

SERFF Tracking Number: AMRP-126211046 State: Arkansas
Filing Company: American Republic Corp Insurance Company State Tracking Number: 42835
Company Tracking Number: 2010 MED SUPP AR CORP - PLAN A
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: 2010 Med Supp AR Corp - Plan A
Project Name/Number: 2010 Med Supp AR Corp - Plan A/2010 Med Supp AR Corp - Plan A

Filing at a Glance

Company: American Republic Corp Insurance Company

Product Name: 2010 Med Supp AR Corp - Plan SERFF Tr Num: AMRP-126211046 State: ArkansasLH

A

TOI: MS08I Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 42835
Standard Plans 2010

Sub-TOI: MS08I.001 Plan A 2010

Co Tr Num: 2010 MED SUPP AR State Status: Approved-Closed
CORP - PLAN A

Filing Type: Form/Rate

Co Status: Reviewer(s): Stephanie Fowler

Authors: Norm Von Seggern, Susan Disposition Date: 08/06/2009

Falk, Sarah Shives, Jamie Mueller,

Michele Kulish, Kerry Reidburn,

Colletta Maddy

Date Submitted: 07/01/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 Med Supp AR Corp - Plan A

Project Number: 2010 Med Supp AR Corp - Plan A

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/06/2009

Deemer Date:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/06/2009

Corresponding Filing Tracking Number: AMRP-126211350, AMRP-126211392, AMRP-126211407

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Filing Description:

Please see Cover Letter under the Supporting Documentations tab.

Company and Contact

Filing Contact Information

Sarah Shives, sarah.shives@americanenterprise.com
 601 6th Ave. (515) 245-2083 [Phone]
 Des Moines, IA 50309

Filing Company Information

American Republic Corp Insurance Company CoCode: 67679 State of Domicile: Nebraska
 P O Box 2780 Group Code: 3527 Company Type: Life and Health
 Omaha, NE 68103-2780 Group Name: American Enterprise State ID Number:
 (800) 987-8988 ext. [Phone] FEIN Number: 23-1609793

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: \$50 for policy form + \$50 for rates= \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Republic Corp Insurance Company	\$100.00	07/01/2009	28916415

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/06/2009	08/06/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	08/04/2009	08/04/2009	Sarah Shives	08/06/2009	08/06/2009

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Disposition

Disposition Date: 08/06/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document (revised)	Outline of Coverage	Approved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Supporting Document	Cover Letter	Accepted for Informational Purposes	Yes
Form (revised)	Plan A	Approved	Yes
Form	Replacement Form	Approved	Yes
Form	Plan A	Disapproved	Yes
Form	Outline of Coverage	Approved	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/04/2009
Submitted Date 08/04/2009
Respond By Date 09/04/2009

Dear Sarah Shives,

This will acknowledge receipt of the captioned filing.

Objection 1

- Outline of Coverage (Supporting Document)
- Plan A (Form)

Comment: Please remove "We may change the premiums on your policy from time to time." This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

Objection 2

- Plan A (Form)

Comment: AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." Please remove the "attained age" language from this filing.

Objection 3

- Plan A (Form)

Comment: Not an objection, just a note...page 4 - "Benefit Period" is not totally bolded.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/06/2009
Submitted Date 08/06/2009

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Dear Stephanie Fowler,

Comments:

Thank you for reviewing this filing and bringing these issues to my attention.

Response 1

Comments: I have corrected the typographical error in bolder of the term "Benefit Period."

Related Objection 1

Applies To:

- Plan A (Form)

Comment:

Not an objection, just a note...page 4 - "Benefit Period" is not totally bolded.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Plan A	A3100AC		Policy/Contract/Fraternal Certificate	Initial		61	A3100AC-AR - Plan A 8-6.pdf
Previous Version Plan A	A3100AC		Policy/Contract/Fraternal Certificate	Initial		61	A3100AC - Plan A.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: I have removed the requested sentence from both the Policy language and the Outline of Coverage as requested.

