

SERFF Tracking Number: NSIC-126371030 State: Arkansas
Filing Company: National States Insurance Company State Tracking Number: 43978
Company Tracking Number: MSOC-2010
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
Standard Plans
Product Name: Medicare Supplement Outlines - 2010
Project Name/Number: Medicare Supplement Outlines - 2010/OC-ASM-1(2010)

Filing at a Glance

Company: National States Insurance Company

Product Name: Medicare Supplement Outlines -SERFF Tr Num: NSIC-126371030 State: Arkansas
2010

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed-Approved- State Tr Num: 43978
Standard Plans Closed

Sub-TOI: MS051.001 Plan A Co Tr Num: MSOC-2010 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Stephanie Fowler

Authors: William Morrison, Disposition Date: 12/01/2009

Anastacia Behrens, Jackie Phillips

Date Submitted: 11/04/2009 Disposition Status: Approved-
Closed

Implementation Date Requested: 01/01/2010

State Filing Description:

Implementation Date:

General Information

Project Name: Medicare Supplement Outlines - 2010

Project Number: OC-ASM-1(2010)

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Missouri does not require the annual filing of the outline of coverage when the only change is the Medicare deductibles.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/01/2009

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 12/01/2009

Deemer Date:

Submitted By: Anastacia Behrens

Filing Description:

Created By: Anastacia Behrens

Corresponding Filing Tracking Number:

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

The outlines of coverage were previously approved in 2009, but they have been updated to reflect the new Medicare

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deductible amounts.

We have bracketed all the amounts in the charts that are subject to change, based on Medicare's determination. We have also bracketed the premiums, which may change, but only after formal approval by the Department.

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] 202 [Ext]
 Ste. 100 314-878-8118 [FAX]
 St. Louis, MO 63146

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 Group Name: State ID Number:
 St. Louis, MO 63146 FEIN Number: 43-0825796
 (314) 878-0101 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$120.00
 Retaliatory? No
 Fee Explanation: 6 forms at \$20 each. Missouri does not require the annual filing of these forms.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National States Insurance Company	\$120.00	11/04/2009	31792759

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/01/2009	12/01/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Plan A Outline of Coverage	Anastacia Behrens	11/05/2009	11/05/2009
Form	Plan B Outline of Coverage	Anastacia Behrens	11/05/2009	11/05/2009
Form	Plan D Outline of Coverage	Anastacia Behrens	11/05/2009	11/05/2009
Form	Plan F Outline of Coverage	Anastacia Behrens	11/05/2009	11/05/2009
Form	Plan J Outline of Coverage	Anastacia Behrens	11/05/2009	11/05/2009

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Disposition

Disposition Date: 12/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form (revised)	Plan A Outline of Coverage	Approved	Yes
Form	Plan A Outline of Coverage	Replaced	Yes
Form (revised)	Plan B Outline of Coverage	Approved	Yes
Form	Plan B Outline of Coverage	Replaced	Yes
Form (revised)	Plan D Outline of Coverage	Approved	Yes
Form	Plan D Outline of Coverage	Replaced	Yes
Form (revised)	Plan F Outline of Coverage	Approved	Yes
Form	Plan F Outline of Coverage	Replaced	Yes
Form (revised)	Plan J Outline of Coverage	Approved	Yes
Form	Plan J Outline of Coverage	Replaced	Yes
Form	Coverpage for Outlines	Approved	Yes

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Amendment Letter

Submitted Date: 11/05/2009

Comments:

After submitting the filing, I realized that I forwarded the incorrect forms for your review and approval.

I have corrected the form numbers and uploaded the correct versions of the outlines of coverage used in Arkansas to the Form Schedule tab for your review and approval.

I am sorry for any inconvenience that this may have caused.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
OC-ASM-3(2010)	Outline of Coverage	Plan A Outline of Coverage	Initial					OC-ASM-3(2010).pdf
OC-BSM-3(2010)	Outline of Coverage	Plan B Outline of Coverage	Initial					OC-BSM-3(2010).pdf
OC-DSM-3(2010)	Outline of Coverage	Plan D Outline of Coverage	Initial					OC-DSM-3(2010).pdf
OC-FSM-3(2010)	Outline of Coverage	Plan F Outline of Coverage	Initial					OC-FSM-3(2010).pdf
OC-JSM-3(2010)	Outline of Coverage	Plan J Outline of Coverage	Initial					OC-JSM-3(2010).pdf

