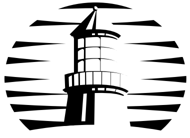


Medico®
Dental Plus Insurance Series

■ Traditional ■ Preferred ■ Preferred Plus

APPLICATION BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

☐ Application for Dental or Dental, Vision and Hearing Insurance Policy

☐ Bank Draft and/or Credit Card Authorization (if applicable)

☐ Additional forms which may be required. See forms marked Complete and Send with Application.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller
Electronic Application Submission Tool
Website: mic.GoMedico.com

Mail
Medico Insurance Company
Administrative Services
PO Box 10386
Des Moines, IA 50306

Fax
1-888-363-3420

If you have any questions, please call 1-800-547-2401-Option 3.

34 112 1058 0716 KS

Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Application for Dental or Dental, Vision and Hearing Insurance Policy

Requested Effective Date of New Policy (optional)

____

Requested Effective Date must be after the application date.
If no Effective Date is requested, the Effective Date will be the day the application is approved by our Underwriting Department.

Policy Delivery Options

Upon approval of this application, the policy will be mailed to:

❒ Applicant ❒ Producer

Part A: General Information – Please Print

Applicant Information

First Name | M.I. | Last Name | Suffix

Date of Birth (MM/DD/YY) | Age | Gender | Social Security Number

Address

City | State | ZIP Code

Phone Number | Alternate Phone Number | Email Address

1. Do you have any dental, vision or hearing insurance currently in force? ❒ Yes ❒ No
2. Is the insurance applied for intended to replace any existing insurance with this or any other company? ❒ Yes ❒ No

If "Yes," provide type of contract or policy number and name of company:

Name of Company	Contract or Policy Number

If replacement is involved, have you received a Replacement Form (in states where required by law)? ❒ Yes ❒ No

Part B: Benefit – Check the Desired Option:

Plan Selection:
❒ Traditional - $1,000 Policy Year Maximum Benefit Amount
❒ Preferred - $1,500 Policy Year Maximum Benefit Amount
❒ Preferred Plus - $2,500 Policy Year Maximum Benefit Amount

Part C: Payment Options

Make all checks payable to: Medico Insurance Company (do not make checks payable to the Producer or leave payee line blank).

Method of Payment:	Frequency of Payment:			
❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Amount Received with Application $ ______ Renewal Premium $ ______

Part D: Application Agreement

I hereby apply to Medico Insurance Company (the Company) for a **Dental or Dental, Vision and Hearing Insurance Policy** to be issued solely and entirely in reliance on my answers. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid and the policy is delivered and accepted by me. I have received the Outline of Coverage for the policy (in states where required by law).

No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an Immediate Family member), either directly, or through wage adjustments or other means of reimbursement.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

I am applying for this Dental or Dental, Vision and Hearing Insurance Policy. The policy provides dental or dental, vision and hearing benefits only. Review your policy carefully.

X ____

Applicant's Signature | Date (MM/DD/YYYY)

Producer's Certification: I certify the information in this application was provided by the applicant and correctly recorded. If the applicant is Medicare eligible, I have provided the applicant a link to the Medicare Buyer's Guide at GoMedico.com or a hard copy of it.

____

Producer's Printed Name | Producer's Number

X ____

Producer's Signature | Date (MM/DD/YYYY)

BANK DRAFT INFORMATION

STOP! Complete this section *only* if you have chosen the monthly automatic payment option.

A. If you requested the "Bank Draft" option, what is to be included?

☐ Only the Coverage Applied for Today ☐ All Coverage (New and Existing)

B. Initial Premium

Authorization to Bank or Other Financial Institution

☐ Checking ☐ Savings

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

C. Ongoing Premium ***(Complete C only if different from Initial Premium information)***

Authorization to Bank or Other Financial Institution

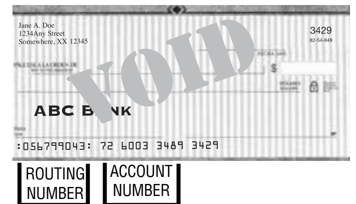
☐ Checking ☐ Savings

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

D. Please read: By providing my account information here and signing the application for insurance coverage, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Medico Insurance Company and/or Medico Corp Life Insurance Company for insurance premiums. I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



CREDIT CARD AUTHORIZATION

STOP! Complete this section *only* if you are paying by credit card.

