

State: Arkansas **Filing Company:** Medico Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: AR A48-S DVH Policy
Project Name/Number: AR A48-S DVH Policy /AR A48-S DVH Policy

Filing at a Glance

Company: Medico Insurance Company
Product Name: AR A48-S DVH Policy
State: Arkansas
TOI: H10I Individual Health - Dental
Sub-TOI: H10I.000 Health - Dental
Filing Type: Form
Date Submitted: 12/17/2012
SERFF Tr Num: MDIC-128814071
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: AR A48-S DVH POLICY

Implementation: On Approval
Date Requested:
Author(s): Luanne Melies
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 12/17/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Medico Insurance Company
TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental
Product Name: AR A48-S DVH Policy
Project Name/Number: AR A48-S DVH Policy /AR A48-S DVH Policy

General Information

Project Name: AR A48-S DVH Policy Status of Filing in Domicile: Pending
 Project Number: AR A48-S DVH Policy Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: Nebraska is our state of Domicile.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 12/17/2012
 State Status Changed: 12/17/2012
 Deemer Date: Created By: Luanne Melies
 Submitted By: Luanne Melies Corresponding Filing Tracking Number:

Filing Description:
 Filing of Dental, Vision and Hearing Policy A48-S, with associated forms. Please see cover letter attached to the Supporting Documents Tab for additional information.

Company and Contact

Filing Contact Information

Luanne Melies, Compliance Analyst Imelies@gomedico.com
 11808 Grant Street 402-496-8237 [Phone]
 Omaha, NE 68164

Filing Company Information

Medico Insurance Company	CoCode: 31119	State of Domicile: Nebraska
11808 Grant Street	Group Code: 3527	Company Type: Life and
Omaha, NE 68164	Group Name: Medico	Health
(402) 496-8209 ext. [Phone]	FEIN Number: 47-0122200	State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 4. Policy and contract forms, all lines, filing corrections in previously filed policy and contract form...\$50.00.
 Per Company: No

Company	Amount	Date Processed	Transaction #
Medico Insurance Company	\$50.00	12/17/2012	65814490

State: Arkansas Filing Company: Medico Insurance Company
TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental
Product Name: AR A48-S DVH Policy
Project Name/Number: AR A48-S DVH Policy /AR A48-S DVH Policy

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/17/2012	12/17/2012

SERFF Tracking #:

MDIC-128814071

State Tracking #:

Company Tracking #:

AR A48-S DVH POLICY

State:

Arkansas

Filing Company:

Medico Insurance Company

TOI/Sub-TOI:

H101 Individual Health - Dental/H101.000 Health - Dental

Product Name:

AR A48-S DVH Policy

Project Name/Number:

AR A48-S DVH Policy /AR A48-S DVH Policy

Disposition

Disposition Date: 12/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	AR A48-S Cover Letter	Approved-Closed	Yes
Form	A48 Dental, Vision and Hearing Policy	Approved-Closed	Yes

State: Arkansas

Filing Company:

Medico Insurance Company

TOI/Sub-TOI: H101 Individual Health - Dental/H101.000 Health - Dental

Product Name: AR A48-S DVH Policy

Project Name/Number: AR A48-S DVH Policy /AR A48-S DVH Policy

Form Schedule

Lead Form Number: DVA48(AR)-S

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 12/17/2012	A48 Dental, Vision and Hearing Policy	DVA48(AR)-S	POL	Revised	Previous Filing Number:	MDIC-128060718		DVA48(AR)-S-12102012.pdf
						Replaced Form Number:	DVA48(AR)		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



MEDICO®
INSURANCE COMPANY

A STOCK INSURANCE COMPANY

[Corporate Office – Omaha, Nebraska]

[Administrative Services – P.O. Box 10386, Des Moines, IA 50306-0386]

[1-800-228-6080]

DENTAL, VISION AND HEARING EXPENSE POLICY

CAUTION: The issuance of this policy is based upon your signed application. Please review the policy and the policy Schedule. If there are any errors contact us at the address shown above. We may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises!

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, pay and your signed application, will put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money, less any claims paid. That will mean your policy was never in force.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We do have the right to change your premium as stated below.

Premium Change: We can change your premium only if we do the same to all policies of this form issued to persons of your class. "Class" means the factors of age, gender, underwriting class and geographic area of 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 policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

NOTICE TO BUYER: This policy may not cover all of the costs incurred by you during the period of coverage. You are advised to carefully review all policy limitations.

