American Republic Insurance Company

Tailored Health℠

Featuring a 3-Year Rate Guarantee

Basic Plan

Basic Medical Summary of Health Insurance Benefits

In-Network Benefits	Most Popular Benefit	Other Options
Deductible (per person, per calendar year)	$5,000	$1,000, $1,500, $2,000 $2,500, $10,000
Co-insurance Percentage	100/0%	80/20%, 50/50%
Co-insurance Limit (per person, per calendar year)	$5,000	$10,000
Maximum Out-of-Pocket (for deductible and co-insurance)	$5,000 per person, per calendar year	Dependent upon deductible and co-insurance selections
Preventive Care Benefit (helps pay for wellness exams, flu shots, etc.)	None	
Prescriptions	Discount card good at 57,000 pharmacies, savings up to 35%	
Rate Guarantee	3 years	2 years, 1 year
Doctor Visits (per person, per calendar year)	5 visits, we pay $50 per visit	5 visits, we pay $0, $25, $75, $100 per visit
Accident Benefit	Pays up to $1,000 for covered expenses	Pays up to: $0, $1,500, $2,000, $2,500, $5,000, $10,000 for covered expenses
Lifetime Maximum Benefits	$5 million per person	$2 million per person
Hospital Stays, including Intensive Care, Surgery and Other Related Services	Your insurance plan pays for all these services based on your deductible and co-insurance decisions	
Emergency Room Co-payment*	$250; waived if admitted within 24 hours	
Accidental Death Benefit (per person)	$5,000 included	$10,000
Term Life Insurance Benefit (not available in CO, OH)	$15,000 individual	$25,000 individual
	Spouse/children benefits based upon plan selection	
Maternity Benefit (not available in MO, VA)	Available–see inside for details	

In addition to the benefits described above, at no cost to you, American Republic has arranged with HealthEquity, Inc. to provide you with these extra services. These services will help you make decisions about your health care. Access to HealthEquity's information can even save you money on medical expenses. The services include …

- **24-hour Nurse Hotline:** You can talk confidentially with a licensed nurse. Having someone there to talk with you about a health concern may save you an unnecessary trip to the doctor – or give you information to help make a decision about your health care.
- **Online Medical Library:** Get access to information about health risks, the prescriptions you take, treatment options and more.
- **Medication Comparison Tool:** Find out about generic and lower-cost alternatives to the prescription drugs you're currently taking.

Plus, your bonus services include information on individual hospitals and their performance as well as objective and unbiased information on new medical tests and treatments.

***Emergency Treatment**

When services, supplies and treatments are received through a hospital emergency room, you must first pay the $250 Emergency Room Co-payment. If you are admitted to the hospital as an inpatient within 24 hours, the co-payment will be waived. Any emergency treatment received outside the network is covered at the preferred provider in-network level. If medically necessary treatment is not available within the network and you are referred by a preferred provider to a non-participating provider, benefits will be provided at the preferred provider level.

In-Network Benefit	Most Popular Benefit	Other Options
Deductible (per person, per calendar year)	$5,000	$1,000, $1,500, $2,000 $2,500, $10,000

- Separate deductibles apply for out-of-network expenses equal to three times the in-network deductible (two times in OH).
- A family limit on deductibles applies when three covered family members each satisfy the in-network deductible amount during a calendar year. Then, the in-network deductible for any other covered family member will be waived for any added in-network expenses that year.
- A separate family limit on out-of-network deductibles applies on the same basis.

In-Network Benefit	Most Popular Benefit	Other Options
Co-insurance Percentage	100/0%	80/20%, 50/50%

- After you meet the deductible, the percentage payable for covered expenses.

	100/0% Plan*		80/20% Plan		50/50% Plan	
	We pay	You pay	We pay	You pay	We pay	You pay
In-network	100%	0%	80%	20%	50%	50%
Out-of-network	80%	20%	60%	40%	50%	50%

**100/0% Plan available with deductibles of $2,500 or greater.*

In-Network Benefit	Most Popular Benefit	Other Options
Co-insurance Limit (per person, per calendar year)	$5,000	$10,000

- The dollar limit at which you no longer pay a percentage of covered expenses.
- A separate out-of-network co-insurance amount equal to three times the in-network amount applies (two times in OH).
- A family maximum on co-insurance applies when three times the in-network co-insurance amount is satisfied during a calendar year. Then, 100% of eligible in-network expenses are payable for all family members for the remainder of the year.
- A separate family maximum of three times the out-of-network co-insurance amount applies.

