Certificate of Coverage

Altus Dental Preferred and Altus Dental Plus

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Altus Dental Insurance Company, Inc.

Certificate of Coverage

Altus Dental Preferred and Altus Dental Plus

Welcome to Altus Dental. This *Certificate* is a means through which *we* at Altus Dental Insurance Company, Inc. in consideration of the application for benefits and payment of applicable fees agree to provide benefits.

This *Certificate*, along with the *Benefits Summary* describes the *Plan*. It describes the dental services covered by *your Plan*. It also explains how each is paid for and tells *you* how to use the *Plan*. If *you* have any questions, please contact Customer Service.

***Our* toll free Customer Service number is:**

1-877-223-0588

Customer Service representatives are available Monday – Thursday from 8 a.m. to 7 p.m. ET, and Friday from 8 a.m. to 5 p.m. ET. *Our* automated information line is available 24 hours a day, seven days a week. *You* may also contact *us* on the Internet at **www.altusdental.com.**

Claims and written correspondence should be sent to:

Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, R.I. 02901-1557

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.

We provide appropriate, free, and timely aids and services, including qualified interpreters, for individuals and information in alternate formats, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

We provide language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner when such services are necessary to provide meaningful access to individuals with limited English proficiency.

If *you* need these services, contact *us* at 1-877-223-0588.

If *you* believe *we* have failed to provide these services or discriminated on the basis of race, color, national origin, disability, or sex, *you* can file a grievance with: Civil Rights Coordinator, Altus Dental Insurance Co., 10 Charles Street, Providence, RI 02904, or by calling 1-877-223-0588. *You* can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-223-0588.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-223-0588.

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-223-0588.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-223-0588.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-223-0588.

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-223-0588.

ﺔﻴﺑﺮﻌﻟا (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-223-0588
(رقم هاتف الصم والبكم: 1-877-223-0588).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-223-0588.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-223-0588.

Bàsɔ́ɔ̀-wùdù-po-nyɔ̀ (Bassa): Dè dɛ nìà kɛ dyédé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ̀] jǔ ní, nìí, à wudu kà kò dò po-poɔ̀ bɛ́ìn m̀ gbo kpáa. Đá 1-877-223-0588.

Igbo asusu (Ibo): Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-877-223-0588.

èdè Yorùbá (Yoruba): AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-877-223-0588.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-223-0588.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-223-0588 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-223-0588.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-223-0588 पर कॉल करें।

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-223-0588.

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-223-0588.

Definitions

This document contains words used in insurance and dentistry. These words have specific meanings that are described below. Insurance or dental terms used in this document will be in *italics.* If *you* are not clear about the meaning of the words used, please refer back to this page.

- *Adverse Benefit Decision* means a decision by Altus Dental not to pay (in whole or in part) for a *covered service*, including a denial; reduction; termination; or, failure to make a payment based on the imposition of a pre-existing condition exclusion; a source of injury exclusion; retroactive rescission of coverage; or, other limitation on *covered services.*
- *Allowance* means the amount *we* base payment on for a *covered service* or procedure.

  The *Allowance* for a *Participating Dentist* is the LOWEST of the:
  a) Amount *we* set for each *dentist*;
  b) Maximum amount *we* will pay any *dentist* for a *covered service* or procedure; or
  c) Amount the *dentist* actually charges.

  Participating dentists cannot charge Altus Dental patients more than the *allowance* for a *participating dentist.*

  The *Allowance* for a *Non-participating Dentist* is the LOWEST of the:
  a) Usual charge by the *dentist* for the same or similar services or supplies;
  b) Average amount *we* determine that most other *dentists* in the same geographic area charge for the same or similar services or supplies; or
  c) Actual charge for the services or supplies.

- *Annual Maximum* means the maximum amount *we* will pay for *covered services* for a continuous 12-month period (usually a calendar year). The *annual maximum* is stated in the *Benefits Summary.*
- *Benefits Summary* is a summary description of the services covered under this dental Policy; with a schedule that shows *you* how much *we* pay toward a procedure. If a service is not listed in the *Benefits Summary, we* will not pay for it.
- *Certificate* means this document and the applicable *Benefits Summary* pages, including any rider pages. This *Certificate* is *your* policy.
- *Coinsurance/Copayment* means the amount *you* pay for *covered services*, after the *deductible*, if any, is met. *Coinsurance* is usually shown as a percentage and *copayment* as a fixed dollar amount. The amount of *coinsurance/copayment* varies with the type of *covered services.*

- *Coverage Level* means the amount *we* pay for *covered services,* after the *deductible* and/or *copayment,* if any, is met. The *coverage level* varies with the type of *covered services* and is shown in the *Benefits Summary*.
- *Covered Services* means those services and procedures listed in the *Benefits Summary.* All *covered services* must be *dentally necessary* and appropriate to qualify for payment.
- *Date of Service* means the date that the service was done. For services requiring more than one visit, except *orthodontics*, the *Date of Service* is the final completion date (Examples: the insertion date of a denture; the date a permanent crown is cemented).
- *Deductible* (if applicable) means the amount *you* pay toward *covered services* before *we* begin paying benefits. *Deductibles* must be met each *year. Deductibles* may vary by type of benefits or by type of provider (participating vs. non-participating) and are specific dollar amounts for each *subscriber* and/or *dependent* per *year.*
- *Dentally Necessary (Dental Necessity)* means that the dental services provided are:
  - appropriate, in terms of type, amount, frequency, level, setting and duration to the *member's* diagnosis or condition;
  - consistent with the symptoms and appropriate and effective for the diagnosis, treatment, or care of the oral condition, disease, or injury for which it is prescribed or performed;
  - appropriate with regard to generally accepted standards of dental practice within the dental community or scientific evidence related thereto; AND
  - the most appropriate level of service which can safely be provided to the *member.*