By providing this information and signing the application for insurance coverage, you authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to bill your MasterCard/Visa account for the initial premium.

A. If you requested the "Credit Card" option, what is to be included?

☐ Only the Coverage Applied for Today ☐ All Coverage (New and Existing)

B. Initial Premium

Credit Card Information: ☐ MasterCard ☐ Visa

Credit Card Number | Card Security Code (3 digits) | Expiration Date MM / YYYY

Billing Address:
Billing information must be entered exactly as it appears on the credit card statement. Please check the statement for accuracy to avoid delays in processing.

First Name | M.I. | Last Name

Billing Address | City | State | Zip Code

C. Ongoing Premium ***(Complete C only if different than Initial Premium Information)***

Credit Card Information: ☐ MasterCard ☐ Visa

Credit Card Number | Card Security Code (3 digits) | Expiration Date MM / YYYY

Billing Address:
Billing information must be entered exactly as it appears on the credit card statement. Please check the statement for accuracy to avoid delays in processing.

First Name | M.I. | Last Name

Billing Address | City | State | Zip Code

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Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Receipt for Initial Premium

Dental, Vision and Hearing Receipt

The applicant has applied for one of the following.

❒ Traditional - $1,000 Policy Year Maximum Benefit Amount

❒ Preferred - $1,500 Policy Year Maximum Benefit Amount

❒ Preferred Plus - $2,500 Policy Year Maximum Benefit Amount

Received of ____
First Name MI Last Name Suffix

an application for insurance as shown above and $ ________

This insurance will not be in force until the policy is delivered and accepted and the first premium is paid.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO **MEDICO INSURANCE COMPANY**. DO NOT MAKE CHECK PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not receive your policy within 30 days, please contact us by one of the following methods:

Write to:
Medico Insurance Company
PO Box 10386 • Des Moines, IA 50306

Call:
Customer Service at 1-800-228-6080

E-mail:
customerservice@GoMedico.com

X ______________________________ ______________________
Producer's Signature Date (MM/DD/YYYY)

____
Producer's Printed Name

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Important Notice to Persons on Medicare

This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

The insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the ***Guide to Health Insurance for People with Medicare***, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or State Health Insurance Assistance Program (SHIP).

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MEDICO® INSURANCE COMPANY

Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Outline of Coverage for Dental Insurance Policy

DENTAL INSURANCE POLICY

RETAIN THIS OUTLINE FOR YOUR RECORDS

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us. You may also review this guide at www.Medicare.gov.

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both You and Your insurance company. It is therefore important that You **READ YOUR POLICY CAREFULLY.**

Limited Benefit Coverage

Policies of this category are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

Dental Coverage

Policies of this category are designed to provide You with coverage for dental services. Coverage is provided for preventive and diagnostic, basic and major dental services. Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.

BENEFITS PROVIDED BY THE POLICY

For any benefit to be payable under the benefits described below, the loss must be incurred while the policy is in force and not excluded from coverage under the Exclusions and Limitations provision. After the Policy Year Deductible is satisfied and subject to any Waiting Periods, We will pay Our Coinsurance amount for the following services up to the Policy Year Maximum Benefit Amount. Please refer to the Policy Schedule and the Benefits section of the policy for a complete description of the benefits.

DENTAL BENEFITS

Diagnostic and Preventive Services

This benefit pays for evaluations, cleanings and bitewing x-rays.

Basic Services

This benefit pays for restorations (fillings), x-rays, nonsurgical extractions and palliative care.

Major Services

This benefit pays for crowns/inlays/onlays, prosthodontic services, endodontic services, periodontal services and oral surgery for an erupted tooth.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for any expense not identified and included as a covered loss under the policy. You will be fully responsible for payment of any expenses that are not a covered loss. We will not pay benefits for:

1. Any loss that occurs while this policy is not in force.
2. Amounts not reimbursed because of applicable Policy Year Deductible, Coinsurance, benefit maximums, or frequency limitations.
3. Any loss that occurs during a Waiting Period.
4. Amounts in excess of the Reasonable and Customary Charge.

