American Republic Insurance Company

Tailored Health℠

Featuring a 3-Year Rate Guarantee

Comprehensive and Basic HSA-Qualified Plans

Z-1928

Comprehensive and Basic HSA-Qualified Medical Summary of Health Insurance Benefits

In-Network Benefits	Most Popular Benefit	Other Options
Deductible (per calendar year)	$2,850 individual $5,650 family	$1,500, $5,000 individual $3,000, $10,000 family
Co-insurance Percentage	100/0%	80/20%
Co-insurance Limit (per calendar year)	$5,000 individual $10,000 family	$10,000 individual $20,000 family
Maximum Out-of-Pocket (for deductible and co-insurance)	$2,850 individual $5,650 family per person, per calendar year	Dependent upon deductible and co-insurance selections
Preventive Care Benefit (helps pay for wellness exams, flu shots, etc.)	Comprehensive: Pays up to $150 per person, per calendar year Basic: None	
Prescriptions	Comprehensive: After you meet the deductible, the plan pays 100% Basic: None	
	Discount card good at 57,000 pharmacies, savings up to 35%	
Rate Guarantee	3 years	2 years, 1 year
Doctor Visits	Comprehensive: After you meet the deductible, the plan pays 100% Basic: None	
Accident Benefit (per person, per calendar year)	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*	$0	
Accidental Death Benefit	$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 VA)	Available–see inside for details	
Premium Reduction Options	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

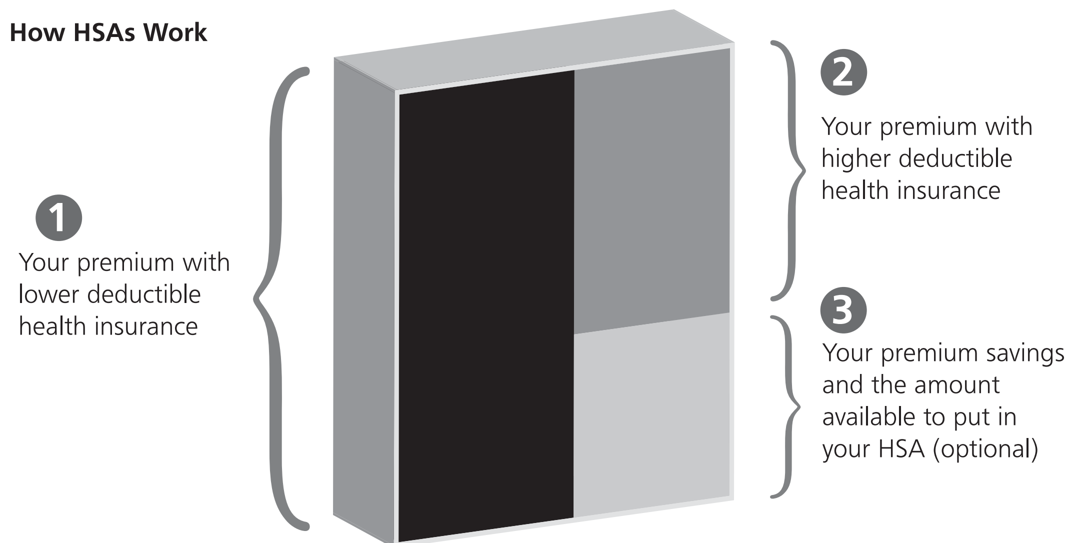
When services, supplies and treatments are received through an out-of-network hospital emergency room, you must first pay the $250 Emergency Room Co-payment. If you are admitted to the hospital as an inpatient within 24 hours, the co-payment will be waived. Any emergency treatment received outside the 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.

There is no Emergency Room Co-payment for services, supplies and treatments received through an in-network hospital emergency room.

Now You Can Cut Your Taxes and Your Insurance Rates with an HSA (Health Savings Account)

Who is eligible for an HSA?
The HSA program is available to anyone covered by a qualified high-deductible health insurance plan. This type of plan qualifies you to open a Health Savings Account (HSA).

How HSAs Work



For illustration purposes only.

Get Triple Tax Savings with an HSA!

