MISSOURI OPTOMETRIC ASSOCIATION
Dental • Vision • Hearing

MISSOURI OPTOMETRIC ASSOCIATION

DENTAL / VISION / HEARING PLAN

Missouri Optometric Association

PROVIDER MANUAL

TABLE OF CONTENTS

MOAIA Board

Jason Lake OD
Kory Scullawl OD
Doug Herriott OD
Terry Gibbons

MOAIA Membership Relations

Wes Kemp OD
417.206.9008 | wkemp@moaia.net

Missouri Optometric Association

LeeAnn Barrett OD
Executive Director

DENTAL / VISION / HEARING PLAN

GENERAL INFORMATION

The MOA DVH plan is a simple indemnity plan that covers dental, vision, and hearing. The plan is available in a $1,000 and $1,500 policy year maximum per person. It can be sold as a group, single person plan or a family plan (up to 2 adults and 3 children). There is a $100 deductible per plan year per person.

Preferred providers for the plan must be MOA members, either primary or secondary members that already belong to another state. MOA members are asked to sign a provider agreement to become a preferred provider. This provider list will be given to all consumers that purchase the plan.

The vision insurance provides an eye examination immediately after the effective date of the policy. Materials (glasses and contact lenses) are also covered starting after the effective date of the policy. During the first year of the plan, 60% of the submitted charges up to the maximum allowed (caps are listed in the chart to follow) are paid. During the second year, the plan pays 70% of the charges, and after 24 months, the plan pays 80% of your charges.

MOA plan providers are asked to write off the remainder on the exam and glasses (up to cap amount). Contact lenses and contact lens fitting fees may be balance billed to the patient.

Policy Schedule Summary
Maximum Payments

Examination	Up to $100
Refraction	Up to $35
Frame	Up to $200 - can bill overage *(see example)*
Single Vision Lenses	Up to $75/pair
FT Bifocal	Up to $125/pair
Trifocal	Up to $150/pair
Progressives	Up to $300/pair
AR	Up to $105
Polycarbonate	Up to $100
Transitions® and other tints	Not a covered service
CL Fitting Fee	Up to $60 - can balance bill patient
Contact lenses (one-time order)	Up to $300 - can balance bill patient

The plan covers one exam/contact lens fitting per year. One pair of glasses AND one contact lens order per year is covered. You can only invoice one order on the contact lenses. It would be in the patient's best interest to order a year's supply of contacts and use the contact lens company's rebate if the company you choose offers one. This is the strength of the MOA plan: it is not glasses or contact lenses but can be glasses AND contact lenses if there is enough policy benefit available.

The MOA is following the non-covered services statute in Missouri. For items that are not covered by the plan, e.g. Transitions®, you may bill the patient your normal fee. If a provider wishes to give any discount on those items, they may do so.

FRAMES

Providers may bill the patient the overages after the maximum cap and discount. The discount is also applied to the overages since frames are a covered service. For example, let's say the patient is in the first year of their plan and has met their deductible. They have their eye on a $500 designer frame.

The plan will reimburse you the maximum $200. You can charge the patient $100. ($500 x 60% = $300).

If the patient was in the third year of the plan, the reimbursement on this same $500 frame would still be $200 and you would bill the patient $200.

($500 x 80% = $400). **From this example, you can see that it is better for the patient to buy a more expensive frame the first plan year, because it is less out of pocket due to the discount.**

CONTACT LENS EXAM/MATERIALS

Contact lenses are balance billed after the discount is applied and maximum payments are applied.

Contact Lens Exam/Fitting

Example:

Your fee is $80. The plan will pay up to $60. During the first year of the plan, you will be reimbursed $48 from the plan and bill the patient $32. During the third year, you will be reimbursed $60 and bill the patient $20.

Contact Lenses:

The same is true of contact lens materials. The plan will pay up to $300. If the materials cost is $300 for a year's supply, the plan will pay $180 the first year and you balance bill the patient $120. During the third year, the plan will reimburse $240 for these same contacts and the patient pays $60. If the year's supply of lenses is $500, the plan pays $300 and the patient pays $200 in all plan years.

It is easy to determine the amount you will be reimbursed, what you write off, and what is collected from the patient. To make it even easier, we have designed a tool/widget you can use to make this calculation for you. You will be provided a copy of the widget.

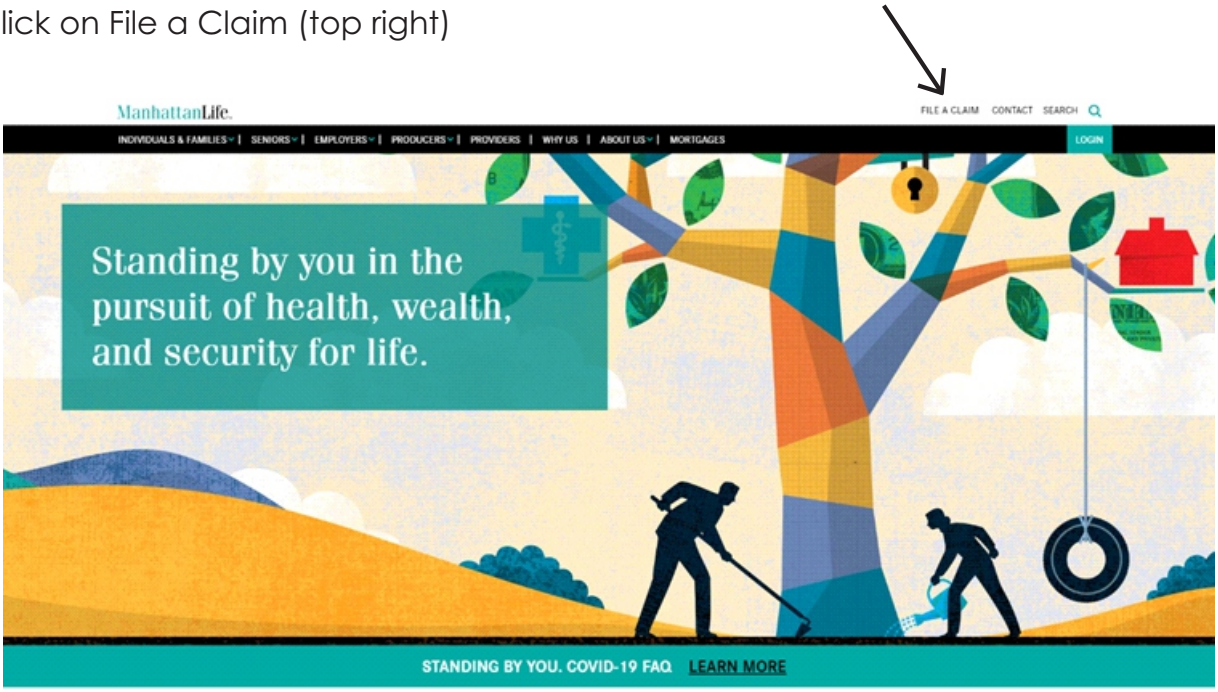
FILING A CLAIM

Filing a claim is done by fax, mail, or Easy Upload online. Fill out the basic HCFA 1500 form and either fax the claim to Manhattan Life at (713)-583-0677, or mail it to:

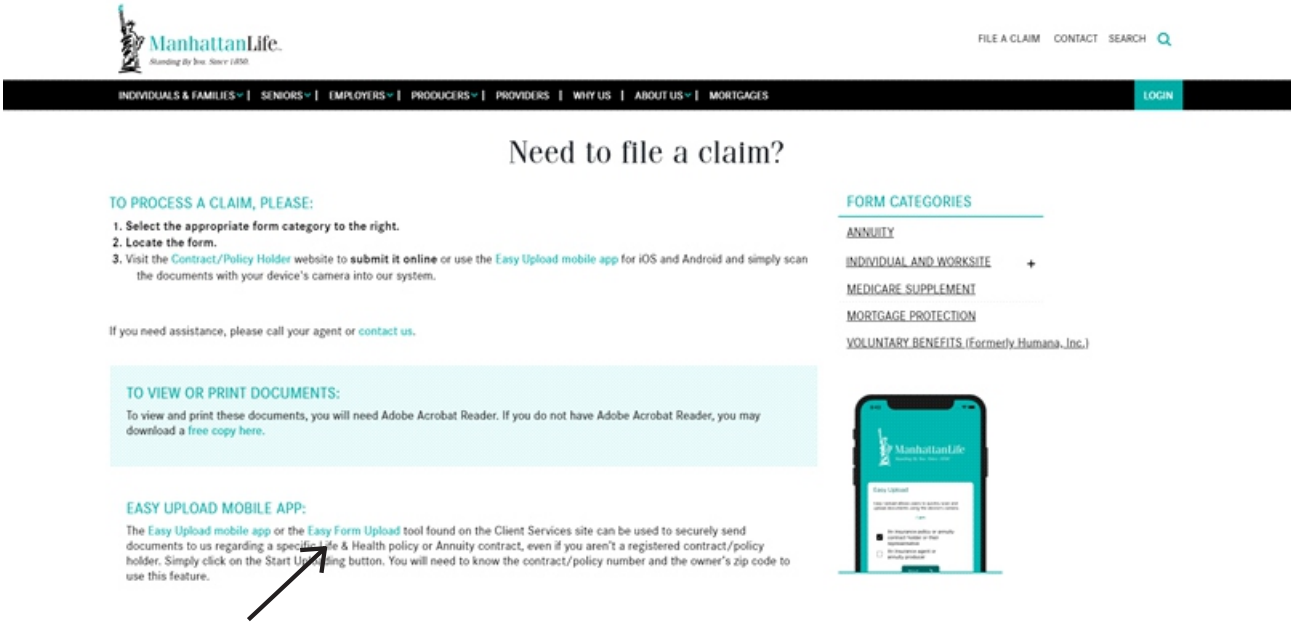
Individual Health SBU, PO Box 924408, Houston, TX 77292-4408

To file a claim online:

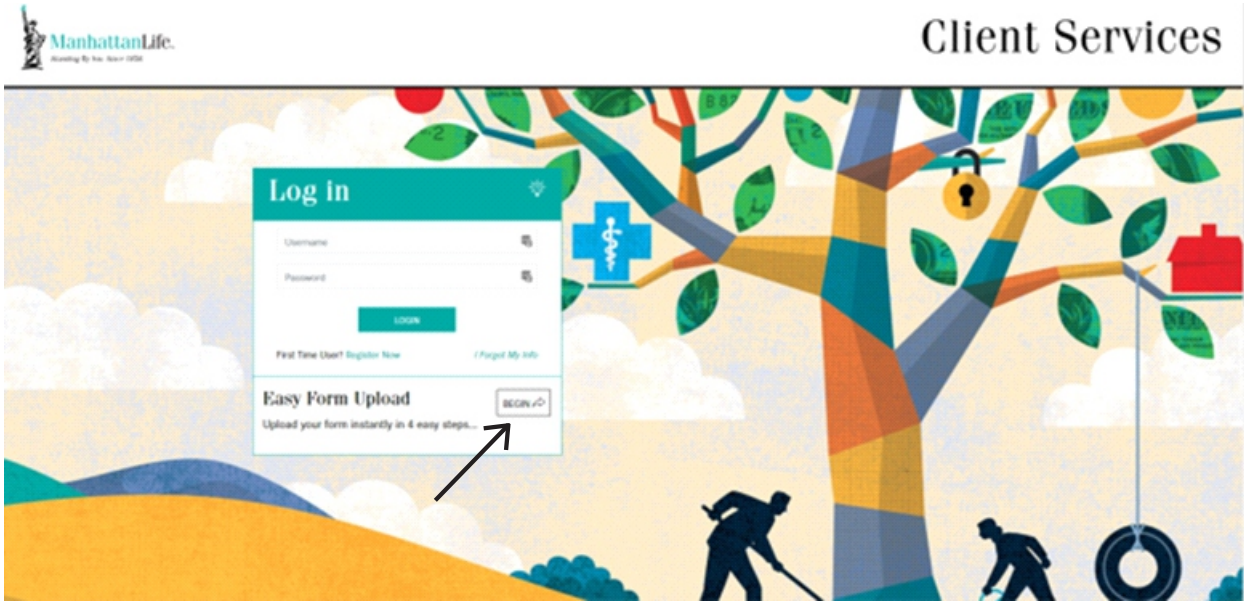
- Scan the completed HCFA claim form and save it to your computer
- Go to www.ManhattanLife.com
- Click on File a Claim (top right)