5. Items, treatments or services:
   a. Not covered under this policy, including any complications arising therefrom;
   b. That are not prescribed by or performed by or under the direct supervision of a Physician in accordance with generally accepted dental or medical standards, to include services not rendered or that are not rendered within the scope of their license;
   c. Not Medically Necessary as determined by Us;
   d. Deemed to be Experimental or Investigational as determined by Us;
   e. That would not routinely be paid in the absence of insurance; or
   f. Performed by an Immediate Family member.
6. Separate fees for services that are considered an integral part of an entire service, such as pulp capping, surgical trays, sutures, or pre and post operative care.
7. Services or procedures that have not been completed.
8. Any cosmetic items, treatments or services provided primarily for the purpose of improving appearance, self-esteem or body image, including characterizing and personalizing prosthetic devices, and correction of congenital malformation.
9. Any device, appliance, or service related to:
   a. Altering vertical dimension;
   b. Restoring or maintaining occlusion;
   c. Splinting teeth or stabilizing teeth for periodontal reasons;
   d. Abrasion, attrition, bruxism, erosion, abfraction;
   e. Coping;
   f. Tooth desensitization; or
   g. Maxillofacial prosthetics.
10. Any surgical or nonsurgical treatments or services, including myofunctional therapy and physical therapy for any jaw joint problems, including, but not limited to: temporomandibular joint disorder (TMJ), craniomandibular disorder, craniomaxillary or other conditions of the joint linking the jaw bone and skull or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to, headaches.
11. Occlusal, athletic, or night guards and related services.
12. Orthodontic treatment or orthognathic surgery and related services.
13. Ridge preservation, augmentation, bone grafts, and tissue regeneration when performed in edentulous sites (toothless areas).
14. Overdentures, precision or semi-precision attachments and related services.
15. Sealants, fluoride treatments, preventive resin restorations, or space maintainers and related services.
16. Supplies, including, but not limited to, services or supplies for temporary or provisional crowns, bridges or dentures, and duplicate or temporary devices, appliances, and prosthetics.
17. Replacing a lost, stolen or missing appliance or prosthetic device.
18. Oral hygiene instructions, behavior modification, diet instruction or infection control.
19. Sterilization of equipment; disposal of medical waste or other requirements mandated by the Occupational Safety and Health Administration (OSHA) or other regulatory agencies.
20. Treatment or diagnosis received while outside the continental United States, except Hawaii.
21. Services, injuries or sickness related to Your job, to the extent You are covered or are required to be covered by the Worker's Compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation law, this policy will not pay those medical benefits that would have been payable in absence of that settlement.
22. Services for which no charge is made or for which You are not legally obligated to pay, including, but not limited to services furnished through:
   a. Your employer, labor union or similar group, in its dental or medical department or clinic; or
   b. A facility owned or run by any government body.
23. Services furnished by, or payable under, any public program (except Medicaid), or paid for or sponsored by any government body.
24. Telephone consultations, charges for failure to keep a scheduled appointment, copy fees, sales tax, charges for completion of a claim form, or any take-home supplies. If You use an external discount or coupon, the amount that is reduced from the Billed Charge is not a covered loss under this policy.

25. Ancillary charges, including, but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
26. Any loss resulting from:
    a. War, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent;
    b. Committing, attempting to commit, or participation in a felony or engaging in an illegal occupation;
    c. Your participation in a riot, rebellion, or insurrection; or
    d. An intentionally self-inflicted injury while sane or insane.
27. Impacted teeth.
28. Prescription and non-prescription drugs, whether dispensed or prescribed, including chemotherapeutic agents.
29. Speech therapy for any purpose.
30. Laboratory and pathology tests and examinations, except as specifically listed in the Benefits section of Your policy.
31. Oral surgery and related services, except as specifically listed in the Benefits section of Your policy.
32. Full mouth debridement.
33. Implantology and related services; implants, including removal of implants, and related services.

RENEWABILITY AND PREMIUM CHANGES

Renewability

This policy is renewable at Your option except for the following reasons: nonpayment of premium, fraud or misrepresentation or We choose to nonrenew all policies of this form in Your state of issue. If this occurs We will provide You advance notice and no refusal of renewal will affect an existing claim.

