

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department  
at: \_\_\_\_\_ fax: \_\_\_\_\_

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction or credit card), quarterly (every three months) or annually (once a year). Send a voided check for your 1st months premium.

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...

 **DELTA DENTAL**



# ***Dental and Vision for Everyone***

**Dental and Vision** Coverage in One Plan\*

*For Individuals, Small Employers, and Senior Citizens*

Marketed by:

**MWG**  
MARKETING

Dental Underwritten by:

**Standard Life**  
AND ACCIDENT  
INSURANCE COMPANY  
League City,  
Texas  
A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

Vision Administered by:

**SPECTERA**  
A UnitedHealth Group Company

# Dental Insurance Policy Benefits

## Two plans to choose from: Indemnity or DPO

- Free choice of dentist
- In- and Out-of-Network benefits
- Benefits up to \$1200 per calendar year
- 6 month waiting period basic
- Benefits increase after the first and second years
- \$100 lifetime deductible on ortho
- Ortho benefits for dependents included at no extra charge
- 12 month waiting period for oral surgery, major and ortho

Your Deductible	Plan Pays 1st Year	Plan Pays 2nd Year	Plan Pays 3rd Year	Services Covered
\$50 per person per calendar year for Types 1, 2 and 3 procedures.	80%	90%	100%	<b>Type 1 - Diagnostic and Preventive Treatment</b> <u>Diagnostic:</u> Routine periodic examinations once in a 6 month period. <u>Preventive:</u> Dental prophylaxis (teeth cleaning and scaling) once in a 6 month period (including application of topical fluoride for dependent children only). <u>Radiography:</u> Bitewing x-rays once in a 6 month period. Full mouth x-rays once in a 36 month period.
See above	60%	70%	80%	<b>Type 2 - Basic Procedures (6 month waiting period)</b> <u>Restorative:</u> Amalgam, synthetic porcelain or plastic fillings. <u>Other:</u> Space maintainers, recementation of crowns.
See above	0%	40%	50%	<b>Type 3 - Major Procedures (12 month waiting period)</b> <u>Endodontics:</u> Pulpal therapy and root canals. <u>Periodontics:</u> Treatment of diseases of the gums. <u>Prosthetics:</u> Gold restorations, crowns, bridges, partials and complete dentures. <b>For enrollees of age 65 or older this benefit is limited to \$600 per person per year.</b> <u>Other:</u> Pontics, repair of crowns and bridges, repair of full and partial dentures. <u>Oral Surgery:</u> Extractions and other oral surgery.
\$100 lifetime	0%	40%	50%	<b>Type 4 - Orthodontia Procedures (12 month waiting period)</b> (\$350 calendar year maximum) (\$1000 lifetime maximum per person for this benefit) This benefit only applies to covered dependents up to age 19.

**Indemnity Plan** benefits are based on Usual, Customary & Reasonable Charges (UCR)

**DPO Plan** benefits in or out of network are based on the negotiated provider fee schedule. Locate Dental Providers at [www.mwgdental.com](http://www.mwgdental.com).

## Monthly Rates

### Indemnity Plan Rates

Area	Member	Plus One	Family
1	\$36.64	\$66.70	\$96.76
2	\$40.12	\$73.48	\$106.85
3	\$43.98	\$81.02	\$118.05
4	\$48.27	\$89.38	\$130.49
5	\$53.03	\$98.66	\$144.29
6	\$58.32	\$108.96	\$159.61
7	\$64.18	\$120.40	\$176.62

Includes: \$4.00 Billing Fee, \$1.00 Association Dues

### DPO Plan Rates

Area	Member	Plus One	Family
1	\$29.68	\$53.12	\$76.57
2	\$32.39	\$58.42	\$84.44
3	\$35.41	\$64.29	\$93.18
4	\$38.75	\$70.82	\$102.88
5	\$42.46	\$78.06	\$113.65
6	\$46.59	\$86.09	\$125.60
7	\$54.16	\$95.01	\$138.86

Includes: \$4.00 Billing Fee, \$1.00 Association Dues

See Dental Price Areas on the insert page.

There will be a one time non-refundable \$25.00 set up fee.