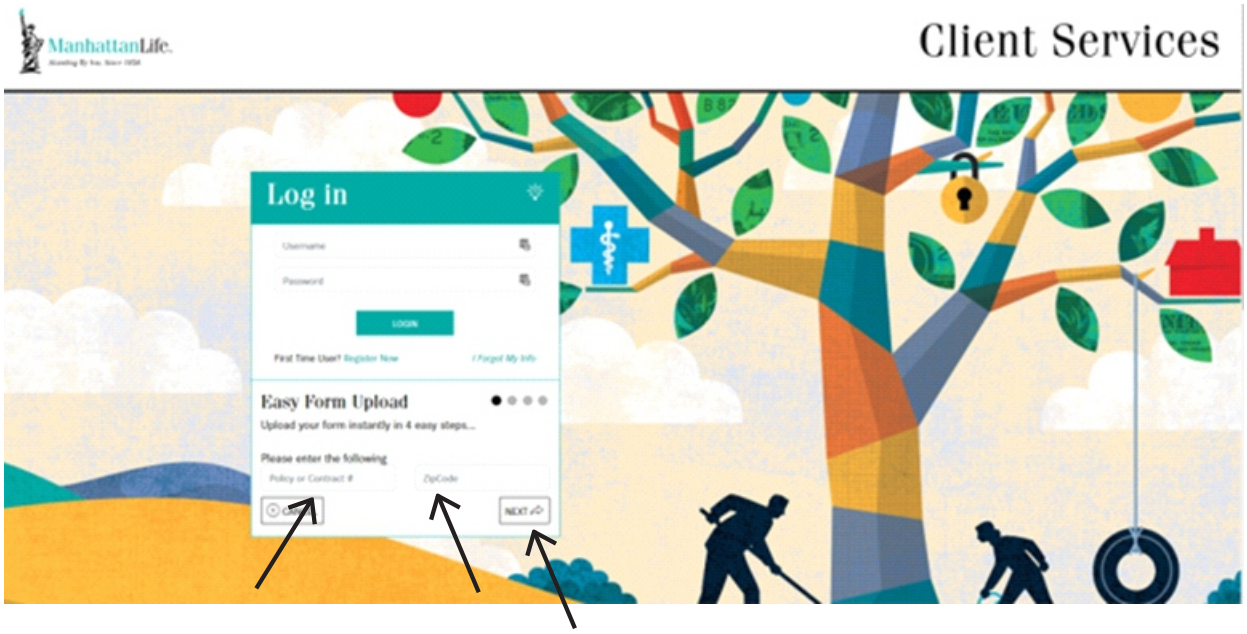
- Click on Easy Form Upload



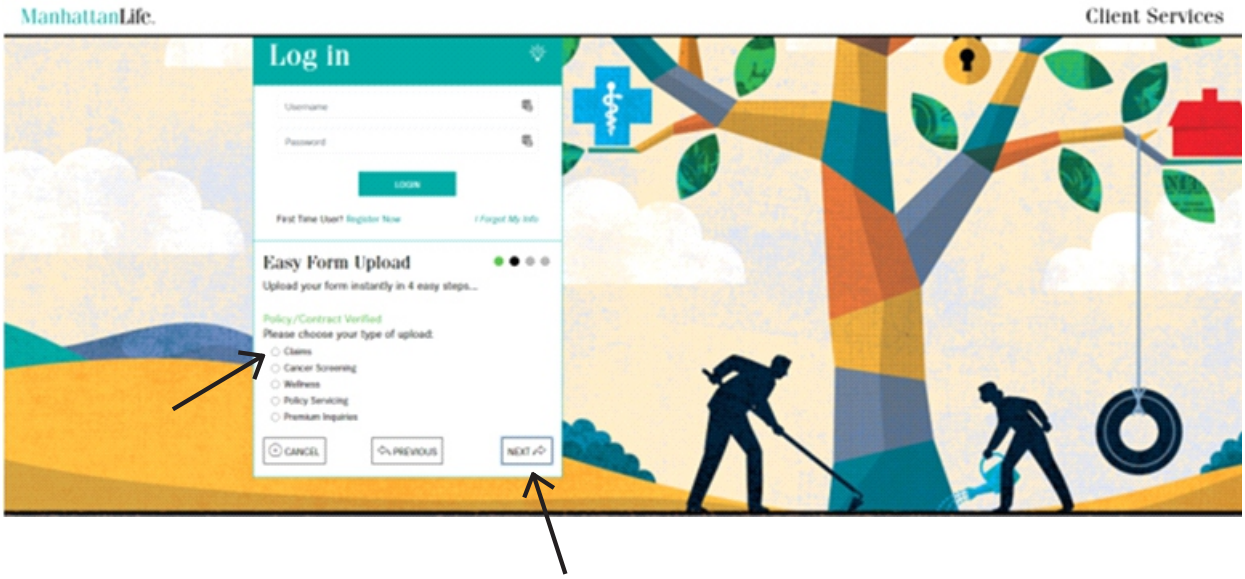
- Click on Easy Form Upload "Begin" button



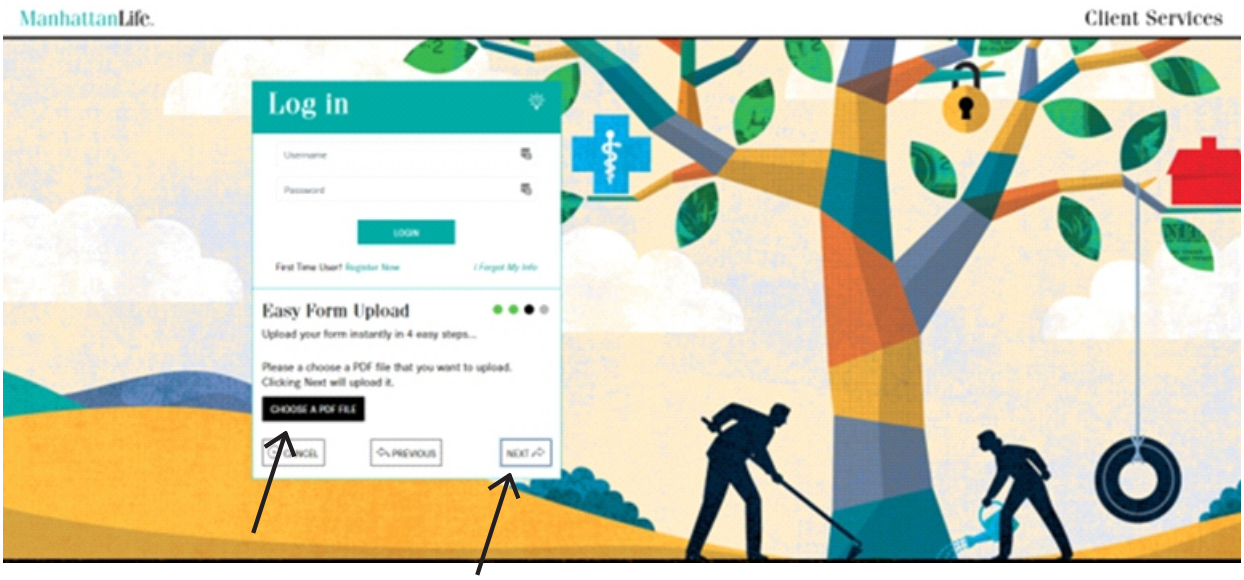
- You will need the policyholder number, the number has eight digits (ie: 72-XXXXXX) but **ONLY** enter the last six digits into the box
- The zip code of the policyholder is entered into the appropriate box
- Click on "Next"



- Click circle by “Claims”
- Click on “Next”



- Click the button that says “Choose a PDF File”, this should be the HCFA file on the policyholder.
- Click on “Next” button and this will upload the file
- You will receive a message “Upload Successful” when process is complete



ManhattanLife Assurance Company of America
Administrative Office: 10777 Northwest Freeway, Houston, TX 77092 800-669-9030

DENTAL, VISION, AND HEARING EXPENSE INSURANCE POLICY
LIMITED BENEFITS

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the "Medicare Supplement Buyer's Guide," available from Us.

