

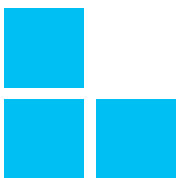
MWG

THE AFFORDABLE MEDICAL PLAN



Limited Benefit Health Insurance
Combined with discount medical services including
access to nationwide provider networks Beech Street and PHCS

No Medical Underwriting



For agent use only. Not for use with the general public.
Product and services not available in all states.
AF-AFF-06-18-2008

Underwritten by:



Over 47 million Americans are without health insurance*

The Affordable Medical Plan

Coverage for groups that cannot afford or cannot get major medical insurance.

Construction Trades

Service Industry

Trucking Industry

Hospitality Industry

Food Preparation Industry

Agricultural Industry

No excluded Industries

The Affordable Medical Plan

Limited Benefit Health Insurance combined with discount medical services including a national provider network of 3,800 hospitals and access to over 900,000 provider locations.



Plan Features:

- No medical underwriting means no health questions asked - Guaranteed Issue.
- Benefits are paid to the provider.
- Covers pregnancy provided childbirth is 10 months after the effective date
- Simplified enrollment - No employee applications required
- Agent or employer electronic bill adjustment. Add new enrollees or delete terminated employees.
- Use the provider network or go out-of-network and choose your own provider
- Nationwide provider networks are included – Beech street and PHCS. **
- Network discounts are given at the point of service. **
- MWG RX Plan**- discounts on most FDA-approved prescription drugs
- Optum Nurse Line** Immediate access to licensed, registered nurses through one toll-free number 24/7/365.

Important: The Affordable Medical Plan is NOT basic health insurance. This is a limited benefit indemnity insurance. It is not a substitute for basic health coverage, major medical insurance, or any other medical expense reimbursement plan. Any provision of the Group Policy which, on it's Effective Date, does not agree with the laws of the state in which the Policy is written, will be amended to the minimum requirements of that state.

*Sources: The centers for Medicare and Medicaid Services, Office of the Actuary; Benefits Selling, July 2007

** These are discount services and administrative services and are not insurance products. Networks are not available in all areas.

The Affordable Medical Plan

Benefit Type	Description	Diamond Plan
IN HOSPITAL BENEFIT		
Hospital Confinement Benefit	<ul style="list-style-type: none"> Pays a daily benefit for the first day of confinement. Covered person must be confined in the hospital for a minimum of 24 hours 	Pays \$500 for the first day of confinement
Hospital Benefit	<ul style="list-style-type: none"> Pays for hospital, surgery, intensive care and maternity eligible expenses Eligible expenses include room and board up to the semi private room rate, intensive care up to two times the semi private room rate, miscellaneous services and supplies, one physician's visit per day while hospitalized, surgically related expenses including surgeons fees. Eligible expenses for anesthesia are limited to 20% of surgeon's eligible expenses. Covered person must be confined in the hospital for a minimum of 24 hours 	<p>After Your \$1,000 Deductible</p> <p>Pays 80% up to \$10,000 Per Calendar Year Per Covered Person.</p> <p>No lifetime maximum</p>
Intensive Care Rider	<ul style="list-style-type: none"> Pays a daily benefit for each day of confinement in a hospital intensive care unit. Covered person must be confined for a minimum of 24 hours 	Pays up to \$1,000 per day Maximum 10 days per covered person per calendar year
OUTPATIENT BENEFIT		
Sickness	<ul style="list-style-type: none"> Pays for professional fee of a physician for each visit to the physician's office, clinic or hospital emergency room Pays hospital charges for use of the emergency room 	<p>Physician's Office Pays up to \$75 per visit. Up to 4 visits per insured person per calendar year.</p> <p>Emergency Room Pays up to \$100 per visit. Up to 2 visits per insured person per calendar year.</p>
Accident	<ul style="list-style-type: none"> Pays for professional fee of a physician, x-rays, casts, splints, bandages in the doctor's office, clinic or hospital emergency room. Pays for charges made by the hospital for use of emergency room Pays for treatment rendered within 5 days of the injury 	<p>Physician's Office Pays up to \$75 Per Visit. Up to 2 visits per insured person per calendar year.</p> <p>Emergency Room Pays up to \$500 per visit up to 2 visits per insured person per calendar year.</p>
Prescription Drugs	<ul style="list-style-type: none"> Provided at contracted discount by network providers 	Pays up to \$20 per prescription / up to 5 prescriptions per insured per calendar year
Surgery	<ul style="list-style-type: none"> Pays 80% of the professional fee of a physician for surgery and anesthesia due to injury or sickness in a physician's office, clinic, ambulatory surgical center or in an outpatient surgical unit of a hospital. Eligible expenses for anesthesiologist are limited to 20% of surgeon's eligible expenses 	<p>Pays up to \$1,500 per Calendar Year per Covered Person.</p> <p>No lifetime maximum</p>
Ambulance	<ul style="list-style-type: none"> Pays the Usual and Customary Charges made by a licensed ambulance service for Medically Necessary air or ground ambulance transportation to the nearest qualified hospital or transfer from one hospital to another. 	<p>Air Ambulance Pays up to \$1,000 - 2 per year</p> <p>Ground Ambulance Pays up to \$200 - 2 per year</p>
ACCIDENTAL DEATH		
Accidental Death	<ul style="list-style-type: none"> Pays for the loss of life of an Insured Person due to an accident or accidental injury. The maximum amount we will pay for the multiple deaths, which occur due to a single accidental event, is 3 times the amount for a single Insured. The death of the Insured must occur within 72 hours of the accident causing the death. 	<p>Employee - \$10,000 Spouse - \$10,000 Child - \$5,000</p>

