

AmFirst  
"VISION CARE BENEFITS"

**IMPORTANT INFORMATION**  
(ABOUT THE USE OF YOUR VISION INSURANCE)

**WHO WILL PROVIDE MY VISION BENEFITS?**

**Spectera, Inc.**

Customer Service may be reached at 800-638-3120

- > For Benefit Information
- > For Claim Information

**HOW SOON CAN I USE MY BENEFITS?**

**In-Network: Allow 2-3 weeks for your information to be entered in the system.**

**HOW DO I LOCATE AN IN-NETWORK PROVIDER?**

**Simply Call:**

Provider location service at **800-839-3242**

**OR**

Use Spectera's web site **www.spectera.com**

**IN-NETWORK BENEFITS**

**EXAMINATION:**

A complete vision examination by a participating optometrist or ophthalmologist every 12 months with only a \$35.00 co-pay the first year you are on the plan and a \$15.00 co-pay each year thereafter.

**LENSES:**

If prescribed, a pair of single vision or standard lined multi-focal lenses every 12 months with only a \$35.00 co-pay the first year you are on the plan and a \$25.00 co-payment each year thereafter.

**CONTACT LENSES:**

In lieu of spectacle lenses and a frame, you may select contact lenses every 12 months with only a \$35.00 co-pay first year (\$25.00 co-pay each year thereafter). Spectera covers a wide variety of contact lenses including disposable, when obtained from a participating provider. If you elect contact lenses outside of Spectera's covered selection, including disposable lenses, you will receive an allowance of \$105.00 toward the usual retail cost of the lenses and any dispensing and fitting fees. There is a \$200.00 allowance for "necessary" contacts. (When your vision cannot be corrected to better than 70/20 with standard lenses) 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. (Co-pay for frames is included with lenses) If you select a frame from outside the covered selection, you will be given a generous frame allowance. For retail chain locations, a generous retail discount is applied toward their already reduced prices.

**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.

**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.**

Individual Vision Benefits – See Other Side Of This Page  
(If this form is e-mailed, the other side is the "rate and benefits" page)

# AmFirst

## Individual Vision Benefits\*\*

(IN-NETWORK ONLY)

### 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 TLC Centers

### Benefit Co-Payments

	<i>First 12 months</i>	<i>After first 12 months</i>
◆ Examinations	\$35.00	\$15.00
◆ Materials	\$35.00	\$25.00

### Monthly Individual Rates

*(Two Year Rate Guarantee)*

*Available to Individuals by:*

*Monthly Bank Draft or Credit Card, or Direct Bill Quarterly  
(Standard Premium Rates – Under Age 65)*

Price Area	1
Member	\$ 9.50
Member & One	\$15.50
Member & Family	\$22.15

*(Standard Premium Rates – Over Age 65)*

Price Area	1
Member	\$10.75
Member & One	\$18.10
Member & Family	\$23.10

◆ Price Area 1 – AL, AR, FL, GA, IN, LA, MS, NC, OK, SC, TN, TX, VA and WV

#### A Product of:

MorganWhiteGroup  
P. O. Drawer 14067  
Jackson, MS 39236  
For more information call  
Ph: (601) 956-2028 or (800) 800-1397  
Fx: (601) 956-1702

**In-Network Access**  
Call Spectera at 1-800-839-3242  
Or go online at [www.spectera.com](http://www.spectera.com)

8893072434



# SPECTERA VISION CARE ENROLLMENT FORM

Vision Application

Member     Member & One     Member & Family

Print with black ink in blocks. Application is electronically processed.

Last Name

First Name

MI

Home Address

City ST

ZIP

Home Phone

Employer/Group

Employer Phone

SSN

DOB

Marital Status Sex

New Application

Change Card

Select Payment Mode

Group Billing

Annual Direct Billing

Semi Annual Direct Billing

Quarterly Direct Billing

Monthly Bank Draft

This authorization will draft monthly payments from my checking account. A voided blank check is enclosed on the bank on which the drafts are to be drawn.

Monthly Credit Card

Visa     Master Card

Credit Card #

Exp. date

### Primary Employee/Member

Dependant Name

DOB

Relationship

Sex

\*Student(Y/N)

Dependant Name	DOB	Relationship	Sex	*Student(Y/N)

\* Are all dependant children between the ages 19 and 24 full-time students (Y/N) "I understand and agree that 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." California law prohibits an HRA from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Signature of Member

Date

Eff.

Date

Plan

Code

SPVIS

Agents Sign and complete

Check w/app?  Yes  No

Grp. Code

Rate Code

Rate

**Electronic data scanners will process enrollment data on all future group and individual enrollments. The form shown above must be used for all enrollments starting January 1, 2001.**

- USE ORIGINAL APPLICATIONS FOR ENROLLMENT.
- DO NOT REPRODUCE THE APPLICATION ON A COPY MACHINE. This may alter the size and location of the data fields and adversely affect the ability of the scanner to read the data.
- Please PRINT within the data fields with BLACK INK.

You can secure a supply of these forms by:

1. E-mail Wendy Reich at [wendy@morganwhite.com](mailto:wendy@morganwhite.com) or call 800-800-1397.
2. A quality Printing Company can use the above camera-ready application and print your original application forms. The printer can get 2 applications per letter sheet.

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# SPECTERA VISION CARE ENROLLMENT FORM

Vision Application

Member     Member & One     Member & Family

- New Application
- Change Card
- Select Payment Mode
- Group Billing
- Annual Direct Billing
- Semi Annual Direct Billing
- Quarterly Direct Billing
- Monthly Bank Draft

Print with black ink in blocks. Application is electronically processed.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Employer/Group: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_

This authorization will draft monthly payments from my checking account. A voided blank check is enclosed on the bank on which the drafts are to be drawn.

### Primary Employee/Member

Dependent Name	DOB	Relationship	Sex	*Student (Y/W)

Monthly Credit Card  
 Visa     Master Card

Credit Card #: \_\_\_\_\_

Exp. date: \_\_\_\_\_

\* Are all dependent children between the ages 19 and 24 full-time students (Y/N) \* I understand and agree that 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. \* California law prohibits an HMO from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Signature of Member	Date	Eff. Date	Plan Code	SPVIS
Agents Sign and complete	Check w/App? <input type="checkbox"/> Yes <input type="checkbox"/> No	Grp. Code	Rate Code	Rate

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