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Related Objection 1

Applies To:

- Outline of Coverage (Supporting Document)
- Plan A (Form)

Comment:

Please remove "We may change the premiums on your policy from time to time." This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Outline of Coverage

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Plan A	A3100AC		Policy/Contract/Fraternal Certificate	Initial		61	A3100AC-AR - Plan A 8-6.pdf
Previous Version							
Plan A	A3100AC		Policy/Contract/Fraternal Certificate	Initial		61	A3100AC - Plan A.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: I have removed the sentence on page 1 of the policy that mentioned attained age rating.

Related Objection 1

Applies To:

- Plan A (Form)

Comment:

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AR Code Ann. 23-79-109(a)(4) states, "all Medicare supplement rates shall be based on a composite age basis only, and shall not be based on any age banding or other groupings." Please remove the "attained age" language from this filing.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Plan A	A3100AC		Policy/Contract/Fraternal Certificate	Initial		61	A3100AC-AR - Plan A 8-6.pdf
Previous Version							
Plan A	A3100AC		Policy/Contract/Fraternal Certificate	Initial		61	A3100AC - Plan A.pdf

No Rate/Rule Schedule items changed.

Thank you for bringing these items to my attention. Please feel free to contact me if you have any further questions. You may contact me at 800-247-2190 ext. 2083.

Sincerely,

Colletta Maddy, Jamie Mueller, Kerry Reidburn, Michele Kulish, Norm Von Seggern, Sarah Shives, Susan Falk

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Form Schedule

Lead Form Number: A3100AC

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	A3100AC	Policy/Cont	Plan A ract/Fratern al Certificate	Initial		61	A3100AC-AR - Plan A 8- 6.pdf
Approved	M3100AC	Other	Replacement Form	Initial		47	M3100AC (12-113-0894- XXXX- US).pdf
Approved	U3100ACAR	Outline of Coverage	Outline of Coverage	Initial		58	12-114-2758- XXXX AR (U3100ACAR)pdf

Medicare Supplement Policy – Benefit Plan A
Benefits Provided by this Policy Are Subject to Changes Made in Medicare.

We have issued this policy based on: (a) your application for it; and (b) your payment of the first premium on or before the Policy Date. The first premium and the Policy Date are shown on Schedule of Benefits.

Read your Policy Carefully! This policy is a legal document between you and us.

Part A – 30-Day Right to Examine Policy

Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

Part B – Guaranteed Renewable; Premiums Subject to Change

We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may not change the premiums unless we do so on all policies of this form issued to persons of your class. We will notify you of the new premium at least 31 days before the first premium due date after which the changes take effect.

Medicare Changes – The benefits of your policy change when the Medicare deductibles and copayment amounts you are required to pay are changed. We may also change the premiums (with state insurance department approval) when the benefits change.

The provisions on the following pages are part of this policy.

In witness whereof, American Republic Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

[  
President Secretary Countersignature]

Notice to Buyer – This Policy may not cover all of your Medical Expenses.

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Schedule of Benefits

COVERED PERSON (S):

[John A. Doe, age 65, the Insured]

POLICY NUMBER: [12345678]

DATE OF ISSUE: [JANUARY 1, 2010]

FIRST RENEWAL DATE: [varies, based on premium mode selected]

INITIAL PREMIUM AND FEES (if applicable): \$ [#####]

FORM NUMBER(S):

POLICY NUMBER:

POLICY DATE:

FIRST POLICY ANNIVERSARY:

COVERED PERSONS:

INSURED [John A. Doe] ISSUE AGE: [-age 65]

COVERED SPOUSE [Jane B. Doe] ISSUE AGE: [65]

PREMIUMS:

FIRST PREMIUM PAID: \$ [XXX.XX]

PREMIUM FREQUENCY: [Monthly, Quarterly, Semi-Annually, Annually]

CLASSIFICATION: [John A. Doe] [Standard, Preferred]
[Jane B. Doe] [Standard, Preferred]

Part C – Definitions

Some words used in your policy have a special meaning. We have defined them below. Also, the words “we,” “our” and “us” refer to American Republic Corp Insurance Company. The words “you” and “your” refer to the insured person named on the Schedule of Benefits.

“**Age**” means your age on your last birthday.

A “**Benefit Period**” starts the first time a covered person enters a hospital on or after the Policy Date. A new benefit period starts the next time that covered person enters a hospital after being out of a hospital and skilled nursing facility for at least 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods allowed.

