

SERFF Tracking Number: AMRP-125641181 State: Arkansas  
Filing Company: American Republic Insurance Co State Tracking Number: 38930  
Company Tracking Number: 110505-ARIC-O  
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A  
Standard Plans  
Product Name: Medicare Supplement - Outline of Coverage  
Project Name/Number: 6/1/08 Outline/110505-ARIC-O

## Filing at a Glance

Company: American Republic Insurance Co

Product Name: Medicare Supplement - Outline of Coverage SERFF Tr Num: AMRP-125641181 State: ArkansasLH

TOI: MS051 Individual Medicare Supplement - Standard Plans SERFF Status: Closed State Tr Num: 38930

Sub-TOI: MS051.001 Plan A

Co Tr Num: 110505-ARIC-O

State Status: Approved-Closed

Filing Type: Form

Co Status: Submitted to State

Reviewer(s): Stephanie Fowler

Author: Susan Zaiger

Disposition Date: 05/27/2008

Date Submitted: 05/09/2008

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: 6/1/08 Outline

Status of Filing in Domicile:

Project Number: 110505-ARIC-O

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type:

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/27/2008

Deemer Date:

State Status Changed: 05/27/2008

Corresponding Filing Tracking Number:

Filing Description:

We are filing the enclosed Medicare Supplement Outline of Coverage for your review. In the near future we plan to discontinue the sale of Medicare Supplement Plan J and this outline reflects that change. The exact date of our discontinuance has not yet been set. When the date is finalized we will notify your Department. We understand there is a waiting period that we must satisfy until American Republic can again sell Plan J in your state.

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## Company and Contact

### Filing Contact Information

Susan Zaiger, Senior Product Analyst  
 601 6th Ave  
 Des Moines, IA 50334

susan.zaiger@americanenterprise.com  
 (515) 245-2248 [Phone]  
 (515) 247-2558[FAX]

### Filing Company Information

American Republic Insurance Co  
 601 6th Ave

Des Moines, IA 50334  
 (800) 987-8988 ext. [Phone]

CoCode: 60836  
 Group Code: 3527

Group Name:  
 FEIN Number: 42-0113630  
 -----

State of Domicile: Iowa  
 Company Type: Life Accident and  
 Health Insurance  
 State ID Number:

## Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Republic Insurance Co	\$0.00	05/09/2008	

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	05/27/2008	05/27/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fees Mailed	Note To Reviewer	Susan Zaiger	05/14/2008	05/14/2008

*SERFF Tracking Number:* AMRP-125641181      *State:* Arkansas  
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## **Disposition**

Disposition Date: 05/27/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.



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**Note To Reviewer**

**Created By:**

Susan Zaiger on 05/14/2008 11:26 AM

**Subject:**

Filing Fees Mailed

**Comments:**

We have mailed via the U.S. Postal Service a check in the amount of \$50 for the filing fees of this outline of coverage. The number of this check is 0001014470. For your information, attached is a copy of that check.

Please let me know if you have any questions or comments.

Thank you

Susan Zaiger



American Republic  
Insurance Company

601 6th Avenue, Des Moines, Iowa 50309

CHECK DATE: 05/12/08  
CHECK NUMBER: 0001014470  
CHECK AMOUNT: \$ 50.00  
INVOICE #:  
REF ID #: ARI051208V40

Forwarding Service Request

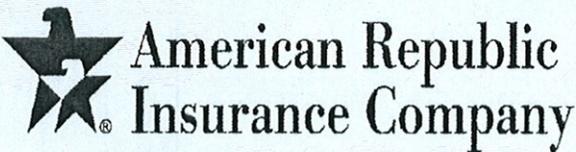
ARKANSAS INSURANCE DEPARTMENT  
INSURANCE DEPARTMENT TRUST FUND  
1200 WEST THIRD STREET  
LITTLE ROCK, AR 72201

SORT CODE: 7965

Check Voucher Information

FILING FOR MEDICARE SUPPLEMENT OUTLINE

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER, A VOID PANTOGRAPH AND MICROPRINTING