In-Network Benefit	Most Popular Benefit	Other Options
Maximum Out-of-Pocket (for deductible and co-insurance)	$5,000 per person, per calendar year	Dependent upon deductible and co-insurance selections

- Maximum out-of-pocket does not include the emergency room co-payment or other shared costs.
- Your out-of-pocket expenses increase if any treatment is received out-of-network.

In-Network Benefit	
Prescriptions	Discount card good at 57,000 pharmacies, savings up to 35%

- A nationwide network of preferred pharmacies is available to serve you. When you present your identification card at a participating pharmacy, you receive an immediate discount on your prescription.

In-Network Benefit	Most Popular Benefit	Other Options
Rate Guarantee	3 years	2 years, 1 year

- Rates guaranteed as long as your area of residence, benefit selections and covered individuals remain the same.

American Republic Insurance Company

Protection from a Financially Strong Company
Founded in 1929, today American Republic is rated A- (Excellent) by A.M. Best Company (January 2007) based on our financial strength and stability. A.M. Best Company is an independent non-government company that rates insurance companies. Our Excellent rating is the fourth highest out of 15 possible ratings.

In-Network Benefit	Most Popular Benefit	Other Options
Doctor Visits (per person, per calendar year)	5 visits, we pay $50 per visit	5 visits, we pay $0, $25, $75, $100 per visit

- The Doctor Office Visit Benefit helps pay eligible expenses up to the benefit amount you select for up to five visits per calendar year for each covered person.
- Coverage helps pay for an annual physical or treatment due to an illness or injury. Your benefit helps cover the office visit charge, including history, examination and diagnosis.
- A doctor office visit does not include laboratory services or other diagnostic tests, x-rays, medications, immunizations, medical supplies, surgeries or minor procedures.
- Doctor Office Visit benefits are not subject to any deductible, co-payment or co-insurance amounts.
- Out-of-network benefits are 1/2 the in-network amount selected.

In-Network Benefit	Most Popular Benefit	Other Options
Accident Benefit	Pays up to $1,000 for covered expenses	Pays up to: $0, $1,500, $2,000, $2,500, $5,000, $10,000 for covered expenses

- Pays first-dollar benefits for covered injuries, meaning no co-insurance, deductibles or co-pays to meet before eligible accident benefits are paid.
- Treatment may be received in- or out-of-network.
- Benefits are payable for eligible expenses normally considered under the coverage and outpatient services associated with an accident or injury.
- Benefits are payable under the Accident Benefit for eligible expenses incurred within 90 days of the accident, up to the calendar-year maximum you choose.
- Base plan provides coverage, per plan provisions, for eligible expenses in excess of the maximum benefit or those incurred after the 90-day period.
- All covered persons elect the same benefit level that is equal to or less than the base deductible.

In-Network Benefit	Most Popular Benefit	Other Options
Lifetime Maximum Benefits	$5 million per person	$2 million per person

In-Network Benefit	
Hospital Stays, including Intensive Care, Surgery and Other Related Services	Your insurance plan pays for all these services based on your deductible and co-insurance decisions

These are just some of the eligible expenses:

- Semi-private hospital room and board and general nursing care expenses.
- Hospital intensive care confinement.
- Medical diagnosis, treatment and surgery by a doctor.
- Anesthesiologist's service for a covered surgery.
- Miscellaneous services, supplies, durable medical equipment, and oxygen and any equipment needed for its use.
- Reconstructive breast surgery following a mastectomy, as provided by the plan.
- Laboratory tests, x-rays and radiology.
- Physical, speech or occupational therapy, sports medicine, pulmonary or cardiac rehabilitation therapy.[1]
- Radiation therapy, chemotherapy and related supplies.
- Prescription drugs and medicines administered while a hospital inpatient.
- Ground and air ambulance service to and from the nearest hospital providing the necessary care, as provided by the plan.
- Bone marrow, heart, lung, liver, kidney, cornea, pancreatic/islet, or intestinal transplants, including pre- and post-transplant services, as well as donor expenses. Limited to one transplant per calendar year for a covered person, up to maximum of $100,000, if services are not provided by a Center of Excellence or preferred provider.[2]
- Nursing facility expenses up to one-half the semi-private hospital room rate for up to 30 days per calendar year (following a hospital stay, as provided by the plan).[3]
- Home health care or nursing visits up to 40 visits per calendar year.
- Hospice care expenses, as provided by the plan.
- Surgery by a doctor.
- Laboratory tests, x-rays, supplies, prescription drugs, oxygen, and durable medical equipment related to and provided on the same day as an outpatient surgery.
- Anesthesiologist's service for a covered surgery.
- Observation room expense, as provided by the plan, up to the semi-private hospital room rate.
- Emergency care and services in an emergency room department of a hospital.
- Pre-admission and pre-surgical testing, including laboratory tests and x-rays, within 14 days of a covered hospital stay or surgery.
- CAT scans and MRIs.
- Mammography screening tests, as provided by the plan.
- Child health supervision and pediatric preventive services, as provided by the plan.
- Diabetes care, treatment and self-management training expenses, as provided by the plan.
- Permanent basic artificial limbs or eyes.
- Radiation therapy.
- Chemotherapy and related supplies for the treatment of cancer.
- Hemodialysis.
- Company-approved cost-effective health care services not otherwise considered eligible.