  We will make a determination whether a service is *dentally necessary* based on the criteria set forth in the utilization review plan and guidelines ("review guidelines") that *we* file with the Rhode Island Office of the Health Insurance Commissioner. A copy of these review guidelines is available on *our* website at: www.altusdental.com. *You* have the right to appeal *our* determination or to take legal action as described in the **Claims Procedures** section of this *Certificate*.
- *Dentist* means any person duly licensed as a Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) practicing within the authority of his or her license. The term *dentist* includes an oral surgeon.
- *Dependent* typically means *your spouse* and *your* unmarried *dependent* children up to a certain age. A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws. Refer to *your Benefits Summary* for *dependent* children age limits. ***Your plan sponsor* determines *dependent* eligibility requirements.** If *you* have family coverage, *your* newborn infant and a newborn infant of a *dependent* child are eligible for coverage from birth. Adopted children are covered from the date of placement in the home. Foster children are covered from the date of the filing of the petition to adopt. Stepchildren and children under *your* own or *your spouse's* legal guardianship who permanently

live in *your* household and are chiefly dependent on *you* for support, are also considered *dependent* children. Married children are not considered *dependents,* regardless of their age.

- *Effective Date* means the date, as shown on *our* records, that *your* coverage begins under this contract or an amendment to it.
- *Emergency Care* means services given to treat a person with a serious medical or health problem. A medical problem includes physical, mental, and dental conditions. *Emergency care* is limited to services which are palliative (to relieve pain) and/or temporary and does not include services such as permanent fillings, crowns or root canals.
- *Endodontics* means a specialty of dentistry that deals with treatment of dental pulp diseases (nerves, blood vessels and other tissues within the tooth). A root canal is an example of *endodontic* treatment.
- *Hygienist* means any person duly licensed as a dental *hygienist* practicing within the authority of his or her license.
- *Lifetime Maximum* means the maximum amount of dollars *we* will allow for *covered services* during a *subscriber's* or *dependent's* lifetime. This provision usually applies only to *orthodontic* services and implants if covered by *your plan.*
- *Material change* means a modification to any of Altus Dental's procedures or documents required by Massachusetts regulation 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier or health care provider.
- *Medically Necessary Orthodontics* means the patient under age 19 must have severe and handicapping malocclusion (faulty contact of upper and lower teeth in biting); as defined by *our* review guidelines.
- *Member* means a *Subscriber* or *Dependent*.
- *Non-participating Dentist* means a *dentist* who does not have a contract with Altus Dental Insurance Company, Inc.
- *Orthodontics* means a specialty of dentistry concerned with prevention and correction of abnormalities in tooth position and their relationship to the jaw (straightening of teeth).
- *Participating Dentist* means a *dentist* who has a contract with Altus Dental Insurance Company, Inc.
- *Pedodontics* means a specialty of dentistry concerned with the treatment of children.
- *Periodontics* means a specialty of dentistry concerned with diseases of the gums and other supportive structures of the teeth.
- *Plan* means the terms, conditions and benefits described in this *Certificate* and applicable *Benefits Summary* pages, including any rider pages.
- *Plan Sponsor* means *your* employer or other organization / association that is sponsoring the *Plan.* In the case of a group subject to the Employee Retirement

Income Security Act of 1974 (ERISA), as amended, the *Plan Sponsor* is the individual or entity designated under that Act.

- *Policy Year* means the continuous 12 month period under which coverage is offered by *your plan sponsor. Your policy year* is either the calendar year or the timeframe beginning with *your* group's coverage start date and ending 12 months later.
- *Prosthodontics* means a specialty of dentistry concerned with the replacement of missing teeth by bridges and dentures.
- *Spouse* means *your* legal *spouse.* A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.
- *Subscriber* means someone who has applied for coverage and been approved by *us* and is eligible to receive benefits under this *Certificate*. In the case of a *subscriber* who is less than 18 years of age, the parent or legal guardian must contract on behalf of the dependent child for the benefits described in this *Certificate.* The parent or legal guardian must assure the dependent child's compliance with any and all terms and conditions outlined in the policy.
- *Usual and Customary Charge* means that charge which is the lowest of: the usual charge by the *dentist* for the same or similar services or supplies; or the average amount *we* determine that most other *dentists* in the same geographic area charge for the same or similar services or supplies; or the actual charge for the services or supplies.
- *Waiting Period* is the amount of time *you* must wait from *your effective date* before a service is covered. If *your plan* has a *waiting period,* it will be shown in the *Benefits Summary* that goes with this *Certificate.*
- *We, Our, Us* means *Altus Dental Insurance Company, Inc.* located at 10 Charles Street, Providence, RI 02904-2208.
- *You* and *yours* means the *Subscriber.*

When You Join the Plan

Who Can Join

You and/or *your* eligible *dependents* can join the *Plan* if *your Plan Sponsor* agrees and complies with *our* underwriting guidelines. ***Your plan sponsor* determines eligibility requirements for *dependents.*** A parent or legal guardian must contract on behalf of a child who is less than 18 years old. The parent or legal guardian is liable for the child's compliance with any and all policy terms and conditions.

Your eligible *dependents* typically are:

- ***Your* legal spouse. A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.** In the event of divorce, *your* ex-spouse will be eligible for continued coverage under the policy without additional premium until either spouse remarries. This is true unless the divorce or separation judgment states otherwise. If *you* remarry, the ex-spouse may,

if so stated in the divorce judgment, stay covered as a *member* at additional premium.

- ***Your* unmarried *dependent* children** up to a certain age. Refer to *your Benefits Summary* for age limits.
- ***Your* unmarried children who have reached the *dependent* age limit up to a higher student age limit,** if a full-time student at an accredited secondary school or college and he or she is primarily dependent on *you* for support;

  NOTE: *Your plan sponsor* must agree to purchase a coverage for this extended period of time. If applicable, the student age limit will be noted in *your Benefits Summary.*
- ***Your* unmarried children who have reached the *dependent* age limit; and, who are mentally or physically disabled and cannot earn a living.** To continue coverage, *you* must submit proof of *your* child's disability within 30 days of the child reaching the *dependent* age limit. The proof must be acceptable to *us*. *You* must continue to provide proof of the disability upon request.