LIMITED BENEFIT INSURANCE POLICY FOR DENTAL, VISION AND HEARING EXPENSES

ALPHABETICAL GUIDE TO YOUR POLICY

	Part		Part
Benefits.....	F	Policy Year Deductible And Maximum Benefit.....	D
Definitions.....	E	Renewal Agreement And Premium Change.....	B
Exceptions And Limitations.....	C	Right To Return.....	A
How To File A Claim.....	H	Schedule.....	Last Page
Other Important Provisions.....	J	Termination.....	G
Payment Of Claims.....	I		

PART C EXCEPTIONS AND 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 to which a contributing cause was 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;
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.

PART D POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFIT

There is a Policy Year Deductible which is shown in the Schedule. After the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit shown in the Schedule.

Audiologist: A person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Covered Expenses: Expenses for necessary medical and dental services or supplies prescribed by a Physician. They may not be more than the Reasonable and Customary Charges for such services or supplies. Covered Expenses for services or supplies will be deemed to be incurred on the date or dates such services or supplies are received by you. Covered Expenses must be incurred while this policy is in force.

Dentist: A person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Experimental or Investigational: The use of a treatment (drugs, devices or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; that is, pre-market approval has not been granted (devices only);
2. benefits to at least one-third of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family: Your spouse, parent, child, brother or sister, or any person living with you.

Injury: A bodily Injury caused directly by an accident, independent of sickness, disease, bodily infirmity or any other cause, occurring on or after the Policy Date and while coverage is in force. See the Exceptions and Limitations Section for Injuries not covered by this policy.

Medically Necessary: A service or care:

1. required for the treatment or management of a medical symptom or condition;
2. which is the most efficient and economical care or service which can be safely provided in keeping with current medical practices;
3. not administered solely for the convenience of an insured person or any provider; and
4. which is prescribed by a Physician.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Ophthalmologist: A Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Optometrist: A Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license, other than a member of the insured person's Immediate Family. Physician includes a licensed Dentist, Optometrist, Ophthalmologist, or Audiologist.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy's premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Policy Year: The year beginning on the Policy Date and on each following policy anniversary of the Policy Date.

Policy Year Deductible: The dollar amount for which you are responsible during each Policy Year. The amount of the Policy Year Deductible is shown in the Schedule.

Policy Year Maximum Benefit: The maximum benefit we will pay during any Policy Year. This amount is shown in the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Reasonable and Customary Charge: The normal and prevailing charge, fee or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Schedule: Is attached to and is a part of this policy.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BENEFITS

After the Policy Year Deductible is satisfied, the policy pays the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% - First Policy Year;
2. 70% - Second Policy Year; and
3. 80% - Third Policy Year and thereafter.

Covered Expenses, subject to the Exceptions and Limitations, are:

1. Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings (prophylaxis), semi-annual periodontal maintenance, biennial periodontal surgery (once every two years), x-rays, the cost of fillings, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.
2. Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of \$200 in any one Policy Year.
3. Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs or supplies.

PART G TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death. In the event of your death, we will promptly return the unused premium. The amount of premium refund will be prorated from the date following the date of death to the end of the contract period for which the premium has been paid.

Except in the case of your death, if the termination date occurs within a period for which we have accepted a premium, or if we accept a premium after such date, this policy will continue in effect until the end of the period for which premiums have been accepted. This does not apply where the acceptance of premium was a result of misstatement of age by you. In that case, the Misstatement of Age Provision controls.

PART H

HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to [P.O. Box 10188, Lancaster, PA 17605] or to one of our Producers.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART I

PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to \$1,000.00 (\$5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

Claim Review and Appeal Procedure: In the event of any claim denial with which you do not agree, you have the right to submit a written request to us asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART J

OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments, is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit On Certain Defenses: For a policy or certificate that has been in force for less than six months, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance of coverage.

For a policy or certificate that has been in force for at least six months, but less than two years, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that:

1. is material to the acceptance for coverage; and
2. pertains to the condition for which benefits are sought.