1. ***The money you contribute into your HSA is tax deductible*** up to the contribution limit set by the federal law.
2. ***Earnings in your account are tax-free.*** Balances not spent each year accumulate and can be used for future health care expenses, or you may let your funds grow for retirement. You are not required to use your HSA for current health care expenses. At age 65, you can take your money out for any reason. You pay only ordinary income tax on the amount you withdraw.
3. ***Withdrawals for qualified expenses are tax-free.*** Qualified medical expenses are those defined by the IRS Code and not covered by insurance. Most medical expenses are qualified, such as …
    - Hospital, doctor or other medical expenses applied to your insurance deductible or shared costs.
    - Qualified long-term care services and long-term care insurance premiums (up to amounts specified).

How do I set up an HSA?
We can help you establish your HSA through HealthEquity, Inc. so you can count on these extra services…

- 3 **FREE account set-up**
- 3 **NO ACCOUNT SERVICE FEES for two years**
- 3 Friendly customer service – you can call 24 hours a day, 7 days a week
- 3 A convenient HSA Visa card – you can pay for your qualified medical expenses at the pharmacy, dentist or anywhere you buy health care supplies
- 3 Fast online reimbursement requests – no paperwork
- 3 A personalized HSA Web site – easy access to your account

Note: There are no income eligibility requirements for an HSA. An individual must be below Medicare eligibility age, and not covered under another health plan which duplicates any benefits in the qualified high-deductible plan.

Please consult your tax advisor regarding tax deductibility. This brochure outlines the advantages of HSAs and high-deductible health insurance plans in general and does not constitute tax advice.

You choose the plan that fits your needs and budget

n Basic Health Coverage – HSA-Qualified

Designed to protect against catastrophic expenses related to hospitalization or surgery.

n Comprehensive Major Medical Coverage – HSA-Qualified

Designed for individuals and families looking for comprehensive coverage for major health care expenses. This plan provides added protection for routine medical expenses like doctor office visits and outpatient prescription drugs.

In-Network Benefit	Most Popular Benefit	Other Options
Deductible (per calendar year)	$2,850 individual $5,650 family	$1,500, $5,000 individual $3,000, $10,000 family

- All covered expenses, both in- and out-of-network, for all family members are applied to the one deductible selected.
- Premium savings available with a separate out-of-network deductible option, equal to three times the in-network amount selected (two times in OH).

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

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

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

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

In-Network Benefit	Most Popular Benefit	Other Options
Co-Insurance Limit (per calendar year)	$5,000 individual $10,000 family	$10,000 individual $20,000 family

- 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).

In-Network Benefit	Most Popular Benefit	Other Options
Maximum Out-of-Pocket (for deductible and co-insurance)	$2,850 individual $5,650 family per person, per calendar year	Dependent upon deductible and co-insurance selections

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

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	
Preventive Care Benefit (helps pay for wellness exams, flu shots, etc.)	Comprehensive: Pays up to $150 per person, per calendar year Basic: None

- Covers 100% of eligible preventive health care expenses[1], up to $150 per person per calendar year, with no waiting period.

In-Network Benefit	Most Popular Benefit	Other Options
Prescriptions	Comprehensive: After you meet the deductible, the plan pays 100% Basic: None	
	Discount card good at 57,000 pharmacies, savings up to 35%	

- Eligible prescription expenses are applied toward your Comprehensive plan deductible and co-insurance.
- Once the deductible and co-insurance are met, the Comprehensive plan pays 100% of eligible expenses.
- You will receive a discount card you can use at a nationwide network of pharmacies that are available to serve you. When you use your 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.

In-Network Benefit	Most Popular Benefit	Other Options
Doctor Visits	Comprehensive: After you meet the deductible, the plan pays 100% Basic: None	

In-Network Benefit	Most Popular Benefit	Other Options
Accident Benefit (per person, per calendar year)	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

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

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 provided by both the Basic and Comprehensive Plans:

Inpatient Hospital, Surgical, and Medical 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.
- Laboratory tests, x-rays and radiology.
- Physical, speech or occupational therapy, sports medicine, pulmonary or cardiac rehabilitation therapy.[2]
- Radiation therapy, chemotherapy and related supplies.
- Prescription drugs and medicines administered while a hospital inpatient.

Human Organ or Tissue Transplant or Replacement Expenses
- Bone marrow, heart, lung, liver, kidney, cornea, pancreatic/islet, or intestinal transplants, including pre- and post-transplant services, as well as donor expenses. If services are not provided by a Center of Excellence or preferred provider, coverage is limited to one transplant per calendar year for a covered person, up to a maximum of $100,000.[3]

Nursing Facility Confinement Expense For Skilled Nursing Care
- 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).[4]

Home Health Care or Nursing Service Visit Expense
- Home health care or nursing visits up to 40 visits per calendar year.