How You Join

You join by completing, signing and returning to *us;* or, to *your plan sponsor* an applicable form. Forms are available from *us* or *your plan sponsor,* or *you* may be able to enroll online. If *your* family status changes and *you* need to add or remove *dependents* from *your plan*, contact *us* or *your plan sponsor*. *We* can only accept membership changes from a *Subscriber* or *your plan sponsor*.

When Coverage Begins

Coverage generally starts the first of the month after *we* accept *your* completed and signed enrollment form and payment arrangements. *Your plan sponsor* can tell *you* if a *waiting period* is required.

You must wait until *your plan sponsor's* next open enrollment period, if *you* or *your dependent(s)* do not enroll when first eligible. *You* may also enroll when there is a qualifying event.

If *you* marry, *you* may enroll *your spouse* within 60 days of marriage. *You* must wait until *your plan sponsor's* next open enrollment period if *your spouse* does not enroll when first eligible. *Your spouse* may also enroll when there is a qualifying event.

If *you* have family coverage, *your* newborn infant and the newborn infant of a *dependent* child are covered from birth. Adopted children are covered from the date of home placement. Foster children are covered from the date of the petition to adopt. Stepchildren and children are considered dependent children if they: are under *your* own or *your spouse's* legal custody; permanently live in *your* household; and, chiefly depend on *you* for support. *We* do not consider married children *dependents,* regardless of their age.

Coverage generally begins on the first of the month after *we* accept *your* enrollment form. If *you* don't enroll within 60 days, *you* must wait until the next open enrollment period to enroll *dependents. Dependents* may enroll when there is a qualifying event.

Notify *us* and *your plan sponsor* of any changes in *your* or *your dependent's* status. This includes marriage; births; attainment of the *dependent* or student (if applicable) age limits; or, changes in *your* address. This will help us maintain up to date eligibility and billing records.

The Cost of Your Coverage

You and/or *your plan sponsor* pay the cost of coverage for *you* and *your* eligible *dependents.* The cost of coverage is based on the arrangement agreed to by *your plan sponsor.* This arrangement must comply with *our* underwriting guidelines.

When Coverage Ends

We or *your plan sponsor* may cancel *your* group's contract under the terms of *our* contract with *your* group. If *your* group's contract is cancelled, *your* coverage will also be terminated on the same date. If *your* group's contract is cancelled for nonpayment of premiums, *we* will duly notify *you* of the cancellation in writing. *We* will honor any claims for *covered services* rendered before the written cancellation date.

In addition, *your* coverage may be cancelled for the following reasons (coverage generally ends on the last day of the month):

- Appropriate premium payments are not made;
- *You* or *your plan sponsor* cancel coverage;
- *You* cease being eligible;
- *You* engage in misrepresentation or fraud;
- *You* commit acts of physical or verbal abuse against a provider or other insured *member.*

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

When Your Dependent's Coverage Ends

Your dependent's coverage typically ends:

- When *you* become legally divorced from *your spouse**, *your* former *dependent spouse* will, unless specified in a court judgment, continue to be considered *your dependent* until the earliest of:
  a. the date *you* remarry, unless coverage must be provided as set forth in the divorce judgment. In that case, *your* ex-spouse can continue to be covered as a *member* of the group at an additional premium; or

b. the date *your* former *dependent spouse* remarries; or
c. the date when he/she ceases to be eligible for continued coverage as specified in the divorce judgment; or
d. the date when *you* or *your spouse* cancels coverage; or
e. the date when *your plan* would have otherwise ended; or
f. the date when appropriate premium payments are not made.

** A spouse includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.*

- At the end of the month in which an eligible *dependent* child marries; or

- When a *dependent* child reaches the *dependent* age limit as set forth in *your Plan's Benefits Summary.*

NOTE: If *your* unmarried *dependent* child is mentally or physically disabled upon reaching the *dependent* age limit; and, he/she cannot earn a living, *you* may apply for continued coverage through *your plan sponsor. You* have 30 days from the date *your* child reaches the *dependent* age limit to apply. *You* must include the medical reason for *your* request. *We* will review *your* application to decide if it meets *our* criteria.

NOTE: If *your plan sponsor* has purchased coverage for students, coverage for a *dependent* child may continue past the *dependent* age limit if enrolled as a full-time student. If *you* have such coverage, the option will be noted in *your Benefits Summary* with a student age limit.

Benefits After Cancellation

All services must be complete to qualify for benefits. For example, permanent crowns must be cemented; bridges or dentures must be inserted. Once *your* coverage is cancelled, *you* will not have benefits for services finished after *your* cancellation date. *Your* covered family *members* will not have benefits either.

When You May Rejoin the Plan

A *member* who voluntarily cancels membership in the group *plan* may not re-enroll in that group *plan* until at least one year after the date of cancellation. The re-enrollment must occur during the group's open enrollment period. If *your Benefits Summary* notes that there is a *waiting period* applicable to any services, this *waiting period* begins again with the new *effective date.* No reinstatement of coverage back to the original *effective date* is allowed.

You may rejoin through a different group plan anytime *you* become eligible for that plan. *Lifetime maximums* and claim history accumulated while covered under a previous plan or any other plan may be carried forward to the new plan.

Features of the Plan

Your plan is designed to help *you* maintain good dental health through regular dental care. It will help *you* to pay for dental expenses. *We* describe *your* exact coverage in the *Benefits Summary.*

Utilization Review Guidelines

Our Dental Case Management area performs clinical claims reviews. These reviews help *us* decide if the service meets *our* review guidelines. Analysts who review claims are registered dental *hygienists;* or, dental assistants with clinical experience. The analysts review claims. They can approve services. Only a dental consultant, who is a licensed *dentist,* can deny a claim.

We review claims using written review guidelines. *We* base *our* guidelines on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. These guidelines, as well as contract limits, are the basis for review decisions. *We* create clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of *participating dentists. Our* dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs

We strive to provide high quality products and services. *We* do this by monitoring, identifying, and tracking key issues over time. *We* deal with these issues as part of *our* review of *our* Quality Program.