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Form Schedule

Lead Form Number: OC-ASM-1(2010)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/01/2009	OC-ASM-3(2010)	Outline of Coverage	Plan A Outline of Coverage	Initial			OC-ASM-3(2010).pdf
Approved 12/01/2009	OC-BSM-3(2010)	Outline of Coverage	Plan B Outline of Coverage	Initial			OC-BSM-3(2010).pdf
Approved 12/01/2009	OC-DSM-3(2010)	Outline of Coverage	Plan D Outline of Coverage	Initial			OC-DSM-3(2010).pdf
Approved 12/01/2009	OC-FSM-3(2010)	Outline of Coverage	Plan F Outline of Coverage	Initial			OC-FSM-3(2010).pdf
Approved 12/01/2009	OC-JSM-3(2010)	Outline of Coverage	Plan J Outline of Coverage	Initial			OC-JSM-3(2010).pdf
Approved 12/01/2009	COVERPA GE(2010)	Outline of Coverage	Coverpage for Outlines	Initial			COVERPAGE (2010) (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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	\$0 [\$275] a day [\$550] a day 100% of Medicare eligible expenses \$0	[\$1,100] (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 [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (Part B Deductible) \$0
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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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (Part B Deductible) \$0
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NATIONAL STATES INSURANCE COMPANY

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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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (Part B Deductible) \$0
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	\$0	Actual charges to \$40 a visit	Balance
-Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
-Calendar year maximum	\$0	\$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

NATIONAL STATES INSURANCE COMPANY

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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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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

NATIONAL STATES INSURANCE COMPANY

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PLAN J

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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 Up to [\$137.50] 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 J

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

*Once you have been billed [\$155] 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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 and medical supplies	100%	\$0	\$0
-Durable medical equipment First [\$155] of Medicare approved amounts*	\$0	[\$155] (Part B Deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
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	\$0	Actual charges to \$40 a visit	Balance
-Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
-Calendar year maximum	\$0	\$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	\$0 \$0	\$120 \$0	\$0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

BENEFIT PLANS A, B, D, F and J 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

*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.

NATIONAL STATES INSURANCE COMPANY - 1830 CRAIG PARK COURT, ST. LOUIS, MISSOURI 63146
 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	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, D - ALL AGES**

	ANNUAL	SEMI--ANNUAL	QUARTERLY	MONTHLY
PLAN A				
	ZIP REGION: 722, 723			
NON-TOBACCO	[\$1,230.00	\$639.60	\$325.95	\$103.32]
TOBACCO	[\$1,476.00	\$767.52	\$391.14	\$123.98]
	ZIP REGION: 727			
NON-TOBACCO	[\$1,107.00	\$575.64	\$293.36	\$92.99]
TOBACCO	[\$1,328.00	\$690.56	\$351.92	\$111.55]
	ZIP REGION: 716-721, 724-726, 728-729			
NON-TOBACCO	[\$984.00	\$511.68	\$260.76	\$82.66]
TOBACCO	[\$1,181.00	\$614.12	\$312.97	\$99.20]
PLAN B				
	ZIP REGION: 722, 723			
NON-TOBACCO	[\$1,553.00	\$807.56	\$411.55	\$130.45]
TOBACCO	[\$1,864.00	\$969.28	\$493.96	\$156.58]
	ZIP REGION: 727			
NON-TOBACCO	[\$1,398.00	\$726.96	\$370.47	\$117.43]
TOBACCO	[\$1,678.00	\$872.56	\$444.67	\$140.95]
	ZIP REGION: 716-721, 724-726, 728-729			
NON-TOBACCO	[\$1,242.00	\$645.84	\$329.13	\$104.33]
TOBACCO	[\$1,491.00	\$775.32	\$395.12	\$125.24]
PLAN D				
	ZIP REGION: 722, 723			
NON-TOBACCO	[\$1,568.00	\$815.36	\$415.52	\$131.71]
TOBACCO	[\$1,882.00	\$978.64	\$498.73	\$158.09]
	ZIP REGION: 727			
NON-TOBACCO	[\$1,411.00	\$733.72	\$373.92	\$118.52]
TOBACCO	[\$1,694.00	\$880.88	\$448.91	\$142.30]
	ZIP REGION: 716-721, 724-726, 728-729			
NON-TOBACCO	[\$1,254.00	\$652.08	\$332.31	\$105.34]
TOBACCO	[\$1,506.00	\$783.12	\$399.09	\$126.50]

