DENTAL PLAN OPEN ENROLLMENT PERIOD

Open Enrollment Ends December 12, 2025

It is time again to decide if you want to change your dental plan for next year. If you are in the Open Plan or the Altus Closed Plan and wish to stay enrolled in your current plan, you do not need to do anything. **Please note that the Trust has discontinued the previously offered Delta Dental PPO Plan effective December 31, 2025. Existing Delta enrollees must select either the Altus Closed Plan or the Open Plan. Any Delta enrollees that do not make an election during the Open Enrollment period will be moved to the Open Plan.**

If you are in the Altus Closed Plan Family Plan and your dependents will age out of the plan, please contact the Trust Administrator to determine your options. If you wish to change your plan, you must fill out the form below.

Each year we get questions asking which plan is best for you and your family. Although that decision is yours to make, we are providing a brief description of each plan starting on page 5. The Open Plan is more fully described on the reimbursement form. You may visit the Altus website at www.altusdental.com.

The MA/MOSES Health and Welfare Trust Fund open enrollment period extends until December 12, 2025. This is your yearly chance to change dental plans. All changes take effect January 1, 2026.

If you wish to stay enrolled in your current plan, you do not need to do anything.
If you wish to change your enrollment, you must fill out the form below and return it directly to the Trust Fund via: email (HWTAdmin@moses-ma.org), fax (617-367-9371), or by mail to the address below.

- ☐ I am currently enrolled in the Open (Reimbursement) Plan or Delta Dental PPO plan and would like to switch to the Altus Plan. Please send me the necessary enrollment information. I understand that I will be required to pay a weekly co-premium of:
  - ☐ $2.00/week for an Altus individual plan
  - ☐ $6.00/week for a 2-person Altus plan
  - ☐ $11.00/week for an Altus family plan

- ☐ I am currently enrolled in the ☐ Delta Dental PPO Plan / ☐ Altus Plan and would like to switch to the Open (Reimbursement) Plan.

Name: _____ Date: _____

Email: _____ Agency: _____

Signature: _____

Mail to: **MA/MOSES HEALTH & WELFARE TRUST FUND**
P.O. Box 8099
Boston, MA 02114