Dental, Vision and Hearing Select

Agent Guide

ManhattanLife Assurance Company of America

Agent Use Only

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Standing By You. Since 1850.

Table of Contents

General

The policy form is a Limited Dental, Vision & Hearing product. The product has the Vision and Hearing benefits filed as Riders.

Guaranteed Renewability

Guaranteed Renewable for the life of the policy. Subject to the Company's right to change premiums (may vary by state).

Issue Ages and Premium Ages

In computing premiums, the Company uses "Age of Last Birthday". The two-parent family premium is based on the older age for bank draft sales. No adult over age 99 is eligible for coverage.

All States:

- Individual (age 18 – 99) and child (rate is for 3 – 17).
- Dependents under age 3 not eligible.
- Child only policies not accepted.
- Increases in benefit amounts are processed by PHS
- Decreases allowed at any time.
- Dependent eligibility is based on the provisions in the policy print for the state applied.

Premium Rates

Tier:

- Individual, Individual & Spouse, Individual & Children, and Family.
    - Family premium rates include up to three children. Additional children are charged the 3-17 rate per person.

Network

We utilize the Careington Maximum Care PPO Dental network.

Policyholders are not required to visit a network provider and can use the dentist of their choice.

Using a network provider, however, may result in a better discounted rate, thus extending the amount remaining of a given Policy Year maximum.

Product Benefits*

PLAN BENEFITS		
Issue Ages	Individual (18 - 99) Children (3 - 17)	
Policy Year Maximum Benefit	$1,000, $1,500 or $3,000	
Policy Year Deductible	$0 or $100 per person (does not apply to Preventative Services)	
Network	Careington Network	
Guaranteed Issue	Yes	
Guaranteed Renewable	Yes	
Network Charges Exhibit	**In-network benefits** will be charged a **discounted fee/contracted fee** for covered services **Out-of-network benefits** will be covered a percentage of **UCR**	
Dental Coverage		
	In-Network	**Out-of-Network**
Preventative Services	100% of contracted rate	80% of UCR
Basic Services	65% of contracted rate 1st yr. 80% thereafter	65% of UCR 1st yr. 80% thereafter
Major Services	20% of contracted rate 1st yr. 50% thereafter	20% of UCR 1st yr. 50% thereafter
All Other Medically Necessary Services *(services not listed above)*	20% of contracted rate 1st yr. 50% thereafter	20% of UCR 1st yr. 50% thereafter
Orthodontia[1]	Year 1 - N/A Year 2+ - 50%	N/A
Vision Rider*		
Vision Services • **Eye Exam** • **Refraction** • **Single Lenses** • **Bifocal Lenses** • **Trifocal Lenses** • **Progressive Lenses**	60% of UCR 1st yr. 70% of UCR 2nd yr. 80% of UCR thereafter 1 per year	
• **Eyeglass Frame**[2] • **Contact Lenses**	$200 maximum per year	
• **Anti-Reflective Lenses**	$45; 1 per year	
• **Polycarbonate Lenses**	$40; 1 per year	
• **Contact Lens Fitting Fee**	$15; 1 per year	
Hearing Rider*		
Hearing Services • **Hearing Exam** • **Hearing Aid and Necessary Repairs or Supplies**[2]	$750 maximum *(per ear, per year)*	

[1] *Lifetime Maximum $1,500*

[2] *12 Month Waiting Period*

**In NM, Vision and Hearing riders are unavailable.*

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Dental Coverage

Preventative Services

1. Dental Examinations
2. Cleanings (prophylaxis)
3. Bitewing X-Rays
4. Fluoride Treatments

Basic Dental Services

1. Limited Oral Evaluation
2. Diagnostic Consultation
3. Emergency Palliative Treatment
4. X-Rays
5. Panoramic X-Ray
6. Periapical X-Ray
7. Fillings
8. Amalgam Restoration
9. Composite Resin (Synthetic) Restoration
10. Pin Retention
11. Basic Oral Surgery
12. Non-Surgical Extractions
13. Periodontal Services
14. Non-Surgical Services
15. Periodontal Scaling and Root Planning
16. Periodontal Maintenance

Dental Major Services

1. Major Restorative Services
2. Inlays, Onlays, and Crowns (excludes core build-up)
3. Endodontic Services
4. Surgical Periodontal Services
5. Prosthodontic Services
6. Implant Services

See policy forms for specific limitations

Definitions

Waiting Periods: Depending on the benefit, there are waiting periods for certain services. Please consult your brochure and ensure that the consumer understands the waiting period provisions as outlined in the brochure.

Annual Maximums: There are three Policy Year Plan Maximums available ($1,000, $1,500, and $3,000). (These may vary by state). Unused Annual Maximums do not roll over to the next year.

Annual Deductible: There is a $0 or $100 per person/per year deductible. Deductible applies to all services except Preventative Services.

Claim Adjudication: When services are eligible for claim, the amount is based on a percentage according to how long the policy has been effective. It is important and helpful that applicants understand how the policy works and the way a claim is to be adjudicated.

For example, if after day one a policyholder was to have Major Services, they would receive 20% of the billed charge for Year 1 that the policy is in force. If the same procedure were to occur after Year 1, the benefit percentage would be 50% of the billed charge (due to certain state regulations, percentage may vary in certain states, notably Ohio).

Contracted Rate: The amount a Dental Practitioner that has a contract with the Dental Provider Network agreed to accept as total payment for the treatment provided.

Usual & Customary: As standard in the industry, we adjudicate claims based on Usual, Customary and Reasonable fees (UCR). It is important that agents and applicants understand this (see below).

Usual Fee: Dentists charge this fee most often for a given type of dental work.