Plan pays benefits up to the amounts indicated in the certificate/policy schedule, but not to exceed the amount incurred by the insured after provider discounts. All Monetary Benefits Reduce by One-Half at Age 65. This is a description of pre-selected benefits. For a complete description of benefits refer to the certificate/policy.

Platinum Plan	Gold Plan	Silver Plan
Pays \$350 for the first day of confinement	Pays \$250 for the first day of confinement	Pays \$250 for the first day of confinement
After Your \$1,000 Deductible Pays 80% up to \$5,000 Per Calendar Year Per Covered Person. No lifetime maximum	After Your \$1,000 Deductible Pays 50% up to \$5,000 Per Calendar Year Per Covered Person. No lifetime maximum	Pays \$300 per day of confinement. Maximum of 20 days per covered person per calendar year. No waiting period due to accident 1 day waiting period for sickness
Pays \$500 per day Maximum 10 days per covered person per calendar year	Pays \$100 per day Maximum 10 days per covered person per calendar year	Pays \$100 per day Maximum 10 days per covered person per calendar year
Physician's Office Pays Up to \$75 Per Visit. Up to 4 visits per insured person per calendar year	Physician's Office Pays Up to \$50 Per Visit. Up to 4 visits per insured person per calendar year	Physician's Office Pays Up to \$50 Per Visit. Up to 4 visits per insured person per calendar year
Emergency Room Pays Up to \$100 per visit. Up to 2 visits per insured person per calendar year.	Emergency Room Pays Up to \$75 per visit Up to 2 visits per insured person per calendar year.	Emergency Room Pays Up to \$75 per visit. Up to 2 visits per insured person per calendar year.
Physician's Office Pays Up to \$75 Per Visit. Up to 2 visits per insured person per calendar year.	Physician's Office Pays Up to \$50 Per Visit. Up to 2 visits per insured person per calendar year.	Physician's Office Pays Up to \$50 Per Visit. Up to 2 visits per insured person per calendar year.
Emergency Room Pays Up to \$300 per visit. Up to 2 visits per insured person per calendar year.	Emergency Room Pays Up to \$100 per visit. Up to 2 visits per insured person per calendar year.	Emergency Room Pays Up to \$100 per visit. Up to 2 visits per insured person per calendar year.
Pays up to \$15 per prescription / up to 5 prescriptions per insured per calendar year	N/A	N/A
Pays Up to \$1,250 Per Calendar Year per Covered Person. No lifetime maximum	Pays Up to \$500 Per Calendar Year per Covered Person No lifetime maximum	Pays Up to \$250 Per Calendar Year per Covered Person No lifetime maximum
Air Ambulance Pays Up to \$1,000 - 2 per year	Air Ambulance Pays Up to \$500 - 2 per year	Air Ambulance Pays Up to \$500 - 2 per year
Ground Ambulance Pays Up to \$200 - 2 per year	Ground Ambulance Pays Up to \$100 - 2 per year	Ground Ambulance Pays Up to \$100 - 2 per year
Employee - \$10,000 Spouse - \$10,000 Child - \$5,000	Employee - \$10,000 Spouse - \$5,000 Child - \$2,500	Employee - \$10,000 Spouse - \$5,000 Child - \$2,500



Nationwide Provider Networks are included

Beech Street Hospital Network - Limited Benefit**

This Beech Street hospital network has more than 3,800 hospitals nationwide. In addition to offering members a quality network of hospitals, Beech Street will also help limit out-of-pocket expenses.

