ENJOY *freedom of* CHOICE

with AlwaysCare Benefits, Inc.

Voluntary Dental and Vision Plans

AlwaysASSIST

Our fully-integrated web site, **www.AlwaysCareBenefits.com** is designed with you in mind! Login today to discover the tools we offer to assist you in managing your benefits.

- Search for Dental & Vision Providers
- Access the Dental Cost Estimator
- Ask an Eye Doctor or Dentist
- Refer a Provider
- Access the Dental Health Center
- Access the Vision Health Center
- Order Contact Lenses
- Print ID Cards

Members

- View benefits
- Modify personal information
- View claims
- Access forms and documents

QUESTIONS?

The **AlwaysCare** Customer Service Team resolves 95% of customers' issues during the first call. We can assist with:

- Explaining Benefits
- Answering Billing Questions
- Accessing AlwaysAssist
- Locating Providers
- Checking Eligibility
- Answering Claim Questions
- Ordering ID Cards

Call our interactive voice response system 24/7 at 1-888-729-5433 ext. 2013 for benefit and eligibility information.

Complete details of covered services will be listed in the Certificate of Insurance you receive upon enrollment. This brochure is a brief overview and does not list all benefits, limitations and exclusions.

Policy Form Series: NDNGRP04/06 and NVIGRP05/07

Administered by: Morrissey Agency, Inc.
400 N. Executive Dr., Suite 302 • Brookfield, WI 53005
(262) 784-7574 • FAX (262) 784-9233 • 1-800-242-7232

Provided by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company) • P.O. Box 98100 • Baton Rouge, LA 70898-9100
1-888-729-5433 ext. 2013 • FAX 1-888-729-7827

Underwritten by: National Guardian Life Insurance Company, Madison, WI. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian or Guardian Life.

WIGT 6-09

Dental Carryover Benefit

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! If an Insured submits qualifying claims for covered expenses during a benefit year and, in that benefit year, receives benefits that are less than their group's Threshold Limit, the Insured will be credited a Carryover Benefit.

Carryover Benefits will be accrued and stored in the Insured's Carryover Account to be used in the next benefit year. If an Insured reaches his or her Certificate Year Maximum Benefit, we will pay a benefit from the Insured's Carryover Account up to the amount stored in the Insured's Carryover Account. The accrued Carryover Benefits stored in the Carryover Account may not be greater than the Carryover Account Limit.

The Limits for this Policy/Certificate are: Carryover Benefit **$250**, Threshold Limit **$500**, Carryover Account Limit **$1000**.

Dental Quarterly Rates

Member Only - $77.34 Member & Spouse - $152.52 Member & Child(ren) - $171.36 Member & Family -$263.94

AlwaysVISION

The **AlwaysVision** plan offers Members low exam co-pays and generous allowances toward the purchases of eyeglass lenses, frames, and contact lenses. Members can also receive discounts on additional purchases at thousands of optical locations.

Members may access our nationwide PPO network of over 22,000 Providers, or choose an out-of-network Provider. Options include independent optometrists and ophthalmologists, plus regional and national retail chains (i.e. Wal-Mart, Sam's Club, Costco*, Pearle Vision, Target, Sears, JCPenney and Eyemasters). Members may choose different Providers for material purchases.

Vision Quarterly Rates

Member Only - $21.66 Member & Spouse - $43.32 Member & Child(ren) - $45.90 Member & Family - $72.00

ALWAYS VISION

SERVICE	PARTICIPATING PROVIDERS	OUT-OF-NETWORK
Exam (once per 12 months)	$10 co-pay	Up to $35
Materials	$25 co-pay	
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
Lens Options: Polycarbonate Lenses for children	Covered by Wal-Mart or Sam's Club only	N/A
Frames (once every 24 months): Members choose from any frame at provider locations	$120 retail allowance ($94 retail frame at Costo*, Wal-Mart and Sam's Club)	Up to $50 retail allowance
Contact Lenses** (once per 12 months): Includes fit, follow-up and materials		
• Elective	Up to $120 retail	Up to $100
• Medically necessary	Up to $210 retail	Up to $210

* Special payment and reimbursement terms apply for materials purchases at Costco. ** Contact lenses in lieu of eyeglass lenses & frames.

AlwaysDENTAL

The **AlwaysDental** plan offers Members the freedom and flexibility to visit the dentist of their choice, including specialists, without a referral. Members using participating providers will also eliminate balance billing and reduce out-of-pocket expenses. This plan waives all waiting periods and includes a Carryover benefit.