READ YOUR POLICY CAREFULLY. This is a legal contract between the owner of the Policy (You) and ManhattanLife Assurance Company of America (ManhattanLife Assurance). It is issued in return for Your application and first premium. ManhattanLife Assurance agrees to pay this Policy's benefits to You if an Insured suffers a loss covered under this Policy while this Policy is in effect, and the Policy's provisions are met.

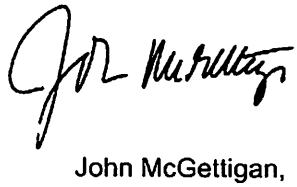
GUARANTEED RENEWABLE FOR LIFE.

RENEWAL PROVISION

You have the right to renew this Policy for life, if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the paragraph titled, "Change in Premium Rate."

TEN-DAY RIGHT TO RETURN

Please read Your Policy. If You are not satisfied for any reason, return the Policy to ManhattanLife Assurance's Administrative Office or to Your ManhattanLife Assurance Company of America's sales Agent within 10 days after You receive it. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will return your premium paid, less any claims paid.



John McGettigan,
Secretary

Dan George,
President

Executed by ManhattanLife Assurance Company of America on the Effective Date.

IMPORTANT NOTICE

PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR ADMINISTRATIVE OFFICE WITHIN 10 DAYS. THE APPLICATION IS A PART OF THIS POLICY, WHICH WAS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.

TABLE OF CONTENTS

POLICY SCHEDULE

Primary Insured: Issue Age: , years Policy Number: 0000000 Policy Effective Date: 00/00/0000

Insured Dependents:

First Policy Anniversary Date: 00/00/0000 Second Policy Anniversary Date: 00/00/0000 Third Policy Anniversary Date: 00/00/0000

Payment Option Mode: Monthly, Quarterly, Semi-Annually, Annually Initial Modal Premium: $000.00 Annual Premium: $000.00

Policy Year Deductible per Insured	$100
Policy Year Maximum Benefit per Insured	$1,000 / 1,500

DESCRIPTION OF COVERAGE **BENEFIT AMOUNT** per Insured (except for Fluoride Treatments). All benefits are determined based on UCR amounts and are limited to the Policy Year Maximum Benefit, Policy Year, per visit, and per pair limitations herein.

DENTAL BENEFITS

Preventative

Dental Examination	$55.00 per visit, 2 visits per Policy Year
Dental Prophylaxis	$100.00 per visit, 2 visits per Policy Year
Bite-wing x-ray (total)	$70.00 per visit, 2 visits per Policy Year
Fluoride Treatment	$15.00 per visit, 2 visits per Policy Year, only for Insured(s) ages 13 years and under
Other Intraoral x-ray	$65.00 1 every 2 Policy Years
Panoramic x-ray	$112.00 1 every 3 Policy Years

Basic

Filling	$130.00 per visit
Simple Extraction	$115.00 per visit

Major

Root Canal	$350.00 per visit
Periodontal Scaling	$110.00 per visit
Surgical Extraction	$300.00 per visit
Crowns	$500.00 per visit
Partial Dentures	$500 / 600 per visit

Subject to the Exclusions and Limitations, any Medically Necessary Preventative, Basic, or Major Dental Benefits not listed above will be subject to the Usual, Customary, Reasonable Charge, and the Policy Year Maximum Benefit.

VISION BENEFITS

Eye Examination	$100.00 1 per Policy Year
Refraction	$35.00 1 per Policy Year
Eyeglass Frame	$200.00 1 per Policy Year
Lenses	
Single Vision Lenses	$75.00 per pair
Bifocal Vision Lenses	$125.00 per pair
Trifocal Vision Lenses	$150.00 per pair
Progressive Lenses	$300.00 per pair
Maximum Benefit	1 pair of lenses per Policy Year
Anti-Reflective Lenses	$105.00 per pair
Polycarbonate Lenses	$100.00 per pair
Contact Lenses	$300.00
Maximum Benefit	1 purchase per Policy Year
Contact Lens Fitting Fee	$60.00 1 per Policy Year

HEARING BENEFITS

$500 / 750.00 per Policy Year per Ear

DEFINITIONS

Agent: A person required to be licensed under the laws of the state to sell, solicit, or negotiate insurance.

Audiologist: A person, other than a member of an Insured person's Immediate Family, duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed.

Covered Expenses: Expenses for necessary dental, vision, and hearing services or supplies prescribed by a Physician. Covered Expenses for services or supplies will be deemed to be incurred on the date or dates such services or supplies are received by the Insured. Covered Expenses must be incurred while this Policy is in force.

Dental Examination: A Dentist's inspection of the teeth and surrounding soft tissues of the oral cavity.

Dental Prophylaxis: The semi-annual removal of dental plaque, calculus, and stains from the exposed surfaces of the teeth by a Dentist or duly licensed dental hygienist, which is done as a dental preventative measure to prevent periodontal disease (gum disease).

Dentist: A person, other than a member of the Insured's Immediate Family, duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Eligible Dependent Child(ren): Unless specifically excluded in any part of this Policy, means:

1. Your unmarried dependent child not more than 25 years of age who is living with You and chiefly dependent on You for support and maintenance; or,
2. Your unmarried dependent child age 25 or over, who is chiefly dependent on You for support and maintenance if he/she is not able to support him/herself because of mental or physical handicap. The burden of proof that such dependent child is and has continued to be incapacitated rests with You. You must give proof of the incapacity acceptable to Us at Our Administrative Office at least 31 days after such child attains age 25. We reserve the right to require subsequent proof of such incapacity and dependency; however, We will not require such proof more than once a year after the 2-year period the dependent child attains age 25.