American Republic  
Insurance Company

601 6th Avenue, Des Moines, Iowa 50309

Wells Fargo Bank, N.A.  
56-382/412

CHECK NUMBER 0001014470

Date  
05/12/08

PAY FIFTY DOLLARS & 00/100

Pay This Amount  
\*\*\*\*\*50.00

PAY TO THE ORDER OF ARKANSAS INSURANCE DEPARTMENT  
INSURANCE DEPARTMENT TRUST FUND  
1200 WEST THIRD STREET  
LITTLE ROCK, AR 72201

**VOID**

*Michael E Abbott*

VOID IF NOT CASHED WITHIN 60 DAYS OF ISSUE DATE

⑈0001014470⑈ ⑆041203824⑆9600091528⑈

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## **Rate Information**

Rate data does NOT apply to filing.

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## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Certification/Notice 05/09/2008  
**Comments:**  
**Attachment:**  
110505-ARIC-O Cert.pdf

**Review Status:**  
**Bypassed -Name:** Application 05/09/2008  
**Bypass Reason:** Not applicable - we are filing the outline of coverage only.  
**Comments:**

**Review Status:**  
**Bypassed -Name:** Health - Actuarial Justification 05/09/2008  
**Bypass Reason:** Not applicable - we are filing the outline of coverage only.  
**Comments:**

**Review Status:**  
**Satisfied -Name:** Outline of Coverage Approved 05/27/2008  
**Comments:**  
**Attachment:**  
A-3146-12 AR Rev. 0508.pdf



# American Republic Insurance Company

601 6th Avenue, Des Moines, Iowa 50309

To: Department of Insurance

RE: Outline of Coverage A-3146-12 AR Rev. 0508

I certify the policy form being filed complies with Rule 19, Rule 49 and ACA 23-79-138.

I also certify the forms being filed meet minimum requirements of the Flesch reading ease policy simplification test, and that: the Flesch reading ease test has been applied to each form, and each form reaches a readability score of at least 40. Also the type size is at least 10 point, one point leaded.

Christopher Aasland, FSA, MAAA  
Vice President and Actuary

Dated: May 9, 2008

# American Republic Insurance Company

National Headquarters, Des Moines, Iowa 50309

## Outline of Medicare Supplement Coverage-cover page 1 of 2 Benefit Plan A, D and F\*

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 copayments 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			
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 A Deductible
	Part B Deductible	Part B Deductible			Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess (100%)	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	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

\* 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 [\$1,900] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$1,900]. 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.

# American Republic Insurance Company

National Headquarters, Des Moines, Iowa 50309

## Outline of Medicare Supplement Coverage-cover page 2 of 2

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	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	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 Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% 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			
	[\$4,440] Out of Pocket Annual Limit***		[\$2,220] 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 AND RENEWABILITY INFORMATION

This policy is Guaranteed Renewable for Life as long as the premiums are paid on time. The premium table for this policy may change by class as determined by the Company. Premiums may change because of a change of residence or as Medicare benefits change. We can only raise your premium if we raise the premium for all policies like yours in this state. No premium change may be made on an individual basis. You have a 31-day grace period to pay your premium.

The premium for \_\_\_\_\_ at issue age \_\_\_\_\_  
Applicant's Name Applicant's Age  
for each plan available on \_\_\_\_\_ is :  
Date

### APP Premiums

Plan A	Plan D	High Deductible Plan F
\$ _____	\$ _____	\$ _____

Mode Factors: [Monthly Direct Bill: 1.044 Quarterly: 3 Semiannual: 6 Annual: 12]

### DISCLOSURES

Use this outline to compare benefits and premiums between 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 the rights and duties of both you and your insurance company.

#### RIGHT TO RETURN POLICY

If you find you are not satisfied with your policy, you may return it to American Republic Insurance Company, P.O. Box 1, Des Moines, Iowa 50301. 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 American Republic 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 & 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.

