MWG MARKETING

Vision for Everyone

Administered by: SPECTERA®

A UnitedHealth Group Company

Plan Features

- **No deductibles**
- **No waiting periods**
- **Your choice of network providers**
- **One pair of standard frames each 24 months**
- **A vision examination annually**
- **One pair of single vision or standard lined multi-focal lenses (or)**
- **Contact lenses each 12 months**
- **Benefits provided In-Network only**
- **Laser eye surgery benefits through Laser Vision Network of America**

Benefit Co-Payments

Examinations $15.00
Materials..... $25.00

For more information
email marketing@morganwhite.com
or call 1-800-800-1397

In-Network Benefits

Exam: A complete vision examination by a participating optometrist or ophthalmologist every 12 months with a $15 co-pay each year.

Lenses: If prescribed, a pair of single vision or standard lined multi-focal lenses every 12 months with a $25 co-pay each year.

Contact Lenses: After a $25 co-pay each year, Spectera Inc's contact lense benefit covers in full the fitting / evaluation fees, contacts (disposable contacts / up to 4 boxes, depending on the prescription and plan selected), and up to two follow up visits. A $105 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera, Inc.'s covered-in-full contacts (materials co-pay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection. Any amount over the allowance is the patient's responsibility.

Frames: Your choice from a wide selection of fashionable frames will be covered-in-full every 24 months. The materials co-pay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses. If you select a frame from outside the covered selection, you will be given a minimum $130 frame allowance for frames purchased at retail chain providers.

Patient Options: Should you select items not covered by the program, such as: progressive lenses, tints, coatings, etc., there will be an additional charge. These charges, however, are below usual retail costs. (Standard Scratch coating is covered in full at no cost to the insured).

Monthly Premium Individual Rates

Two Year Rate Guarantee. *Available to Individuals by: Monthly bank draft or credit card*

Standard Premium Rates	
Member	$10.50
Member & One	$16.50
Member & Family	$23.15

Rates include a $2 billing fee.

Available States	AR, AL, AZ, CA,CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WY, WV

In-Network Provider Access

Call Spectera at 1-800-839-3242 or go online at www.spectera.com

SPECTERA * Vision Enrollment Form

Social Security No. - -	Primary Enrollee: Last Name First Initial	Birthdate / /	Sex ❑ M ❑ F
Home Phone ( )	Street		
	City State Zip		

LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different) First Name Initial	Birthdate	Sex
1. Spouse		❑ M ❑ F
2. Dependents		❑ M ❑ F
3.		❑ M ❑ F
4.		❑ M ❑ F
5.		❑ M ❑ F
6.		❑ M ❑ F

MODE OF PAYMENT

❑ Annually or ❑ Monthly
❑ Bankdraft or ❑ Credit Card

BANKDRAFT: This is authorization for Morgan-White Administrators, Inc., on behalf of Spectera to draft payments from my checking account for payment of my insurance premiums. Drafts will occur between the 1st - 5th of each month for the following month's premium. **Enclosed is a check for the first month's premium plus a blank voided check on the bank on which drafts are to be drawn.**

OR ❑ Charge Premiums to:
❑ Visa ❑ Mastercard
Credit Card #:

_____

Exp. Date _____/_____

Signature: _____

If dependent children (between the ages of 19 and 24) are not full-time students they are not eligible to enroll.

"I understand and agree that (1) the insurance shall not take effect unless the application has been accepted and approved by the Company and until the Effective Date of the Certificate and (2) the agent does not have the authority to make or alter any contract or waive any of the Company's other rights or requirements." California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Applicant's Signature _____ Date _____

DDO3VOLU

AGENT NAME (if applicable): _____

AGENT # (Your state license #):_____ Phone: (_____) _____

Forward enrollment form to: MorganWhiteGroup - P.O. Box 14067 Jackson, MS 39236