Eligible Spouse: Your spouse listed on the application unless specifically excluded in any part of this Policy. Your spouse will cease to be an Eligible Spouse on the day a valid decree of divorce is issued between You and Your spouse.

Experimental or Investigational: The use of a treatment (drugs, devices, or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven, that is, pre-market approval has not been granted (devices only);
2. benefits to at least one-third of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and,
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Full Dentures: A dental appliance that replaces all of the teeth in both jaws.

Immediate Family: Your spouse, parents, grandparents, children or siblings, and their spouses.

Injury: A bodily Injury caused directly by an accident, independent of sickness, disease, bodily infirmity, or any other cause, occurring on or after the Policy Effective Date and while the Insured's coverage is in force. *See*, the Exclusions and Limitations provision for Injuries not covered by this Policy.

Insured: The Primary Insured and any Insured Dependents shown on the Policy Schedule.

Insured Dependents: The Insured Dependents shown on the Policy Schedule.

Maximum Benefit Amount: The Maximum Benefit Amount that We will pay for each Insured is stated on the Policy Schedule--corresponding to the applicable benefit.

Medically Necessary: A service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or sickness and is: (1) prescribed by a Physician or duly licensed healthcare practitioner; (2) consistent with the diagnosis and treatment of the Injury or sickness; (3) in accordance with the generally accepted standards or medical practice; and, (4) not solely for the convenience of the Insured or their Physician.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Ophthalmologist: A Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Optometrist: A Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of the Insured's Immediate Family.

Physician: Any practitioner of the healing arts acting within the scope of his/her license. It does not include the Insured or any member of the Insured's Immediate Family. Physician includes a duly licensed Dentist, Optometrist, Ophthalmologist, or Audiologist.

Policy Effective Date: The effective date of this Policy is shown on the Policy Schedule. It will be used to determine premium due dates and anniversary dates. The Policy Effective Date is the date coverage begins.

Policy Renewal Date: The month and date Your Policy's premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option You selected. This is shown on the Policy Schedule.

Policy Schedule: Is attached to and is a part of this Policy.

Policy Year: The year beginning on the Policy Effective Date and on each following Policy anniversary of the Policy Effective Date.

Policy Year Deductible: The dollar amount for which You are responsible for each Insured during each Policy Year. The amount of the Policy Year Deductible is shown in the Policy Schedule.

Policy Year Maximum Benefit: The maximum benefit We will pay for each Insured during any Policy Year. This amount is shown in the Policy Schedule.

Partial Dentures: A dental appliance that replaces less than the full number of teeth in either jaw.

Periodontal Scaling: A process in which a Dentist performs a deep cleaning underneath the outermost edges of the gum.

Renewal Premiums: The amount You must pay Us to keep this Policy in force.

Simple Extraction: Removal of a visible tooth by a Physician.

Surgical Extraction: Removal of a tooth by a Physician that is impacted in the jaw and cannot be removed without making an incision.

Usual, Customary and Reasonable Charge ("UCR"): Those charges or portion of the charges that do not exceed the prevailing charges in the geographic area where the expense incurred. Such charges must be:

1. for necessary care and treatment of the Insured;
2. in keeping with the extent of the care and treatment provided;
3. as defined by Us or Our vendor.

We, Us, Our or the Company: ManhattanLife Assurance Company of America.

You and Your: The Primary Insured named in the Policy Schedule.

PREMIUMS AND REINSTATEMENT

Premium Payments: The first premium is due on the Policy Effective Date. Premiums paid after the first premium are Renewal Premiums.

The date Renewal Premiums are due is called the due date. Subject to the Grace Period, Your Policy will end if a Renewal Premium is not paid by the due date. All premiums are payable to Us.

Change in Premium Rate: We have the right to change premiums. If We do change the premiums, We will do so only:

1. if We change the premiums for all policies of this same form and issue age in Your state of issue;
2. if such change is in accordance with the laws and regulations of Your state of issue; and,
3. if We give You a 30 day notice before such change becomes effective.

Any change in the premium will be based on Your age on the Policy Effective Date.

Grace Period: This Policy has a 31-day Grace Period. This means that if a premium (other than the first) is not paid on or before the date it is due, it may be paid during the next 31 days after it is due. During the Grace Period, the Policy will stay in force. If You do not pay the premium by the end of the Grace Period, Your Policy will lapse (end).

Reinstatement: If any Renewal Premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized Agents, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We or any of Our authorized Agents require an application for reinstatement and issue a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from any Injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after that date. In all other respects, the Company and You shall have the same rights thereunder as the Company and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon and attached hereto in connection with reinstatement.

Refund of Unearned Premium: Within 30 days of proof of an Insured's death, We will refund any unearned premium paid for such person for any period beyond the end of the month in which death occurred.

Unpaid Premiums: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFITS

There is a Policy Year Deductible which is shown in the Policy Schedule. After the Policy Year Deductible has been met, benefits are limited to the applicable Maximum Benefit Amount and Policy Year Maximum Benefit, which are shown in the Policy Schedule.

BENEFITS

After the Policy Year Deductible is satisfied, the Policy pays the following percentages of UCR for Covered Expenses up to the Maximum Benefit Amount and Policy Year Maximum Benefit amounts shown on the Policy Schedule:

1. 60% - first Policy Year;
2. 70% - second Policy Year; and,
3. 80% - third Policy Year, and thereafter.

Covered Expenses, subject to the Exclusions and Limitations, Maximum Benefit Amounts (where applicable) and Policy Year Maximum Benefit, are:

1. **Dental Benefits.** Medically Necessary services, performed by a Dentist, including:
    a. **Preventative**—Dental Examination, bite-wing x-ray, other Intraoral x-ray, panoramic x-ray, Dental Prophylaxis, and fluoride treatment for Insured(s) ages 13 years old and under. The bite-wing x-ray benefit will not be paid in addition to the Intraoral x-ray benefit.

b. **Basic**—Filling, and Simple Extraction.
c. **Major**—Root canal, Periodontal Scaling, Surgical Extraction, crowns, and Partial Dentures.

Subject to the Exclusions and Limitations, any Preventative, Basic, or Major, Medically Necessary dental services prescribed by a Dentist that are not listed above will be subject to the UCR, and the Policy Year Maximum Benefit amount shown on the Policy Schedule.

2. **Vision Benefits.** Medically Necessary services by an Optometrist or Ophthalmologist, including:
   a. Eye examination, refraction, and eyeglasses frame.
   b. Prescribed vision lenses, either single, bifocal, trifocal, or progressive.
   c. Anti-reflective, or polycarbonate lenses for the prescribed vision lenses.
   d. Prescribed contact lenses.
   e. Fitting for prescribed eyeglasses.