# American Republic Insurance Company

National Headquarters, Des Moines, Iowa 50309

## Arkansas

### [2007] APP Attained Age Rates

[Zip Codes  
71800-71899  
72300-72599]

	A-3146	A-4079		A-4028	
All Ages 65+	Plan A	Plan D		Plan HDF	
		Preferred	Standard	Preferred	Standard
APP	123.02	117.80	138.59	54.06	63.60
Monthly	128.43	122.98	144.69	56.44	66.40
Quarterly	369.06	353.40	415.77	162.18	190.80
Semiannual	738.12	706.80	831.54	324.36	381.60
Annual	1,476.24	1,413.60	1,663.08	648.72	763.20

[Zip Codes  
71700-71799  
72600-72999]

	A-3146	A-4079		A-4028	
All Ages 65+	Plan A	Plan D		Plan HDF	
		Preferred	Standard	Preferred	Standard
APP	116.87	111.19	131.66	51.36	60.42
Monthly	122.01	116.83	137.45	53.62	63.08
Quarterly	350.61	335.73	394.98	154.08	181.26
Semiannual	701.22	671.46	789.96	308.16	362.52
Annual	1,402.44	1,342.92	1,579.92	616.32	725.04

[Zip Codes  
72200-72299]

	A-3146	A-4079		A-4028	
All Ages 65+	Plan A	Plan D		Plan HDF	
		Preferred	Standard	Preferred	Standard
APP	135.32	129.58	152.45	59.47	69.96
Monthly	141.27	135.28	159.16	62.09	73.04
Quarterly	405.96	388.74	457.35	178.41	209.88
Semiannual	811.92	777.48	914.70	356.82	419.76
Annual	1,623.84	1,554.96	1,829.40	713.64	839.52

[All other zip codes]

	A-3146	A-4079		A-4028	
All Ages 65+	Plan A	Plan D		Plan HDF	
		Preferred	Standard	Preferred	Standard
APP	129.17	123.69	145.52	56.76	66.78
Monthly	134.85	129.13	151.92	59.26	69.72
Quarterly	387.51	371.07	436.56	170.28	200.34
Semiannual	775.02	742.14	873.12	340.56	400.68
Annual	1,550.04	1,484.28	1,746.24	681.12	801.36

# American Republic Insurance Company

National Headquarters, Des Moines, Iowa 50309

## PLAN A

### Medicare (Part A) Hospital Services Per Benefit Period<sup>1</sup>

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY <sup>2</sup>
<b>HOSPITALIZATION<sup>1</sup></b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,024] (Part A Deductible) All but [\$256] a day All but [\$512] a day \$0 \$0	\$0 [\$256] a day [\$512] a day 100% of Medicare eligible expenses \$0	[\$ 1,024] \$0 \$0 \$0 <sup>3</sup> All costs
<b>SKILLED NURSING FACILITY CARE<sup>1</sup></b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$128] a day \$0	\$0 \$0 \$0	\$0 Up to [\$128] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>1</sup> 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.

<sup>2</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

<sup>3</sup> 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 for Medicare-covered items or services.

**PLAN A (continued)**

**Medicare (Part B) - Medical Services - Per Calendar Year**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN A PAYS</b>	<b>YOU PAY<sup>2</sup></b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> 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 <sup>1</sup> (Part B Deductible) Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$0 \$0 [\$135] (Part B Deductible)
<b>PART B EXCESS CHARGES (Above Medicare-approved amounts)</b>	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare-approved amounts <sup>1</sup> (Part B Deductible) Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Medicare (Parts A and B) Hospital and Medical Services**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY<sup>2</sup></b>
<b>HOME HEALTH CARE- MEDICARE-APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul> First [\$135] of Medicare-approved amounts <sup>1</sup> Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$0 \$0 [\$135] (Part B Deductible)

<sup>1</sup> Once you have been billed [\$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

<sup>2</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

## PLAN D

### Medicare (Part A) - Hospital Services - Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY <sup>2</sup>
<b>HOSPITALIZATION<sup>1</sup></b> Semiprivate room and board, general nursing and miscellaneous services and supplies  First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,024] All but [\$256] a day All but [\$512] a day \$0 \$0	[\$1,024] (Part A Deductible) [\$256] a day [\$512] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0 <sup>3</sup> All costs
<b>SKILLED NURSING FACILITY CARE<sup>1</sup></b> 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 21st thru 100th day 101st day and after	All approved amounts All but [\$128] a day \$0	\$0 Up to [\$128] a day \$0	\$0 \$0 All costs
<b>BLOOD</b>  First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b>  Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>1</sup> 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.