Terms Under Which We May Change Premiums

We can change Your premium only if We do the same to all policies of this form, which are issued to persons of Your class. Your premiums may change due to: age, a change in Your premium payment method, a new rate table being applied, a rating classification change, or a misstatement on the application that results in the proper amount due not being charged. If you have a change in Residence, premiums may change to reflect Your current geographic area. If We make a change, it will not be based on any physical impairment You might have or any claims You have incurred under this policy. If it is necessary to change the premium for Your policy, We will send You written notice in advance of the change in premium.

Cancellation by Insured

You may cancel this policy at any time by writing to Us. Cancellation is effective on the date We receive Your notice unless You specify a later date. If You do cancel, We will promptly refund to You the excess of premium paid above the prorated premium for the expired time (the date We received notice from You). Cancellation will not affect an existing claim.

TOTAL PREMIUM $____________

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay Your premium. Your policy stays in force during Your grace period.

____

Producer's Printed Name Producer's Number

X ____

Producer's Signature Date (MM/DD/YYYY)

MEDICO®
INSURANCE COMPANY

Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Outline of Coverage for Dental, Vision and Hearing Insurance Policy

DENTAL,VISION, AND HEARING INSURANCE POLICY

RETAIN THIS OUTLINE FOR YOUR RECORDS

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us. You may also review this guide at www.Medicare.gov.

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both You and Your insurance company. It is therefore important that You **READ YOUR POLICY CAREFULLY.**

Limited Benefit Coverage

Policies of this category are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

Dental, Vision and Hearing Coverage

Policies of this category are designed to provide You with coverage for dental, vision and hearing services. Coverage is provided for preventive and diagnostic, basic and major dental services and limited vision and hearing services. Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.

BENEFITS PROVIDED BY THE POLICY

For any benefit to be payable under the benefits described below, the loss must be incurred while the policy is in force and not excluded from coverage under the Exclusions and Limitations provision. After the Policy Year Deductible is satisfied and subject to any Waiting Periods, We will pay Our Coinsurance amount for the following services up to the Policy Year Maximum Benefit Amount. Please refer to the Policy Schedule and the Benefits section of the policy for a complete description of the benefits.

DENTAL BENEFITS

Diagnostic and Preventive Services

This benefit pays for evaluations, cleanings and bitewing x-rays.

Basic Services

This benefit pays for restorations (fillings), x-rays, nonsurgical extractions and palliative care.

Major Services

This benefit pays for crowns/inlays/onlays, prosthodontic services, endodontic services, periodontal services and oral surgery for an erupted tooth.

VISION AND HEARING BENEFITS

Vision Benefits

This benefit pays for eye examinations or an eye refraction test and eyeglasses and contact lenses.

Hearing Benefits

This benefit pays for hearing examinations and hearing aids and any necessary repairs.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for any expense not identified and included as a covered loss under the policy. You will be fully responsible for payment of any expenses that are not a covered loss. We will not pay benefits for:

1. Any loss that occurs while this policy is not in force.
2. Amounts not reimbursed because of applicable Policy Year Deductible, Coinsurance, benefit maximums, or frequency limitations.
3. Any loss that occurs during a Waiting Period.
4. Amounts in excess of the Reasonable and Customary Charge.
5. Items, treatments or services:
   a. Not covered under this policy, including any complications arising therefrom;
   b. That are not prescribed by or performed by or under the direct supervision of a Physician in accordance with generally accepted dental or medical standards, to include services not rendered or that are not rendered within the scope of their license;
   c. Not Medically Necessary as determined by Us;
   d. Deemed to be Experimental or Investigational as determined by Us;
   e. That would not routinely be paid in the absence of insurance; or
   f. Performed by an Immediate Family member.
6. Separate fees for services that are considered an integral part of an entire service, such as pulp capping, surgical trays, sutures, or pre and post operative care.
7. Services or procedures that have not been completed.
8. Any cosmetic items, treatments or services provided primarily for the purpose of improving appearance, self-esteem or body image, including characterizing and personalizing prosthetic devices, and correction of congenital malformation.
9. Any device, appliance, or service related to:
   a. Altering vertical dimension;
   b. Restoring or maintaining occlusion;
   c. Splinting teeth or stabilizing teeth for periodontal reasons;
   d. Abrasion, attrition, bruxism, erosion, abfraction;
   e. Coping;
   f. Tooth desensitization; or
   g. Maxillofacial prosthetics.
10. Any surgical or nonsurgical treatments or services, including myofunctional therapy and physical therapy for any jaw joint problems, including, but not limited to: temporomandibular joint disorder (TMJ), craniomandibular disorder, craniomaxillary or other conditions of the joint linking the jaw bone and skull or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to, headaches.
11. Occlusal, athletic, or night guards and related services.
12. Orthodontic treatment or orthognathic surgery and related services.
13. Ridge preservation, augmentation, bone grafts, and tissue regeneration when performed in edentulous sites (toothless areas).
14. Overdentures, precision or semi-precision attachments and related services.
15. Sealants, fluoride treatments, preventive resin restorations, or space maintainers and related services.
16. Supplies, including, but not limited to, services or supplies for temporary or provisional crowns, bridges or dentures, and duplicate or temporary devices, appliances, and prosthetics.
17. Replacing a lost, stolen or missing appliance or prosthetic device.
18. Oral hygiene instructions, behavior modification, diet instruction or infection control.
19. Sterilization of equipment; disposal of medical waste or other requirements mandated by the Occupational Safety and Health Administration (OSHA) or other regulatory agencies.
20. Treatment or diagnosis received while outside the continental United States, except Hawaii.