A “**Calendar Year**” begins January 1 and ends December 31 each year.

“**Class**” means the factors that went into making up the premium rate when coverage was issued. In addition to the plan of insurance, those factors include age and geographic region.

“**Covered Person(s)**” means you and/or your covered spouse as approved by us, or added to coverage by endorsement, provided coverage has not been terminated.

“**Covered Spouse**” means your lawful spouse, as named in the application and approved by us, or as added to coverage by endorsement, provided coverage has not been terminated.

“**Hospice Care**” means treatment in a hospice program as defined by Medicare.

“**Hospital**” means an institution which meets Medicare’s definition of a hospital.

“**Injury**” means accidental bodily injury which occurs while this policy is in force.

“**Loss**” means the Medicare eligible expenses incurred by a covered person resulting from a covered sickness or injury.

“**Medicaid**” means the “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as amended.

“**Medicare**” means Title XVIII (Health Insurance for the Aged) of the Social Security Act as added by the Social Security Amendments of 1965 as then constituted or later amended.

“**Medicare Eligible Expenses**” shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

“**Physician**” is a physician meeting Medicare’s definition of physician.

“**Respite Care**” is treatment that meets Medicare’s definition of respite care.

“**Sickness**” means a condition, a state of ill health, or an illness, first manifested by a covered person while this policy is in force.

Part D – Benefits

We will pay benefits for the following items of expense a covered person incurs and that are approved but not paid for by Medicare Parts A and B. In determining benefits to be paid, we will consider the covered person to be enrolled in and eligible for Medicare Parts A and B. Medicare eligible expenses must be incurred during the benefit period while this policy is in force.

Basic (Core) Plan Benefits

- a. Medicare Part A Hospital Services and Supplies Expenses
 1. Part A Medicare eligible expenses for hospitalization from the 61st through the 90th day in any Medicare benefit period;
 2. Part A Medicare eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used; and
 3. When all Medicare hospital inpatient coverage and lifetime reserve days are used up, we will pay 100% of the Part A Medicare eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the covered person for any balance.
- b. Medicare Part A and Part B Blood Deductibles – Coverage under Medicare Parts A and B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.
- c. Medicare Part B Medical Insurance – After the Medicare Part B Deductible, we will pay the Medicare Part B coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) for eligible expenses approved but not paid for by Medicare.
- d. Hospice Care – We will provide coverage of cost sharing (Medicare copayment or coinsurance amounts) for all Part A Medicare eligible expenses for hospice care and respite care. In order to receive this benefit, you must meet Medicare's requirements including a physician's certification of terminal illness.

Part E – Benefit Changes

Benefits will change automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors.

Part F – Benefit Extensions

Termination of coverage shall be without prejudice to a continuous loss which commenced while this policy was in force. Extension of benefits beyond the period this policy was in force is:

- a. subject to the covered person's continuous total disability;
- b. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
- c. limited to the duration benefits would have been paid had this policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Part G - Exclusions

We will not pay benefits for:

- a. services for which a charge is normally not made when there is no insurance;
- b. expense incurred before the Policy Date; or
- c. that portion of expense incurred which is paid for by Medicare.

Part H – Premium Provisions

Premium Payment – The premium must be paid on or before the date it is due or during the grace period.

Grace Period – The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

Lapse – This policy will go out of force if the premium is not paid by the end of the grace period.

Reinstatement – If this policy should lapse, we, or an agent we specifically authorize to accept premiums, may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other rights of ours or yours will be the same as they were before this policy lapsed. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid.

Suspension and Reinstitution of Coverage

Suspension of Coverage

Eligibility for Medicaid – Benefits and premiums under this policy shall be suspended at a covered person's request for a period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). The covered person must notify us within 90 days after becoming entitled to such assistance. Upon receipt of timely notice, we will return that portion of the premium for the period of time the covered person is eligible for Medicaid. The refunded premiums will be reduced by the amount of claims paid for the period the covered person is eligible.

