



**MEDICO®**  
INSURANCE COMPANY

# Medico®

## Dental Insurance Portfolio

- Dental
- Dental Plus
- D.V.H. \$1,000
- D.V.H. \$1,500

### SALES KIT BOOKLET

#### PRODUCER INSTRUCTIONS

**Please complete the following:**

- Application for Dental or Dental, Vision and Hearing Insurance
- Bank Draft Information (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](http://mic.GoMedico.com)

**Mail**

Medico Insurance Company

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.

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Application for Dental or Dental, Vision and Hearing Insurance

**Requested Effective Date of New Policy/Certificate (optional)**

MM/DD/YYYY

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/Certificate Delivery Options**

Upon approval of this application, the policy/certificate will be delivered to:

Applicant  Producer

**Part A: General Information – Please Print**

**Applicant Information**

Full Name of Applicant - *First Name, M.I., Last, Suffix*

Address

City

State

ZIP Code

Phone Number

Alternate Phone Number

Email Address

Date of Birth (MM/DD/YY)

Age

Gender

Social Security Number

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", please provide the following:**

Company Name

Policy Number

Type of Coverage

**Part B: Benefit**

**Plan Selection – Check the Desired Option:**

- Dental - \$1,000 Policy Year Maximum Benefit Amount
- Dental, Vision and Hearing - \$1,000 Certificate Year Maximum Benefit Amount
- Dental, Vision and Hearing - \$1,500 Certificate Year Maximum Benefit Amount
- Dental Plus - \$2,500 Policy Year Maximum Benefit Amount

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## Part C: Payment Options

### Method and Frequency of Payment

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

**Method of Payment:**

- Automatic Bank Withdrawal  
 Direct Bill  
 Credit/Debit Card

**Frequency of Payment:**

- |                                  |                                    |  |                                   |
|----------------------------------|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Annually |

Amount Received with Application \$ \_\_\_\_\_ Renewal Premium \$ \_\_\_\_\_

## Part D: Application Agreement

### Applicant Certification

I hereby apply to Medico Insurance Company (the Company) for a **Dental or Dental, Vision and Hearing Insurance Policy/Certificate** 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/certificate is delivered and accepted by me. I have received the Outline of Coverage for the policy/certificate (in states where required by law).

No portion of the premium will be paid, during the period the policy/certificate 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/certificate.**

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

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## Part E: Fraud Warnings

**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.

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

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**Arkansas, Louisiana and West Virginia:** 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.

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**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

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**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

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**Kansas:** Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.

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**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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**Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

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**New Mexico:** 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 civil fines and criminal penalties.

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**Ohio:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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**Oregon:** 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 may be a violation of federal law.

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**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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# BANK DRAFT INFORMATION

Complete this section only if you selected the automatic bank withdrawal payment option.

## Ongoing 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)

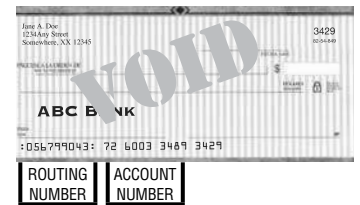
Bank or Financial Institution Name (including branch, if any)

Routing Number

Bank or Financial Institution's Address

Account Number

**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, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") for insurance premiums. I authorize the 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.



**Note:** Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

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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 the following (select one):

- Dental - \$1,000 Plan Year Maximum Benefit Amount
- Dental, Vision and Hearing - \$1,000 Plan Year Maximum Benefit Amount
- Dental, Vision and Hearing - \$1,500 Plan Year Maximum Benefit Amount
- Dental Plus - \$2,500 Plan 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 contract 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 contract 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**

P.O. Box 10386, Des Moines, Iowa 50306-0386

## **IMPORTANT NOTICE**

Illinois recently passed the Illinois Religious Freedom Protection and Civil Union Act recognizing civil unions. Effective June 1, 2011, an individual that enters into a civil union is treated the same under Illinois law as if he or she were married.

**Therefore, where the term “spouse” or “marriage” appears in any application, policy or other form issued by Medico, the term should be understood to include a civil union spouse and a civil union, respectively.** Medico will administer the policy for spouses in a civil union exactly as we would spouses in a marriage.