3. **Hearing Benefits.**
   a. Hearing examinations/tests performed by a Physician.
   b. Medically Necessary hearing aid prescribed by a Physician, including the cost of the hearing aid and any necessary repairs or supplies.

EXCLUSIONS AND LIMITATIONS

We will NOT pay benefits for the following items and/or services during the first six (6) months following the Policy Effective Date:

1. Eyeglasses or contact lenses.

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. endodontics (including root canals), Periodontal Scaling, Surgical Extraction, bridges, crowns, Partial Dentures, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions, or outpatient dental surgery;
2. hearing aids, including repairs.

We will NOT pay benefits for:

1. Full Dentures;
2. fluoride treatment for individuals age 14 and above;
3. any loss resulting from war, declared or undeclared;
4. while sane, any intentionally self-inflicted Injury or illness;
5. any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation;
6. any services that are not recommended by a Physician;
7. any Experimental or Investigational procedure or treatment;
8. orthodontic treatment or dental implants and all related services;
9. any expenses incurred for the diagnosis or treatment of temporomandibular joint (TMJ) disorder or dysfunction, unless benefits are otherwise required by your state;
10. expenses incurred for surgical procedures (other than Medically Necessary outpatient dental surgery following the first Policy Year) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
11. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
12. impacted wisdom teeth;
13. occlusal guards;
14. prescription drugs;
15. treatment or diagnosis received while outside the territorial limits of the United States;
16. services for which you are not liable or for which no charge normally is made in the absence of insurance;
17. loss that occurs while this Policy is not in force;
18. broken appointments or for the completion of claim forms required by Us;
19. prostheses or appliances which have been lost, stolen or misplaced;

20. dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
21. services or supplies rendered for dietary planning for the control of dental caries, plaque or for oral hygiene instructions;
22. services or supplies rendered for full mouth reconstructions, or vertical dimension correction;
23. services or supplies provided solely for cosmetic purposes, unless necessitated as a result of Injury sustained while covered by this Policy;
24. services other than those provided by Medicaid for which no charge would be made in the absence of this insurance; and,
25. services that are not Medically Necessary.

PRE-EXISTING CONDITIONS LIMITATION

This Policy does not cover Pre-Existing Conditions whether disclosed in the application or not, for the first 12 months beginning on the date that person becomes an Insured on this Policy.

By Pre-Existing Conditions, We mean those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the 12-month period immediately preceding the Policy Effective Date.

Conditions specifically named or described as excluded in any part of this Policy are never covered.

TERMINATION

All coverage under this Policy shall terminate when this Policy ceases to be in force.

This Policy will end on the earlier of:

1. when You fail to pay premiums within Your Grace Period;
2. when You die; or,
3. the date You notify Us in writing to end this Policy.

Coverage for an Insured Dependent will end on the date such Insured ceases to be an Eligible Dependent Child or Eligible Spouse, as defined in this Policy.

When such Insured's insurance ends, We will:

1. consider any claim that began before the insurance ended; and,
2. allow a conversion policy for an Eligible Dependent Child or Eligible Spouse, as set forth in the Conversion Privilege.

You may cancel this Policy at any time by sending Us written notice. Upon cancellation, We will return the unearned portion of any premium paid. See the "Cancellation" provision, under the "General Provisions" below.

ELIGIBILITY AND ADDITION OF PERSONS

Your spouse and any other children who qualify as Eligible Dependent Child, as defined in this Policy, may be added to this Policy. To add a person (other than a newborn, foster, or adopted child) to this Policy after the Policy Effective Date, You must:

1. make written application to Us; and,
2. pay the additional premium due for that person. The first premium for the person to be added will be determined from the effective date of his/her coverage. The person added will be subject to the Pre-Existing Conditions Limitation provision of this Policy.

Any child born to You while this Policy is in force will be automatically insured from the moment of birth for 31 days. A child placed with You for adoption after the Policy Effective Date shall automatically be covered for a period of 31 days from the earlier of: (1) the date of placement for the purpose of adoption; or, (2) the date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption. A child placed with You as a foster child shall automatically be covered for a period of 31 days from the date of placement.

Coverage and benefits for the child will be the same as those that are provided for the following Insureds, successively:

1. any other Insured Dependents; if none, then,
2. You.

The Pre-Existing Conditions Limitation provision of this Policy is waived with respect to such child. Coverage for a child placed for the purpose of adoption will end if the adoption is stopped prior to legal adoption and the child is removed.

Without Eligible Dependent Children coverage: To continue coverage for the newborn, foster, or adopted child beyond the 31 day period, You must: (1) notify Us in writing; and, (2) pay the premium for the child within 31 days from the date of birth, placement or order granting custody. Premiums for the child will be prorated to the next premium due date of this Policy. If We are not notified and the required premium is not paid within 31 days, the coverage for the child will end 31 days after the date of birth, placement, or order granting custody.

With Eligible Dependent Children coverage: Please notify Us in writing as soon as possible to be sure that the child is properly enrolled, that coverage is in place and that medical care can be obtained when sought. A newborn child will be covered from the moment of birth. A foster child will be covered from the moment of placement. An adopted child will be covered from the earlier of: (1) the date of placement for the purpose of adoption; or, (2) the date of the entry of an order granting the adoptive parent custody of the child for the purpose of adoption.

CONVERSION PRIVILEGE

When an Eligible Dependent Child ceases to be an Eligible Dependent Child, coverage can be converted to a new policy. We must receive a written application and the required premium within 31 days after the date this coverage is to end. The new policy will:

1. be issued without evidence of insurability;
2. be a policy form We offer in the state the person lives which is most similar to (but not greater than) this Policy; and,
3. exclude any conditions that were excluded in this Policy for such Insured and cover Pre-Existing Conditions to the extent they are covered in this Policy.

Coverage under the new policy will begin on the next day after the date coverage for the Eligible Dependent Child ended under this Policy. The premium will be based on Our table of rates in effect on the Policy Effective Date of the new policy for such person's attained age and state of residence at the time of conversion.

Your Eligible Spouse may convert to a new policy if you become divorced or if you die. Written application for the policy must be made to Us and the required premium paid within 60 days after the date this coverage is to end. The new policy will:

1. be issued without evidence of insurability;
2. be a policy form We offer for conversion in the state the person lives (but not greater than this Policy); and,
3. exclude any conditions that were excluded in this Policy for such Insured and cover Pre-Existing Conditions to the extent they are covered in this Policy.