Hospice Care Expenses, as provided by the plan

Outpatient Services, including
- Outpatient surgery in a hospital outpatient department or surgical center.
- Anesthesiologist's services for a covered outpatient surgery.
- Miscellaneous services including laboratory tests, x-rays, supplies, prescription drugs, oxygen and durable medical equipment related to and provided on the same day as a covered outpatient surgery.
- Observation room expense.
- Child health supervision services for a covered child.
- Diabetes care and treatment.
- Mammography screening tests.
- Chemotherapy, radiation therapy, and hemodialysis.
- Reconstructive breast surgery following a mastectomy.
- Permanent basic artificial limbs/eyes.

Alternative Care or Treatment Plan
- Company-approved, cost-effective health care services not otherwise considered eligible.

These plan specific additional eligible expenses are also covered, subject to coverage provisions:

Basic Health Coverage

Ambulance Expenses
- Up to $1,000 for ground ambulance and $5,000 for air ambulance services per person per calendar year. Covers transportation to the nearest hospital providing the necessary care, when admitted to the hospital within 24 hours.

Emergency Treatment
- Emergency care and services in an emergency room department of a hospital, subject to the Emergency Room co-payment.

Outpatient Services
- Outpatient pre-admission pre-surgical testing, including laboratory tests and x-rays, within 14 days of a covered hospital stay or surgery.
- Outpatient CAT scans and MRIs.

Comprehensive Major Medical Coverage

Ambulance Expenses
- Professional ambulance service to the nearest hospital providing the necessary care.

Emergency Treatment
- Emergency care and services in an emergency room department of a hospital (subject to the Emergency Room co-payment), doctor's office, surgical center or urgent care center.

Outpatient Services
- Medical diagnosis, treatment and surgery by a doctor in a doctor's office. For manipulative therapy, includes up to 10 outpatient visits for any services, supplies or treatments.
- Outpatient laboratory tests, x-rays and radiology, including CAT scans and MRIs. Services are not limited to a hospital stay or surgery.
- Anesthesiologist's service in a doctor's office for a covered outpatient surgery.
- Outpatient miscellaneous services and supplies.
- Outpatient prescription drugs. Includes drugs dispensed through a hospital's outpatient department, an outpatient surgical center, a doctor's office, or a retail pharmacy.
- Outpatient physical medicine, including physical, speech or occupational therapy, sports medicine, pulmonary or cardiac rehabilitation therapy.[5]
- Durable medical equipment used on an outpatient basis.

Preventive Care Expenses
- Covers 100% of eligible preventive health care expenses, up to $150 per person per calendar year.[1]

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 VA)	Benefit not available on the Basic Plan or if either or both of the Optional Premium Reduction Options are selected

Eligible expenses include:

- Prenatal care
- Prescription prenatal vitamins
- Delivery, includes inpatient care for a minimum of 48 hours following a vaginal delivery and 96 hours for a Caesarean section delivery (does not include newborn care)
- Postpartum care up to 6 weeks following delivery.
- Optional Maternity Benefit available only on the 100% Comprehensive Plans with deductibles of less than $5,000 for individual coverage; $10,000 for family coverage.

Benefits paid under the Maternity Benefit are not applied to the deductible and co-insurance under the base plan.

Maternity Benefit	
Deductible	$2,500 per calendar year
Co-insurance	We pay 100% of eligible expenses per calendar year
Waiting Period	9 months before conception

In-Network Benefit

Premium Reduction Options	Benefit not available on the Basic Plan or when the Optional Maternity Benefit is selected

Calendar Year Outpatient Maximum

- Covered outpatient benefits are limited to the amount you choose each calendar year in exchange for lower premiums. Outpatient services include any service received if treated on an outpatient basis at a hospital outpatient department, doctor's office or clinic.

Optional Limit Amounts (per person)		
$5,000	$10,000	$15,000

Calendar Year Maximum

- Limits the total amount of benefits paid each calendar year to the amount you choose in exchange for lower premiums.

Optional Limit Amounts (per person)	
$100,000	$250,000

Tailored Health℠ HSA-Qualified Plan 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. When you use network providers you realize substantial cost savings on covered services and help keep your insurance premiums lower.

- **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. We do encourage the use of network providers whenever possible to ensure that you receive maximum benefits and cost savings.