Beech Street Corporation currently serves over 16 million members across the United States. Beech Street's goal is to contract with the most respected hospitals that are willing to comply with quality standards designed to provide convenient patient access to high quality, cost effective care.

Beech Street currently contracts with 74% of the hospitals represented on the *America's Best Hospitals 2004* list published by *U.S. News and World Report*. This report is based on three key criteria: reputation, mortality ratio and annual surveys performed by the American Hospital Association (AHA).

Beech Street has negotiated reimbursement arrangements with the hospitals in its network that result in significant cost savings. When members visit an in-network hospital these savings are passed on to the member, helping to minimize out-of-pocket costs.

Beech Street Provider Network - Limited Benefit**

Beech Street has over 380,000 provider locations nationwide including over 52,000 ancillary providers nationwide. In addition to offering members a quality network of physicians, Beech Street will also help limit out-of-pocket expenses. Members will have access to savings from an average of 30% to 50% on medical services.

Members can save money on services such as routine office visits and ancillary services, including lab work and imaging centers by accessing a participating provider, including Beech Street hospitals and physician assistants.

Beech Street Corporation currently serves over 16 million members across the United States. Their Preferred Provider Organization Network consists of more than 750,000 locations and over 200 preferred provider specialties. Beech Street's goal is to contract with the most respected physicians and other healthcare professionals that are willing to comply with quality standards designed to provide convenient patient access to high quality, cost effective care.

Private Health Care Systems Network (PHCS)**

Provider Network: Over 525,000 healthcare professionals and over 66,000 ancillaries. Discount Range: 20% to 45% savings

Personalized Concierge Service

Careington International brings a significant competitive advantage to clients through the personalized, concierge service with which they administer their physician discount program.

Members of Careington's Physician discount program receive an identification card and "Dear Doctor" letter in their fulfillment kit with instructions to call Careington's Physician Relations Department where a live operator will provide them with a list of providers, and verify participation of those providers. The members will then call and schedule an appointment with the participating provider.

The Careington PRS will also instruct the provider to contact Careington at the time of checkout and give the CPT codes for the services rendered. Careington will then communicate to the provider the PHCS allowable amount and instruct the provider to file the claim for the reduced amount on behalf of the insured. Some providers may ask the insured to pay the amount due and file their own insurance claim. This may be done via phone, fax, email, or regular mail. The live operator feature with the PHCS option ensures that the member's experience is a positive one with very little room for error or confusion on either the member's or the doctor's part at the time of service.

With other partners who provide physician discounts, it is the member's responsibility to make an appointment with a participating physician

and identify himself as a member by showing his card at the time of service. The physician will call the phone number on the card to access the call center with repricing information. Potential drawbacks to this plan lie in the fact that the member doesn't have a live Careington operator to help ensure that the doctor is participating and understands how to process the discounts, or is aware of how the plan works, and will charge correctly. Instead, he makes his own appointment, and if he doesn't have his card, the doctor will not be able to give him his discounts.

PHCS is the first and only national PPO to earn four endorsements of quality from two independent, nationally recognized quality assurance organizations, the National Committee for Quality Assurance (NCQA) and URAC.

NCQA certification for Credentialing and Re-credentialing (August 2001)

NCQA certification for Utilization Management (May 2001)

URAC accreditation for Health Network with Credentialing (October 2001)

URAC accreditation for Health Utilization Management (July 1993)

Key Features of PHCS:

- PHCS is the largest proprietary PPO in the country with nationwide access
- The live-operator feature ensures a positive member/provider experience
- Providers must pass strict credentialing criteria
- PHCS has relationships with providers associated with the majority of specialties

Value Added Programs

All persons enrolled with the Affordable Medical Plan are provided these programs at no additional cost

MWG RX Plan**

This plan is designed to save you money by giving you access to discounts on most FDA-approved prescription drugs. There are over 53,000 participating pharmacies throughout the United States, including most community Drug stores. This plan is not insurance.

Optum Nurse Line**

Immediate access to licensed, registered nurses through one toll-free number 24/7/365. Unlimited home care advice and recommendations. Information about prescription usage and over-the-counter medication usage and drug interaction.

*** Networks are not available in all areas. Call Careington Member services for assistance – 1-888-335-8222.*

Disclosures

1. THE DISCOUNT PLANS AND ADMINISTRATIVE SERVICES DESCRIBED ON THIS PAGE ARE NOT INSURANCE. THEY ARE NOT A MEDICARE PRESCRIPTION DRUG PLAN.

2. These plans provide discounts at certain health care providers for medical services. The range of discounts will vary depending on the type of provider and service.
3. These discount plans do not make payments directly to the providers of medical services.
4. Plan members are obligated to pay for all health care services, but will receive a discount from those health care providers who have contracted with the discount medical plan organization.
5. Discount Medical Plan Organization and administrator: Careington International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-441-0380.