Maximize Your Benefits and Cost Savings Using PPO Network Providers

When you choose participating providers in the PPO network, you receive the maximum benefits from your coverage and take advantage of negotiated rates for covered services that are usually less than the rates normally charged by the network provider. When covered services or supplies are received from a PPO network provider, the actual agreed-upon price charged by the provider is considered the usual and customary allowance for eligible expenses.

If you use providers outside the PPO network, your share of eligible expenses is greater. And, you may have additional expenses to pay if the amount charged by the provider is more than the usual and customary amount allowed by American Republic for the same or comparable services or supplies for other providers in the same locality. The provider can bill you for the balance of charges over and above what your insurance allows.

In-Network Benefit	Most Popular Benefit	Other Options
Accidental Death Benefit (per person)	$5,000 included	$10,000

In-Network Benefit	Most Popular Benefit	Other Options
Term Life Insurance Benefit (not available in CO, OH)	$15,000 individual	$25,000 individual
	Spouse/children benefits based upon plan selection	

- The term life insurance option is available from ages 19-62.
- Children must be at least 14 days but not more than 19 years of age (23 if enrolled as a full-time student).
- You may keep this protection in force until the renewal date following your 65th birthday. Your covered spouse may keep this protection until age 65, unless legally separated or divorced.

	Life Insurance Benefit Amount	
Individual Plan	**Plan A**	**Plan B**
You:	$25,000	$15,000
Family Plan	**Plan A**	**Plan B**
You:	$25,000	$15,000
Your Spouse:	$12,500	$7,500
Your Children: 6 months and older: 14 days to 6 months:	 $2,000 $500	 $1,000 $250

In-Network Benefit	
Maternity Benefit (not available in MO, VA)	Provides coverage to help pay expenses associated with a normal pregnancy, childbirth, and newborn hospital expenses; up to eight units of coverage can be purchased.

- Benefits are determined by the coverage year in which the pregnancy ends, and will be paid after the pregnancy ends. The Maternity option is available to eligible females ages 17 through 39.

Coverage Year	1 Unit	2 Units	3 Units	4 Units	5 Units	6 Units	7 Units	8 Units
1	$250	$500	$750	$1,000	$1,250	$1,500	$1,750	$2,000
2	$375	$750	$1,125	$1,500	$1,875	$2,250	$2,625	$3,000
3 and after	$500	$1,000	$1,500	$2,000	$2,500	$3,000	$3,500	$4,000

Tailored Health℠ Basic Features Work for You

- **Substantially Reduced Rates for Persons Who Do Not Use Tobacco.** If you do not use or have not used tobacco at all in the 12 months prior to your application date, your rates will be considerably lower.
- **Cost Savings.** Tailored Health gives you access to high-quality, cost-effective preferred provider (PPO) hospitals and doctors and participating pharmacies in your geographic area. Cost savings are possible because of negotiated discounts on health care services.
- **Complete Freedom of Choice.** With Tailored Health you have complete freedom to choose your own doctors and hospitals. Coverage is provided whether treatment is received from preferred providers in-network or from non-participating providers outside the network.
- **Only One Basic Deductible for Common Accidents.** When more than one person incurs eligible expenses due to the same accident, only one basic deductible applies.
- **Coverage In Force for Covered Accidents or Sickness Immediately After Issue.** Covers accidents that occur and sickness that first manifests itself after the effective date of coverage. Pre-existing conditions fully disclosed on the application are covered immediately, unless excluded by name or specific description.
- **Guaranteed Coverage for Newborns.** Your children are covered immediately at birth for 31 days (60 days in WI). Within this 31-day period, newborns may be added to the coverage by notifying the Company and paying an added premium.
- **Guaranteed Continuation of Coverage.** Your children may remain on the coverage as long as you wish—no age or full-time student requirements.
- **Guaranteed Conversion at Medicare Age.** You may convert to any available American Republic Medicare Supplement without proof of insurability.
- **Reward for Finding Errors on Hospital Bill.** If you find an error of $50 or more, we will give you 50% of the savings—up to a $500 reward—per hospital stay.