Group Health Plan – Benefits and premiums under this policy shall be suspended, at a covered person's request, (for any period that may be provided by federal regulation) if the covered person is entitled to benefits under section 226(b) of the Social Security Act as amended; and covered under a group health plan (as defined in section 1862(b) (1) (A) (v) of the Social Security Act, as amended).

Reinstitution

If a covered person loses entitlement to medical assistance (Medicaid) during a period of suspension, this policy will be automatically reinstated. This will be effective the date of termination of the entitlement. The covered person must provide us with notice of the loss of the entitlement within 90 days after the date of the loss and pay the premium attributed to the period effective as of the date of termination of entitlement. Upon reinstatement:

- a. there will be no additional waiting period with respect to treatment of preexisting conditions;
- b. coverage will be substantially equivalent to coverage in effect before the date of the suspension; and
- c. premiums will be classified on terms that are at least as favorable to the covered person as the premium classification terms that would have applied to the covered person had the coverage not been suspended.

Part I – How Your Covered Spouse May Convert to His/Her Own Policy

If you and your spouse get divorced from each other, you may both continue your insurance. Either you or your covered spouse may obtain a separate policy without having to provide us evidence of insurability. The request for the new policy must be made within 31 days after you or your spouse are removed from the coverage of this policy. The new policy will be effective on the date coverage ended under this policy. We will not issue a new policy to anyone who is not a permanent resident of the United States.

Part J – How to File a Claim

Notice of Claim – We must be notified of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may provide us with the notice, or you can have someone provide it for you. The notice should include your name and either your policy number or identification number. The notice should be sent to us at: American Republic Corp Insurance Company, [P.O. Box 2780, Omaha, Nebraska 68103-2780], or to any of our agents.

Claim Forms – When we receive your notice of claim for benefits, we will send you any necessary forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of claim if you notify us in writing about the expenses for which you are making a claim for benefits within 90 days after the expenses are incurred.

Proof of Your Claim – We must have proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be provided to us within 1 year after the time proof is otherwise required, unless you are not legally competent to act.

Part K – Payment of Claims Provision

Payment of Claims – Benefits are paid to the covered person. Any benefits unpaid at the covered person's death we may pay to their beneficiary (if one is named); otherwise, we may pay them to the covered person's estate. We may also pay up to \$1,000 of unpaid benefits to any of the covered person's relatives we deem properly qualified to receive them. We will be discharged of liability for payments we make in good faith to the covered person's relatives.

Time of Payment of Claims – All benefits due are paid as soon as we receive the covered person's proper written proof of loss.

Subrogation – To the extent allowed by law, we will be subrogated to all rights of recovery that a covered person may have against another party or insurer (including an uninsured or underinsured motorist carrier or workers' compensation) for all benefits paid by us that were incurred by the covered person as a result of acts or omissions of a third party for which a third party or insurer is or may be responsible to the covered person. Medicare claims or liens take priority over our subrogation rights. However, following Medicare, our right to repayment shall be a first priority lien against any recovery by the covered person and is to be paid regardless of whether the covered person is fully compensated. Our right to repayment is enforceable regardless of whether the recovery is by judgment, settlement or otherwise, and regardless of how the recovery proceeds are allocated. The amount of any repayment will be no more than the total amount of benefits we paid to the covered person, but no more than the amount paid by the other party. No attorney fees may be deducted, unless prior written approval is obtained from us. The covered person agrees to provide us with all necessary and requested information, and to complete all documents required by us to assist us in the enforcement of our right of subrogation recovery.

Part L – General Provisions

Entire Contract; Changes – This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of ours may make a change and the change must appear in writing as a part of this policy.

Time Limit on Certain Defenses – Unless based on fraudulent misstatement by you on the application, we will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the Policy Date because of misstatements.

Physical Examination – We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require.

Legal Action – Before you can bring a legal action to recover under this policy, you must wait for at least 60 days after you have given us due proof, in writing, of the particular claim for benefits. Any legal action under this section must be brought by you within three years of the date we receive your proof of the claim on which you intend to pursue the legal action.

Other Insurance With Us – The insurance in force at any one time on a covered person under a policy or policies with us specifically supplementing any part of Medicare (Part A and/or Part B) will be limited to the policy with the greatest benefit. The premium for any such excess insurance will be returned.