Assessment of New Dental Materials and Treatments

We study new dental materials and treatments. *We* also study how effective they are and the cost. Then, *we* decide if *we* will cover the material or treatment.

Continuity of Care

If *your dentist* moves or ever decides not to participate, *you* can choose a new *dentist* from the network. There will not be any disruption in *your* coverage or benefits. If *you* change from a *participating dentist* to a *non-participating dentist,* the treatment or procedure would still be covered. This is true so long as it is a covered benefit; but, *you* will be responsible for any difference between *our* payment and the *dentist's* charge.

Pre-treatment Estimate / Prior Authorization

A pre-treatment estimate / prior authorization is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic;* and *orthodontic* services.

Prior Authorization

Prior authorization is required for *medically necessary orthodontic* treatment if covered by *your Plan.* *Medically necessary orthodontics* is covered for *dependent* children under age 19 only if there is an EHB pediatric dental rider with the *Plan.* Refer to the *Benefits Summary* pages of *your Certificate.* The treatment must meet *our* criteria. **No payment will be made if prior authorization is not obtained.**

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example is if *you* lose coverage before the new service is finished.

How to Use Altus Dental

You pay a set dollar amount or a percentage thereof for each *covered service* (or nothing for some services). The amount *we* pay is shown in the *Benefits Summary. You* may go to any *dentist you* choose. You must first pay the *deductible* amount, if applicable, for *covered services* before *we* make any payment. There are advantages to going to a *dentist* that is part of *our network.* When *you* visit a *participating dentist,* after the *deductible* is met, *you* pay only the *copayment/coinsurance* amount for *covered services.* However, if *you* visit a *non-participating dentist* (i.e., a *dentist* who is "out-of-network"*),* after *you* pay the *deductible* and any *copayment/coinsurance* amount; *you* also pay the difference between the *non-participating dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *non-participating dentists.*

Maximize Your Coverage with Participating Dentists

If *you* go to a *participating dentist, your* out-of-pocket expenses will always be less. The *dentist* will file claims on *your* behalf. *We* will pay *participating dentists* directly. By choosing a *participating dentist, you* get the best value from *your* dental *plan*.

You can go to a *dentist* that is not in *our network*. When *you* go to a *non-participating dentist, you* are responsible for filing the claim; and, for paying the *dentist*. Most *non-participating dentists* will file the claim on *your* behalf. *Your* out-of-pocket cost will be more; because, after you pay the deductible and any *copayment/coinsurance* amount, *you* also pay the difference between the *non-participating dentist's* charge and the amount *we* pay.

Finding a Participating Dentist

To find a *participating dentist*, visit *our* website – www.altusdental.com. The *network* includes general *dentists* and specialists throughout Massachusetts, Rhode Island and New Hampshire border towns. *We* do not require *you* or *your dentist* to get referrals to see a specialist; however, not all services done by a specialist may be covered under *your plan*. Check *your Benefits Summary* for a list of *covered services. Participating dentists* will file claims on *your* behalf; and, *we* will pay them directly.

CONNECTION Dental

If *your* Altus Dental Identification Card has a CONNECTION Dental logo on it, *you* have access to a national network of *dentists* in addition to the Altus *dentists* in Massachusetts and Rhode Island and New Hampshire border towns. To find a CONNECTION Dental *dentist*, visit *our* website – www.altusdental.com and follow the instructions in the Find a *Dentist* section. CONNECTION Dental *dentists* will file claims on *your* behalf; and, *we* will pay them directly. CONNECTION Dental *dentists* agree to accept the *allowance* as payment in full for *covered services*.

Payments for Services

Participating dentists will accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services*. *We* will pay *participating dentists* directly. When *your participating dentist* provides services that are not covered; or, *covered services* that do not meet *dental necessity* criteria as per *our* review guidelines, *you* may be liable for the *dentist's* charge.

Your participating dentist may charge *you* more than the *allowance* when:

- *You* or *your dependents* receive *covered services;* and, *you* have gone over the *annual maximum.*

- *You* and *your dentist* decide to use non-covered services; such as, treatments or materials that cost more than those normally given by most *dentists;* or, that are being done to improve *your* appearance. In these cases, *we* may pay an *allowance* suitable for a less costly, generally accepted material or service.

Non-participating dentists have not agreed to accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services. You* will pay more. That's because, after you pay the *deductible* and any *copayment/coinsurance* amount, *you* also pay the difference between the *non-participating dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *non-participating dentists.*

When a *non-participating dentist* treats *you, we* will make benefit payments to *you;* unless, *you* and *your dentist* agree to assign benefit payment to *your dentist. Your dentist* may not agree to this; and, he/she may request payment from *you.*

If *your Benefits Summary* indicates *you* have Altus Dental Preferred, *we* will pay for services rendered by *non-participating dentists* at no less than 80% of the in-network *coverage level* (illustrated in *your Benefits Summary)* for that type of service, based on the *usual and customary charge* for *your dentist's* area, less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *non-participating dentist's* charge.

Altus Dental Preferred

Example* of How Claims are Paid – *Participating* v. *Non-Participating Dentist*

	Participating Dentist	***Non-Participating Dentist***
Type of Service	Root Canal	Root Canal
Dentist's Charge	$840	$840
Allowance	$680	N/A
Usual and Customary Charge	N/A	$810
*Coverage Level*** (Refer to *your Benefits Summary)*	80% (in-network)	64% (80% of 80%) (out-of-network)
Altus Payment	$544 (80% of the $680 *allowance*)	$518.40 (64% of the $810 *usual and customary charge*)
You Pay	$136 (the difference between *our* payment and the *allowance)*	$321.60 (the difference between *our* payment and the *dentist's* charge)

***These are examples only. Actual charges and *allowances* will vary.** All services must be complete to qualify for benefits (e.g., permanent crowns cemented, bridge or denture inserted).