Coverage under the new policy will begin on the next day after the date coverage for the Eligible Spouse ended under this Policy. The premium will be based on Our table of rates in effect on the Policy Effective Date of the new policy for such person's attained age and state of residence at the time of conversion.

At the option of the Eligible Spouse, any Eligible Dependent Children covered under this Policy (for whom the Eligible Spouse has the obligation of support) may also be converted to the new policy. Said conversion is subject to the same conditions as the Eligible Spouse's conversion.

CLAIM PROVISIONS

Notice of Claim: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Our Administrative Office as indicated on the cover of this Policy or to any of Our authorized agents. Notice should include the name of the Insured and this Policy Number.

Claim Forms: When We receive the notice of claim, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) days after receiving written notice of claim, Your written statement will be accepted if We receive written proof of the event and type and extent of the loss within the time stated below in the proof of loss provision.

Proof of Loss: Written proof of loss must be furnished to Us at Our Administrative Office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. Proof must be sent as soon as reasonably possible, except in the absence of legal capacity, no later than one (1) year from the time proof is otherwise required. We have the right to request records as may reasonably be necessary to determine if benefits are payable under this policy.

Time of Payment of Claims: All benefits payable under this Policy will be payable immediately upon receipt of due written proof of such loss.

Payment of Claims: Any accrued benefits unpaid at Your death will be paid to Your estate, unless they have been assigned to a provider. Loss of life benefits, if any, will be paid to the last designated beneficiary shown in Our records. If no beneficiary designation is then in effect, the benefits will be paid to Your estate. Any other accrued benefits unpaid at Your death, may, at Our option, be paid to either Your designated beneficiary or to Your estate. All other benefits will be paid to You.

If any benefit is payable to Your estate or to a beneficiary who is a minor or otherwise not competent to give a valid release, We may pay up to $1,000.00 to any relative of Yours by blood or connection by marriage, or any beneficiary that We find equitably entitled to the payment. Any payment We make in good faith will fully discharge Us to the extent of the payment.

Claim Appeal: You have the right to request a review of all adverse claim decisions. A review must be requested in writing within 180 days following Your receipt of the notice that the claim was denied or reduced.

GENERAL PROVISIONS

Entire Contract; Changes: This Policy, including the endorsements, application, and attached documents, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No Agent has authority to change this Policy or to waive any of its provisions.

Cancellation: You may cancel this Policy at any time by written notice delivered or mailed to Us, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, We will return promptly the unearned portion of any premium paid. If You cancel, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where You resided when the Policy was issued.

Time Limit On Certain Defenses: After two (2) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by You in the application for the Policy shall be used to void the Policy or to deny a claim or loss incurred commencing after the expiration of the two (2) year period.

Physical Examination and Autopsy: We, at Our expense, can have You examined by a Physician as often as reasonably needed while a claim is pending. We, at Our expense, can require an autopsy in the event of an Insured's death, unless prohibited by law in the state that the Insured lives.

Misstatement of Age: If an Insured's age has been misstated, all amount payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Legal Action: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Assignment: You may assign benefits under this Policy. Benefit payments may be assigned to another person in whole or in part. We will not honor any assignment of this Policy, unless it is in writing and filed with Us at Our Administrative Office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Expense, the full benefit amount will be paid to the provider.

Change of Beneficiary: Unless You make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for You, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

Other Insurance With Us: You can be insured under only one policy like this one with Us at any one time. If You are insured under more than one such policy, You can select the one that is to remaining effect. In the event of death, this selection will be made by Your estate. We will return all premiums paid (less any claims paid) for any policy that does not remain in effect.

Term of Coverage: The initial term of this Policy begins at twelve (12:00) o'clock, midnight, Standard Time, at the place where you reside on the Policy Effective Date shown on the Policy Schedule. It ends at twelve (12:00) o'clock, midnight, Standard Time, on the date Your premium is due, subject to the Grace Period. The date Your premium is due is determined by the mode of payment as shown on the Policy Schedule. You may then renew this Policy subject to the Renewal Provision on the cover of this Policy.

Conformity With State Statutes: Any provision of the Policy which, on its Policy Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

ManhattanLife Assurance Company of America
10777 Northwest Freeway
Houston, Texas 77092
Customer Service: 800-669-9030

LIMITED BENEFIT INSURANCE POLICY FOR DENTAL, VISION, AND HEARING EXPENSES

GUARANTEED RENEWABLE FOR LIFE.

ManhattanLife Assurance Company of America

POLICY FORM: DVH
Exhibit II – Monthly Premiums

	$1,000 Maximum Benefit		
Issue Age	**Adult**	**Family**	**Extra Child**
3-17			$20.50
18-39	$22.56	$78.96	
40-54	$27.46	$96.10	
55-64	$34.37	$103.11	
65-74	$40.30	$92.68	
75-85	$48.30	S103.85	
	$1,500 Maximum Benefit		
Issue Age	**Adult**	**Family**	**Extra Child**
3-17			$27.05
18-39	$29.81	$104.32	
40-54	$35.53	$124.37	
55-64	$45.04	$135.12	
65-74	$53.27	$122.52	
75-85	$63.89	$137.37	

Family rates include up to three children.

Additional children are charged the age 3 - 17 rate per person.

We are also including the attachment on how to bill the dental benefits. Why? In case you have staff members who have the policy and experience difficulties, or if a patient buys the plan through your office and has questions. We hope they will call the Manhattan number, however, this is a MOA DVH plan and not the general DVH from Manhattan so we want you to be able to hand them information if needed.

DENTAL PROVIDERS

1. Choose you own dentist (additional savings may be available if the dentist is in Careington/DenteMax Network).

2. Three ways to find a dentist who participates in this Network:
   - Go to www.moadvh.com or www.careington.com/co/maxcare
   - Call Careington at (800) 290-0523, Monday through Friday, 7AM to 7PM Central Time
   - Call ManhattanLife Customer Service Department at (800) 999-2971 and they will be happy to assist you

3. **MAKE SURE YOU BRING YOUR CARD WHEN YOU GO TO YOUR OFFICE VISIT.**
   - Your insurance identification card should have the Careington Maximum Care PPO logo on it.

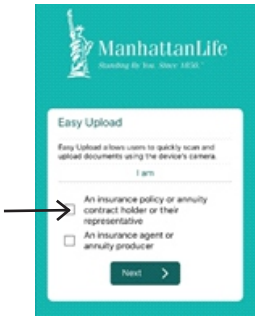
4. Voluntary use of this Network may help you save money on your dental treatment. If you go outside the Network, you will have to file the visit with ManhattanLife and will be **reimbursed directly from them**.