Conformity With State Law – If this policy does not comply with the laws of the state where you live on the Policy Date shown on the Schedule of Benefits, we will treat it as if it had been amended to comply.

Misstatement of Age – If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

Premium Refund at Death – If the covered person dies while this policy is in force, we will refund part of your premium. The refund will be the unused premium beginning with the first policy month after the covered person's date of death.

Change of Beneficiary – The covered person may change the beneficiary at any time by providing us written notice. The covered person does not need the consent of the beneficiary to make this or any other change, unless the covered person has made a designation that cannot be changed.

Assignment – If the covered person assigned the benefits to someone else, we will pay them to the assignee instead of to the covered person, the covered person's beneficiary, or the covered person's estate. We will not be bound to an assignment until we receive a valid written assignment.

Annual Meeting Information – The annual meeting of the members of American Enterprise Mutual Holding Company will be held at the mutual holding company's principal office at nine o'clock a.m. on the first Tuesday in March of each year. Each such meeting will be for the purpose of electing a director or directors and transacting any other business properly coming before the annual meeting. At every annual meeting, each member of the mutual holding company who is a member as of the record date fixed by the board of directors which record date shall not be more than 90 days prior to the date of the meeting, shall have one vote upon any proposition coming before such meeting, which vote may only be cast in person or by ballot furnished by the mutual holding company. In order to vote by ballot, a member as of the record date must request a ballot from the Secretary of the mutual holding company at least 15 days prior to the annual meeting.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage to be issued by American Republic Corp Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT/BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (✓ one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other. (please specify)

1. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
2. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Date

MM / DD YYYY

Signature of Agent, Broker or Other Representative

Applicant's Signature

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage to be issued by American Republic Corp Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT/BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (✓ one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

Other. (please specify)

1. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
2. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Date

MM / DD YYYY

Signature of Agent, Broker or Other Representative

Applicant's Signature

American Republic Corp Insurance Company / National Headquarters, Des Moines, Iowa 50309

Outline of Medicare Supplement Coverage - Benefit Plans A, F, K & L

This chart shows 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.

BASIC BENEFITS included in A, B, C, D, F, F*, G, M and N. **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. **Medical Expenses:** Part B coinsurance (20% of Medicare approved expenses, or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments). **Blood:** First 3 pints of blood each year. **Hospice:** Part A coinsurance.

A	B	C	D	F	F*	G	K**	L**	M	N
Basic Benefits, including 100% Part B coinsurance	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 75%	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for Emergency Room						
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance				
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
		Part B Deductible		Part B Deductible						
				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
							Out-of-pocket limit*** [\$4,620]; paid at 100% after limit reached	Out-of-pocket limit*** [\$2,310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$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.

**Plans K and L cost share differently than Plans A, B, C, D, F, F*, G, M or N. 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.

PREMIUM INFORMATION

We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may change the premiums on your policy from time to time. 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 your state. No premium change may be made on an individual basis. We will notify you of the new premium at least 31 days before the next due date. You have a 31-day grace period to pay your premium. Please refer to the attached rate schedule.

Applicant's premium at issue age _____ for each plan available on _____ is:
Date

ANNUAL PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

Spouse's premium at issue age _____ for each plan available on _____ is: (if applying)
Date

ANNUAL PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

MODE FACTORS

Monthly Direct Bill: [0.087]
Quarterly: [0.25]
Semiannual: [0.50]
Annual: [0.08334]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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

Please read this policy and the attached Application carefully. If you find that you are not satisfied with your policy, you may return it to American Republic Corp Insurance Company, P.O. Box 2780, Omaha, Nebraska 68103-2780, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid less the amount of any claims paid. If the amount of claims paid by us exceeds the amount of premiums paid by you, you shall reimburse us the difference. Then, the policy will be void from the beginning as if no policy had been issued.