****Some Preferred Plans may have a Point of Service (POS) option.** With this option, some services may be covered at the same *coverage level* in and out of network, while others have higher coverage amounts for services received from a *participating dentist.*

If *your Benefits Summary* indicates *you* have Altus Dental Plus, *we* will pay for services rendered by *non-participating dentists* at the *coverage level* (illustrated in *your Benefits Summary*) for that type of service, based on the *usual and customary charge* for *your dentist's* area, less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *non-participating dentist's* charge.

Altus Dental Plus

Example* of How Claims are Paid – *Participating* v. *Non-Participating Dentist*

	Participating Dentist	***Non-Participating Dentist***
Type of Service	Root Canal	Root Canal
Dentist's Charge	$840	$840
Allowance	$680	N/A
Usual and Customary Charge	N/A	$810
Coverage Level (Refer to *your Benefits Summary)*	80%	80%
Altus Payment	$544 (80% of the $680 *allowance*)	$648 (80% of the $810 *usual and customary charge*)
You Pay	$136 (the difference between *our* payment and the *allowance*)	$192 (the difference between *our* payment and the *dentist's* charge)

***These are examples only. Actual charges and *allowances* will vary.** All services must be complete to qualify for benefits (e.g., permanent crowns cemented, bridge or denture inserted).

NOTE:

- If *you* see more than one *dentist* for the same service; or, need more than one visit, the total amount of *your* benefits will not be more than the amount *you* would have received if only one *dentist* had given all of the treatment. *You* may be liable for the difference.

- If *you* or *your dependent* has coverage for *orthodontic* treatment, *we* will make periodic payments for covered *orthodontic* services spread over the expected course of the treatment. If *you* or *your dependent* is already in active treatment when *you*/he/she becomes eligible for these services, *we* will prorate *our* payments for the remaining treatment. Should coverage cease during active treatment, *we* will discontinue payments as of the date the coverage ended regardless of whether or not the treatment is complete.

Emergency Services

If *you or your covered dependents* require *emergency care* and cannot reasonably reach a *participating dentist*, payment will be made at the same level and in the same manner as if the treating *dentist* was a *participating dentist*.

We cover services received in a dental facility by a licensed *dentist,* as long as they are covered under *your plan. We* do not cover services received in a hospital; surgi-center; or, urgent care facility.

In the case of a life-threatening emergency, *you* should go to the nearest hospital. Hospital claims must be sent to *your* medical insurance plan. If *you* have an urgent dental condition, *you* should go to the nearest *dentist's* office. *You* do not need prior approval. *We* will only pay for *covered services.* Most dental offices treat existing patients within 24 hours for an urgent appointment. If *you* need help finding a *participating dentist,* call *us* at 877-223-0588. *You* may also use *our* online tool at www.altusdental.com.

Medically Necessary Orthodontics

Medically necessary orthodontics (braces and related services) is covered for *members* under the age of 19 only if there is an EHB pediatric dental rider with the *Plan.* Refer to the *Benefits Summary* pages of *your Certificate.* This means that the *member* must have severe and handicapping malocclusion (faulty contact of upper and lower teeth in biting) as defined by a specific scoring used in this area of dental specialty that is referred to as the HLD index score. Treatment is also covered if one or more automatic qualifying conditions is met. Guidelines for determining medical necessity are found at altusdental.com. **Before treatment starts, *you* must have *your dentist* send *us* documentation for approval. *Your dentist* may do this by sending *us* a *pre-treatment estimate* form.**

When Your Benefits May Be Continued

When You Leave the Group

If *you* leave the group to which this policy has been issued, *you* may continue coverage, at *your* expense, for the 31-day period after the date such benefits would have ended because *your* employment ended. However, coverage will terminate on the earliest of: the date *you* become eligible for other similar coverage, the day the policy ends or the day any premium payable by *you* is due and unpaid.

Federal Election to Continue Coverage (COBRA)

You and *your dependents* may have the right to continue coverage through *your plan sponsor* under the provision of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Contact *your plan sponsor* for information concerning this option.

You and *your dependents* may have the right to continue coverage for limited periods under various state laws even under conditions that would otherwise make *you* ineligible for coverage, so long as the appropriate premium is paid in full. Contact *your plan sponsor* for information concerning these options.

When There is Other Coverage

Right to Receive and Release Needed Information

Certain information, including but not limited to Coordination of Benefits (COB), is needed to accurately process claims. *We* have the right to receive information reasonably related to a claim filed under the *plan*. *We* can get this information from, or give it to, any organization or person with a legitimate interest. When *you* file a claim, *you* must give *us* any information needed to process the claim. *You* must give *us* information regarding other insurance coverage when *you* first enroll. *You* must also let *your dentist* know of other coverage when *you* receive care. *We* will ask *you* for updated information from time to time.

Coordination of Benefits

Your plan is designed to prevent overpayment of benefits when *you* or a *dependent* is covered under more than one Plan. The other Plan may be a dental Plan or a medical plan that covers certain services also covered under this p*lan*.

When *you* are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When *you* file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid does not exceed the cost of *covered services*. This process is called "Coordination of Benefits" (COB). If *you,* or a family *member,* are also covered by other medical or dental plans, *we* will coordinate payment with them. *We* use standard

insurance industry guidelines in most cases. The standard guidelines that govern this process are set forth below. If other guidelines apply to *your Plan,* they will be noted on *your Benefits Summary.* As used in these rules, the terms "Plan" and "Allowable Expenses" are defined as follows:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, *usual and customary* item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

The effect of the COB rules on benefits payable during any particular claim period is as follows: If *you* are covered under more than one Plan, the total payment *you* receive will never be more than *your* Allowable Expenses.

