Medico® Insurance Company

Dental, Vision & Hearing Plan – Form **A58**

DVH PLUS with Coverage Schedule CSA58PP

Premium Rates by Mode

Monthly – Automatic Bank Withdrawal

Issue Age	$1,000 Max	$1,500 Max
18-39	$27.00	$35.00
40-54	$28.00	$37.00
55-64	$30.00	$40.00
65-79	$32.00	$42.00
80-89	$35.00	$46.00

Quarterly – Automatic Bank Withdrawal

Issue Age	$1,000 Max	$1,500 Max
18-39	$81.00	$105.00
40-54	$84.00	$111.00
55-64	$90.00	$120.00
65-79	$96.00	$126.00
80-89	$105.00	$138.00

Monthly – Credit Card

Issue Age	$1,000 Max	$1,500 Max
18-39	$27.86	$36.12
40-54	$28.90	$38.18
55-64	$30.96	$41.28
65-79	$33.02	$43.34
80-89	$36.12	$47.47

Quarterly – Credit Card

Issue Age	$1,000 Max	$1,500 Max
18-39	$83.59	$108.36
40-54	$86.69	$114.55
55-64	$92.88	$123.84
65-79	$99.07	$130.03
80-89	$108.36	$142.42

Semi-Annual – Credit Card

Issue Age	$1,000 Max	$1,500 Max
18-39	$166.86	$216.30
40-54	$173.04	$228.66
55-64	$185.40	$247.20
65-79	$197.76	$259.56
80-89	$216.30	$284.28

Annual – Credit Card

Issue Age	$1,000 Max	$1,500 Max
18-39	$333.72	$432.60
40-54	$346.08	$457.32
55-64	$370.80	$494.40
65-79	$395.52	$519.12
80-89	$432.60	$568.56

Quarterly – Direct Bill

Issue Age	$1,000 Max	$1,500 Max
18-39	$87.48	$113.40
40-54	$90.72	$119.88
55-64	$97.20	$129.60
65-79	$103.68	$136.08
80-89	$113.40	$149.04

Semi-Annual – Direct Bill

Issue Age	$1,000 Max	$1,500 Max
18-39	$168.48	$218.40
40-54	$174.72	$230.88
55-64	$187.20	$249.60
65-79	$199.68	$262.08
80-89	$218.40	$287.04

Annual – Direct Bill

Issue Age	$1,000 Max	$1,500 Max
18-39	$324.00	$420.00
40-54	$336.00	$444.00
55-64	$360.00	$480.00
65-79	$384.00	$504.00
80-89	$420.00	$552.00

PLEASE REVIEW THE PREMIUM DIFFERENCES IN THE RATES ABOVE AS MODAL FACTORS VARY BASED ON PAYMENT METHODS AND FREQUENCY OF PAYMENTS.

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 Date (effective date of coverage).

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

POLICY EFFECTIVE DATE - Effective Date can be any day from the 1st through the 28th of the month, and must be less than 90 days 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.

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

For Producer Use Only

DVH Plus

DENTAL, VISION & HEARING INSURANCE

PROTECTING YOUR FUTURE TODAY℠

MEDICO®
INSURANCE COMPANY

www.GoMedico.com

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DENTAL, VISION & HEARING INSURANCE

PROTECTING YOUR FUTURE TODAY℠

WHY DENTAL, VISION, HEARING COVERAGE?

When you choose Medico, you get an affordable way to cover routine care as well as the unexpected, which can be inconvenient and expensive! This is a true insurance policy, not simply a discount program.

Designed for individuals age 18 to 89:

- With no coverage or limited coverage
- On Medicare (Medicare coverage is very limited)

OVERALL BENEFITS

- Guaranteed Acceptance—no health questions
- Choose $1,000 or $1,500 Policy Year Maximum Benefit
- Freedom to choose any Provider
- Bonus—Choose a Provider in our Dental network for better discounts
- Low $100 Policy Year Deductible
- Increasing percentage paid for non-Major Services
  - 60% first Policy Year
  - 70% after first Policy Year
  - 80% after 2nd Year and thereafter
- Policy pays for covered expenses, based on the contracted fee for Participating Dentists and the Reasonable and Customary Charges for Non-Participating Dentists, up to the policy maximum
- Pays you or your Provider regardless of any other policy

MONTHLY PREMIUM

($1,000 ANNUAL BENEFIT)

Age	Premium
18-39	$27
40-54	$28
55-64	$30
65-79	$32
80-89	$35

Premiums are subject to change.