# Vision Benefits

- No deductible
- No waiting period
- Your choice of eye care providers
- In- and Out-of-Network benefits
- Laser eye surgery benefits through the Laser Vision Network of America (LVNA)
- Network Providers include Private Practice Doctors and Retail Chain Providers
- A vision examination each 12 months
- One set of frames each 24 months
- One pair of standard lenses or contact lenses each 12 months

## In-Network Benefits

- A comprehensive vision examination annually with only a \$10.00 copayment.
- Lenses: If prescribed, a pair of single vision or standard lined multi-focal lenses every 12 months with only a \$20.00 co-pay.
- In lieu of lenses and a frame (\$20.00 co-payment applies), you may select from Spectera’s wide variety of covered contact lenses when obtained from a network provider. A \$105.00 credit will be applied toward any fitting fees, and the purchase of non-covered contact lenses once every 12 months.
- There is a \$210 allowance for “necessary” contacts. (When your vision cannot be corrected to better than 70/20 with standard lenses.)
- One pair of frames (each 24 months) from a wide selection of high quality men’s, women’s and children’s frames and a set of lined single/bifocal/trifocal lenses (each 12 months) for a \$20.00 co-pay. If you select a frame from outside the covered selection, you will pay the wholesale cost minus a \$50.00 frame allowance. In the case of retail chain provider locations, due to their pricing structures, the participant will receive a minimum \$130 frame allowance for frames purchased at retail chain providers. Please consult with the specific provider in your area.
- **Patient Options:** Should you select items not covered by the program, such as progressive lenses, tints, coatings, ect., 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.)
- To locate an In-Network Provider call 800-839-3242 or use Spectera’s web site [www.spectera.com](http://www.spectera.com) (Click on provider locator, enter zip code, enter social security number or [any 9 digit number], enter birth date and click submit.)

## Out-of-Network Benefits

*(Out-of-Network – Reimbursement up to the following amounts once in a 12-month period – frames once in a 24-month period)*

Annual Vision Examination .....	\$40.00
Single Vision Lenses.....	\$40.00
Bifocal.....	\$60.00
Trifocal .....	\$80.00
Frames.....	\$50.00
Elective Contacts .....	\$105.00
Necessary Contacts.....	\$210.00

## Monthly Premiums Vision

Area	Member	Plus One	Family
1	\$8.38	\$14.51	\$24.47
2	\$8.80	\$15.23	\$25.69
3	\$9.30	\$16.11	\$27.16
4	\$9.88	\$17.12	\$28.88

## Vision Rate Areas

<b>Price Area 1</b>	AL, AR, DC, DE, FL, GA, LA, MD, MI, MS, PA, SC, TN, TX, VA and WV
<b>Price Area 2</b>	CA, IL, IN, KY, MA, MO, NC, NY, OH, OK and RI
<b>Price Area 3</b>	AZ, CO, CT, IA, ME, MN, NJ, ND, NE, NM, NV and UT
<b>Price Area 4</b>	AK, ID, KS, MT, OR, SD, WA, WI and WY

## Important Information About Out-of-Network Benefits

Spectera will accept receipts and reimburse you once each 12 months (frames each 24 months) (from date of service) when you use an “out -of-network” provider. While you can file for reimbursement anytime after you receive your exam and eyewear, in order to maximize your “out-of-network” benefits, itemized receipts should be collected (i.e. several purchases of contact lenses) until they total (at least) the maximum reimbursement amounts. Be sure to include with the receipts the participant’s social security number and patient’s date of birth.

MAIL TO: Spectera Claims Department  
P.O. Box 30978  
Salt Lake City, UT 84130

When scheduling your appointment, be sure to say that you are covered under the MorganWhiteGroup / Spectera Vision Plan so that the provider can confirm your eligibility and benefits prior to the appointment.

# World Travelers of America

**Working to make travel safer, more affordable, and hassle free.**

As a member of World Travelers of America you have access to the following benefits and services:

Theme park and zoo discounts, travel booking, hotel, auto, cruise and vacation condo discounts, travel safety information, travel tips, first-hand destination information, travel health info, travel insurance, travel alerts and so much more. World Travelers will communicate member info to you via email or visit [www.worldtravelers.org](http://www.worldtravelers.org) to learn more about your membership.