The National Association of Insurance Commissioners sets the rules that decide which Plan is primary. They are, in part, as follows:

- The Plan without a coordination of benefits provision is primary.
- When another Plan's rules and this *plan's* rules require this *plan* to pay its benefits first, this *plan* is primary.
- The Plan covering the patient directly rather than as an employee's *dependent* is primary.
- If a child is covered under both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.
- If a child is covered under both parents' Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents' Plans, the Plan of the male parent is primary).
- If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.
- If the parents are separated or divorced, benefits for the child are determined in this order:
    - The Plan of the parent with custody.
    - The Plan of the *spouse* of the parent with custody.
    - The Plan of the parent not having custody, unless one of the parents is made responsible for the child's health expenses by a court decree.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
- If a full-time student is eligible for coverage as a *dependent* under this *Certificate*, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this *plan*.
- The benefits of a Plan which covered a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same is true if a person is a *dependent* of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:
    - First, the benefits of a Plan covering the person as an employee, *member* or *subscriber* (or as that person's *dependent*);
    - Second, the benefits under the continuation coverage.
    - If the other plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
    - If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if *you* use more benefits than *you* are covered for during a calendar year, the insurer covering *you* first will cover *you* up to its *allowance.* The secondary insurer will cover any allowable benefit *you* use over that amount. The insurers will never pay more than the total amount of coverage that would have been provided if benefits were not coordinated.

Subrogation

If someone caused *your* illness or injury, *you* may have the legal right to get back some of *your* dental care costs. When *you* have this right, *you* must let *us* use it if *we* decide to recoup any payments *we* made for services related to the illness or injury. If *you* use this right to recoup money from someone else, *you* must repay *us* for the payments *we* made. *Our* right to repayment comes first. It can be reduced only by *our* share of *your* reasonable cost of collecting *your* claim against the other person; or, if the payment received is for other than dental expenses. *You* must give *us* information and assistance and sign documents needed to help *us* receive *our* repayment. *You* must not do anything that might limit *our* repayment.

Facility of Payment

If another Plan pays a benefit that should have been paid under this *plan, we* may reimburse the other Plan for that amount. It will be considered a benefit paid by this *plan*.

Right of Recovery

If *we* pay more than *we* should have paid under the COB provision, *we* have the right to recoup the excess amount *we* paid. This includes recouping from other insurance companies and organizations. The amount that can be recouped includes the reasonable cash value of any benefits provided in the form of services.

When You Have a Claim

When to File a Claim

You should send *us* completed claim forms for services covered under this *Certificate*. *You* have up to one year from the date *you* get services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. *Participating dentists* will send claim forms on *your* behalf. *You* will not be responsible for payment on *covered services* when a *participating dentist* sends claims more than one year after the date *you* get the service; except, for any *deductibles; copayments; coinsurance;* or amounts in excess of the *annual dollar maximum. We* will deny claims that a *non-participating dentist* sends to *us* more than one year after *you* get the services. *You* must pay such claims, unless the failure to send a claim within one year was because of a legal incapacity.

How to File a Claim

Participating Dentist

When *you* go to a *dentist* who has agreed to participate, *your* claim will be filed for *you*. *Participating dentists* are encouraged to file claims within six (6) months from the *date of service.* In no event may a *participating dentist* file a claim more than one year after the *date of service.* It must include all necessary supporting information such as x-rays. *We* accept claims from *dentists* on paper and in an electronic, HIPAA compliant format.

Non-participating Dentist

When *you* go to a *dentist* who is not participating, *you* must mail the claim to the following address. *You* don't have to do this if the *dentist* agrees to file it for *you*. Dental claim forms are available on *our* website at: **www.altusdental.com** or from *your dentist*.

MAIL CLAIMS TO: Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, RI 02901-1557

Claims Procedures

Call Customer Service if *you* have a question about how a claim was paid, or why *we* denied it. The number is 877-223-0588. Customer Service representatives are available Monday – Thursday from 8 a.m. to 7 p.m. ET, and Friday from 8 a.m. to 5 p.m. ET. *You* have a right to request a full and fair review of *your* claim. **To consider a claim for payment, *we* must get it within one year of the date *you* get the service.**

Pre-treatment Estimates / Prior Authorization

A pre-treatment estimate / prior authorization is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic*; and elective *orthodontic* services.

Prior Authorization

Prior authorization is required for *medically necessary orthodontic* treatment if covered by *your Plan.* *Medically necessary orthodontics* is covered for *dependent* children under age 19 only if there is an EHB pediatric dental rider with the *Plan.* Refer to the *Benefits Summary* pages of *your Certificate.* **No payment will be made if prior authorization is not obtained.**

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example is if *you* lose coverage before the new service is finished.

We must have all of the information *we* need to review the treatment plan; and, to make a benefit decision. *We* will send *you our* initial decision in writing within 15 calendar days. For urgent or emergency services, *we* will give *you our* decision within 72 hours.

If the service is denied, the notice will explain the reason(s) for the denial. The notice will include the process for filing an appeal. Once a denial is made, *you* have 180 days from the day *you* get *our* notice to file an appeal.

Post-service Claims

A post-service claim is a claim that is filed after dental care has been received. All services must be complete to qualify for benefits; e.g., permanent crowns must be cemented; bridges or dentures must be inserted. *We* will send *you our initial decision in writing* within 30 calendar days of the day *we* receive the claim. *We* will send *you* a notice if *we* can't process a post service claim because information is missing. The notice will be sent to *you* within 30 days. It will tell *you* what additional information *we* need to process the claim. A *participating dentist* must give *us* the information *we* need to process a claim. If not provided, the *dentist* may not charge the patient for any un-paid amount. Refer to the **Expedited Reviews** section for claims involving urgent or emergency services.

We will provide notice or payment to *you* or *your dentist* within 45 days after receipt of a complete claim. A complete claim has all the supporting documentation *we* need to make a claim decision. If *we* do not notify or pay within this time, *we* will pay interest on the amount not paid. Interest will be paid at a rate of 1 ½ percent per month (not to exceed 18% per year). Interest is paid from the 45th day after *we* received the complete claim.

If the service is denied, the notice will explain the reason(s) for the denial. It will include the process for filing an appeal. Once a denial is made, *you* have 180 days from the day *you* receive *our* notice to file an appeal.