DENTAL COVERAGE

COVERED IMMEDIATELY:

- Fillings
- Extractions up to 4 teeth annually (excluding impacted Wisdom Teeth)
- Diagnostic X-rays
- Diagnostic Exams
- Emergency Palliative Treatment

COVERED AFTER 3 MONTHS:

- Cleaning/Examinations (twice annually)
- Examination X-rays

COVERED AFTER 1 YEAR:

(60% Paid per Policy Year)*

- Endodontics, including Root Canals
- Periodontal Surgery
- Bridges, Crowns, full or partial Dentures

*Not a comprehensive list

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VISION COVERAGE

Covered Immediately:

- Eye Exam

Covered after 6 Months:

- Eyeglasses or Contact Lenses
- Up to $200 over 2 years
- Part of your Policy Year Maximum Benefit

HEARING COVERAGE

Covered after 1 Year:

- Hearing Exam
- Hearing Aids
- Up to $500 annually
- Part of your Policy Year Maximum Benefit

POLICY PROVISIONS

- Guaranteed Issue
- No Policy Fee
- No Coordination of Benefits

30-DAY FREE LOOK PERIOD

Take 30 days after you receive your policy to review your coverage. If for any reason at all you decide it is not what you had in mind, just return it to us or to the producer. We will promptly refund your premium.

ACCEPTANCE

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

PROVIDER NETWORK

Maximum Care Network:

- Through one of the largest dental networks nationally with a focus on neighborhood dentists, the Maximum Care Network can help you save on services such as routine oral exams, cleanings, and major work such as dentures, root canal and crowns.
- To locate a participating dental provider, please visit www.GoMedico.com to access our online provider search.

PROTECTING YOUR FUTURE TODAY℠

ABOUT THE COMPANY

PROTECTION FROM A FINANCIALLY STRONG COMPANY

Medico Insurance Company has served the insurance needs of Americans since 1930, establishing a proven track record in providing quality insurance solutions. Today, Medico Insurance Company's products are designed to help protect the financial well-being of our policyholders while our employees are dedicated to providing the kind of customer service they deserve.

To learn more about Medico Insurance Company and the products we offer, we invite you to visit our website at www.GoMedico.com.

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Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
1.800.228.6080 • www.GoMedico.com

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 further details. For costs and further details of coverage, see your producer or write to the Company. This is a solicitation of insurance and a licensed producer may contact you. THIS IS A LIMITED POLICY.

Dental, Vision & Hearing A58

DVH PLUS

Instructions For The State Of:

Colorado

Medico's Dental, Vision & Hearing product can be sold online by using our MyEnroller program. Simply log in to mic.GoMedico.com to get started.

The Application Pocket Packet, PP-DVA58PP-CO, was created with your ease-of-use in mind. It contains most of the forms you will need to write a DVH application, all in one convenient packet.

Thank you for choosing Medico!

Please complete the following forms and return them to Medico.

- ☐ HAA58(CO) Application
- ☐ MI21F-078-C Payment Authorization Form

  The Payment Authorization must be completed and submitted with the application if the applicant chooses to pay by payment withdrawal. This is the recommended method for premium payments.
- ☐ 9F-4482 Premium Worksheet

Please leave the following forms with the applicant.

- ☐ Advertising Brochure – See MIC Website for the version approved in this state.
- ☐ 9F-4457 Receipt
- ☐ MI9F-4185DV(CO) Medicare Duplication Notice

  The Medicare Duplication Notice must be left with any applicant eligible for Medicare.
- ☐ MEDICARE BUYERS GUIDE

  The Medicare Buyers Guide must be provided to any Medicare-eligible applicant. You may leave the applicant a hard copy or the applicant can choose to accept an electronic version of the Medicare Buyers Guide. The Internet link is provided on the bottom of the receipt.

(over)

For Producer Use Only

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Additional Instructions

Commission Disclosure Form – MI25F-008

Colorado requires that a producer soliciting or negotiating an application for health insurance must disclose to the applicant they will receive a commission from the insurance carrier. The producer must also disclose the standard commission amount to the applicant for the particular product. The producer must maintain "written certification" they have provided the disclosure to the applicant. The "written certification" documentation must be maintained by the producer for the present year and for two prior years. You may use form **MI25F-008** or an alternative form. You may go to the MIC website at mic.GoMedico.com and print off a copy.

Rate Guide –

Use form **RGA58PP-60** to calculate the rates for **Colorado.**

Please review the premium differences in the Rate Guide as modal factors vary based on Methods of Payment and Frequency of Payments.

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 Date (effective date of coverage).

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

Policy Effective Date –

Effective Date can be any day from the 1st through the 28th of the month, and must be less than 90 days 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.

If you have questions, please call the Customer Service Center: **1-800-228-6080**.

For the most current product information and forms visit: **mic.GoMedico.com**.

For questions on this product or any other products, call Agent Sales Support.

