

**SELECT BOARD**

Eric S. Beckerman, Chair  
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**TOWN ADMINISTRATOR**

# Town of Avon Massachusetts

Town Offices  
Buckley Center 02322  
(508) 588-0414  
FAX (508) 559-0209



## ALTUS DENTAL INSURANCE

The annual renewal date for optional dental insurance through Altus Dental Insurance Company is coming up on July 1, 2025. The Town has received rates which will be effective from July 1, 2025 through June 30, 2027. The premiums have not increased from the previous year.

The premium will be effective with your June deduction, as the June deduction pays for the July premium.

### Altus Dental Rates effective July 1, 2025 through June 30, 2027

| Plan Type     | Premium  | Town Share<br>(at 0%) | Monthly<br>Deduction |
|---------------|----------|-----------------------|----------------------|
| <b>DENTAL</b> |          |                       |                      |
| Individual    | \$50.19  | \$0                   | \$50.19              |
| Family        | \$138.04 | \$0                   | \$138.04             |

Altus Dental Insurance Company, Inc.  
PO Box 1557  
Providence, RI 02901-1557  
877-223-0588

| GROUP INFORMATION     |              |                              | To be completed by Human Resources or Benefit Administrator. |  |  |
|-----------------------|--------------|------------------------------|--------------------------------------------------------------|--|--|
| Employer / Group Name |              |                              | Group No.                                                    |  |  |
| Dental Division No.   | Date of Hire | Location No. (if applicable) |                                                              |  |  |

| I. SUBSCRIBER INFORMATION     |  |                            |      |                          |     |
|-------------------------------|--|----------------------------|------|--------------------------|-----|
| Subscriber Name (First, Last) |  | Date of Birth (MM/DD/YYYY) |      | Social Security / I.D. # |     |
| Street Address / P.O. Box No. |  | Apt. No.                   | City | State                    | Zip |
| Preferred Mobile Number       |  | Preferred Email            |      |                          |     |

| II. ENROLLMENT INFORMATION            |                                                  |                                                  |                                                                    |                                                       |                                                                 |
|---------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------|
| Effective Date of Action (MM/DD/YYYY) |                                                  | TYPE OF COVERAGE <input type="checkbox"/> Dental |                                                                    |                                                       |                                                                 |
| QUALIFYING EVENT                      | <input type="checkbox"/> Open Enrollment         | <input type="checkbox"/> Marriage                | <input type="checkbox"/> Birth or Adoption                         | <input type="checkbox"/> Return from Leave of Absence | <input type="checkbox"/> Full-Time/Part-Time Status             |
|                                       | <input type="checkbox"/> New Hire/Re-hire        | <input type="checkbox"/> Divorce                 | <input type="checkbox"/> Workers' Compensation                     | <input type="checkbox"/> Loss of Coverage             | <input type="checkbox"/> Death of a Member                      |
| ACTION CODE                           | ADDITIONS                                        |                                                  | TERMINATION                                                        |                                                       | COBRA                                                           |
| Check one.                            | <input type="checkbox"/> New Subscriber          | <input type="checkbox"/> Remove Subscriber       | <input type="checkbox"/> Name / Address Change                     |                                                       | <input type="checkbox"/> Reinstatement of Subscriber            |
|                                       | <input type="checkbox"/> Add Dependent to Family | <input type="checkbox"/> Remove Dependent        | <input type="checkbox"/> Transfer from Division # _____ to # _____ |                                                       | <input type="checkbox"/> Addition of Dependent Prior ID # _____ |
|                                       | <input type="checkbox"/> Reinstatement           | List name in Section III                         |                                                                    |                                                       |                                                                 |

| III. DEPENDENT INFORMATION |                          |                            |              |                          |
|----------------------------|--------------------------|----------------------------|--------------|--------------------------|
| First Name                 | Last Name (if different) | Date of Birth (MM/DD/YYYY) | Relationship | Enroll In:               |
|                            |                          |                            |              | Dental                   |
|                            |                          |                            |              | <input type="checkbox"/> |
|                            |                          |                            |              | <input type="checkbox"/> |
|                            |                          |                            |              | <input type="checkbox"/> |
|                            |                          |                            |              | <input type="checkbox"/> |
|                            |                          |                            |              | <input type="checkbox"/> |
|                            |                          |                            |              | <input type="checkbox"/> |

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. 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 |
|--------------------|------|--------------------------------------|------|

## TOWN OF AVON

Group Number: 7932-0001

Altus Dental Plus - Includes Connection Dental and DenteMax Networks

### Annual Maximum

\$1,200

### Maximum Lifetime Cap

Unlimited

Carry Over Max: \$250

In Network Bonus: \$100

Carry Over Limit: \$1000

### Deductible

Individual \$0

Family \$0

### Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

**P Pre-treatment Estimate Recommended**

**A Prior Authorization Required**

See back page for additional information >

### Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per calendar year
- Cleanings twice per calendar year. More frequent cleanings may be allowed for pregnant women, or patients with diabetes or compromised immune systems. Documentation is required
- 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 unilateral space maintainers once per lifetime for lost deciduous (baby) teeth. Bilateral space maintainers once every 60 months for lost deciduous (baby) teeth
- Periodontal maintenance following active therapy two per year