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

The policy may not fully cover all of your medical costs. Neither American Republic Corp 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 the "Medicare & You" government publication 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. This paragraph does not apply to you if you are 65 or older and within 6 months of becoming eligible for Medicare. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Arkansas

Medicare Supplement Rates

Zip Codes 717, 726-729

Effective 6-1-2010

PLAN A A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	113.36	113.36	128.29	128.29	133.36	133.36	150.92	150.92
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	118.33	118.33	133.92	133.92	139.22	139.22	157.55	157.55
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	340.04	340.04	384.83	384.83	400.05	400.05	452.74	452.74
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	680.09	680.09	769.65	769.65	800.11	800.11	905.48	905.48
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,360.17	1,360.17	1,539.30	1,539.30	1,600.21	1,600.21	1,810.95	1,810.95	

Arkansas

Medicare Supplement Rates

{ Zip Codes 718, 723-725 }

{ Effective 6-1-2010 }

PLAN A								
A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	119.08	119.08	134.76	134.76	140.10	140.10	158.55	158.55
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	124.31	124.31	140.68	140.68	146.25	146.25	165.51	165.51
QUARTERLY								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
357.22	357.22	404.26	404.26	420.26	420.26	475.60	475.60	
SEMI-ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
714.44	714.44	808.52	808.52	840.51	840.51	951.21	951.21	
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,428.87	1,428.87	1,617.04	1,617.04	1,681.02	1,681.02	1,902.41	1,902.41	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN A								
A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	131.68	131.68	149.02	149.02	154.91	154.91	175.32	175.32
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	137.46	137.46	155.56	155.56	161.72	161.72	183.02	183.02
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	395.00	395.00	447.02	447.02	464.71	464.71	525.91	525.91
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	790.00	790.00	894.04	894.04	929.42	929.42	1,051.82	1,051.82
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,580.00	1,580.00	1,788.08	1,788.08	1,858.83	1,858.83	2,103.63	2,103.63	

Arkansas

Medicare Supplement Rates

Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN A A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	125.95	125.95	142.54	142.54	148.18	148.18	167.69	167.69
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	131.48	131.48	148.80	148.80	154.69	154.69	175.06	175.06
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	377.83	377.83	427.59	427.59	444.50	444.50	503.04	503.04
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	755.65	755.65	855.17	855.17	889.01	889.01	1,006.08	1,006.08
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,511.30	1,511.30	1,710.34	1,710.34	1,778.01	1,778.01	2,012.16	2,012.16	

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN F								
A3101AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
155.51	155.51	176.00	176.00	182.96	182.96	207.05	207.05	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
162.34	162.34	183.73	183.73	190.99	190.99	216.15	216.15	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
466.50	466.50	527.95	527.95	548.83	548.83	621.11	621.11	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
933.00	933.00	1,055.90	1,055.90	1,097.65	1,097.65	1,242.23	1,242.23	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,866.00	1,866.00	2,111.79	2,111.79	2,195.30	2,195.30	2,484.45	2,484.45	

Age 65 - 99

Arkansas
Medicare Supplement Rates
Zip Codes 718, 723-725

Effective 6-1-2010

PLAN F A3101AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	163.37	163.37	184.88	184.88	192.20	192.20	217.51	217.51
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	170.54	170.54	193.00	193.00	200.64	200.64	227.06	227.06
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	490.06	490.06	554.61	554.61	576.54	576.54	652.48	652.48
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	980.12	980.12	1,109.22	1,109.22	1,153.09	1,153.09	1,304.97	1,304.97
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,960.24	1,960.24	2,218.44	2,218.44	2,306.17	2,306.17	2,609.93	2,609.93	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN F								
A3101AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
180.65	180.65	204.44	204.44	212.52	212.52	240.52	240.52	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
188.58	188.58	213.42	213.42	221.86	221.86	251.08	251.08	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
541.90	541.90	613.27	613.27	637.52	637.52	721.50	721.50	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,083.79	1,083.79	1,226.55	1,226.55	1,275.05	1,275.05	1,442.99	1,442.99	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
2,167.58	2,167.58	2,453.09	2,453.09	2,550.09	2,550.09	2,885.98	2,885.98	