21. Services, injuries or sickness related to Your job, to the extent You are covered or are required to be covered by the Worker's Compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation law, this policy will not pay those medical benefits that would have been payable in absence of that settlement.
22. Services for which no charge is made or for which You are not legally obligated to pay, including, but not limited to services furnished through:
    a. Your employer, labor union or similar group, in its dental or medical department or clinic; or
    b. A facility owned or run by any government body.
23. Services furnished by, or payable under, any public program (except Medicaid), or paid for or sponsored by any government body.
24. Telephone consultations, charges for failure to keep a scheduled appointment, copy fees, sales tax, charges for completion of a claim form, or any take-home supplies. If You use an external discount or coupon, the amount that is reduced from the Billed Charge is not a covered loss under this policy.
25. Ancillary charges, including, but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
26. Any loss resulting from:
    a. War, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent;
    b. Committing, attempting to commit, or participation in a felony or engaging in an illegal occupation;
    c. Your participation in a riot, rebellion, or insurrection; or
    d. An intentionally self-inflicted injury while sane or insane.
27. Impacted teeth.
28. Prescription and non-prescription drugs, whether dispensed or prescribed, including chemotherapeutic agents.
29. Speech therapy for any purpose.
30. Laboratory and pathology tests and examinations, except as specifically listed in the Benefits section of Your policy.
31. Oral surgery and related services, except as specifically listed in the Benefits section of Your policy.
32. Full mouth debridement.
33. Implantology and related services; implants, including removal of implants, and related services.
34. Any surgical procedure performed in the treatment of cataracts.
35. Vision surgery to correct visual acuity, including, but not limited to, LASIK and other laser surgery, radial keratotomy (RK) services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures.
36. Orthoptic or vision therapy training and any associated supplemental testing, medical or surgical treatment or services of the eyes or supporting structures.

RENEWABILITY AND PREMIUM CHANGES

Renewability

This policy is renewable at Your option except for the following reasons: nonpayment of premium, fraud or misrepresentation or We choose to nonrenew all policies of this form in Your state of issue. If this occurs We will provide You advance notice and no refusal of renewal will affect an existing claim.

Terms Under Which We May Change Premiums

We can change Your premium only if We do the same to all policies of this form, which are issued to persons of Your class. Your premiums may change due to: age, a change in Your premium payment method, a new rate table being applied, a rating classification change, or a misstatement on the application that results in the proper amount due not being charged. If you have a change in Residence, premiums may change to reflect Your current geographic area. If We make a change, it will not be based on any physical impairment You might have or any claims You have incurred under this policy. If it is necessary to change the premium for Your policy, We will send You written notice in advance of the change in premium.

Cancellation by Insured

You may cancel this policy at any time by writing to Us. Cancellation is effective on the date We receive Your notice unless You specify a later date. If You do cancel, We will promptly refund to You the excess of premium paid above the prorated premium for the expired time (the date We received notice from You). Cancellation will not affect an existing claim.