### Plan pays 80%; Member Coinsurance 20%

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings and composite (white) fillings
- 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.
- P • Root planing and scaling once per quadrant every 24 months
- P • Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered)
- P • Gingivectomies once per site every 24 months
- P • Soft tissue grafts once per site every 60 months
- P • Crown lengthening once per site every 60 months
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months

### Plan pays 50%; Member Coinsurance 50%

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

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms. The Certificate includes any limitations or exclusions not seen here. For a complete listing of frequencies and limitations go to [www.altusdental.com/el](http://www.altusdental.com/el). To be covered, services must be dentally necessary and appropriate as per our review guidelines.

**Note:** *This plan does not include a missing tooth clause. In addition, if covered, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist.* Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

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

### Out-of-Network Coverage

You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate in our network. Non-participating dentists have not agreed to accept the Altus Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. To be eligible, all claims must be filed within one year of the date of service. To find a participating dentist near you, use our Find A Dentist tool at [www.altusdental.com](http://www.altusdental.com).

### How to Find a Dentist

Choose from Altus Dental's extensive network of dentists, you're sure to find one that's right for you. Visit [www.altusdental.com](http://www.altusdental.com) to use our online Find A Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs – as well as maps and driving directions.

### Beyond Benefits

When you visit us at [www.altusdental.com](http://www.altusdental.com), you can access a wealth of important dental health information and manage your plan by:

- Checking your benefits and claims
- Reviewing your deductibles and maximums
- Using our Find A dentist tool to find a dentist in your area

### Notice of Nondiscrimination and Accessibility Policy

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

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

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

# Take Advantage of Maximum Carry Over



**altus  
dental™**

## Get the most out of your benefits with Maximum Carry Over

Taking advantage of preventive care services like regular dental check-ups and exams is the best way to maintain your oral health.

And with Altus Dental's Maximum Carry Over provision, you can carry unused portions of your annual maximum to the following year as long as you use those preventive care benefits.

These unused benefit dollars can be saved in case more expensive treatments are needed later.

Depending on your particular plan's benefits, you can carry over unused balances up to \$1,500.

## Who is eligible?

You are eligible for Maximum Carry Over benefits if:

1. You and your dependents have been enrolled in the plan for a full calendar year.
2. You receive a preventive care benefit (e.g. exams and cleanings) during the year.
3. Your claims during the year did not exceed the annual cap set under your benefit plan.

Maximum Carry Over benefits are calculated based on your plan's annual maximum:

|                   | Plan A  | Plan B  | Plan C  |
|-------------------|---------|---------|---------|
| ANNUAL MAXIMUM    | \$1,000 | \$1,500 | \$2,000 |
| CLAIMS CAP        | \$500   | \$700   | \$800   |
| ANNUAL CARRY OVER | \$250   | \$350   | \$400   |
| CARRY OVER BONUS* | \$100   | \$150   | \$200   |

\*A bonus is available for members who receive all services from participating Altus Dental dentists.

Members are eligible to accrue benefit dollars up to their plan's Carry Over maximum.

|                    | Plan A  | Plan B  | Plan C  |
|--------------------|---------|---------|---------|
| ANNUAL MAXIMUM     | \$1,000 | \$1,500 | \$2,000 |
| CARRY OVER MAXIMUM | \$1,000 | \$1,250 | \$1,500 |

**Please note:** Carry Over amounts are made available to the member by March 15th of the following plan year. This feature applies to benefit programs that cover major restorative services (crowns and bridges) and offer annual benefit maximums of \$1,000 or more. Orthodontic benefits and lifetime benefit programs are excluded from this provision.

## How Maximum Carry Over works

Jordan's dental plan offers an annual maximum of \$1,000. Last March, Jordan received a cleaning and dental exam. Later in the year, he had a filling replaced. The cost for these procedures did not exceed his company's \$500 claims cap. As a result, Jordan is eligible to carry over \$250 to the new plan year. Because Jordan received treatment from participating Altus Dental dentists, he is eligible for a Carry Over bonus of \$100 - bringing his Carry Over total to \$350 (\$250 + \$100).

## Maximum Carry Over definitions

### Claims cap:

An annual limit on the amount of claims dollars you can spend to qualify for Carry Over benefits.

### Maximum Carry Over:

The maximum amount of dollars that a member is eligible to carry over to the following year.

### Preventive care benefits:

Routine dental exams and cleanings.

### Major restorative services:

More expensive dental treatments that include crowns and bridges.

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