

How the DENTAL plan works:

Each plan pays a **flat dollar amount** per dental procedure based on the fee schedule in your policy. Visit one of our in-network providers for additional savings. We will pay the lesser of the provider's actual charge or the amount listed on the Schedule of Covered Dental Procedures, subject to policy year deductible, annual maximum, and limitations and exclusions. The following is a partial listing of the 300+ insured covered dental procedures and schedule amounts. Choose the right plan for you and your family – Value, Standard or Preferred!

SAMPLING OF COVERED DENTAL PROCEDURES		SCHEDULE AMOUNT		
PROCEDURE CODE	DESCRIPTION	VALUE PLAN	STANDARD PLAN	PREFERRED PLAN
Oral Evaluations }				
D0120	Periodic Oral Evaluation	\$19	\$27	\$35
D0150	Comprehensive Oral Evaluation	\$31	\$44	\$57
Prophylaxis (Simple Cleaning) }				
D1110	Prophylaxis - Adult	\$36	\$52	\$67
D1120	Prophylaxis - Child	\$26	\$37	\$48
Radiographs }				
D0210	Intraoral - Complete Series (Including Bitewings)	\$53	\$75	\$98
D0272	Bitewings - Two Films	\$17	\$24	\$31
D0330	Panoramic Film	\$43	\$61	\$79
Sealants }				
D1351	Sealant - Per Tooth	\$21	\$30	\$39
Space Maintainers }				
D1510	Space Maintainer - Fixed - Unilateral	\$132	\$187	\$242
Fillings }				
D2140	Amalgam - One Surface, Primary or Permanent	\$39	\$56	\$72
D2150	Amalgam - Two Surfaces, Primary or Permanent	\$48	\$68	\$88
D2331	Resin - Two Surfaces, Anterior	\$55	\$79	\$102
Palliative (Emergency Treatment)* }				
D9110	Palliative Treatment of Dental Pain - Minor Procedure	\$16	\$23	\$29
Oral Surgery* }				
D7140	Extraction - Erupted or Exposed Root	\$44	\$62	\$81
D7230	Removal of Impacted Tooth - Partially Bony	\$63	\$89	\$116
Endodontics* }				
D3310	Root Canal, Anterior	\$114	\$162	\$209
D3330	Root Canal, Molar	\$171	\$242	\$313
Periodontics* }				
D4260	Osseous Surgery - Per Quadrant	\$170	\$241	\$312
D4341	Periodontal Scaling and Root Planing - Per Quadrant	\$38	\$54	\$70
Single Tooth Restorations* }				
D2750	Crown - Porcelain Fused to High Noble Metal	\$167	\$237	\$306
D2950	Core Build-up, Including Any Pins	\$39	\$56	\$72
D2952	Post and Core in Addition to Crown, Indirectly Fabricated	\$59	\$83	\$108
Prosthodontics* }				
D5110	Complete Denture - Maxillary	\$189	\$268	\$347
D5213	Maxillary Partial Denture - Cast Metal	\$214	\$303	\$393
D6210	Pontic - Cast High Noble Metal	\$158	\$223	\$289
D6721	Crown - Resin with Predominantly Base Metal	\$148	\$209	\$271

* Waiting period applies.

VISION PLAN - OUTLINE OF BENEFITS

Freedom of Choice.

We offer you a national network of participating vision providers. The provider panel contains independent optometrists and ophthalmologists, as well as regional and national retail chains (including Wal-Mart, Sam's Club, Costco*, Pearle Vision, Target, Sears, JCPenney and EyeMasters).

You may choose different providers for vision exam and materials purchases. Out-of-Network benefits are available. Most participating providers (excluding Wal-Mart, Sam's Club & Costco*) offer discounts on items purchased after the insurance benefit has been used.

You can even use your benefits to order contact lenses directly from our website at www.AlwaysCareBenefits.com.

Additional Savings!

AlwaysCare has negotiated special fees with thousands of optical locations for extra purchases of lenses and coatings, frames, contact lenses and other products that may be used in conjunction with your insurance transaction for non-covered services as well as with additional purchases. Providers identified as "Value Added (VA)" or "Service Plus (SP)" in the AlwaysCare Online Directory at AlwaysCareBenefits.com offer additional values on these extra products.