<sup>2</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

<sup>3</sup> 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 for Medicare covered items or services.

**PLAN D (continued)**

**Medicare (Part B) - Medical Services - Per Calendar Year**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY<sup>2</sup></b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> 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 <sup>1</sup> Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$135] (Part B Deductible) \$0
<b>PART B EXCESS CHARGES (Above Medicare-approved amounts)</b>	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare-approved amounts <sup>1</sup> Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$135] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Parts A and B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY<sup>2</sup></b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul> First [\$135] of Medicare-approved amounts <sup>1</sup> Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$135] (Part B Deductible) \$0
<b>AT-HOME RECOVERY SERVICES— NOT COVERED BY MEDICARE</b> 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 <ul style="list-style-type: none"> <li>• Benefit for each visit</li> <li>• Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)</li> <li>• Calendar year maximum</li> </ul>	\$0 \$0 \$0	Actual charges to [\$40] a visit Up to the number of Medicare Approved visits, not to exceed 7 each week [\$1,600]	Balance

<sup>1</sup> Once you have been billed [\$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

<sup>2</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

PLAN D (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY <sup>1</sup>
<p>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</p> <p>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <p>First [\$250] each calendar year</p> <p>Remainder of charges</p>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% of a lifetime maximum benefit of [\$50,000]</p>	<p>[\$250]</p> <p>20% and amounts over the [\$50,000] lifetime maximum</p>

<sup>1</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

## HIGH DEDUCTIBLE PLAN F

### Medicare (Part A) - Hospital Services - Per Benefit Period

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1,900] DEDUCTIBLE, <sup>2</sup> PLAN PAYS	IN ADDITION TO [\$1,900] DEDUCTIBLE, <sup>2</sup> YOU PAY <sup>3</sup>
<b>HOSPITALIZATION<sup>1</sup></b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,024]	[\$1,024] (Part A Deductible)	\$0
61st thru 90th day	All but [\$251] a day	[\$251] a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but [\$512] a day	[\$512] a day	\$0
• Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare eligible expenses	\$0 <sup>4</sup>
• Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE<sup>1</sup></b> 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	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$128] a day	Up to [\$128] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

<sup>1</sup> 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.

<sup>2</sup> This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1,900] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible..

<sup>3</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

<sup>4</sup> 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 for Medicare covered items or services.

**HIGH DEDUCTIBLE PLAN F (continued)**  
**Medicare (Part B) - Medical Services - Per Calendar Year**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1,900 ] DEDUCTIBLE, <sup>2</sup> PLAN PAYS	IN ADDITION TO [\$1,900] DEDUCTIBLE, <sup>2</sup> YOU PAY <sup>3</sup>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> 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 <sup>1</sup> Remainder of Medicare-approved amounts	\$0  Generally 80%	[\$135] (Part B Deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES (Above Medicare-approved amounts)</b>	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare-approved amounts <sup>1</sup> Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs [\$135] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Parts A and B**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1,900 ] DEDUCTIBLE, <sup>2</sup> PLAN PAYS	IN ADDITION TO [\$1,900] DEDUCTIBLE, <sup>2</sup> YOU PAY <sup>3</sup>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul> First [\$135] of Medicare-approved amounts <sup>1</sup> Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  [\$135] (Part B Deductible) 20%	\$0  \$0 \$0

<sup>1</sup> Once you have been billed [\$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

<sup>2</sup> This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1,900] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

<sup>3</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

**HIGH DEDUCTIBLE PLAN F (continued)**  
**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1,900] DEDUCTIBLE, <sup>2</sup> PLAN PAYS	IN ADDITION TO [\$1,900] DEDUCTIBLE, <sup>1</sup> YOU PAY <sup>2</sup>
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> 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	\$0 \$0	\$0 80% of a lifetime maximum benefit of [\$50,000]	[\$250] 20% and amounts over the [\$50,000] lifetime maximum

<sup>1</sup> This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1,900] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

<sup>2</sup> \$0 indicates your liability for covered charges. You are responsible for all other noncovered charges.