Important Information About Your Tailored Health℠ Basic Plan

Deductible Carryover

Eligible expenses incurred during the last three months of the calendar year that are applied toward a basic deductible will carry over and apply to that deductible amount for the next calendar year. If either the in-network or out-of-network deductible is satisfied prior to the end of the year, deductible carryover does not apply.

Other Coverage

If you have other coverage or become eligible for Medicare, benefits may be reduced[4] (not applicable to any life insurance benefits provided in conjunction with the plan). Plan provisions determine whether the benefits of this coverage are considered before or after those of the other coverage.

Pre-authorization[5]

An important part of your health insurance plan is the pretreatment authorization program. Pre-authorization can help you take a more active role in making your own health care decisions, reducing your out-of-pocket costs, and controlling future premium increases.

You must call for authorization prior to inpatient and outpatient surgeries, or any scheduled hospital or skilled nursing stay, home health or hospice care, home infusion, or transplants or replacements. Authorization is not required before treatment in an emergency situation; however, a later authorization is required. For human organ or bone marrow transplants or replacements, authorization is required at the time your doctor first indicates a transplant or replacement may be needed.

When you make the required toll-free call, the pre-authorization medical team will work with your doctor to evaluate the proposed care by verifying the diagnosis, treatment, and the care setting. Pre-authorization evaluates the medical necessity of proposed treatment, as defined in your coverage; it does not deny treatment. The final decision about the treatment you receive is between you and your doctor.

Pre-authorization provides you with information so that you can make a more informed decision about what is best for you and your family. Pre-authorization decisions relate to the need for medical care; not what is or is not covered by your plan. Pre-authorization does not guarantee that benefits will be paid. Payment of benefits will be determined by the terms of your coverage. Benefits may be reduced if pre-authorization procedures are not followed or treatment is unauthorized.

Premiums and Renewability

You may renew the coverage for any covered person by paying the premiums as they come due. A 31-day grace period is allowed for payment of your premium. We may decline to renew the certificate: (a) if we decline to renew all other forms of the same class as yours issued to everyone in the state; or (b) for any fraudulent misstatements on your personal application or any fraudulent claim.

Initial premium rates are guaranteed for 12 months from coverage issue date, so long as your area of residence, benefit selections and covered persons remain the same. We reserve the right to change premium rates on any renewal date after coverage has been in effect for 12 consecutive months, or the end of the selected guarantee period if you choose the Rate Guarantee Option. The total premium you pay each year for your coverage may vary depending on the mode (frequency of payments) and method you select for premium payment.

All applications are underwritten and each person is assigned a rate class. Should a rate class premium change be necessary in the future, it will only be made if made on all forms in the same class as determined by us and not on an individual basis. At most ages, the premium will increase because a covered person is one year older. If the Rate Guarantee option is selected, such premium changes will not be made during the rate guarantee period selected. At the end of the guarantee period, premium for the option will end and your coverage premium will be the current rate at that time for the covered person(s) rate class and age.

We may change benefits under the coverage or any deductible, co-insurance, co-payment or maximum of the coverage. Such changes may be made on a renewal date or at the beginning of a calendar year and will only be made by class, not on an individual basis. We reserve the right to change the preferred provider network.

