



# ***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:

  
vsp®

# Dental Insurance Policy Benefits

## Two plans to choose from: Indemnity or DPO

- **No deductibles**
- **Free choice of dentist**
- **In- and Out-of-Network benefits**
- **Benefits up to \$2000 per calendar year**
- **6 month waiting period basic**
- **\$400 calendar year maximum for ortho**
- **Benefits increase after the first and second years**
- **Ortho benefits for dependents included at no extra charge**
- **12 month waiting period for oral surgery, major and ortho**
- **\$1500 lifetime maximum per person on ortho benefit**

Co-Pay	Plan Pays 1st Year	Plan Pays 2nd Year	Plan Pays 3rd Year	Services Covered
\$20 per office visit	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.
None	0%	40%	50%	<b>Type 4 - Orthodontia Procedures (12 month waiting period)</b> (\$400 calendar year maximum) (\$1500 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.mwg dental.com](http://www.mwg dental.com).

## Monthly Rates

### Indemnity Plan Rates

Area	Member	Plus One	Family
1	\$39.80	\$72.87	\$105.94
2	\$43.63	\$80.33	\$117.04
3	\$47.88	\$88.62	\$129.36
4	\$52.60	\$97.82	\$143.04
5	\$57.83	\$108.03	\$158.22
6	\$63.65	\$119.36	\$175.07
7	\$70.10	\$131.94	\$193.78

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

### DPO Plan Rates

Area	Member	Plus One	Family
1	\$32.15	\$57.93	\$83.73
2	\$35.13	\$63.76	\$92.38
3	\$38.45	\$70.22	\$102.00
4	\$42.13	\$77.40	\$112.67
5	\$46.21	\$85.37	\$124.52
6	\$50.75	\$94.20	\$137.66
7	\$55.78	\$104.01	\$152.25

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 \$35.00 setup fee.

# Vision Benefits Through VSP

## Signature Choice Plan

### Your Coverage from a VSP Doctor

**WellVision Exam®** \$10 Co-Pay – every 12 months

**Prescription Glasses** \$20 Co-Pay

**Lenses:** every 12 months

- Single vision, lined bifocal, and lined trifocal lenses
- Polycarbonate lenses for dependent children

**Frames:** every 24 months

- \$130 allowance for frame of your choice
- 20% off the amount over your allowance

**\*\* Or \*\***

**Contacts Lense Care** No Co-pay – every 12 months

- \$130 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained. Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses.

### Extra Discounts and Savings

#### Glasses and Sunglasses

- 20% off lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options\*

#### Contacts\*

15% off cost of contact lens exam (fitting and evaluation)

#### Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price from contracted facilities

*\* Available from any VSP doctor within 12 months of your last eye exam*

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

#### Out-of-Network Reimbursement Amounts:

Exam.....	Up to \$34
Single vision lenses.....	Up to \$17
Lined bifocal lenses.....	Up to \$30
Lined trifocal lenses.....	Up to \$43
Frame.....	Up to \$38.25
Contacts.....	Up to \$100

## Exam Plus Plan

### Your Coverage from a VSP Doctor

**WellVision Exam®** \$15 copay – every 12 months

**Prescription Glasses Discounts**

**Lenses:** 20% discount when a complete pair of glasses is purchased

**Frames:** 20% discount when a complete pair of glasses is purchased

**Contacts\*** 15% discount off the contact lens fitting and evaluation exam. This additional exam ensures proper fit of your contacts.

### Extra Discounts and Savings

#### Glasses and Sunglasses

- 20% off lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options\*

#### Contacts\*

15% off cost of contact lens exam (fitting and evaluation)

#### Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price from contracted facilities

*\* Available from any VSP doctor within 12 months of your last eye exam*

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

#### Out-of-Network Reimbursement Amounts:

Exam: Up to \$34

# Benefits Association

As a member of Benefits Association you receive the following Benefits and Services:

Prescription Drug Assistance • Online Storage • Auto Rental Discounts • Discounted Hotel Rates • Office Supplies  
Legal Documents • Apparel and Hunting Accessories

## 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
Idaho	All	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
North Dakota	All	1
Ohio	430-436, 439-445	2
	450-452, 456	2
	All Others	1
Oklahoma	730-731, 740-741	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
North Dakota	All	1
Ohio	430-436, 439-445	1
	450-452, 456	1
	All Others	1
Oklahoma	730-731, 740-741	2
	All Others	1
Oregon	970-972	5
	All Others	4

Dental price areas continued on reverse side...

### Benefits Association, Inc. Enrollment Form: (Signature Required)

Social Security No.	Primary Enrollee:			Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Last Name	First	Initial		
Home Phone	Street				
	City	State	Zip	Date _____	

"I hereby enroll in Benefits Association, Inc. To Purchase the insurance, you must first become a member of Benefits Association Inc. The BAI monthly membership fee is \$1.00 and is included in the monthly rates."

**Member Signature:**

Date \_\_\_\_\_

### Dental Price Areas (Cont.) – Indemnity Plan

States	Zip Code	Area
Oregon	970-975	6
	All Others	5
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
Wisconsin	535-538	3
	All Others	4
Wyoming	All	1

### Dental Price Areas (Cont.) – DPO Plan

States	Zip Code	Area
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
Wisconsin	535-538	3
	All Others	4
Wyoming	All	1

### Vision Monthly Rates

	Signature Choice	Exam Plus
<b>Member</b>	\$7.54	\$3.00
<b>Member + 1</b>	\$15.11	\$6.00
<b>Member + Family</b>	\$24.34	\$9.00

<b>Dental Selection:</b> <input type="checkbox"/> Indemnity Dental <input type="checkbox"/> DPO Dental <b>Type of Coverage</b> <input type="checkbox"/> Member <input type="checkbox"/> Member + 1 <input type="checkbox"/> Member + Family <b>Optional Vision Coverage:</b> <input type="checkbox"/> Exam Plus <input type="checkbox"/> Signature Choice				<b>METHOD OF PAYMENT</b> <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Bankdraft: This is my authorization for Morgan-White Administrators, Inc., on behalf of Standard Life & Accident Insurance Company to draft payments from my checking account for payment of my insurance premiums. Below is the Routing Number and Checking Account number for the account on which drafts are to be drawn. Name of Bank: _____  Name as it appears on Check: _____  Routing Number (Bottom Left Corner of Check) _____  Account Number (2nd set of numbers on bottom) _____  <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard Credit Card #: _____  Exp. Date _____/_____/_____ Security Code _____ (3 digit code on back of card)		
Social Security No.	Primary Enrollee: Last Name		First	Initial	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone	Street					
	City		State		Zip	
	E-mail address:					
<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
"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.						
Association Member's Signature _____						Date _____

**For Agent Use Only**    AGENT NAME (if applicable): \_\_\_\_\_

AGENT # (Your state license #): \_\_\_\_\_