

SERFF Tracking Number: NSIC-125850905 State: Arkansas
 Filing Company: National States Insurance Company State Tracking Number: 40502
 Company Tracking Number:
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
 Standard Plans
 Product Name: Medicare Supplement Outlines of Coverage - 2009
 Project Name/Number: OC-ASM-1(2009)/

Filing at a Glance

Company: National States Insurance Company

Product Name: Medicare Supplement Outlines of Coverage - 2009 SERFF Tr Num: NSIC-125850905 State: ArkansasLH

TOI: MS051 Individual Medicare Supplement - Standard Plans SERFF Status: Closed State Tr Num: 40502

Sub-TOI: MS051.001 Plan A

Filing Type: Form

Co Tr Num:

State Status: Approved-Closed

Co Status:

Reviewer(s): Stephanie Fowler

Authors: William Morrison,
Anastacia Behrens, Jackie Phillips

Disposition Date: 11/07/2008

Date Submitted: 10/08/2008

Disposition Status: Approved

Implementation Date Requested: 01/01/2009

Implementation Date:

State Filing Description:

General Information

Project Name: OC-ASM-1(2009)

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/07/2008

State Status Changed: 11/07/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are our Medicare Supplement outlines of coverage.

The outlines of coverage were previously approved in late 2007 for 2008, but they have been updated to reflect the new Medicare deductible amounts. We submitted a letter, under separate filing, notifying your Department of our intent to

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cease the sales of Plan C (our CSM-1(05)) effective January 1, 2009. Therefore, we have deleted the reference to Plan C from page one of the COVERPAGE(2009); and the rates for Plan C from page 3 of the COVERPAGE(2009).

We submitted a filing to Missouri, our state of domicile on October 2, 2009. Missouri does not require the filing of the outline each year when the only changes are the rates (after approval) and the Medicare deductible amounts, but with the withdrawal from sale of Plan C, we submitted the outline notifying them of the same changes.

Thank you for your review and approval.

Company and Contact

Filing Contact Information

Anastacia Behrens, abehrens@nstates.com
 1830 Craig Park Court (800) 868-6788 [Phone]
 St. Louis, MO 63146 (314) 878-8118[FAX]

Filing Company Information

National States Insurance Company CoCode: 60593 State of Domicile: Missouri
 1830 Craig Park Court Group Code: Company Type: Life and Health
 Ste. 100
 St. Louis, MO 63146 Group Name: State ID Number:
 (314) 878-0101 ext. [Phone] FEIN Number: 43-0825796

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 5 forms at \$20 each.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National States Insurance Company	\$100.00	10/08/2008	23052535

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	11/07/2008	11/07/2008

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Disposition

Disposition Date: 11/07/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage	Approved	Yes
Form	Medicare Supplement Plan A Outline	Approved	Yes
Form	Medicare Supplement Plan B Outline	Approved	Yes
Form	Medicare Supplement Plan D Outline	Approved	Yes
Form	Medicare Supplement Plan F Outline	Approved	Yes
Form	Coverpages for the Outlines of Coverage	Approved	Yes

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Form Schedule

Lead Form Number: OC-ASM-1(2009)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	OC-ASM-1(2009)	Outline of Coverage	Medicare Supplement Plan A Outline	Initial			OC-ASM-1(2009).pdf
Approved	OC-BSM-1(2009)	Outline of Coverage	Medicare Supplement Plan B Outline	Initial			OC-BSM-1(2009).pdf
Approved	OC-DSM-1(2009)	Outline of Coverage	Medicare Supplement Plan D Outline	Initial			OC-DSM-1(2009).pdf
Approved	OC-FSM-1(2009)	Outline of Coverage	Medicare Supplement Plan F Outline	Initial			OC-FSM-1(2009).pdf
Approved	COVERPA GE(2009)	Outline of Coverage	Coverpages for the Outlines of Coverage	Initial			COVERPAGE (2009) (AR).pdf

NATIONAL STATES INSURANCE COMPANY

1830 Craig Park Court, St. Louis, Missouri 63146

314-878-0101

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the Additional 365 days	All but [\$1,068] All but [\$267] a day All but [\$534] a day \$0 \$0	\$0 [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	[\$1,068] (Part A Deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$133.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed [\$135] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$135] (Part B Deductible) \$0
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NATIONAL STATES INSURANCE COMPANY