To Appeal an Adverse Benefit Decision

If *you* receive an *adverse benefit decision, you* have the right to have it reviewed. An adverse decision means a decision not to approve a service, in whole or in part. *Adverse benefit decisions* include:

- *Administrative adverse benefit decisions.* These do not require us to use dental judgment or clinical criteria. Examples include decisions not to approve because a *member* is not eligible for coverage, or a decision that a benefit is not a covered benefit under the *Plan,* or that the *waiting period* has not been met, or that the frequency on a service has gone above the limit.

- *Non-administrative adverse benefit decisions.* These require *us* to use dental judgment or clinical criteria to determine if the service is *dentally necessary* and/or appropriate. These decisions are made by *dentists* using *our* review guidelines, which detail the clinical criteria that must be met for a service to be covered. These guidelines are found at altusdental.com.

For all adverse decisions, follow the process below to file an appeal. If *you* are in Rhode Island and feel that *we* did not follow the appeals process as described in this part, *you* may contact the Rhode Island Resource, Education and Assistance Consumer Helpline (RIREACH) at 1210 Pontiac Ave., Cranston, RI 02920, 1-855-747-3224,

www.rireach.org. This is Rhode Island's Health Insurance Consumer Assistance Program.

When to File an Appeal: *You* must file *your* appeal within 180 days of the date *you* receive the original coverage denial.

How and Where You Can File an Appeal: *You* must file an appeal in writing. For urgent or emergency services*, *you* may call Customer Service to start an appeal. **Send *your* appeal to: Altus Dental Insurance Company, Inc., Attn: Appeals, P.O. Box 1557, Providence, RI, 02901-1557.** *Your* appeal should ask *us* to reconsider and tell *us* why *you* believe the service was wrongly denied. It should include a copy of the Explanation of Benefits or Pre-treatment Estimate notice. *You* should include the patient's name; the *subscriber* identification number; and, a detailed description of *your* concern. Appeals of coverage decisions based on *dental necessity* should also include clinical treatment notes; narratives; photos; x-rays; charting; and, any other necessary clinical documents that support *your* claim. To be covered, services must meet the criteria in *our* review guidelines found at altusdental.com. *Your* appeal will be reviewed based on the material *you* send *us.* If the file is incomplete, *we* might not have all the information *we* need to make an appropriate decision. *You* should add any information that is relevant to considering the appeal.

The Explanation of Benefits or Pre-treatment Estimate notice sent to *you* with the original denial has numbered messages. These messages explain the reason(s) for *our* denial. They also refer to any plan terms the decision was based on; and may refer to any guideline; protocol; or, criteria *we* used to make the denial. *You* have the right to see copies of all documents related to the claim. *We* will also give *you* a copy of any internal rule, guideline, or protocol *we* used. *We* will also explain the scientific or clinical judgment *we* used to make *our* decision. *We* will give *you* this information, if *you* ask for it, at no charge.

Who Will Review Your Appeal: Appeals will be investigated by an Appeals Coordinator in *our* Program Integrity department. He or she will talk with appropriate departments and decisions will be made by individuals who know about the issues involved in *your* appeal. Appeals regarding *non-administrative adverse benefit decisions* will be reviewed by a licensed *dentist* who has not been involved in any prior reviews and who has not been involved in the direct care of the patient.

Response to Your Appeal: *We* will reconsider *our* decision and send *you* a written response within 15 calendar days of receiving *your* appeal (72 hours for urgent or emergency services). If *we* do not change *our* decision, *you* have 180 days from the date *you* receive *our* notice to continue the appeal process by sending *us* a written request for an appeal. *We* will send *you* a written response within 15 calendar days of receiving *your* request (72 hours for urgent or emergency services). Before *we* make a final internal appeal decision, *you* have the right to inspect the entire appeal file and add information. Additional information must be sent in writing and will be held confidential in accordance with applicable state and federal laws.

External Review Option: If *your* final internal appeal to reverse a *non-administrative adverse benefit decision* is denied, *you* may request an external appeal. External appeals are sent to an independent review agency. *You* have 125 calendar days from the date *you* receive *our* final internal appeal decision to send *your* request to *us* in writing. *You* can add information to the file for review by sending it to *us* in writing within 5 business days after starting the appeal. *We* will send all documentation *we* reviewed to the review agency.

Cost for External Review: *You* must pay $50 (up to a maximum of $150 per *policy year* per *member).* Include a check made payable to Altus Dental Insurance Company, Inc. for *your* share of the cost with *your* request. If *your plan* includes pediatric dental essential health benefits for children under age 19 and the appeal involves a service for a *member* under age 19, the cost of the external review is $25 (up to a maximum of $75 per *policy year* per *member).* The fee may be waived if paying it would cause *you* undue financial hardship.

Response to Your External Appeal: The review agency will notify *you* about the outcome of *your* appeal within 10 calendar days of their receipt of all information needed to complete the review. If the external review agency overturns *our* decision, *we* will reimburse *you* within 60 days of the notice of overturn for *your* share of the fee.

Additional Information: Under certain circumstances, once the internal appeals process is exhausted, the *member* may also have the right to bring a civil action. This right is given under Section 502(a) of the ERISA Act. The *member* does not have this right if he/she is a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

Expedited Reviews

If *your* claim involves urgent or emergency services as defined below, *you* have the right to an expedited review. For expedited reviews, *we* will complete *our* review and make a decision within 72 hours. *We* must receive all of the information needed to review the claim. Call Customer Service to obtain an expedited review.

*"Urgent services" includes those resources necessary to treat a symptomatic health care condition that a prudent layperson, acting reasonably would believe necessitates treatment within a 24 hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include "emergency services" as defined below.

"Emergency services" means those resources provided in the event of the sudden onset of a health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Resolution of Inquiries and Complaints

Inquiries

If *you* have questions or concerns, send an email to customerservice@altusdental.com. *You* may also call Customer Service toll-free at **1-877-223-0588;** or, mail or fax the inquiry to: **Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI 02901-1557, Fax: 401-457-7260.** *We* will try to resolve it as soon as *we* can. The appeals process above describes how to appeal a claim decision.