Age 65 - 99

Arkansas
Medicare Supplement Rates
Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN F								
A3101AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
172.79	172.79	195.55	195.55	203.28	203.28	230.06	230.06	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
180.38	180.38	204.14	204.14	212.21	212.21	240.16	240.16	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
518.34	518.34	586.61	586.61	609.81	609.81	690.13	690.13	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,036.67	1,036.67	1,173.22	1,173.22	1,219.61	1,219.61	1,380.26	1,380.26	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
2,073.34	2,073.34	2,346.43	2,346.43	2,439.22	2,439.22	2,760.51	2,760.51	

Age 65 - 99

Arkansas

Medicare Supplement Rates

Zip Codes 717, 726-729

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	80.41	80.41	91.00	91.00	94.60	94.60	107.06	107.06
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	83.94	83.94	94.99	94.99	98.75	98.75	111.76	111.76
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	241.20	241.20	272.97	272.97	283.77	283.77	321.14	321.14
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	482.41	482.41	545.95	545.95	567.54	567.54	642.29	642.29
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
964.81	964.81	1,091.89	1,091.89	1,135.07	1,135.07	1,284.57	1,284.57	

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	84.47	84.47	95.59	95.59	99.37	99.37	112.46	112.46
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	88.18	88.18	99.79	99.79	103.74	103.74	117.40	117.40
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	253.39	253.39	286.76	286.76	298.10	298.10	337.36	337.36
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	506.77	506.77	573.52	573.52	596.20	596.20	674.73	674.73
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,013.54	1,013.54	1,147.04	1,147.04	1,192.40	1,192.40	1,349.45	1,349.45	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	93.40	93.40	105.71	105.71	109.89	109.89	124.36	124.36
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	97.50	97.50	110.35	110.35	114.71	114.71	129.82	129.82
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	280.19	280.19	317.09	317.09	329.63	329.63	373.05	373.05
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	560.37	560.37	634.18	634.18	659.26	659.26	746.09	746.09
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,120.74	1,120.74	1,268.36	1,268.36	1,318.52	1,318.52	1,492.18	1,492.18	

Arkansas

Medicare Supplement Rates

Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	89.34	89.34	101.11	101.11	105.11	105.11	118.95	118.95
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	93.27	93.27	105.55	105.55	109.72	109.72	124.18	124.18
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	268.01	268.01	303.30	303.30	315.30	315.30	356.83	356.83
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	536.01	536.01	606.61	606.61	630.60	630.60	713.66	713.66
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,072.02	1,072.02	1,213.21	1,213.21	1,261.19	1,261.19	1,427.31	1,427.31	

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN L								
A3105AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
110.64	110.64	125.21	125.21	130.16	130.16	147.31	147.31	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
115.50	115.50	130.71	130.71	135.88	135.88	153.78	153.78	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
331.90	331.90	375.60	375.60	390.46	390.46	441.89	441.89	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
663.79	663.79	751.20	751.20	780.93	780.93	883.77	883.77	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,327.58	1,327.58	1,502.40	1,502.40	1,561.85	1,561.85	1,767.54	1,767.54	

Age 65 - 99

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN L A3105AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	116.23	116.23	131.53	131.53	136.74	136.74	154.75	154.75
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	121.33	121.33	137.31	137.31	142.74	142.74	161.54	161.54
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	348.66	348.66	394.57	394.57	410.19	410.19	464.20	464.20
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	697.32	697.32	789.14	789.14	820.37	820.37	928.41	928.41
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,394.63	1,394.63	1,578.28	1,578.28	1,640.74	1,640.74	1,856.81	1,856.81	

PLAN L								
A3105AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
128.52	128.52	145.45	145.45	151.20	151.20	171.11	171.11	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
134.17	134.17	151.83	151.83	157.84	157.84	178.63	178.63	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
385.54	385.54	436.31	436.31	453.57	453.57	513.30	513.30	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
771.07	771.07	872.61	872.61	907.14	907.14	1,026.60	1,026.60	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,542.14	1,542.14	1,745.22	1,745.22	1,814.27	1,814.27	2,053.20	2,053.20	

Age 65 - 99

Arkansas

Medicare Supplement Rates

Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN L A3105AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	122.93	122.93	139.12	139.12	144.63	144.63	163.67	163.67
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	128.33	128.33	145.23	145.23	150.98	150.98	170.86	170.86
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	368.77	368.77	417.34	417.34	433.85	433.85	490.98	490.98
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	737.55	737.55	834.67	834.67	867.70	867.70	981.97	981.97
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,475.09	1,475.09	1,669.34	1,669.34	1,735.39	1,735.39	1,963.93	1,963.93	

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but [\$1,068]</p> <p>All but [\$267] a day</p> <p>All but [\$534]</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>[\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare Eligible expenses</p> <p>\$0</p>	<p>[\$1,068] (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$133.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$133.50] a day</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a physician's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

* 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.

