



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

For more information, please visit our website at www.altusdental.com

PHONE

1-877-223-0388
 Monday - Friday
 8:00am - 5:00pm EST
 1-800-223-0388
 24 hours a day

CUSTOMER SERVICE

1-877-223-0388
 Monday - Friday
 8:00am - 5:00pm EST
 1-800-223-0388
 24 hours a day

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 relieve 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
- Rebasement or relining of partial or complete dentures; once every 60 months

Plan pays 50%; Member Coinsurance 50% Deductible Applies

- Root canal therapy for bicuspid 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: 7/1/2015-6/30/2017

\$33.39 Single
 \$93.41 Family

Bi-Weekly Rates:

\$16.70 single
 \$46.71 family



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
- 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 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: 7/1/2015-6/30/2017

Bi-Weekly Rates:

\$46.49 Single

\$23.25 single

\$116.29 Family

\$58.15 family

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 visit our website for information on the 24 hours a day 7 days a week at www.altusdental.com

PHONE

1-877-221-0388

Make our customer care specialists your go-to for any questions you may have. Our specialists are available 24 hours a day 7 days a week.

CUSTOMER SERVICE

1-877-221-0388

Discussion with our Customer Service Specialists are available Monday - Thursday 8 am to 7 pm and Friday 8 am to 5 pm PT.

ENROLLMENT FORM

Please print.

Employer Group Name		Altus Dental Group Number		Date of Hire	Location No. (if applicable)																								
Social Security No. / Subscriber ID No.		Subscriber Name: First - Last		Email Address																									
Date of Birth - MM/DD/YYYY		Street Address / P.O. Box No.																											
Effective Date of Action:		Apt. No.	City	State	Zip																								
QUALIFYING EVENT <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> New Hire/Re-Hire <input type="checkbox"/> Return From Leave of Absence <input type="checkbox"/> Marriage <input type="checkbox"/> Dependent's Loss of Coverage <input type="checkbox"/> Divorce <input type="checkbox"/> Full-Time/Part-Time Status <input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Death of a Member			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. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																							
ACTION CODE (Check one. Changes must be made on the first of the month.) <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement			DENTIST INFORMATION List the dentists you or your covered family members use: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Dentist(s) Last Name</th> <th style="width: 30%;">First Name</th> <th style="width: 30%;">City/Town</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Dentist(s) Last Name	First Name	City/Town																					
Dentist(s) Last Name	First Name	City/Town																											
TERMINATION: <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent / Student			CORRECTIONS / OTHER REMARKS 																										
STATUS CHANGE: <input type="checkbox"/> Change "Type of Coverage" Please indicate (e.g. individual to Family) under "Type of Coverage". <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Sublocation # _____ to # _____																													
COBRA: <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent — (From prior ID # _____)			TYPE OF COVERAGE (Check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family		PLAN TYPE (Please check box if applicable.) <input type="checkbox"/> High Option <input type="checkbox"/> Low Option																								
COORDINATION OF BENEFITS																													
DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																													
Other Dental Insurance Name: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Please Complete the Section Below.																													
Name of Medical Insurance Company / HMO: _____				Type of Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> 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 _____