Complaints

If *you* have a complaint, send an email to customerservice@altusdental.com; or, call *us* at 1-877-223-0588. *We* settle most complaints on first contact. However, if *your* complaint needs more research (e.g., it involves quality of care; fraud; or, abuse, etc.), *we* will settle it as soon as *we* can. If *you* are not satisfied, *you* may call the Massachusetts Division of Insurance.

Other Provisions

Claims Review

This *Certificate* provides coverage only for *dentally necessary* and appropriate care. The decision whether a service is *dentally necessary* is solely for the purpose of claims payment. It is not a professional dental judgment. *You* have the right to appeal *our* decision. Refer to the **Claims Procedures** section, and the definition of "*dentally necessary*" in the **Definitions** section.

Although *we* may conduct review, *we* do not act as a *dentist. We* do not provide dental care. *We* do not make dental judgments. Nothing here is meant to change; or, affect *your* relationship with *your dentist.*

Access to Records

When *you* file a claim, *you* agree to give *us* the right to get, from any source, all dental records and/or related information that *we* need. *We* will keep *your* information confidential. *We* can also have a licensed *dentist* examine, at *our* expense, any person making a claim. *You* agree that *dentists* may give *us* individually identifiable health information. *You* also agree that *we* may use and disclose such information as described in *our* Notice of Privacy Practices. *You* can find this Notice on *our* website. *You* can also call Customer Service for a copy.

Participating dentists must give *us* all of the information *we* need to process *your* claim. They will not charge for this service.

If *you* get services from a *non-participating dentist*, *you* must help *us* get all of the records *we* need. *We* will not pay the *dentist* for giving *us* this information. If the *non-participating dentist* does not give *us* this information, *we* may not provide benefit payments to *you*.

Document Changes

We or *your plan sponsor* may change a part of *your Certificate*. This is usually done on the anniversary date of *your plan sponsor's* contract with *us.* Any change will have an effective date. The change will apply to all benefits for services *you* receive on or after the effective date. Changes in the *Certificate* are not valid unless approved by an officer of Altus Dental; and, are made a written part of this *Certificate* or the *Benefits Summary*. *We* will give the group representative of *your plan sponsor* at least 60 days advance notice when *we* make any *material changes* to *covered services.* The notice will include any changes in clinical review standards. The notice will also include the effect such changes may have on *your* personal liability for the cost of such changes. *We* will also give *your* group representative an annual notice listing all *participating dentists.*

We will provide an addendum or supplementary insert for each enrolled *subscriber* residing in Massachusetts for notice of all *material changes* to this *Certificate*.

Notices

To *You*: When *we* send a notice to *your plan sponsor*, *we* will send it by first class mail, e-mail or fax. Once *we* send the notice, *we* are not responsible for its delivery. It will be *your plan sponsor's* responsibility to notify *you* if the notice is sent to *your plan sponsor.* This applies to any notices regarding premium charges as well as to a notice of a change in the premium charge or a change in the *Certificate*. If *your* name or mailing address should change, *you* should notify *us* or *your plan sponsor* at once. Be sure to give *us* or *your plan sponsor* both *your* old name and address as well as *your* new name and address.

To *Us:* Send mail to Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI 02901-1557; or email us at customerservice@altusdental.com. Always include *your* name and *your* ID number.

Acts of Providers

We will not get involved with the relationship between *dentists* and patients. *We* are not responsible if a *dentist* refuses to treat *you. We* are not liable for injuries or damages resulting from the acts or omissions of a *dentist*. *We* are not responsible if *you* are dissatisfied with the treatment or services *your dentist* provides.

Right to Recover Overpayments

If *we* pay more than *we* should, *we* can recoup payment from either *you;* or, the *dentist*. *We* can also deduct any payment *we* have made from any benefits properly paid under this policy if the payment was made:

1. In error; or
2. Due to a misstatement in a proof of loss; or
3. Due to fraud or misrepresentation of a material fact to procure coverage or under the terms of the coverage; or
4. For an ineligible person; or,
5. Due to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease, to the extent that such benefits are recovered.

If *we* have already made claim payments to a covered person; *we* can reduce the payment *we* would make on a future claim to recoup an overpayment.

Conformity with Applicable Laws

We amend any term of this *Certificate* which conflicts with any relevant law. *We* do this to conform to the minimum requirements of such law.

This *Certificate* and the *Benefits Summary,* is a description of *your* benefits; rights; and, obligations under the *plan*.

Your subscriber ID card identifies *you* as a person with these benefits. Please show the ID card to *your dentist* whenever *you* or *your dependents* receive services.

Preexisting Conditions

There are no preexisting condition limitations in this *plan.*

Waiting Periods

Some dental plans require *you* to wait a certain amount of time before a particular procedure is covered. This is called a *waiting period.* If *your plan* has a *waiting period,* it will be noted in the *Benefits Summary.*

Services Not Covered by the Plan

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

- Services that are not *dentally necessary* and appropriate according to *our* review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; *orthodontics;* and, oral surgery. *We* will make a decision whether a service is *dentally necessary* based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a *dentist. Our* guidelines can be found on *our* website at www.altusdental.com. *You* can have *your dentist* send *us* a request for a Pre-treatment Estimate in advance of the service to see if the service meets *our* guidelines.

- Services greater than the *annual maximum.*
- 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* decide is employment-related.
- Services *you* would not have to pay for if *you* did not have this Altus Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done 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 done by someone who is not a licensed *dentist* or a licensed *hygienist* working 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 needed because *you* grind *your* teeth or due to erosion, abrasion, or attrition.
- Services done mainly 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.
- Prescription drugs.
- Guided tissue regeneration.
- General anesthesia or intravenous sedation given by anyone other than a *dentist.*
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.

We can adopt and apply policies that *we* deem reasonable when *we* approve the eligibility of *subscribers;* and, the appropriateness of treatment plans and related charges.