It is important to note that federal law does not recognize civil unions. This Act does not affect any rights and responsibilities provided under federal law.

**CURRENT POLICYHOLDERS:** As of June 1, 2011, your policy is considered amended by operation of law to conform to the Act. For spouses in a civil union, this Act may change the eligibility requirements and/or benefits under the policy for you or your civil union spouse. For example, parties to a civil union may now elect coverage for his or her civil union spouse and/or dependent child(ren) if such coverage is provided to spouses and dependents under the terms of your policy.

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Outline of Coverage for  
Group Dental, Vision and Hearing (DVH) Policy with Dental  
Preferred Provider Organization (DPPPO) for Dental Option  
DVA59

PO Box 10386  
Des Moines, IA 50306  
[www.GoMedico.com](http://www.GoMedico.com)  
Toll-Free 1-800-228-6080

## **Group Dental, Vision and Hearing Coverage Limited Benefit Certificate**

### **Retain This Outline For Your Records This Policy Is Not A Medicare Supplement Policy**

#### **READ YOUR CERTIFICATE CAREFULLY**

This Outline of Coverage provides a very brief description of the important features of your certificate. This is not the insurance contract. Only the actual certificate provisions will control. The certificate sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR CERTIFICATE CAREFULLY.**

#### **Limited Benefit Coverage**

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

#### **Coverage Provided by the Certificate**

Your certificate provides benefits for (1) preventive, basic and major dental services, and (2) vision and hearing services. All benefits are subject to any applicable Waiting Period, Certificate Year Deductible, Certificate Year Maximum Benefit, Exceptions and Limitations and all other provisions of the certificate. Refer to the Coverage Schedule provided with your certificate for details.

Plans may be offered with or without a Preferred Provider Organization (PPO) for dental expenses. Please refer to your Certificate for details.

#### **Renewability**

The certificate is renewable at your option unless:

1. Your premium is not received before the Grace Period ends;
2. We choose to non-renew all certificates of the same form in your state of issue; or
3. Subject to the Coverage Ends provision provided in the certificate.

If we choose to non-renew certificates per item 2 above, we will provide advance notice to you. No refusal of renewal will affect an existing claim.

#### **Premiums**

We can change your premium only if we do the same to all certificates of this form issued to persons of your class. "Class" means the factors of age and your state of residence that determined your premium rate when coverage was issued. 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 certificate. If it is necessary to change the premium for your certificate, we will notify you in advance of the change in premium.

## Outline of Coverage for Dental Insurance Policy

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### 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](http://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;
  - d. Deemed to be Experimental or Investigational;
  - 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, except infections which result from an accidental injury, or infection which results from accidental, involuntary, or unintentional ingestion of a contaminated substance.
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. Work-related sickness or injury for which You are eligible for any workers' compensation, employers' liability or similar laws, whether or not benefits are claimed.
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 intentional 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.

**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.

## Outline of Coverage for Dental, Vision and Hearing Insurance Policy

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### **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](http://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;
  - d. Deemed to be Experimental or Investigational;
  - 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, except infections which result from an accidental injury, or infection which results from accidental, involuntary, or unintentional ingestion of a contaminated substance.
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. Work-related sickness or injury for which You are eligible for any workers' compensation, employers' liability or similar laws, whether or not benefits are claimed.
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 intentional 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.

**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.



# Medico® Dental Insurance Portfolio

- Dental
- D.V.H. \$1,000
- Dental Plus
- D.V.H. \$1,500

## RATE GUIDE

### Premium Withdrawal

If the applicant chooses the Automatic Bank Withdrawal or Credit Card method of payment and the application is submitted without any premium, the initial premium will be drafted from the Insured's account on the Policy/Certificate Date (effective date of coverage).

**Note:** Unless a future Effective Date is requested, the premium will be drawn as soon as the policy/certificate is issued. Please make sure the applicant is aware of this.

### Policy/Certificate Effective Date

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.