## Dental Exclusions

### EXCLUSIONS AND LIMITATIONS (\*may vary by state.)

Limitations on all Benefits – Optional Services:

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures. For example:

- (a) a crown where a filling would restore the tooth;
- (b) a precision denture/partial where a standard denture/partial could be used;
- (c) an inlay/onlay instead of an amalgam restoration;  
or
- (d) a composite/resin restoration instead of an amalgam restoration on posterior teeth.

If you receive Optional Services, your Benefits will be based on the lower cost of the customary service or standard practice instead of the higher cost of the Optional Service. You will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard practice.

### EXCLUSIONS (\*Exclusions may vary by state.)

Standard Life does not pay Benefits for:

- a) Services for injuries or conditions which are compensable under workers' compensation or employers' liability laws; services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision except as such exclusion may be prohibited by law.
- b) Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration) of the teeth,

and andontia (congenitally missing teeth), except those services provided to newborn children for congenital defect or birth abnormalities or services that may be provided under Orthodontic Benefits.

- c) Services for restoring tooth structure lost from wear, erosion, or abrasion, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to: equilibration, periodontal splinting, occlusal adjustment.
- d) Any Single Procedure started prior to the date the person became covered for such services under this program.
- e) Prescribed drugs, medication or analgesia.
- f) Experimental procedures.
- g) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- h) Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.
- i) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- j) Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- k) Services performed by any person other than a Dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a Dentist.
- l) Replacement of teeth extracted prior to the member's effective date.
- m) Replacement of any Crown, Jacket, Cast Restoration, Bridge or Denture that the patient received in the previous five (5) years.

The preceding information is a brief description of coverage. See policy POL-DENT (10/05) for complete details.

# Dental and Vision for Everyone

## Dental Price Areas

### Indemnity Plan

States	Zip Code	Area
Alaska	995-996	7
	All Others	6
Arizona	864, 856-865	2
	All Others	1
Arkansas	All	1
California	900-905, 915-918	7
	956-958	4
	906-914, 919-927, 930-939	6
	949, 952, 955, 959-961	6
	All Others	5
Colorado	803, 808-810	4
	All Others	1
Connecticut	068-069	6
	All Others	5
Delaware	All	2
Florida	320-322	4
	330-334	5
	All Others	3
Georgia	300-303	2
	All Others	3
Illinois	600-605	2
	606-608	3
	All Others	1
Indiana	463-464	3
	473	2
	All Others	1
Iowa	All	1
Kansas	660-662	2
	All Others	1
Kentucky	All	1
Louisiana	712	3
	707-711	2
	All Others	1
Maryland	207-212	4
	All Others	2
Michigan	480-483, 490-491	2
	488-489	3
	All Others	1
Minnesota	554	3
	550-553, 555	2
	All Others	1
Mississippi	390-392	2
	All Others	1
Missouri	640-641, 644-648	2
	All Others	1
Nebraska	All	1
New Mexico	881	2
	882	5
	All Others	1
Nevada	893-898	5
	All Others	4
North Carolina	277, 287-289	2
	286	3
	All Others	1
Ohio	430-436, 439-445	2
	450-452, 456	2
	All Others	1

### DPO Plan

States	Zip Code	Area
Alaska	995-996	7
	All Others	6
Arizona	864, 856-865	2
	All Others	1
Arkansas	All	1
California	900-905, 915-918	7
	956-958	4
	906-914, 919-927, 930-939	6
	949, 952, 955, 959-961	6
	All Others	5
Colorado	803, 808-810	4
	All Others	1
Connecticut	068-069	6
	All Others	5
Delaware	All	2
Florida	320-322	4
	330-334	5
	All Others	3
Georgia	300-303	1
	All Others	2
Illinois	600-605	2
	606-608	2
	All Others	1
Indiana	463-464	2
	All Others	1
Iowa	All	1
Kansas	660-662	2
	All Others	1
Kentucky	All	2
Louisiana	712	3
	707-711	2
	All Others	1
Maryland	207-212	3
	All Others	2
Michigan	480-483, 490-491	2
	488-489	3
	All Others	1
Minnesota	554	3
	550-553, 555	2
	All Others	1
Mississippi	390-392	2
	All Others	1
Missouri	640-641, 644-648	2
	All Others	1
Nebraska	All	1
New Mexico	881	2
	882	5
	All Others	1
Nevada	893-898	5
	All Others	4
North Carolina	277, 287-289	4
	286	5
	All Others	3
Ohio	430-436, 439-445	1
	450-452, 456	1
	All Others	1

Dental price areas continued on reverse side...