Exceptions and Limits

This coverage, including all endorsements, does not cover loss which results from:

- any treatment that is not medically necessary, or charges for which benefits are not specifically provided;
- any complications arising from any medical procedure or condition not covered as an eligible expense;
- outpatient medical services, including doctor office visits and diagnostic testing, except as specifically provided;
- outpatient physical medicine, including physical, chiropractic/ manipulative, speech or occupational therapy, sports medicine, pulmonary or cardiac rehabilitation therapy, unless specifically provided;
- durable medical or home care equipment, oxygen and equipment needed for its use, and medical services and supplies, except as specifically provided;
- rest cures, custodial care or routine physical exams, except as specifically provided;
- alternative medicine including but not limited to acupressure, acupuncture, homeopathy, hypnotism, massage therapy, aroma therapy, and rolfing;
- mental or nervous disorders and alcohol or drug abuse or any complications, except as provided in OH, VA and WI;
- childbirth, pregnancy (except for complications of pregnancy) or routine newborn care, unless optional maternity benefits are selected;
- sexual dysfunction, including but not limited to sex transformations, penile implants, or any complications;
- treatment for infertility or any complications;
- sterilization (in CO, sterilization due to a covered injury or sickness is covered after 1 year);
- outpatient prescription drugs and medicines, except as specifically provided;
- dental care or surgery (except as provided in CO and WI);
- temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD), except as provided in WI;
- cosmetic surgery or any complications, except for certain reconstructive surgery;
- breast reduction or augmentation for any reason;
- weight modification programs or surgical treatment of obesity;
- eyeglasses, contact lenses, or hearing aids and examinations for prescription or fitting thereof, eye exercises, or visual training or treatment of myopia or hyperopia;
- foot inserts, orthopedic shoes or supportive devices for the feet;
- suicide, attempted suicide, or intentionally self-inflicted injury;
- wigs or scalp-hair prosthesis;
- any services, supplies, or treatment covered under any federal, state, or any other government plan or law, except Medicaid;
- the amount Medicare provides for eligible expenses;
- care in a convalescent home or a convalescent, rest, or nursing facility, or custodial, educational, or rehabilitative care facility, or a facility for the aged, alcohol or drug abusers, except as specifically provided;
- expenses covered by Worker's Compensation, employer's liability, occupational disease, or similar law;
- any services, supplies or treatments received outside the United States or its possessions, unless incurred while on a trip of less than 60 days in duration;
- any services performed by a family member, except in CO;
- services, supplies, or treatment for which no charge is normally made in the absence of insurance, except Medicaid;
- use of any aircraft (including ultralight), except as a fare paying passenger on any commercial aircraft;
- parachuting;
- war;
- experimental or investigational treatments;
- in CO only, loss resulting from taking part in organized contests of speed, rodeo activities or climbing;
- intoxication or being under the influence of a narcotic, unless taken on advice of a physician; or
- committing or attempting to commit a felony or engaging in an illegal occupation.

THIS COVERAGE PROVIDES LIMITED BENEFITS.

This coverage is designed to pay for accidents that occur or sickness that first manifests itself after the date of issue. We will not pay for a pre-existing condition or disease for up to two years after issue which is not admitted on the application. Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical treatment has been recommended or received within 5 years prior to issue. Pre-existing conditions admitted on the application will be covered after the issue date, unless excluded by name or specific description. Any false statement, misrepresentation or omissions in the application may result in benefits being denied or the contract being rescinded, subject to the Time Limit on Certain Defenses. (Provisions may vary by state.)

"Hospital" does not include a nursing home, convalescent home, extended care facility or a clinic.

This brochure provides a description of some of the important features of your plan. The benefits, exclusions and limitations listed are typical, but your state may have slight differences. The policy and your certificate are the contract and set forth in detail the rights and obligations of both you and the Company. This plan is not being sold as an employee benefit plan. For further details about this or other available coverage, please contact your agent or American Republic Insurance Company. In CO, a Health Plan Description form for this product is available for your review.

1 In CO, includes physical, occupational and speech therapy (up to 20 visits per calendar year for each therapy) for children up to age 5 for treatment of congenital defects and birth abnormalities.
2 In WI, up to $30,000 per year for kidney disease treatment, including transplantation and related services, as provided by the plan.
3 In CO, skilled nursing facility confinement expense. In MO, skilled or intermediate nursing facility confinement expense. In WI, skilled nursing facility confinement expense for up to 30 days per confinement, as provided by the plan.
4 In CO, other medical expense coverage will not be used in calculating the deductible (see your insurance contract).
5 Not applicable in CO, MO and VA.

American Republic Insurance Company

Tailored Health Basic Forms: A-3892, A-3902, A-3918, A-3919, A-3886, A-3971, A-3972, A-3705, A-2724, A-4125, A-3713

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