**Please review the premium differences in the rates shown, as modal factors vary based on payment methods and frequency of payments.**

**Note:** Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

*If you have questions, please call 1-800-547-2401 – Option 3*

## Dental

### \$1000 Policy Year Maximum Benefit Amount

Monthly Bank Draft	
Issue Age	Premium
18-65	33.86
66-79	35.86
80-89	39.84

Quarterly Bank Draft	
Issue Age	Premium
18-65	102.00
66-79	108.00
80-89	120.00

Semi-Annual Bank Draft	
Issue Age	Premium
18-65	204.00
66-79	216.00
80-89	240.00

Annual Bank Draft	
Issue Age	Premium
18-65	408.00
66-79	432.00
80-89	480.00

Monthly Credit Card	
Issue Age	Premium
18-65	35.09
66-79	37.15
80-89	41.28

Quarterly Credit Card	
Issue Age	Premium
18-65	105.26
66-79	111.46
80-89	123.84

Semi-Annual Credit Card	
Issue Age	Premium
18-65	210.12
66-79	222.48
80-89	247.20

Annual Credit Card	
Issue Age	Premium
18-65	420.24
66-79	444.96
80-89	494.40

Quarterly Direct Bill	
Issue Age	Premium
18-65	110.16
66-79	116.64
80-89	129.60

Semi-Annual Direct Bill	
Issue Age	Premium
18-65	212.16
66-79	224.64
80-89	249.60

Annual Direct Bill	
Issue Age	Premium
18-65	408.00
66-79	432.00
80-89	480.00

**For Producer Use Only**



# D.V.H. \$1,000 and D.V.H. \$1,500 Form A59

Monthly Bank Draft			Quarterly Bank Draft			Semi-Annual Bank Draft			Annual Bank Draft		
Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max
18-39	29.00	37.00	18-39	87.00	111.00	18-39	174.00	222.00	18-39	348.00	444.00
40-54	31.00	41.00	40-54	93.00	123.00	40-54	186.00	246.00	40-54	372.00	492.00
55-64	33.00	44.00	55-64	99.00	132.00	55-64	198.00	264.00	55-64	396.00	528.00
65-79	35.00	46.00	65-79	105.00	138.00	65-79	210.00	276.00	65-79	420.00	552.00
80-89	38.00	49.00	80-89	114.00	147.00	80-89	228.00	294.00	80-89	456.00	588.00

Monthly Credit Card			Quarterly Credit Card			Semi-Annual Credit Card			Annual Credit Card		
Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max
18-39	29.93	38.18	18-39	89.78	114.55	18-39	179.22	228.66	18-39	358.44	457.32
40-54	31.99	42.31	40-54	95.98	126.94	40-54	191.58	253.38	40-54	383.16	506.76
55-64	34.06	45.41	55-64	102.17	136.22	55-64	203.94	271.92	55-64	407.88	543.84
65-79	36.12	47.47	65-79	108.36	142.42	65-79	216.30	284.28	65-79	432.60	568.56
80-89	39.22	50.57	80-89	117.65	151.70	80-89	234.84	302.82	80-89	469.68	605.64

Quarterly Direct Bill			Semi-Annual Direct Bill			Annual Direct Bill		
Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max	Issue Age	1,000 Max	1,500 Max
18-39	93.96	119.88	18-39	180.96	230.88	18-39	348.00	444.00
40-54	100.44	132.84	40-54	193.44	255.84	40-54	372.00	492.00
55-64	106.92	142.56	55-64	205.92	274.56	55-64	396.00	528.00
65-79	113.40	149.04	65-79	218.40	287.04	65-79	420.00	552.00
80-89	123.12	158.76	80-89	237.12	305.76	80-89	456.00	588.00

# Dental Plus

**\$2500 Policy Year Maximum Benefit Amount**

Monthly Bank Draft	
Issue Age	Premium
18-65	59.76
66-79	67.73
80-89	73.70

Quarterly Bank Draft	
Issue Age	Premium
18-65	180.00
66-79	204.00
80-89	222.00

Semi-Annual Bank Draft	
Issue Age	Premium
18-65	360.00
66-79	408.00
80-89	444.00

Annual Bank Draft	
Issue Age	Premium
18-65	720.00
66-79	816.00
80-89	888.00

Monthly Credit Card	
Issue Age	Premium
18-65	61.92
66-79	70.18
80-89	76.37

Quarterly Credit Card	
Issue Age	Premium
18-65	185.76
66-79	210.53
80-89	229.10

Semi-Annual Credit Card	
Issue Age	Premium
18-65	370.80
66-79	420.24
80-89	457.32