After a policy or certificate has been in force for two years, it is not contestable upon grounds of misrepresentation alone. The policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

The reinstated policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects, you and we will have the same rights under this policy that we had before it lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. The premium we accept to reinstate this policy will be used for a period for which premiums had not been paid. We must receive all back premiums for the policy to be reinstated.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Misstatement Of Age: If your age has been misstated, a premium adjustment will be made so that we receive the premiums that would have been due at the correct age.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change Of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Other Insurance With Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid, less any claims paid, for all other such policies.

Term Of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our [President and Assistant Corporate Secretary] sign this policy in our behalf.

[]
[President]

[]
[Assistant Corporate Secretary]

SERFF Tracking #:

MDIC-128814071

State Tracking #:

Company Tracking #:

AR A48-S DVH POLICY

State: Arkansas

Filing Company:

Medico Insurance Company

TOI/Sub-TOI: H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name: AR A48-S DVH Policy

Project Name/Number: AR A48-S DVH Policy /AR A48-S DVH Policy

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/17/2012
Comments:			
Attachment(s):			
AR A48-S Flesch Certificate-Hall.doc.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/17/2012
Comments:	Application form HAA48(AR)-S will be used by individual applicants to apply for the DVA48(AR)-S policy. Minor revisions were made to the application including removing the replacement questions from the application. After further reviewing the Accident and Sickness Model Act, it has been determined that requesting replacement information from an applicant is not necessary on the dental and vision plans.		
Attachment(s):			
HAA48(AR)-S-12102012.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/17/2012
Bypass Reason:	N/A This is not a rate filing.		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	12/17/2012
Comments:	The Outline of Coverage form 9F-4434(AR)-S will be furnished to each applicant as required by state law. Form 9F-4434(AR)-S replaces the previously approved form 9F-4434(AR) under Serff Filing MDIC-128060718. The minor changes in the outline mimic the changes in the policy.		
Attachment(s):			
9F-4434(AR)-S-12102012.pdf			

		Item Status:	Status Date:
Satisfied - Item:	AR A48-S Cover Letter	Approved-Closed	12/17/2012

SERFF Tracking #:

MDIC-128814071

State Tracking #:

Company Tracking #:

AR A48-S DVH POLICY

State:

Arkansas

Filing Company:

Medico Insurance Company

TOI/Sub-TOI:

H10I Individual Health - Dental/H10I.000 Health - Dental

Product Name:

AR A48-S DVH Policy

Project Name/Number:

AR A48-S DVH Policy /AR A48-S DVH Policy

Comments:

Attachment(s):

AR A48-S Cover Letter 12-12.pdf

FLESCH READABILITY CERTIFICATION

Form Number DVA48(AR)-S has been Flesch tested.
The Flesch Readability Score was computed to be 51.6.

Form Number HAA48(AR)-S & 9F-4434(AR)-S has been Flesch tested.
The Flesch Readability Score was computed to be 47.0.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

MEDICO INSURANCE COMPANY


Timothy Hall
President



[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 Insurance
DVA48(AR)-S

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.

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 # E-mail Address
Beneficiary Relationship Address

Part B: Benefit – [Check the Desired Benefit:] Policy Year Maximum: [] [\$1,000] [] [\$1,500]

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 [] Monthly [] Quarterly [] Semi-Annually [] Annually
[] Credit/Debit Card [] Monthly [] Quarterly [] Semi-Annually [] Annually

Amount Received with Application \$ Renewal Premium \$

[The effective date of the policy will be the first of the month following receipt of your application in our office.]

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 written statements. The above statements, 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]
[Note: Policy will be mailed to Producer in states where a policy delivery receipt is required by law.]

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.

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

Applicant’s Signature Date

Dated at City State

Producer’s Name (Please print)

Distributor Number (4 digits) Producer Number (5 digits)

Producer’s Signature Date



[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 Policy DVA48(AR)-S

DENTAL, VISION AND HEARING COVERAGE
LIMITED BENEFIT POLICY

RETAIN THIS OUTLINE FOR YOUR RECORDS
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

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

BENEFITS PROVIDED BY THE POLICY

Policy Year Maximum Benefit: The maximum benefit we will pay during any one Policy Year. [You may choose from:] [The Policy Year Maximum Benefit is:]

[\$1,000] [\$1,500]

Policy Year Deductible: You are responsible for the first \$100 of Covered Expenses during each Policy Year.

