

Tailored HealthSM

Featuring a 3-Year Rate Guarantee

Comprehensive Plan

Comprehensive Major Medical Summary of Health Insurance Benefits

| In-Network Benefits | Most Popular Benefit | Other Options |
|---|--|--|
| Deductible (per person, per calendar year) | \$2,500 | \$1,000, \$1,500, \$2,000 \$5,000, \$10,000 |
| Co-insurance Percentage | 80/20% | 100/0%, 50/50% |
| Co-insurance Limit (per person, per calendar year) | \$5,000 | \$10,000 |
| Maximum Out-of-Pocket (for deductible and co-insurance) | \$3,500 per person, per calendar year | Dependent upon deductible and co-insurance selections |
| Preventive Care Benefit (helps pay for wellness exams, flu shots, etc.) | Pays up to \$150 per person, per calendar year | |
| Prescriptions | Brand Name: \$500 annual deductible Generic: \$0 deductible | Brand Name: \$1,000 annual deductible Generic: \$0 deductible |
| | Brand Name: \$50 co-pay Generic: \$20 co-pay see inside for details and mail order | |
| Rate Guarantee | 3 years | 2 years, 1 year |
| Doctor Visits (per person, per calendar year) | 4 visits, \$50 co-pay | No benefit |
| 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 | \$3 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 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 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) | \$2,500 | \$1,000, \$1,500, \$2,000 \$5,000, \$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 | 80/20% | 100/0%, 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 | 75% | 25% | 50% | 50% | 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 selected 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) | \$3,500 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 | |
|---|--|
| Preventive Care Benefit (helps pay for wellness exams, flu shots, etc.) | Pays up to \$150 per person, per calendar year |

- Covers 100% of eligible preventive health care expenses¹, up to \$150 per person per calendar year, with no waiting period.



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 |
|----------------------|--|--|
| Prescriptions | Brand Name: \$500 annual deductible Generic: \$0 deductible | Brand Name: \$1,000 annual deductible Generic: \$0 deductible |
| | Brand Name: \$50 co-pay Generic: \$20 co-pay See inside for details and mail order | |

Network Discounts

- You receive an immediate discount on your prescription. Claims are electronically submitted at the pharmacy. There are no claims forms to complete and you don't wait for reimbursement.

Out-of-Network

- You pay the full cost of the prescription at the pharmacy and must submit a claim form. Claim payment will be based on the price that would have been charged for the prescription at a participating pharmacy.

Eligible Expenses

- Up to a 34-day supply of a prescription drug when dispensed by a retail pharmacy.
- Prescription orders in excess of a 34-day supply up to a total prescription maximum of a 90-day supply when dispensed by a mail-order pharmacy.
- Up to 3 vials of one type of insulin or 100 disposable insulin syringes (not to exceed a 34-day supply).

Outpatient Prescription Drug expenses are not subject to and will not be used to satisfy the basic deductible or co-insurance amount. Eligible expenses under the Outpatient Prescription Drug benefit (including drug deductibles, co-insurance amounts, and other shared costs) will not be considered as eligible expenses under the basic major medical protection or any other attached endorsement.

Outpatient Prescription Drug Benefit

| Drug Deductible (per person, per calendar year) | | |
|--|------------------------|--|
| Brand Name | \$500 or \$1,000 | |
| Generic | \$0 | |
| Drug Co-pay | Retail Pharmacy | Mail Order (up to a 90-day supply) |
| Brand Name* | \$50 | \$125 |
| Generic** | \$20 | \$50 |

* After your co-payment, we pay up to the amount charged for the brand name drug.

** After your co-payment we pay up to the full allowable cost for the generic drug.

| 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 (per person, per calendar year) | 4 visits, \$50 co-pay | No benefit |

- The Doctor Office Visit benefit pays 100% of eligible expenses after your co-payment. Your co-payment covers the office visit charge and services associated with that visit, including history, examination and diagnosis as well as any drugs or surgical procedures.

| Doctor Office Visit Benefit | |
|---|--|
| Waiting Period | none |
| Co-payment | \$50 in-network / \$100 out-of-network |
| Calendar-Year Maximum (per person) | 4 visits |

Coverage for other eligible expenses, including those in excess of the calendar-year visit limit or services not covered by this benefit, is provided under the base major medical protection.

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 |
|--|---|--|
| 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 | \$3 million per person |

| In-Network Benefit | Other Options |
|---|---|
| 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:

- | | |
|---|---|
| <ul style="list-style-type: none"> • Semi-private hospital room and board and general nursing care expenses. • Hospital intensive care confinement. • Observation room expenses at a hospital, as provided by the plan. • Nursing facility confinement expense for skilled nursing care up to one-half the semi-private hospital room rate for up to 60 days per calendar year (following a hospital stay, as provided by the plan).² • Medical diagnosis, treatment and surgery by a doctor in or out of the hospital. • Outpatient manipulative therapy, up to 15 visits per person per calendar year. • Anesthesiologist's service for a covered surgery. • Home health care or nursing service visits, up to 40 visits per calendar year, as provided by the plan. • Hospice care expenses for inpatient or home care, as provided by the plan. • Laboratory tests in or out of the hospital. • X-rays and radiology in or out of the hospital, including mammograms, as provided by the plan. • Prescription drugs and medicines administered while in a hospital, a nursing facility, a hospital outpatient department or surgical center, or a doctor's office. • Prescription injectable drugs, infusion drugs and solutions, as provided by the plan. • Ground and air ambulance service to and from the nearest hospital providing the necessary care, as provided by the plan. • Oxygen and any rented equipment for its use, in or out of the hospital. • Reconstructive breast surgery following mastectomy, as provided by the plan. | <ul style="list-style-type: none"> • Rental or Company-authorized purchase of a basic wheelchair, hospital-type bed, or durable medical equipment for therapeutic use. • Child health supervision and pediatric preventative services, as provided by the plan. • Diabetes care, treatment and self-management training expenses, as provided by the plan. • Bone marrow, heart, lung, liver, kidney, cornea, pancreatic/islet, or intestinal transplants, or implantable prosthetic lens in connection with cataracts, including donor expenses, as provided by the plan, up to \$1,000,000 lifetime in- and out-of-network (limited to \$250,000 for any out-of-network services).³ • Physical, speech or occupational therapy, sports medicine, pulmonary or cardiac rehabilitation therapy, in or out of the hospital. • Permanent basic artificial limbs, eyes, casts, splints, trusses, braces or crutches. • Inpatient treatment for mental or nervous disorders and alcohol or drug abuse, up to \$3,000 per calendar year.⁴ • Company-approved alternative care or treatment plan. • Growth therapy treatment, up to \$10,000 lifetime. • Temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD) expenses up to \$1,000 lifetime. Nonsurgical treatment is limited to diagnostic examination and x-rays, muscle relaxant or therapeutic drug injections, and physical, diathermy or ultrasound therapy. • Miscellaneous services, supplies, and durable medical equipment used while in a hospital, a hospital's outpatient department, a doctor's office, or when prescribed by a doctor as part of an outpatient treatment plan. |
|---|---|

| 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 Spouse/children benefits based upon plan selection | \$25,000 individual |

- 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: | \$2,000 | \$1,000 |
| 14 days to 6 months: | \$500 | \$250 |

| In-Network Benefit | |
|---|--|
| Maternity Benefit (not available in VA) | Benefit not available 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.

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 when the Optional Maternity Benefit is selected |

Calendar Year Outpatient Maximum

- Covered outpatient benefits are limited each calendar year to the amount you choose 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, per calendar year) | | |
|--|----------|----------|
| \$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, per calendar year) | |
|--|-----------|
| \$100,000 | \$250,000 |

Tailored HealthSM Comprehensive 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 HealthSM 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 (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.

In CO, other medical expense coverage will not be used in calculating the deductible (see your insurance contract).

Pre-authorization

(not applicable in CO, MO and VA)

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:

- expenses not for the treatment of a specific accident or sickness or rest cures, custodial care or routine physical exams, except as specifically provided;
- mental or nervous disorders and alcohol or drug abuse or any complications, except as specifically provided;
- childbirth or pregnancy (except for complications of pregnancy), 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);
- prescription drugs and medicines except as specifically provided;
- dental care or surgery, except as provided;
- temporomandibular joint dysfunction (TMJ) or craniomandibular joint dysfunction (CMD), except as specifically provided;
- 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;
- any services, supplies, or treatment covered under any federal, state, or any other government plan or law, except Medicaid;
- care in 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 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;
- wigs or scalp-hair prosthesis;
- the amount Medicare provides;
- 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 complications arising from any medical procedure or medical condition that is not covered as an eligible expense under this coverage;
- war;
- use of any aircraft (including ultralight), except as a fare paying passenger on any commercial aircraft; parachuting;
- in CO only, taking part in organized contests of speed, participating in rodeo activities, or climbing;
- 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 does not cover:

- over a 34-day supply per prescription from a retail pharmacy, over a 90-day supply from mail-order, or over the drug manufacturer's recommendation;
- infertility drugs or medicines, immunization agents, biological sera, blood or blood plasma;
- 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, vitamins, and drugs not covered by the Drug Formulary;
- 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 Worker's Compensation or Occupational Disease Law;
- drugs and medicines dispensed in a hospital, doctor's office or other medical facility;
- drugs for cosmetic purposes including Retin-A (tretinoin), 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 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 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 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 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. For tax, legal or investment advice, please consult a qualified professional.



¹ State-specific benefits may apply under the base plan for certain preventive services, such as child immunizations/health supervision (CO and OH), gynecological exams and pap smears (MO and VA), mammograms (CO and OH) and prostate cancer screening (CO, MO, and VA).

² 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 injury or sickness, as provided by the plan.

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 VA, inpatient and outpatient treatment as provided in the plan. In WI, up to \$7,000 per calendar year. In OH, inpatient mental or emotional disorders or drug abuse expenses up to \$3,000 per calendar year; outpatient mental or emotional disorders expenses up to \$550 per calendar year; and inpatient, outpatient and intermediate care expenses for alcoholism up to \$550 per calendar year.

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Policy Forms: A-3795, A-3799

Endorsement Forms: A-3713, A-3886, A-4051, A-4053, A-4054, A-4066, A-4125, A-4126, A-4127, A-4129, A-4136