



**ManhattanLife**<sup>™</sup>

Standing By You. Since 1850.

## Dental, Vision and Hearing Insurance

A plan with choices for you  
and your family

### The Importance of Dental | Vision | Hearing

- Quality of Life
- Unforeseen situations that are painful, inconvenient and expensive
- Basic Medicare does not cover dental, vision or hearing expenses

#### PRODUCTS HIGHLIGHTS

- Choose your dentist - *In network or out of network*
- Family Rates (includes a maximum of 3 children)
- Individual 18 - 85
- \$1,000 - \$5,000 policy year benefit option available
- Guaranteed Issue
- Guaranteed renewable for life\*

*\* Subject to our right to change premiums.*

#### **NEW! Careington Network**

Clients can now access the Careington Maximum Care PPO Dental Network. Use of network completely optional.

- Policyholders can now use, if they choose, a dental provider from the Careington Dental network.
- Policyholders can also use the dentist of their choice, even if not part of the dental network.
- Network discounts may help extend the policy year maximum with reduced charges.
- Careington can be contacted at (800) 290-0523.

**Careington**  
SOLUTIONS SIMPLIFIED



Protect Your Smile  
and Smile Brighter!



Protect Your Sight  
and See Clearer!



Protect Your Hearing  
and Hear Better!

This is a Limited Benefit Insurance Policy  
for Dental, Vision and Hearing Expenses



**175 Years**  
*And Counting.*

Underwritten by ManhattanLife Insurance  
and Annuity Company

## PLAN BENEFITS <sup>1</sup>

|                                                                                                                        |                                                                                  |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <b>Eligibility</b>                                                                                                     | Anyone age 18 - 85                                                               |
| <b>Policy Year Maximum Benefit</b>                                                                                     | <b>\$1,000, \$1,500, \$3,000 or \$5,000</b><br>(choose one)                      |
| <b>Policy Year Deductible</b>                                                                                          | \$100 per person                                                                 |
| <b>Dental Coverage</b>                                                                                                 |                                                                                  |
| <b>Preventive Services</b><br>Semi-Annual exams, cleaning and x-rays                                                   | <b>Year 1 - 60%</b><br><b>Year 2 - 70%</b><br><b>Year 3 and thereafter - 80%</b> |
| <b>Waiting Period</b>                                                                                                  | <b>None</b>                                                                      |
| <b>Basic Services</b><br>Including x-ray, fillings and extractions (other than "full mouth")                           | <b>Year 1 - 60%</b><br><b>Year 2 - 70%</b><br><b>Year 3 and thereafter - 80%</b> |
| <b>Waiting Period</b>                                                                                                  | <b>None</b>                                                                      |
| <b>Major Services</b><br>Including bridges, crowns, full dentures or partials, full mouth extractions, and root canals | <b>Year 1 - 0%</b><br><b>Year 2 - 70%</b><br><b>Year 3 and thereafter - 80%</b>  |
| <b>Waiting Period</b>                                                                                                  | <b>12 months</b>                                                                 |
| <b>Vision Coverage</b>                                                                                                 |                                                                                  |
| Basic eye exam, eye refraction, including the cost of eye glasses or contact lenses                                    | <b>Year 1 - 60%</b><br><b>Year 2 - 70%</b><br><b>Year 3 and thereafter - 80%</b> |
| <b>Waiting Period</b>                                                                                                  | <b>6 months</b><br>on eyeglasses and contact lenses                              |
| <b>Hearing Coverage</b>                                                                                                |                                                                                  |
| Exam, hearing aid and necessary repairs or supplies                                                                    | <b>Year 1 - 60%</b><br><b>Year 2 - 70%</b><br><b>Year 3 and thereafter - 80%</b> |
| <b>Waiting Period</b>                                                                                                  | <b>12 months</b><br>new hearing aids and existing hearing aid repairs            |

<sup>1</sup> Refer to your policy for a complete description of limitations and exclusions.

## INDIVIDUAL MONTHLY PREMIUM

| Age     | \$1,000 | \$1,500 | \$3,000 | \$5,000 |
|---------|---------|---------|---------|---------|
| 18 - 39 | \$32.42 | \$42.80 | \$51.49 | \$64.92 |
| 40 - 54 | \$35.01 | \$45.31 | \$55.97 | \$70.30 |
| 55 - 64 | \$37.61 | \$49.25 | \$63.76 | \$78.98 |
| 65 - 74 | \$40.21 | \$53.19 | \$68.86 | \$84.53 |
| 75 - 85 | \$46.21 | \$61.16 | \$79.25 | \$94.92 |

## FAMILY MONTHLY PREMIUM \*

| Age     | \$1,000  | \$1,500  | \$3,000  | \$5,000  |
|---------|----------|----------|----------|----------|
| 18 - 39 | \$103.61 | \$136.74 | \$164.95 | \$213.21 |
| 40 - 54 | \$108.80 | \$141.93 | \$171.04 | \$223.96 |
| 55 - 64 | \$113.99 | \$149.63 | \$184.65 | \$241.33 |
| 65 - 74 | \$119.19 | \$157.51 | \$203.99 | \$252.43 |
| 75 - 85 | \$137.01 | \$181.07 | \$234.88 | \$273.21 |

## CHILD MONTHLY PREMIUM \*

| Age    | \$1,000 | \$1,500 | \$3,000 | \$5,000 |
|--------|---------|---------|---------|---------|
| 3 - 17 | \$24.36 | \$32.15 | \$38.68 | \$52.12 |

\* Family rates include up to three children. Additional children are charged the age 3 - 17 rate per person.

\* Individual and (1) child will be charged an individual + child rate.

Premiums are subject to change. Premium rates based on \$1,000, \$1,500, \$3,000 or \$5,000 Policy Year Maximum. Use the age of the oldest applicant. Benefit exclusions and limitations apply.

Policy Form Numbers: AK7016-IN

Underwritten by: ManhattanLife Insurance and Annuity Company  
10777 Northwest Freeway, Houston, TX 77092 Toll Free Telephone: 800-669-9030

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Dental, Vision and Hearing product at [disclosure.manhattanlife.com](https://disclosure.manhattanlife.com). Please review this information before applying for coverage. The amounts of benefits provided depend on the plan selected. Premiums will vary according to the selection made.