Deductible

$50 per person, per benefit year. Maximum 3 per family. Does not apply to Preventive (Class A) Services.

Benefit Year Maximum

$1000 per benefit year (includes Class A, B, and C services)

ALWAYS DENTAL

CLASS A *Preventive Services (No Waiting Period)*

Coinsurance: Year 1 – 100% Year 2 – 100% Year 3 – 100%

- Routine Exams (2/12 months) • Prophylaxis (2/12 months)*
- Bitewing X-rays (max 4 films) (1/12 months)
- Adjunctive Pre-Diagnostic Oral Cancer Screening (max 1 per 12 months for age +40)
- Fluoride Treatment for children up to age 16 (1/12 months)
- Space Maintainers for children to age 16 (1/24 months)
- Sealants for children to age 16 (permanent molars only, 1 per 36 months)

CLASS B *Basic Services (No Waiting Period)*

Coinsurance: Year 1 – 50% Year 2 – 80% Year 3 – 80%

- Full mouth X-ray (1 per 24 months) • Simple Extractions
- Emergency Pain (1 per 12 months) • Fillings

CLASS C *Major Services (No Waiting Period)*

Coinsurance: Year 1 – 0% Year 2 – 25% Year 3 – 50%

- Anesthesia (subject to review, covered with complex oral surgery)
- Non-surgical Periodontics • Endodontics (root canals)
- Repair of Denture, Bridge or Crown • Inlays and Onlays
- Oral Surgery (extractions and impacted teeth)
- Surgical Periodontics (gum treatment)
- Crowns, Bridges, Dentures, and Endosteal Implants

* Coverage is enhanced to include one additional cleaning or periodontal maintenance per year if Member is in second or third trimester of pregnancy. Written proof must be submitted at the time of the claim.

AlwaysCare **Effective Date:** ________

YES! *Please enroll me in the **AlwaysCare** Voluntary Dental and Vision Plans*

Name of Member: ______________________________

Date of Birth: ______________________ ❑ M ❑ F

Social Security No.: ____________________________

Address: ______________________________________

City: ___________________ State: ____ Zip: ________

Daytime Phone: (________) ______________________

Indicate Dental Coverage Desired (check only one):

❑ Member only ❑ Member & Child(ren)

❑ Member & Spouse ❑ Member & Family

Indicate Vision Coverage Desired (check only one):

❑ Member only ❑ Member & Child (ren)

❑ Member & Spouse ❑ Member & Family

Dependent information (if applying):

Spouse Name: __________________________________

Date of Birth: __________________________________

Social Security No.: ____________________________

Children (eligible children include your unmarried, dependent children up to age 19 years, 25 if a full-time student):

Name: ______________________ Date of Birth: __/__/__

Name: ______________________ Date of Birth: __/__/__

Name: ______________________ Date of Birth: __/__/__

Name: ______________________ Date of Birth: __/__/__

Payment Method Desired (check only one per line):

- ❑ Direct Bill ❑ Easy Pay (if easy pay, please fill out reverse.)
- ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly

I understand the coverage applied for shall become effective on the first day of the month after receipt of my enrollment form.

______________________________ ____/____/____

Member's Signature *Date*

______________________________ ____/____/____

Spouse's Signature (if applying) *Date*

Contact the Morrissey Agency, Inc. with any questions
(262) 784-7574 • 1-800-242-7232

Easy Pay -

Automated Insurance Payment Plan

Payments taken directly from your account

I (we) hereby authorize the financial institution designated below to transfer to Morrissey Agency, Inc. from my checking account the premium payment for my coverage administered by Morrissey Agency, Inc. I understand that I may withdraw this authority at any time by notifying Morrissey Agency, Inc. in such time and in such manner as to afford Morrissey Agency, Inc. and your financial institution a reasonable opportunity to act on it. Statements of premium due will still be mailed to you prior to any withdrawals being made.

My Financial Institution __________________________

Branch ______________________________________

Address ______________________________________

City, State, Zip_________________________________

Account No.___________________________________

Routing No. ___________________________________

Type of Account: *Money Market Accounts are not allowed.*

❑ Checking ❑ Savings

Date ______________

Name (please print): ___________________________

Signature ____________________________________

Joint Account Holder:

Name (please print) ____________________________

Signature ____________________________________

Please return the completed form, along with a voided check, to our office. A faxed copy of this information is acceptable. We will be deducting the premiums on the due date. If the due date is a weekend/ bank holiday, the premium will be deducted from your account on the available bank date immediately prior to the due date.

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