After satisfaction of the \$100 Policy Year Deductible, the policy will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit based on the Policy Year:

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

Covered Expenses, subject to the limitations described in the Exceptions and Limitations Section, are:

- (1) Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings (prophylaxis), semi-annual periodontal maintenance, biennial periodontal surgery (once every two years), x-rays, the cost of fillings, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.
- (2) Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of \$200 in any one Policy Year.
- (3) Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs or supplies.

Reasonable and Customary Charges are the normal and prevailing charges, fees or expenses for the service rendered or for the material furnished in the geographic area where rendered or furnished.

EXCEPTIONS AND LIMITATIONS

Benefits will not be payable for the following items and/or services **during the first six months following the Policy Date:**

- (1) Eyeglasses or contact lenses.

Benefits will not be payable 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.

Benefits will not be paid under this policy 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 to which a contributing cause was 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; (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 the policy is not in force.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR DENTAL, VISION AND HEARING NEEDS.

RENEWABILITY AND PREMIUM CHANGES

Renewability – Guaranteed Renewable – This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums before the end of the grace period.

Terms Under Which We May Change Premiums – We can change premiums only if we do the same to all policies of this form issued to persons of your class in your state, and we notify you in advance of the due date. “Class” means the factors of age, gender, underwriting class and geographic area of 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 the policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PREMIUMS

[PAYMENT METHOD]	[MONTHLY]	[QUARTERLY]	[SEMI-ANNUALLY]	[ANNUALLY]
[AUTOMATIC BANK WITHDRAWAL]	[]	[]	[]	[]
[DIRECT BILL]	[]	[]	[]	[]
[CREDIT/DEBIT CARD]	[]	[]	[]	[]

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®

INSURANCE COMPANY

Corporate Office – Omaha, Nebraska
Administrative Services – P.O. Box 10386, Des Moines, Iowa 50306-0386

December 12, 2012

MEDICO INSURANCE COMPANY
NAIC # 31119
New Serff Filing – MDIC-128814071

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: **A48-S** Individual Dental, Vision and Hearing Policy

Enclosed Material:

DVA48(AR)-S – Policy

HAA48(AR)-S – Application

9F-4434(AR)-S - Outline of Coverage

Enclosed is a copy of our Dental Vision and Hearing Policy and accompanying forms for your review and approval. This filing is intended to replace forms that were previously approved by your state under Serff Filing MDIC-128060718. All other forms approved in the previous filing for the A48 DVH product will remain active and will be used with these revised forms submitted.

We intend to continue to market this product through our producers, an internet-based electronic application process and direct marketing.

DVA48(AR)-S is a limited benefit policy form that replaces the previously approved form DVA48(AR). This form will be used to provide benefits for dental, vision and hearing. The applicant may select a policy year maximum amount of \$1,000 or \$1,500. The revisions in the policy are minor. There is no revision in the benefits or the current rates, associated with this product, at this time.

Application form HAA48(AR)-S will be used by individual applicants to apply for the DVA48(AR)-S policy. Minor revisions were made to the application including removing the replacement questions from the application. After further reviewing the Accident and Sickness Model Act, it has been determined that requesting replacement information from an applicant is not necessary on the dental and vision plans.

Since the replacement question has been eliminated from the application, we are requesting that the replacement form 9F-1061 originally approved for the A48 DVH product under Serff Filing MDIC-128060718 be withdrawn from only this dental, vision and hearing product.

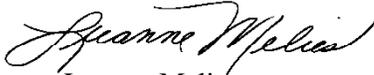
The Outline of Coverage form 9F-4434(AR)-S will be furnished to each applicant as required by state law. Form 9F-4434(AR)-S replaces the previously approved form 9F-4434(AR) under Serff Filing MDIC-128060718. The minor changes in the outline mimic the changes in the policy.

Any bracketed material on the forms represents variable information. Variability is also requested for all forms submitted for bracketed text concerning our contact information that is subject to change (i.e., Home Office physical address, website address, telephone and fax numbers, time of operation, company inter department names & officers) as well as potential changes in payment methods or payment modes. No such items will be contradictory to any applicable state or federal law.

We will not attach any elimination waivers or riders to exclude, limit or reduce coverage or benefits for named pre-existing conditions or physical conditions beyond any stated waiting period.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,



Luanne Melies
Compliance Analyst
Medico Insurance Company
Phone: (402)-496-8237
Fax: (402) 452-2762
luanne.melies@americanenterprise.com