Annual Credit Card	
Issue Age	Premium
18-65	741.60
66-79	840.48
80-89	914.64

Quarterly Direct Bill	
Issue Age	Premium
18-65	194.40
66-79	220.32
80-89	239.76

Semi-Annual Direct Bill	
Issue Age	Premium
18-65	374.40
66-79	424.32
80-89	461.76

Annual Direct Bill	
Issue Age	Premium
18-65	720.00
66-79	816.00
80-89	888.00

# Disclosures

**Please leave with your customer.**

# Notice of Privacy Practices for AmericanEnterprise Group Companies

## MEDICAL

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company, (“Company”) we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about “information” or “health information” in this notice we mean individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Individually identifiable health information is health information that:

- Is created or received by the Company’s designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

#### How We Use or Share Information

Subject to state and federal laws, we are permitted to use and/or share your information without your authorization in certain circumstances, such as:

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs. We will not use or disclose genetic information, including family history, for underwriting purposes.
- To use or disclose your information to provide you with information about health related benefits and services that

you may be interested in. We will not share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates without your authorization.

- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

There are also state and federal laws that may require or permit us to release your information to others without your authorization.

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services and the Iowa Division of Insurance.
- To share information for public health activities. For example, we may report information to government authorities conducting public health investigations.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law. For example audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding. For example pursuant to a valid court order or subpoena.
- To report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information to a funeral director as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes, or tissue.

## NOTICE OF PRIVACY PRACTICES—MEDICAL (continued)

- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law.

If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information.** In any case, we must obtain authorization for the use and disclosure of psychotherapy notes. If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

### What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Service Center. Contact information for our Customer Service Center is located at the end of this Notice.

- **You have the right to be notified** in the event there is a breach of your health information.
- **You have the right to ask us to restrict** how we use or disclose your information for payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care and uses and disclosures for disaster relief purposes. *Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions.*
- **You have the right to request confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain.** All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Service Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission.** We are not obligated to make all requested

amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment. Amendment request forms are available from our Customer Service Center at the address below.

- **You have the right to receive an accounting** of certain disclosures of your information. Please note that we are not required to release:
  - Any information collected prior to April 14, 2003.
  - Information disclosed or used for treatment, payment, and/or health care operations purposes.
  - Information disclosed to you or pursuant to your authorization.
  - Information that is incidental to a use or disclosure otherwise permitted.
  - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
  - Information disclosed for national security or intelligence purposes.
  - Information disclosed to correctional institutions, law enforcement officials or health oversight agencies.
  - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Accounting request forms are available from our Customer Service Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period.

### Exercising Your Rights

- **You have a right to receive a copy of this notice upon request at any time.** We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Service Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint.**

### Contact Information

If you have any questions or complaints, please contact us at:

**Notice of Privacy Practices**  
**American Enterprise Group Companies, Customer Service Center**  
**P.O. Box 9371, Des Moines, IA 50306-9371**

You can call us at: **1-800-247-2190.**

[www.americanenterprise.com](http://www.americanenterprise.com)

# Notice of Privacy Practices for AmericanEnterprise Group Companies

## FINANCIAL

**THIS NOTICE APPLIES TO ALL PROSPECTS, APPLICANTS, CUSTOMERS AND FORMER CUSTOMERS WHO HAVE INQUIRED ABOUT OR PURCHASED INSURANCE PRODUCTS USED PRIMARILY FOR PERSONAL, FAMILY OR HOUSEHOLD PURPOSES.**

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company, (“Company”) we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

### What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records (“nonpublic personal information”). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

### What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- to process your application and issue your policy.
- to pay your claims.
- to make any policy changes you may request.
- to offer you additional opportunities to improve your financial security.

We may also disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf

or with whom we have joint marketing agreements. We will not, however, disclose your health information for marketing purposes.

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

### Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

### How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

### What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

### How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

### Questions?

**If you have any questions, please call  
our toll-free Customer Service line.**

**1-800-247-2190**

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