Customary Fee: This refers to the fee level that the administrator of a dental benefit plan sets. They base this amount on actual fees dentists have billed for a certain type of dental work. It is the most an insurer will pay under a plan for that type of work.

Reasonable Fee: This is the fee a dentist charges for dental work that is more complex than usual. For instance, work that has been changed by the nature and severity of the problem that is being treated. It accounts for any medical or dental complications or unusual circumstances. Thus, it may differ from the dentist's "usual" fee or the plan's "customary" fee.

Indemnity plan claims, including ours, are based on UCR. This type of plan pays each claim based on the amount insurers determine to be usual, customary, and reasonable for each type of work and for each market area. Fees for service may vary by geographical area.

Claim Processing: Claims billing is determined by the provider; Providers can bill MAC by completing the ADA form or insured can file a claim by completing the MAC claim form. Claims forms must be submitted with supporting documentation.

Claims may be filed up to 15 months from the service date

Effective Dates

The Effective Date of a policy will be the policy date on the policy schedule page. It is not the date the application is signed. The effective date cannot be the application signature date. Policyholders can choose 1 day after, or up to 6 months from the signature date. Effective dates can only be from the 1st to the 28th of any month.

Effective Date Changes

Policyholders can request an effective date up to 180 days from the signature date. Changes can be made by contacting customer service at 1-800-999-2971, option 2.

WE DO NOT BACK DATE POLICY EFFECTIVE DATES BEYOND THE APPLICATION SIGNATURE DATE

Benefit Changes

- Benefit Increases and decreases require a new application to be submitted.
    - Benefit Increases are allowed only on the policy anniversary date.
    - The additional benefit amount will be subject to first policy year coverage percentage and waiting periods
    - A rider for the additional increase would be added to the policy.

For additional information please contact customer service at 1-800-999-2971, option 2.

- Dependent addition or removal
    - Addition of dependents require a new application.
    - Removal of dependents can be requested through email, fax, or mail.

Reinstatement Guidelines

Insureds may pay back premiums and reinstate with no lapse in coverage within 30 days of the Term Date. If outside of 30 days, the insured must apply for reinstatement which will have a gap in coverage.

To apply for new coverage, they must be inactive for 90 days from Term Date.

Please note, waiting periods start over, including deductibles.

Underwriting and Effective Dates

Coverage is guaranteed issue.

The "Effective Date" of a policy will be the policy date stated on the policy schedule page. It is not the date the application is signed. Policies will not be effective the 29, 30 or 31st of the month.

Completing the Application

Prior to soliciting any applications, you must be properly licensed and/or appointed by the department of insurance and the Company in the state you are soliciting applications.

Use the appropriate state version of the DVH application, as well as current approved state sales material.

In addition, an Outline of Coverage for this product **must** be left with the applicant.
Complete all questions on the application.

Application Delivery Methods

Agents can submit applications by:

- US Mail
  - Regular Mail: PO Box 924408, Houston, TX 77292-4408
  - Specialty Mail: DVH Dept., 10777 Northwest Freeway, Houston, TX 77092
- Fax: 713-583-0677, Attention: DVH New Business
- Easy UPLOAD: Log in to the agent portal and access from the agent dashboard
- Online Electronic Application: Log in to the agent portal; click on agent tools; click Individual enrollment.

Billing and Premium Modes

The Company accepts business on the Bank Draft (EFT), List Bill and Direct methods of payment.

The annual, semi-annual, and quarterly modes of payment are acceptable for all forms of payments. Monthly premium notices are not available.

The Company does not accept: (a) post-dated checks; (b) C.O.D. applications; (c) partial payments; (d) money orders or cashier checks; (e) applications with the date altered; (f) applications where "white-out" has been used; (g) personal checks from an agent or agency; (H) Credit Cards, Debit Cards, or Prepaid Cards. All premium checks must be payable to ManhattanLife Insurance Company of America or Family Life Insurance Company.

Bank Change

Bank change requests require an updated Bank Draft Authorization (BDA) form, or the insured can send in a letter from the bank, on bank letterhead. The insured can complete the bank change request by one of the following Methods:

Bank Letterhead
Insured can have the bank send a letter with their routing and account number. The letter must include the banks' letterhead, a bank rep's name, address, and phone number. Or the insured can request a Bank Draft Authorization form by calling 1-800-999-2971 option 2.

Bank Draft Authorization form
Policyholder can log in to their policyholder center: On the Left side of the screen there is an online forms section > Click on the Bank Draft Authorization form link > Select the policies the insured would like to update and complete all required fields > Enter the Mother's Maiden Name and Click "Confirm". The Electronic BDA will generate, and a Premiums rep will update the information. Please allow 1-2 business days for update to process.

Or Contact customer service at 1-800-999-2971 option 2 to request one.

Bill Pay

Online **bill payment** is a secure electronic **service** that allows customers to **pay bills** without having to write checks and mail them. Online **bill payment** is usually tied to a checking account from which funds are withdrawn electronically for **payment** of one-time or recurring **bills**. This must be set up with the Insured's bank. This option can only be used for Quarterly, Semi-Annual and Annual Direct Bill Mode.

Direct Bill

The Direct Bill Payment Mode is available quarterly, semi-annual, and annual. The policyholder will receive a paper bill at least 21 days prior to the bill due date. The policyholder must remit payment by electronic bill pay or personal check.

Commissions

Commissions are not paid until the effective date of the policy is reached and premium has been posted.

When paid by EFT, earned and renewal commissions are processed on or around the 15th, as well as the last day of the month. There is a $25 minimum requirement for outgoing commissions. If paid by check, they are processed on the last day of the month with a $100 minimum.

Advanced commissions are processed daily when paid by eft with no minimum. If paid by check, they are processed every Thursday with no minimum.

Policy form number: AK7034 (including state variations)