetime cap: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Oral exam - twice per calendar year
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 twice per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars
- Space maintainers once every 60 months for lost deciduous (baby) teeth

Plan pays 80%; Member Coinsurance 20%; Deductible applies

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. 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.
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth - one procedure per tooth per lifetime. Vital pulpotomy and apicoectomies also covered once per tooth per lifetime.
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasement or relining of partial or complete dentures once every 60 months
- Periodontal maintenance following active therapy - two per year
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered).
- Gingivectomies once per site every 24 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

Plan pays 50%; Member Coinsurance 50%; Deductible applies

- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months
- Bridges and crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Surgical placement of endosteal implant and abutment; replacement limited to once every 60 months

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

Monthly Premium:
Individual: \$45.28
Family: \$115.93