Note to Texas Consumers: Regulated by the Texas Department of Licensing and Registration, P.O. Box 12157, Austin, Texas 78711; telephone 1-800-803-9202 or (512)463-6599 website: www.license.state.tx.us/complaints. The program and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. Medicare statement applies to MD residents when pharmacy discounts are part of program. This program is not available in Vermont or Montana.

Tips on using this plan: How to file a claim

1. Reduce medical cost by using an In-Network provider. Call Careington Member services for assistance 1-888-335-8222
2. Ask the provider to file your insurance claim for you. This reduces your paperwork and your out-of-pocket expenses at the point of service. Many hospitals and doctors will file your AmFirst insurance claim for you. At the point of service give the provider your AmFirst Insurance Card and your Network Identification Card.
3. If you choose to file your own claim, ask your doctor and/or hospital to provide you with an itemized bill (HCFA 1500 or UB92) which will explain the medical provider's charges. If you went In-Network make sure the provider gave you the In-Network discounts.
4. Send the itemized bill (HCFA 1500 or UB92) to Morgan-White Administrators.

Exclusions

Any provision of the Group Policy which, on its Effective Date, does not agree with the laws of the state in which the Policy is written, will be amended to the minimum requirements of that state. Benefits otherwise provided by the Insurance Policy and the Certificate will not be payable for services or expenses or other loss resulting from or in connection with:

1. Dental treatment except dental treatment caused by covered Injury to sound natural teeth;
2. Normal pregnancy or childbirth within the first ten months after the Effective Date;
3. Sickness or Injury for which Workers' Compensation, Workmen's Compensation, Employer's Liability or Occupational Disease benefits are payable;
4. (in Mississippi) War or any act of war declared or undeclared, or participation in a riot, insurrection or rebellion; (In Oklahoma) War or any act of war declared or undeclared, when serving in the military or an auxiliary unit, or participation in a riot, insurrection or rebellion;
5. Service in the armed forces or units auxiliary thereto; premiums will be refunded on a pro-rata basis for any Insured Person who enters military service and all coverage for that Insured Person will be suspended until military service is over;
6. Any intentional self-inflicted injury, suicide or attempted suicide;
7. Drug addiction, overdose, or being under the influence of narcotics, hallucinogens, controlled/uncontrolled substances, unless administered on and according to the advice of a Physician;
8. Routine well baby care, except immunizations as may be specifically provided in the Benefits Section of the Policy;
9. Hospitalization or Outpatient expenses for the principal purposes of physical examination or diagnosis;
10. Elective abortion or any elective procedure or treatment including sterilization, sterilization reversal, sexual transformation;
11. Sexual dysfunction or erectile dysfunction;
12. Venereal or other sexually transmitted disease;
13. Sleep disorders, including sleep apnea, or any complications therefrom;
14. Alcoholism or Loss due to an Insured Person's being intoxicated as defined by the laws of the state in which the Policy is issued;
15. In-vitro fertilization or other expenses, services or prosthesis relating to or in connection with assisted reproductive technology, male or female;
16. Mental or nervous disorders without demonstrable organic disease;
17. Charges incurred outside the United States, if an Insured Person traveled to the location for the purpose of receiving medical services, drugs or supplies;
18. Care or treatment for which no charges are made which You are required to pay, except Medicaid;
19. Eye glasses, hearing aids or the examination for the prescription or fitting of them, radial keratotomy or any eye surgery solely for the purpose of correcting refractive defects;
20. Cosmetic surgery or reconstructive surgery except when: (a) incidental to trauma, infection or disease of the involved part; or (b) to correct a congenital defect or anomaly of a newborn child that has resulted in a functional defect; or (c) incidental to a mastectomy for which benefits are payable under the Policy.
21. Custodial or intermediate care confinement in a Hospital;
22. Chemical Dependency;
23. An Insured Person engaged in an illegal occupation or any illegal activity.
24. Exogenous obesity (i.e. obesity due to excessive food intake)
25. Pre-Existing Conditions: Injury or Sickness that would have caused an ordinary prudent person to seek or receive medical advice, diagnosis, care during the six (6) months immediately preceding the effective date of coverage. We will not deny benefits for an Insured Person for losses due to a Pre-Existing condition incurred for more than twelve (12) months following the effective date of the Insured Person's coverage.

Learn more about how MWG MARKETING can benefit you and your clients.



We know **Dental**. We know **Vision**.
We know **Medical Gap Products**.
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