TOTAL PREMIUM $____________

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay Your premium. Your policy stays in force during Your grace period.

Producer's Printed Name Producer's Number

X

Producer's Signature Date (MM/DD/YYYY)

Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Outline of Coverage for Dental, Vision and Hearing Insurance Policy

DENTAL,VISION AND HEARING INSURANCE POLICY

RETAIN THIS OUTLINE FOR YOUR RECORDS

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us. You may also review this guide at www.Medicare.gov.

READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both You and Your insurance company. It is therefore important that You **READ YOUR POLICY CAREFULLY.**

Limited Benefit Coverage

Policies of this category are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

Dental, Vision and Hearing Coverage

Policies of this category are designed to provide You with coverage for dental, vision and hearing services. Coverage is provided for preventive and diagnostic, basic and major dental services and limited vision and hearing services. Coverage is subject to any deductible amounts, coinsurance amounts, or other limitations that may be set forth in the policy.

BENEFITS PROVIDED BY THE POLICY

For any benefit to be payable under the benefits described below, the loss must be incurred while the policy is in force and not excluded from coverage under the Exclusions and Limitations provision. After the Policy Year Deductible is satisfied and subject to any Waiting Periods, We will pay Our Coinsurance amount for the following services up to the Policy Year Maximum Benefit Amount. Please refer to the Policy Schedule and the Benefits section of the policy for a complete description of the benefits.

DENTAL BENEFITS

Diagnostic and Preventive Services

This benefit pays for evaluations, cleanings and bitewing x-rays.

Basic Services

This benefit pays for restorations (fillings), x-rays, nonsurgical extractions and palliative care.

Major Services

This benefit pays for crowns/inlays/onlays, prosthodontic services, endodontic services, periodontal services, oral surgery for an erupted tooth and implants.

VISION AND HEARING BENEFITS

Vision Benefits

This benefit pays for eye examinations or an eye refraction test and eyeglasses and contact lenses.

Hearing Benefits

This benefit pays for hearing examinations and hearing aids and any necessary repairs.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid for any expense not identified and included as a covered loss under the policy. You will be fully responsible for payment of any expenses that are not a covered loss. We will not pay benefits for:

1. Any loss that occurs while this policy is not in force.
2. Amounts not reimbursed because of applicable Policy Year Deductible, Coinsurance, benefit maximums, or frequency limitations.
3. Any loss that occurs during a Waiting Period.
4. Amounts in excess of the Reasonable and Customary Charge.
5. Items, treatments or services:
   a. Not covered under this policy, including any complications arising therefrom;
   b. That are not prescribed by or performed by or under the direct supervision of a Physician in accordance with generally accepted dental or medical standards, to include services not rendered or that are not rendered within the scope of their license;
   c. Not Medically Necessary as determined by Us;
   d. Deemed to be Experimental or Investigational as determined by Us;
   e. That would not routinely be paid in the absence of insurance; or
   f. Performed by an Immediate Family member.
6. Separate fees for services that are considered an integral part of an entire service, such as pulp capping, surgical trays, sutures, or pre and post operative care.
7. Services or procedures that have not been completed.
8. Any cosmetic items, treatments or services provided primarily for the purpose of improving appearance, self-esteem or body image, including characterizing and personalizing prosthetic devices, and correction of congenital malformation.
9. Any device, appliance, or service related to:
   a. Altering vertical dimension;
   b. Restoring or maintaining occlusion;
   c. Splinting teeth or stabilizing teeth for periodontal reasons;
   d. Abrasion, attrition, bruxism, erosion, abfraction;
   e. Coping;
   f. Tooth desensitization; or
   g. Maxillofacial prosthetics.
10. Any surgical or nonsurgical treatments or services, including myofunctional therapy and physical therapy for any jaw joint problems, including, but not limited to: temporomandibular joint disorder (TMJ), craniomandibular disorder, craniomaxillary or other conditions of the joint linking the jaw bone and skull or treatment of the facial muscles used in expressions and chewing functions, for symptoms including, but not limited to, headaches.
11. Occlusal, athletic, or night guards and related services.
12. Orthodontic treatment or orthognathic surgery and related services.
13. Ridge preservation, augmentation, bone grafts, and tissue regeneration when performed in edentulous sites (toothless areas).
14. Overdentures, precision or semi-precision attachments and related services.
15. Sealants, fluoride treatments, preventive resin restorations, or space maintainers and related services.
16. Supplies, including, but not limited to, services or supplies for temporary or provisional crowns, bridges or dentures, and duplicate or temporary devices, appliances, and prosthetics.
17. Replacing a lost, stolen or missing appliance or prosthetic device.
18. Oral hygiene instructions, behavior modification, diet instruction or infection control.
19. Sterilization of equipment; disposal of medical waste or other requirements mandated by the Occupational Safety and Health Administration (OSHA) or other regulatory agencies.
20. Treatment or diagnosis received while outside the continental United States, except Hawaii.