If you need to file your claim there are three choices available.
   - Easy Upload App. (phone) - Use Invoice
   - Easy Form Upload (online) - Use Invoice
   - ManhattanLife Form to be filled out by dentist – Mail or Fax

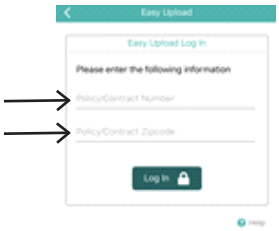
On the Easy Upload Mobile:

1. Download Easy Upload App

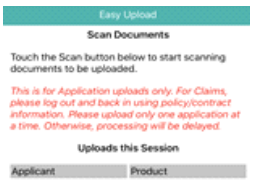
2. Mark box "An insurance policy or annuity contract holder or their representative"



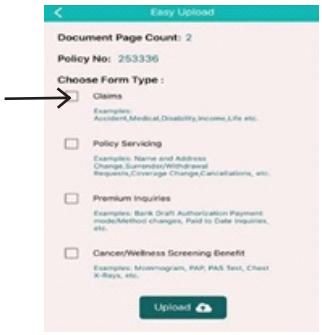
3. Enter "Policy/Contract Number" and "Zipcode"



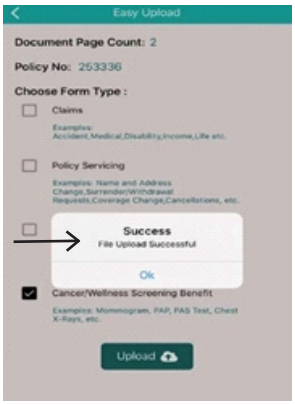
4. Click the "Scan" button and push "blue button" to take picture then hit "Continue"



5. Enter "Policy/Contract Number" and "Zipcode"



6. The screen will say "Success"



MOA

CLAIM FOR DENTAL BENEFITS

Submit x-rays with:

- treatments involving gold restoration, crowns, root canals, or bridgework

X-RAYS MAY BE REQUESTED FOR OTHER SERVICES

Any person who knowingly and with intent to injure, defraud, or deceive any insurance Company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

MAIL TO:
CLAIMS DEPARTMENT
P.O. BOX 925309
HOUSTON, TX 77292-2728

FAX TO: 713-583-0677

PART 1

1. Patient Name	2. Relationship to Employee				3. Sex		4. Patient Birthday			5. If full time student	
	Self	Spouse	Child	Other	M	F	MO	Day	Year	School	City

6. Employee			7. Employee Social Security No.			8. Group number if known
First	Middle	Last				

9. Employee Mailing Address	City, State	Zip

10. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Patient's Signature (Parent if minor).

PART 2

11. Dentist Name
First Middle Last

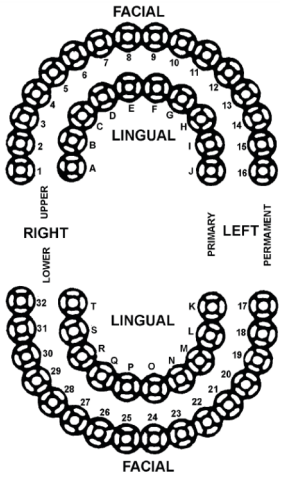
12. Mailing Address	City, State	Zip

TO BE COMPLETED BY DENTIST

13. Dentist Soc. Sec. or ITIN	14. Dentist License No.	15. Dentist Phone No.	16. First Visit Date Current Series	17. Place of Treatment				18. Radiographs or Models Enclosed?			
				Office	Hosp.	ECF	Other		No	Yes	How Many?

19. Dentist - Check One

❑ Pretreatment Estimate
❑ Statement of Actual Services



32. Examination and treatment Plan - List in order from tooth number 1 through tooth number 32
Use chart system shown

For Home Office Only: ❑ Schedule ❑ Other

Tooth No. or Ltr.	Surface	Description of Services (including X-rays, Prophyaxis Materials Used, etc.)	Date Service Performed Mo.	Day	Yr.	Procedure Code	Fee	

Dental Unit Use

Employee Eligible Date _____
Employee Effective Date _____
Termination Date _____
Verified By _____
Date _____

These benefits will, subject to Policy provisions, be payable if the described procedures are performed while the patient is insured with ManhattanLife Assurance Company of America

Total Fee Actually Charged		
Deductible		
Patient pays		
Insurance will pay		

Part 3 TO BE COMPLETED BY DENTIST

I hereby certify that the services listed above have been performed on the above named patient on the dates indicated

Dentist Signature _____ Date _____

www.manhattanlife.com

ManhattanLife Since 1850

❑ Please pay all dental/vision benefits to **provider**.

❑ Please pay all dental/vision benefits to **insured**

ManhattanLife
Since 1850

ManhattanLife Assurance Company of America
10777 Northwest Freeway
Houston, Texas 77092
800-669-9030

DENTAL, VISION, HEARING CLAIM FORM

Claimant's Proof of Loss

Patient Name: _____ Date of Birth: _____

Relationship to Insured: _____

Address: _____
Street City State Zip Code

Social Security No: _____ Telephone No: _____

THIS SECTION MUST BE COMPLETED BY THE AUDIOLOGIST/OTOLOGIST

1. Name of Examiner: _____ License No: _____
2. Date of Most Recent Hearing Aid Test: _____
3. Date of Prescription for Hearing Aid: _____
4. In my professional opinion, a hearing aid ❑ is required ❑ is not required
5. Hearing Loss (%) Left Ear_____ % Right Ear_____ %

THIS SECTION MUST BE COMPLETED BY THE HEARING AID DEALER

1. Hearing Aid Center: _____ License No: _____
2. Hearing Aid Type or Mode: _____
3. Cost of Hearing Aid Appliance $ _____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE BELOW)

Date(s) of Service MM DD YY	Place of Service	Type of Service	Modifier	Procedures, Services, or Supplies CPT or HCPCS Code	Diagnosis Code	Charges	Or Units	Leave Blank

Federal Tax I.D. Number SSN ❑ EIN ❑	Patient's Account No.	Accept Assignment? ❑ YES ❑ NO	Total Charges $	Amount Paid $	Balance Due $

Signature of Physician or Supplier Including Degrees or Credentials	Name and Address of Facility Where Services Were Rendered (if other than home or office)	Physician's, Supplier's Billing Name, Address, Zip Code and Phone #
Signed _____ Date _____		PIN # _____ GRP # _____

I certify the above is complete and correct and that I am claiming benefits for charges incurred by the above-named patient.

Subscriber Signature _____ Date _____

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ManhattanLife
Since 1850