

Dental, Vision & Hearing Insurance

Guaranteed Renewable

Medico doesn't charge a policy fee and although some limitations do apply, your acceptance in this program is guaranteed. We cannot refuse to renew your policy for any reason if your premiums are paid on time.

30-Day Right to Examine

You have 30 days after you receive the policy to examine it and return it to us or to the producer if you are dissatisfied. We will then refund the premium you paid and void the policy.



about the company

Medico Insurance Company began operations in 1930. We're proud to call America's heartland our home for over 80 years. Our goal is to provide our policyholders with the products they need, and the service they deserve. We understand that insurance is about more than the details of a policy; it's about protecting your future, and protecting your family.

To learn more about Medico Insurance Company and the products we offer, please visit us online at www.GoMedico.com.



Protecting Your Future Today[®]

Corporate Office - Omaha, NE
Administrative Services - P. O. Box 10386
Des Moines, IA 50306
Toll-Free 1.800.228.6080 - www.GoMedico.com



Protecting Your Future TodaySM



Dental, Vision & Hearing Insurance

Why is Dental, Vision & Hearing coverage important for your family?

Medico understands that your teeth, eyesight and hearing are a part of your quality of life; unexpected problems can be painful, inconvenient and expensive! We want to make it possible for you to find an affordable way to protect these assets. This product is designed to help you pay toward their coverage.

Benefits

Once the \$100 Policy Year Deductible is satisfied, your policy pays for covered expenses, not to exceed Reasonable and Customary Charges, up to the Policy Year Maximum:

- 60% - First Policy Year
- 70% - Second Policy Year
- 80% - Third Policy Year and thereafter.

Deductible

Our Dental, Vision and Hearing Insurance includes a standard \$100 Policy Year Deductible.

Acceptance

This plan is issued individually. Premiums are determined according to your age and the benefit you select.

Monthly Premium

Age	Premium*
18-39	\$25.28
40-54	\$27.48
55-64	\$28.57
65-79	\$30.77
80-89	\$32.97

*Premiums are subject to change. Rates are illustrative. Please do not send money to the Company in response to this ad. No coverage exists until you have completed an application for coverage. Premium rates shown above are based on \$1000 Policy Year Maximum.

Product Highlights

- Available ages 18 - 89
- No Network - Choose any provider
- \$1,000 & \$1,500 Policy Year Benefit options available
- Guaranteed Issue - No Health Questions

Covered Immediately

- Cleanings
- Dental X-rays
- Extractions (other than "full mouth")
- Examinations
- Fillings

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Exceptions & Limitations

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

1. eyeglasses or contact lenses.

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

1. endodontics (including root canals), periodontal surgery, bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions, fluoride treatments or outpatient dental surgery; or

2. hearing aids.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared;
2. any intentionally self-inflicted injury;
3. any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation;
4. any services that are not recommended by a Physician;
5. any Experimental or Investigational procedure or treatment;
6. orthodontic treatment or dental implants;
7. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state;
8. expenses incurred for surgical procedures (other than Medically Necessary outpatient dental surgery following the first Policy Year) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
9. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures, except for cosmetic reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
10. impacted wisdom teeth;
11. occlusal guards;
12. prescription drugs;
13. charges in excess of Reasonable and Customary Charges;
14. treatment or diagnosis received while outside the territorial limits of the United States;
15. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
16. loss that occurs while this policy is not in force.

Policy Form DVA48(VA). THIS IS A LIMITED POLICY. This brochure is intended to provide a general description of the policy benefits. Policy provisions and benefits may vary from state to state. Please see the policy for details. For costs and further details of the coverage, including exclusions, any restrictions or limitations and the terms under which the policy may be continued in force, see your producer or write to the Company. This is a solicitation of insurance and a licensed producer may contact you.