Agent Sales Support – 1-800-547-2401 – Option 3

Submit applications to the Office either by:

Mail:	**Medico Insurance Company** **Administrative Services** **PO Box 10386** **Des Moines, IA 50306**	**or**	**FAX:** **1-888-363-3420**	**or**	**File Upload:** **mic.GoMedico.com**

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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

Application for Dental, Vision and Hearing (DVH) Insurance with Dental Preferred Provider Organization (DPPO) Option

DVA58

The policy you are applying for DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a stand-alone plan or as a covered benefit in another health plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage.

Part A: General Information – Please Print

Name _____ _____ _____ _____ _____
First MI Last Date of Birth (Mo./Day/Yr.) Age Sex

Address _____
Street Address City State Zip

Social Security # _____

Phone # _____ Email Address _____

Beneficiary _____ Relationship _____ Address _____

Part B: Benefit – Check the Desired Options:

Policy Year Maximum Benefit: ❒ $1,000 ❒ $1,500

Plan Selection: DVH Plus

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		
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Amount Received with Application $_____

Requested Effective Date of New Policy (optional): _____

Effective Date can be any day from the 1st through the 28th of the month, and must be less than 90 days 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.

Part D: Application Agreement

I hereby apply to Medico Insurance Company for a **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).

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

❒ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at GoMedico.com/products.

❒ 2. I have received a hard copy of the Medicare Buyers Guide.

❒ 3. I am not eligible for Medicare.

Policy Delivery Options: Upon approval of this application, the policy will be mailed to: ❒ Applicant ❒ Producer

CAUTION: 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 producer 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.

I am applying for this Dental, Vision and Hearing Insurance.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Name _____
(Please Print)

Producer's Number _____

Producer's Signature _____ Date _____

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

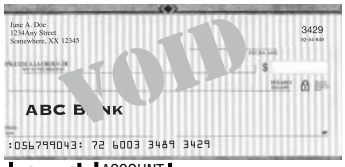
☐ Checking ☐ Savings

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

Medico® Insurance Company
Medico® Corp Life Insurance Company
Corporate Offices – Omaha, NE
Administrative Services
Des Moines, IA 50306
www.GomMedico.com
Toll-Free 1-800-228-6080

Disclosure

I represent Medico® Insurance Company and/or Medico® Corp Life Insurance Company with regard to the sale of its product(s). I am providing you services on behalf of such insurance company. I am required by state law to advise you that I will receive a commission from the company for the products you purchase. The standard compensation that I will receive for the sale of this product is _____%.

Acknowledged By:

Producer's Name (Please print)	Applicant's Name (Please print)
Producer's Signature	Applicant's Signature
Date	Date

Producer Instructions: Colorado law now requires producers to make certain disclosures to an insurance customer at the time of sale. This form is appropriate if you do **not** receive compensation from the insured customer for the sale of the product. Please note that Medico® Insurance Company and/or Medico® Corp Life Insurance Company prohibits producers from charging and collecting fees from customers for services. Disclosures are required for all health products. For your convenience, we have created a Disclosure Form that you may use. The disclosure must be completed at the time of taking the product application. We recommend that you use this or an alternative form and keep a completed copy of it in your files.

PRODUCER COPY

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Medico® Corp Life Insurance Company
Corporate Offices – Omaha, NE
Administrative Services –
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Disclosure

I represent Medico® Insurance Company and/or Medico® Corp Life Insurance Company with regard to the sale of its product(s). I am providing you services on behalf of such insurance company. I am required by state law to advise you that I will receive a commission from the company for the products you purchase. The standard compensation that I will receive for the sale of this product is _____%.

Acknowledged By:

Producer's Name (Please print)	Applicant's Name (Please print)
Producer's Signature	Applicant's Signature
Date	Date

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LEAVE WITH APPLICANT

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

RECEIPT

The applicant has applied for the Dental, Vision and Hearing Insurance Policy, DVA58, with a Policy Year Maximum Benefit in the amount of: ❒ $1,000 ❒ $1,500

Received of _____
First Name MI Last Name

an application for insurance as shown above and $_____.

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

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, Iowa 50306

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

E-mail: customerservice@GoMedico.com

_____ Date _____
Producer Signature

_____
Producer Name

If you are eligible for Medicare, The Medicare Buyers Guide, "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," can be found on our website at www.GoMedico.com/products.

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Medico Dental, Vision & Hearing Premium Worksheet

(Please complete and submit this form with the application.)

Applicant's Name _____
First MI Last

Age _____ Benefit: ❒ $1,000 ❒ $1,500 Renewal Premium $_____

Rate quotes are for illustrative purposes only and are not guaranteed. This quote is not an offer or contract. We reserve the right to adjust quoted rates based on the information provided by the application, the underwriting process, applicant interviews, or to correct any errors on the quotation.

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services 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:

- any of the services covered by the policy are also covered by Medicare

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

- hospitalization
- physician services
- 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).