altus dental
Altus Dental Insurance Company, Inc.

Benefit Highlights

Plus Plan

Welcome to Altus Dental

This flyer highlights your dental benefits and explains how your Plus plan works. At Altus Dental we pride ourselves on providing our members with excellent customer service. We look forward to providing you and covered family members with dental insurance. When your coverage begins, we will send you an ID card and a Certificate of Coverage.

How to Contact Us

INTERNET
You can access your account information online 24 hours a day, 7 days a week at www.altusdental.com

INFOLINE
1-877-223-0588
InfoLine, our automated telephone information system, is also available 24 hours a day, 7 days a week.

CUSTOMER SERVICE
1-877-223-0588
Our customer service representatives are available Monday – Thursday 8 am to 7 pm and Friday 8 am to 5 pm ET

CITY OF PEABODY & PEABODY PUBLIC SCHOOLS – LOW OPTION PLAN

Your group number: **7600-0001, 0003**

The annual maximum is: $1000 per member per calendar year
The annual deductible is: $50 per individual /$150 per family
The maximum lifetime cap is: Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Two oral exams per calendar year
- Two cleanings per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- One set of bitewing x-rays per calendar year
- One complete x-ray series or panoramic film every 36 months
- Single x-rays as required
- Sealants for children under age 16, once per unrestored permanent molar every 36 months
- Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months

Plan pays 80%; Member Coinsurance 20% Deductible Applies

- Palliative treatment (minor procedures necessary to relive acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on all teeth.
- Root canal therapy for permanent front teeth
- Extractions and other routine oral surgery not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for complex surgical procedures
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges
- Rebasing or relining of partial or complete dentures; once every 60 months

Plan pays 50%; Member Coinsurance 50% Deductible Applies

- Root canal therapy for bicuspids and molars
- 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 tooth every 60 months

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

Monthly Rates: 7/1/2017-6/30/2019	Bi-Weekly Rates:
$34.39 Single	$17.20 single
$96.22 Family	$48.11 family

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Altus Dental Insurance Company Inc.

Benefit Highlights

Plus Plan

CITY OF PEABODY & PEABODY PUBLIC SCHOOLS – HIGH OPTION PLAN

Your group number: **7600-0002, 0004**

The annual maximum is:	$1500 per member per calendar year
The annual deductible is:	$50 per individual /$150 per family
The maximum lifetime cap is:	Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Two oral exams per calendar year
- Two cleanings per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- One set of bitewing x-rays per calendar year
- One complete x-ray series or panoramic film every 36 months
- Single x-rays as required
- Sealants for children under age 16, once per unrestored permanent molar every 36 months
- Space maintainers for lost deciduous (baby) teeth, replacement limited to once every 60 months

Plan pays 80%; Member Coinsurance 20% Deductible Applies

- Simple extractions not requiring surgery
- Palliative treatment (minor procedures necessary to relive acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on all teeth.
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges
- Rebasing 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 tooth every 60 months

Plan pays 50%; Member Coinsurance 50% Deductible Applies

- Surgical extractions and other routine oral surgery not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Surgical placement of endosteal implant and abutment; replacement limited to once every 60 months
- Crowns over natural teeth, build ups, posts and cores; replacement limited to once every 60 months
- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures; 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 Rates: 7/1/2017-6/30/2019	Bi-Weekly Rates:
$47.89 Single	$23.95 single
$119.78 Family	$59.89 family

Welcome to Altus Dental

This flyer highlights your dental benefits and explains how your Altus plan works. At Altus Dental we pride ourselves on providing our members with excellent customer service. We look forward to providing you and covered family members with dental insurance. When your coverage begins we will send you a welcome kit and a Certificate of Coverage.

How to Contact Us

[redacted]

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ENROLLMENT FORM

Please print.

P.O. Box 1557
Providence, RI 02901-1557
877-223-0588

Employer Group Name	Altus Dental Group Number	Date of Hire	Location No. (if applicable)

Social Security No. / Subscriber I.D. No.	Subscriber Name: First - Last	

Date of Birth - MM / DD / YYYY	Street Address / P.O. Box No.	Email Address

Effective Date of Action:	Apt. No.	City	State	Zip

QUALIFYING EVENT

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers' Compensation
- ____ Return From Leave of Absence
- ____ Dependent's Loss of Coverage
- ____ Full-Time / Part-Time Status
- ____ Death of a Member

ACTION CODE (Check one. *Changes must be made on the first of the month.*)

ADDITIONS:

- ____ New Subscriber
- ____ Add Dependent to Family
- ____ Reinstatement

TERMINATION:

- ____ Remove Subscriber
- ____ Remove Dependent / Student

STATUS CHANGE:

- ____ Change "Type of Coverage"
  Please indicate change (e.g. Individual to Family) in the section below.
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:

- ____ Reinstatement of Subscriber
- ____ Addition of Dependent — (From prior ID # _____)

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

DENTIST INFORMATION

List the dentists you or your covered family members use:

Dentist(s) Last Name	First Name	City/Town

CORRECTIONS / OTHER REMARKS

TYPE OF COVERAGE (Check one) ☐ **Individual** ☐ **Family**

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ☐ **No** ☐ **Yes** **If Yes, Please Complete the Section Below.**

Other Dental Insurance Name: _____ **Type of Coverage:** ☐ **Individual** ☐ **Family**

Other Dental Insurance Address: _____

Employer Name Through Which You /Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ **No** ☐ **Yes** **If Yes, Please Complete the Section Below.**

Name of Medical Insurance Company / HMO: _____ **Type of Coverage:** ☐ **Individual** ☐ **Family**

Name of Health Plan / Type of Coverage: _____

Employer Name Through Which You / Your Dependents Have Other Insurance: _____

Group Policy No.	Policyholder Name	Policyholder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Altus Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ **Date** _____

Benefits Administrator Authorization _____ **Date** _____