- **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 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℠ HSA-Qualified Plans

Other Coverage

If you have other coverage or become eligible for Medicare, benefits may be reduced (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.[6]

Prescription Drugs

Tailored Health HSA-Qualified Plans provide cost savings on outpatient prescriptions through negotiated discounts with participating pharmacies in our pharmacy network, as well as a mail-order program for maintenance medications. If you choose to use a non-participating pharmacy, you do not get the advantage of the negotiated discounts.

If you select comprehensive major medical protection, your participating pharmacy will submit your claims for you. If you use a non-participating pharmacy, you will need to submit the claims. Benefits under the comprehensive major medical protection will be based on the prescription price that would be charged by a participating pharmacy. You are responsible for any additional cost that may be incurred if you choose a non-participating pharmacy. The full generic drug price charged by a participating pharmacy is considered eligible. If you choose a brand name drug over a generic equivalent, you pay any cost above the eligible generic drug price. When a generic is not available, the brand name drug cost is considered.

Certain prescription drugs require authorization prior to purchase. Your participating pharmacist will assist you in obtaining authorization when necessary.

Pre-authorization[7]

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 medical review 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 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 coverage: (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. Coverage will be nonrenewed: if you move outside the United States or, for dependent coverage, when they no longer meet the definition of dependent child (unmarried, under age 23 and who qualify as legal dependents for tax exemption purposes). When a child is no longer a dependent, their coverage can be continued without proof of insurability as provided by the plan. Some conditions of renewability may not apply in your state. See the insurance contract for details.

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. Benefits and premiums will vary depending on plan, coverage choices and optional benefits which you select. 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 individually 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, unless 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, unless specifically provided; •rest cures, custodial care or routine physical exams, unless 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 specifically provided; •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, unless specifically provided; •growth hormone therapy; •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; •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, unless 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), unless a fare paying passenger on any commercial aircraft; parachuting; war; •loss resulting from taking part in organized contests of speed, or rodeo activities (CO only), or climbing (CO only); •experimental or investigational treatments; •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.

The Outpatient Prescription Drug benefit available under the Comprehensive Major Medical Protection does not cover:

•drugs not covered by the drug formulary; •over a 34-day supply per prescription from a retail pharmacy, a 90-day supply from mail-order, or the drug manufacturer's recommendation; •infertility drugs or medicines; •contraceptive medications, including Norplant, regardless of intended use (CO only); •durable medical equipment; •over-the-counter medications; •compounded drugs not containing at least one legend ingredient, unit-dose drugs, dietary supplements, or vitamins; •prescription refills exceeding the doctor's prescription order or dispensed more than one year after the original prescription date; •experimental or investigational drugs; •drugs covered by a Workers' Compensation or Occupational Disease Law; •drugs and medicines dispensed in a hospital, doctor's office or medical facility; •immunization agents, biological sera, blood or blood plasma; •drugs for cosmetic purposes (including Retin-A) or treatment of hair loss; •drugs prescribed for care, services or treatment not provided under the plan or for treatment of any sickness or injury not covered by the plan; •drugs used for the purpose of weight loss or treatment of sexual dysfunction; •drugs containing nicotine or its derivatives, or smoking cessation drugs; •DDAVP or other drugs used for treatment of bed-wetting (under age six); •any drug not consistent with the diagnosis and treatment of a sickness or injury or excessive in terms of the scope, duration or intensity of drug therapy needed; •convenience drugs; or •drugs prescribed for conditions or diseases excluded by name or specific description under the plan.

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 five 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 insurance contract sets 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 is available for your review.

1 State-specific benefits may apply under the base plan for certain preventive care services, such as child immunizations/health supervision (CO, OH & PA), clinical breast exams (PA), gynecological exams and pap smears (MO, PA & VA), mammograms (CO & OH) and prostate cancer screening (CO, MO & VA).
2 In CO, includes physical, occupational and speech therapy (up to 20 visits per calendar for each therapy) for children up to age 5 for treatment of congenital defects and birth abnormalities.
3 In WI, up to $30,000 per year for kidney disease treatment, including transplantation and related services, as provided by the plan.
4 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.
5 In CO, limited to 15 outpatient visits for each covered person per calendar year.
6 In CO, other medical expense coverage will not be used in calculating the deductible (see your insurance contract).
7 In CO, MO and VA, pre-authorization procedures are not applicable.

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Policy Forms: A-3912, A-3913, A-3966, A-3968
Endorsement Forms: A-3713, A-3886, A-3910, A-3964, A-3971, A-3972, A-4051, A-4054, A-4066, A-4125, A-4126, A-4129
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