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PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the Additional 365 days	All but [\$1,068] All but [\$267] a day All but [\$534] a day \$0 \$0	[\$1,068] (Part A Deductible) [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$133.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed [\$135] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$135] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$135] (Part B Deductible) \$0
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NATIONAL STATES INSURANCE COMPANY

1830 Craig Park Court, St. Louis, Missouri 63146
314-878-0101

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the Additional 365 days	All but [\$1,068] All but [\$267] a day All but [\$534] a day \$0 \$0	[\$1,068] (Part A Deductible) [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed [\$135] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$135](Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135](Part B Deductible) \$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and and medical supplies -Durable medical equipment First [\$135] of Medicare approved amounts* Remainder of Medicare approved amounts AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan -Benefit for each visit -Number of visits covered (Must be received within 8 weeks of last Medicare approved visit) -Calendar year maximum	100% \$0 80% \$0 \$0 \$0	\$0 \$0 20% Actual charges to \$40 a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$1,600	\$0 [\$135](Part B Deductible) \$0 Balance Balance Balance
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OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

NATIONAL STATES INSURANCE COMPANY

1830 Craig Park Court, St. Louis, Missouri 63146

314-878-0101

PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the Additional 365 days	All but [\$1,068] All but [\$267] a day All but [\$534] a day \$0 \$0	[\$1,068] (Part A Deductible) [\$267] a day [\$534] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed [\$135] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [\$135] of Medicare approved amounts*	\$0	[\$135] (Part B Deductible)	\$0
Remainder of Medicare approved amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare approved amounts*	\$0	[\$135] (Part B Deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment	100%	\$0	\$0
First [\$135] of Medicare approved amounts*	\$0	[\$135] (Part B Deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

BENEFIT PLANS A, B, D and F ARE OFFERED

These charts show the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans.

BASIC BENEFITS for PLANS A - J:

HOSPITALIZATION: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

MEDICAL EXPENSES: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayment for hospital outpatient services.

BLOOD: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible					Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Basic Benefits for Plans K and L include similar services as plans A-J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4,620] Out of Pocket Annual Limit***	[\$2,310] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

**PREMIUM RATES FOR NATIONAL STATES
PLANS A, B, F - ALL AGES**

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
PLAN A	\$1,682.00	\$866.73	\$446.48	\$152.30
PLAN B	\$3,002.00	\$1,546.53	\$796.28	\$271.10
PLAN F	\$3,207.00	\$1,652.11	\$850.61	\$289.55

**PREMIUM RATES FOR NATIONAL STATES
PLAN D - ALL AGES**

	ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY
ZIP REGION: 721, 724, 727, 729				
NON-SMOKER	\$1,182.00	\$614.64	\$313.23	\$99.29
SMOKER	\$1,313.00	\$682.76	\$347.95	\$110.29
ZIP REGION: 719-720, 722				
NON-SMOKER	\$1,255.00	\$652.60	\$332.58	\$105.42
SMOKER	\$1,395.00	\$725.40	\$369.68	\$117.18
ZIP REGION: 716-718, 725-726, 728				
NON-SMOKER	\$1,329.00	\$691.08	\$352.19	\$111.64
SMOKER	\$1,477.00	\$768.04	\$391.41	\$124.07
ZIP REGION: 723				
NON-SMOKER	\$1,403.00	\$729.56	\$371.80	\$117.85
SMOKER	\$1,559.00	\$810.68	\$413.14	\$130.96

PREMIUM INFORMATION

We, National States Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to National States Insurance Company, 1830 Craig Park Court, St. Louis, Missouri 63146. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither National States Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice 10/08/2008
Bypass Reason: N/A to this filing. We are just updating the Medicare deductibles on the outlines of coverage for 2009.

Comments:

Review Status:

Bypassed -Name: Application 10/08/2008
Bypass Reason: N/A to this filing. We are just updating the Medicare deductibles on the outlines of coverage for 2009.

Comments:

Review Status:

Bypassed -Name: Health - Actuarial Justification 10/08/2008
Bypass Reason: N/A to this filing. We are just updating the Medicare deductibles on the outlines of coverage for 2009.

Comments:

Review Status:

Satisfied -Name: Outline of Coverage Approved 11/07/2008

Comments:

2009 Medicare Supplement outlines of coverage are being submitted under the Form Scheudle tab.