### World Travelers of America Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<p>"I hereby enroll in World Travelers of America. To purchase the insurance, you must become a member of World Travelers of America. The WTA monthly membership fee is \$1.00 and will appear on my monthly invoice."</p> <p><b>Member Signature:</b></p> <p>Date _____</p>
Home Phone	Street	City		State	Zip	

For additional information email MorganWhiteGroup at [marketing@morganwhite.com](mailto:marketing@morganwhite.com) or call 1-800-800-1397

**Sign Here**

Dental Price Areas (Cont.) – Indemnity Plan

States	Zip Code	Area
Oklahoma	730-731, 740-741	2
	All Others	1
Pennsylvania	170-178, 182-187	3
	190-191	4
	All Others	2
South Carolina	All	1
Tennessee	370-374, 380-384	2
	All Others	1
Texas	754	4
	750-753	3
	756, 757, 776, 777	1
	All Others	2
Utah	All	5
Virginia	201, 220-221	5
	222-223	6
	224-225, 230-232	1
	228-229, 240-244	2
	All Others	4
West Virginia	255-257, 262-265	2
	All Others	1
Wyoming	All	1

Dental Price Areas (Cont.) – DPO Plan

States	Zip Code	Area
Oklahoma	730-731, 740-741	2
	All Others	1
Pennsylvania	170-178, 182-187	3
	190-191	4
	All Others	2
South Carolina	All	2
Tennessee	370-374, 380-384	2
	All Others	1
Texas	754	4
	750-753	3
	756, 757, 776, 777	1
	All Others	2
Utah	All	5
Virginia	201, 220-221	5
	222-223	6
	224-225, 230-232	1
	228-229, 240-244	2
	All Others	4
West Virginia	255-257, 262-265	2
	All Others	1
Wyoming	All	1

STANDARD LIFE & ACCIDENT INSURANCE COMPANY Dental For Everyone Enrollment Card

Please choose:  Indemnity Dental  DPO Dental

MODE OF PAYMENT

Social Security No.	Primary Enrollee: Last Name	First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Annually <input type="checkbox"/> Quarterly  <input type="checkbox"/> Monthly Bankdraft BANKDRAFT: This is authorization for Morgan-White, on behalf of Standard Life & Accident Insurance Company to draft payments from my checking account for payment of my insurance premiums. 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 <input type="checkbox"/> Charge Premiums to: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____ Exp. Date ____/____
Home Phone	Street					
	City	State	Zip			
<b>LIST ALL DEPENDENTS TO BE COVERED BELOW</b>						
Last Name (if different)	First Name	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
2. Spouse				<input type="checkbox"/> M <input type="checkbox"/> F		
3. Dependents				<input type="checkbox"/> M <input type="checkbox"/> F		
4.				<input type="checkbox"/> M <input type="checkbox"/> F		
5.				<input type="checkbox"/> M <input type="checkbox"/> F		
6.				<input type="checkbox"/> M <input type="checkbox"/> F		
7.				<input type="checkbox"/> M <input type="checkbox"/> F		
Question: 1) Are all dependent children applicants between the ages of 19 and 24 full-time students (Y/N)? If no, then which child(ren) are not full-time students? _____						
"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 _____	

STNDLIFE 06-06  
POL-DENT (10/05)

AGENT NAME (if applicable): JIM BARRICKS

AGENT # (Your state license #): CA# 0383850 PHONE (310) 827-7286

Forward enrollment form to: MorganWhite Group - Attn: Dental for Everyone - P.O. Drawer 14067, Jackson, MS 39236

Optional Vision Coverage – Please check one:

- YES**, please enroll everyone listed on the dental application in the vision plan. *Note: Vision plan is not available unless you enroll in the dental plan.*
- No, I would not like to purchase vision benefits