21. Services, injuries or sickness related to Your job, to the extent You are covered or are required to be covered by the Worker's Compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation law, this policy will not pay those medical benefits that would have been payable in absence of that settlement.
22. Services for which no charge is made or for which You are not legally obligated to pay, including, but not limited to services furnished through:
    a. Your employer, labor union or similar group, in its dental or medical department or clinic; or
    b. A facility owned or run by any government body.
23. Services furnished by, or payable under, any public program (except Medicaid), or paid for or sponsored by any government body.
24. Telephone consultations, charges for failure to keep a scheduled appointment, copy fees, sales tax, charges for completion of a claim form, or any take-home supplies. If You use an external discount or coupon, the amount that is reduced from the Billed Charge is not a covered loss under this policy.
25. Ancillary charges, including, but not limited to, hospital, ambulatory surgical center or similar facility; or use of provider office space.
26. Any loss resulting from:
    a. War, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent;
    b. Committing, attempting to commit, or participation in a felony or engaging in an illegal occupation;
    c. Your participation in a riot, rebellion, or insurrection; or
    d. An intentionally self-inflicted injury while sane or insane.
27. Impacted teeth.
28. Prescription and non-prescription drugs, whether dispensed or prescribed, including chemotherapeutic agents.
29. Speech therapy for any purpose.
30. Laboratory and pathology tests and examinations, except as specifically listed in the Benefits section of Your policy.
31. Oral surgery and related services, except as specifically listed in the Benefits section of Your policy.
32. Full mouth debridement.
33. Any surgical procedure performed in the treatment of cataracts.
34. Vision surgery to correct visual acuity, including, but not limited to, LASIK and other laser surgery, radial keratotomy (RK) services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures.
35. Orthoptic or vision therapy training and any associated supplemental testing, medical or surgical treatment or services of the eyes or supporting structures.

RENEWABILITY AND PREMIUM CHANGES

Renewability

This policy is renewable at Your option except for the following reasons: nonpayment of premium, fraud or misrepresentation or We choose to nonrenew all policies of this form in Your state of issue. If this occurs We will provide You advance notice and no refusal of renewal will affect an existing claim.

Terms Under Which We May Change Premiums

We can change Your premium only if We do the same to all policies of this form, which are issued to persons of Your class. Your premiums may change due to: age, a change in Your premium payment method, a new rate table being applied, a rating classification change, or a misstatement on the application that results in the proper amount due not being charged. If you have a change in Residence, premiums may change to reflect Your current geographic area. If We make a change, it will not be based on any physical impairment You might have or any claims You have incurred under this policy. If it is necessary to change the premium for Your policy, We will send You written notice in advance of the change in premium.

Cancellation by Insured
You may cancel this policy at any time by writing to Us. Cancellation is effective on the date We receive Your notice unless You specify a later date. If You do cancel, We will promptly refund to You the excess of premium paid above the prorated premium for the expired time (the date We received notice from You). Cancellation will not affect an existing claim.

TOTAL PREMIUM **$____________**

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay Your premium. Your policy stays in force during Your grace period.

Producer's Printed Name | Producer's Number

X
Producer's Signature | Date (MM/DD/YYYY)

Notes

about the company

Medico Insurance Company began operations in 1930. We offer quality health and life insurance products for Americans nationwide.

Today Medico Insurance Company continues a proud tradition of service to our policyholders.

We are located in the heart of the United States. When you call our number, the people who answer the phone understand your problems and are anxious to help you find solutions.

For more information about Medico Insurance Company visit www.GoMedico.com.

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