VISION CARE SERVICES

	IN-NETWORK	OUT-OF-NETWORK ALLOWANCES
Co-Pays }		
Exam (Once per 12 months)	\$15	Up to \$35
Materials	\$20	See below
Standard Plastic Lenses }		
(Once per 12 months)		
Single Vision	Covered by Co-pay	Up to \$25
Bifocal	Covered by Co-pay	Up to \$40
Trifocal	Covered by Co-pay	Up to \$50
Lenticular	\$80 Allowance	Up to \$50
Progressive	\$70 Allowance	Up to \$40
Frames }		
(Once per 12 months)		
Choose any frame available at provider locations	\$120 retail frame Covers a wide selection of frames	Up to \$50
Contact Lenses }		
(Once per 12 months)		
(Includes fit, follow-up and materials)	\$20 co-pay	
In lieu of eyeglass lenses & frames		
• Elective	Up to \$120 retail	Up to \$100 retail allowance
• Medically necessary	Up to \$210 retail	Up to \$210 retail allowance

Additional discounts on optical materials purchased through Value Added and Service Plus Providers cannot be combined with other offers and promotions.

* Special payment and reimbursement terms apply for material purchases at Costco.

MORE ABOUT YOUR COVERAGE

When does your coverage start?

Your coverage starts when we receive your application and process your first premium payment. This allows you to apply even faster and begin using your benefits. If an application is received and premiums are paid prior to the 25th of the month, then you will be charged:

- For the pro-rated premium based on the number of days remaining in the month.
- Again on or about the 25th of the month for the next month.

If payment is processed after the 25th, first premium payment will cover the period through the end of the following month.

How much does it cost?

For Adults
(Ages 19 to 64)

MONTHLY DENTAL & VISION RATES			
	VALUE PLAN	STANDARD PLAN	PREFERRED PLAN
Individual	\$25.52	\$33.54	\$41.55
Individual + Spouse	\$51.04	\$67.07	\$83.10
Individual + Children	\$54.29	\$71.31	\$88.33
Individual + Family	\$85.14	\$111.85	\$138.56

Rates remain the same until to age 65. At age 65 please refer to the Senior 65+ rate chart.

For Seniors
(Ages 65 +)

MONTHLY DENTAL & VISION RATES			
	VALUE PLAN	STANDARD PLAN	PREFERRED PLAN
Individual	\$30.85	\$40.92	\$50.99
Individual + Spouse	\$61.69	\$81.84	\$101.99
Individual + Children	\$59.61	\$78.69	\$97.77
Individual + Family	\$95.79	\$126.62	\$157.44





AFFORDABLE DENTAL & VISION BENEFITS FOR YOU AND YOUR FAMILY

DENTAL PLAN - OUTLINE OF BENEFITS

Freedom of Choice.

Choose any dental provider or visit one of over 100,000 participating provider access points in our network and pay even less. Visit www.AlwaysCareBenefits.com for a listing of participating providers.

Each plan reimburses for covered procedures up to the scheduled amount in your policy. See page 2 for examples.

Benefit Year Maximum.

\$1,000 per person per benefit year (Applies to all services)

Deductible.

\$50 Annual. Maximum 3 per family
(Does not apply to preventive services)

Preventive Services.

- Routine exams (2 per 12 months)
- Prophylaxis (Simple Cleaning) (2 per 12 months)
- Full mouth x-ray (1 per 24 months)
- Space maintainers to age 16 (1 per 24 months)
- Fluoride to age 16 (1 per 12 months)
- Bitewing x-rays (max 4 films per 12 months)
- Sealants to age 16
(permanent molars, 1 per 36 months)
- Adjunctive pre-diagnostic oral cancer screening
(max 1 per 12 months for age 40+)

Other Services. 12 month waiting period applies.

- Fillings (12 month waiting period does not apply to fillings)
- Simple extractions
- Oral surgery (surgical extractions & impactions)
- Anesthesia
(subject to review, covered with complex oral surgery)
- Emergency pain (1 per 12 months)
- Non-Surgical Periodontics
- Crowns, Bridges, and Dentures
- Surgical Periodontics (gum surgery)
- Inlays and Onlays
- Endodontics (root canals)
- Repairs: Crown, Denture, and Bridge