



**ManhattanLife**

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 - \$1,500 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

- 5% to 50% below the 80th percentile of Reasonable and Customary Charges
- No claims need to be filed with ManhattanLife after visit
- Network discounts help the policy maximum last longer
- Network dentist will not bill client for any expense above Careington Network benefit
- Claims remain the same out of network - 100% of Usual and Customary charges

For more information, contact Careington at (800) 290-0523



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

Underwritten by ManhattanLife Insurance Company of America and Family Life Insurance Company.

Not available in all states

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

<b>Eligibility</b>	Anyone age 18 - 85
<b>Policy Year Maximum Benefit</b>	<b>\$1,000 or \$1,500</b> (choose one)
<b>Policy Year Deductible</b>	\$100 per person

### Dental Coverage

#### Preventive Services

Semi-Annual exams, cleaning and x-rays

**Year 1 - 60%**  
**Year 2 - 70%**  
**Year 3 and thereafter - 80%\***

#### Waiting Period

**None**

*\*In OH, year 2 and thereafter is 70%*

#### Basic Services

Including x-ray, fillings and extractions (other than "full mouth")

**Year 1 - 60%**  
**Year 2 - 70%**  
**Year 3 and thereafter - 80%\***

#### Waiting Period

**None**

*\*In OH, year 2 and thereafter is 70%*

#### Major Services

Including bridges, crowns, full dentures or partials, full mouth extractions, and root canals

**Year 1 - 0%**  
**Year 2 - 70%**  
**Year 3 and thereafter - 80%\***

#### Waiting Period

**12 months**

### Vision Coverage

Basic eye exam, eye refraction, including the cost of eye glasses or contact lenses

**Year 1 - 60%**  
**Year 2 - 70%**  
**Year 3 and thereafter - 80%\***

#### Waiting Period

**6 months**  
on eyeglasses and contact lenses

*\*In OH, year 2 and thereafter is 70%*

### Hearing Coverage

Exam, hearing aid and necessary repairs or supplies

**Year 1 - 60%**  
**Year 2 - 70%**  
**Year 3 and thereafter - 80%\***

#### Waiting Period

**12 months**  
new hearing aids and existing hearing aid repairs

*\*In OH, year 2 and thereafter is 70%*

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

## \$1,000 POLICY YEAR MAXIMUM

### INDIVIDUAL MONTHLY PREMIUM

Age	Premium
18 - 39	\$30.25
40 - 54	\$32.75
55 - 64	\$35.08
65 - 74	\$37.58
75 - 85	\$43.17

### FAMILY MONTHLY PREMIUM<sup>2</sup>

Age	Premium
18 - 39	\$96.83
40 - 54	\$101.67
55 - 64	\$106.50
65 - 74	\$111.42
75 - 85	\$128.08

## \$1,500 POLICY YEAR MAXIMUM

### INDIVIDUAL MONTHLY PREMIUM

Age	Premium
18 - 39	\$40.00
40 - 54	\$42.33
55 - 64	\$46.00
65 - 74	\$49.67
75 - 85	\$57.08

### FAMILY MONTHLY PREMIUM<sup>2</sup>

Age	Premium
18 - 39	\$127.75
40 - 54	\$132.67
55 - 64	\$139.92
65 - 74	\$147.17
75 - 85	\$169.25

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

<sup>2</sup> Family rates include up to three children. Additional children are charged the age 3 - 17 rate per person.

### \$1,000 Policy Year Maximum

Age	Premium
3 - 17	\$22.75

### \$1,500 Policy Year Maximum

3 - 17	\$30.00
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Policy Form Numbers: C-DVH16, F-DVH16, DVH17, DVH17-LA, DVH17-OK, DVH17-TX (including state variations)

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](http://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.