**PREMIUM RATES FOR NATIONAL STATES
PLANS F and J - ALL AGES**

	ANNUAL	SEMI--ANNUAL	QUARTERLY	MONTHLY
PLAN F				
ZIP REGION: 722, 723				
NON-TOBACCO	[\$1,694.00	\$880.88	\$448.91	\$142.30]
TOBACCO	[\$2,033.00	\$1,057.16	\$538.75	\$170.77]
ZIP REGION: 727				
NON-TOBACCO	[\$1,525.00	\$793.00	\$404.13	\$128.10]
TOBACCO	[\$1,830.00	\$951.60	\$484.95	\$153.72]
ZIP REGION: 716-721, 724-726, 728-729				
NON-TOBACCO	[\$1,355.00	\$704.60	\$359.08	\$113.82]
TOBACCO	[\$1,626.00	\$845.52	\$430.89	\$136.58]
PLAN J				
ZIP REGION: 722, 723				
NON-TOBACCO	[\$1,729.00	\$899.08	\$458.19	\$145.24]
TOBACCO	[\$2,075.00	\$1,079.00	\$549.88	\$174.30]
ZIP REGION: 727				
NON-TOBACCO	[\$1,556.00	\$809.12	\$412.34	\$130.70]
TOBACCO	[\$1,868.00	\$971.36	\$495.02	\$156.91]
ZIP REGION: 716-721, 724-726, 728-729				
NON-TOBACCO	[\$1,383.00	\$719.16	\$366.50	\$116.17]
TOBACCO	[\$1,660.00	\$863.20	\$439.90	\$139.44]

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.

SERFF Tracking Number: NSIC-126371030 State: Arkansas
 Filing Company: National States Insurance Company State Tracking Number: 43978
 Company Tracking Number: MSOC-2010
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
 Standard Plans
 Product Name: Medicare Supplement Outlines - 2010
 Project Name/Number: Medicare Supplement Outlines - 2010/OC-ASM-1(2010)

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification		
Bypass Reason: N/A to this filing.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: N/A to this filing.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification		
Bypass Reason: N/A to this filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage		
Comments:		
Outlines for the Medicare Supplement plans we are currently offering are included in the Form Schedule tab.		

SERFF Tracking Number: NSIC-126371030 State: Arkansas
 Filing Company: National States Insurance Company State Tracking Number: 43978
 Company Tracking Number: MSOC-2010
 TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
 Standard Plans
 Product Name: Medicare Supplement Outlines - 2010
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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/04/2009	Form	Plan D Outline of Coverage	11/05/2009	OC-DSM-1(2010).pdf (Superseded)
11/04/2009	Form	Plan F Outline of Coverage	11/05/2009	OC-FSM-1(2010).pdf (Superseded)
11/04/2009	Form	Plan J Outline of Coverage	11/05/2009	OC-JSM-2(2010).pdf (Superseded)
11/04/2009	Form	Plan A Outline of Coverage	11/05/2009	OC-ASM-1(2010).pdf (Superseded)
11/04/2009	Form	Plan B Outline of Coverage	11/05/2009	OC-BSM-1(2010).pdf (Superseded)

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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (Part B Deductible) \$0
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	\$0	Actual charges to \$40 a visit	Balance
-Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
-Calendar year maximum	\$0	\$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

NATIONAL STATES INSURANCE COMPANY

1830 Craig Park Court, St. Louis, Missouri 63146

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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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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

NATIONAL STATES INSURANCE COMPANY

1830 Craig Park Court, St. Louis, Missouri 63146

314-878-0101

PLAN J

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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 Up to [\$137.50] 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 J

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

*Once you have been billed [\$155] 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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 [\$155] of Medicare approved amounts*	\$0	[\$155] (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 and medical supplies	100%	\$0	\$0
-Durable medical equipment First [\$155] of Medicare approved amounts*	\$0	[\$155] (Part B Deductible)	\$0
Remainder of Medicare approved amounts	80%	20%	\$0
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	\$0	Actual charges to \$40 a visit	Balance
-Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
-Calendar year maximum	\$0	\$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges	\$0 \$0	\$120 \$0	\$0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

NATIONAL STATES INSURANCE COMPANY

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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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	\$0 [\$275] a day [\$550] a day 100% of Medicare eligible expenses \$0	[\$1,100] (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 [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (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 [\$1,100] All but [\$275] a day All but [\$550] a day \$0 \$0	[\$1,100] (Part A Deductible) [\$275] a day [\$550] 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 [\$137.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$137.50] 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 [\$155] 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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$155] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (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 [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$155] (Part B Deductible) \$0
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