** **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 (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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* (Part B deductible) 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* (Part B deductible) 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

Medicare (Parts A and B) - Home Health Care

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • 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

* 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.

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but [\$1,068] All but [\$267] a day All but [\$534] \$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 21st thru 100th day 101st 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 You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*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.

*** **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 (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER 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

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

* 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.

PLAN F (continued)
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	\$0	\$0	\$250
Remainder of charges	\$0	80% of a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,068]	[\$534] (50% of Part A deductible)	[\$534] (50% of Part A deductible)◆
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but [\$534]	[\$534] a day	\$0
• Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare Eligible expenses	\$0***
• Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	Up to [\$66.75] a day	Up to [\$66.75] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance◆

**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.

*** **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 K (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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	\$0	[\$135] (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
BLOOD First 3 pints	\$0	50%	50%◆
Next [\$135] of Medicare Approved Amounts****	\$0	\$0	[\$135] (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [\$4,620] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** 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.

PLAN K (continued)
MEDICARE (PARTS A AND B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First [\$135] of Medicare Approved Amounts*****	\$0	\$0	[\$135] (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	10%	10%◆

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,068]	[\$808.50] (75% of Part A Deductible)	[\$267] (25% of Part A Deductible)◆
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but [\$534]	[\$534] a day	\$0
• Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
• Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50 a day]	Up to [\$100.13] a day	Up to [\$33.38] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of Medicare copayment/coinsurance◆

** 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.

*** **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 L (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	[\$135] (Part B deductible)****◆ All costs above Medicare approved amounts 5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
BLOOD First 3 pints Next [\$135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ [\$135] (Part B deductible)◆ Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [\$2,310] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** 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.

PLAN L (continued)
MEDICARE (PARTS A & B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First [\$135] of Medicare Approved Amounts*****	\$0	\$0	[\$135] (Part B deductible)♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

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

SERFF Tracking Number: AMRP-126211046 *State:* Arkansas
Filing Company: American Republic Corp Insurance Company *State Tracking Number:* 42835
Company Tracking Number: 2010 MED SUPP AR CORP - PLAN A
TOI: MS08I Individual Medicare Supplement - *Sub-TOI:* MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: 2010 Med Supp AR Corp - Plan A
Project Name/Number: 2010 Med Supp AR Corp - Plan A/2010 Med Supp AR Corp - Plan A

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: AMRP-126211046 State: Arkansas
Filing Company: American Republic Corp Insurance Company State Tracking Number: 42835
Company Tracking Number: 2010 MED SUPP AR CORP - PLAN A
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: 2010 Med Supp AR Corp - Plan A
Project Name/Number: 2010 Med Supp AR Corp - Plan A/2010 Med Supp AR Corp - Plan A

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Accepted for Informational Purposes 08/06/2009

Comments:

Attachment:

Compliance Certification - ARCIC - AR.pdf

Bypassed -Name: Application **Review Status:** Approved 08/06/2009

Bypass Reason: Application previously approved. Form C-1031 approved on 2/27/08. SERFF # AMRP-125379102.

Comments:

Satisfied -Name: Outline of Coverage **Review Status:** Approved 08/06/2009

Comments:

Attachment:

12-114-2758-XXXX AR (U3100ACAR) 8-6.pdf

Satisfied -Name: Cover Letter **Review Status:** Accepted for Informational Purposes 08/06/2009

Comments:

Attachment:

AR Corp Cover Letter Arkansas - Plan A.pdf



To: Department of Insurance

RE: Forms A3100AC (Medicare Supplement Plan A), A3101AC (Medicare Supplement Plan F), A-3104AC (Medicare Supplement Plan K), A3105AC (Medicare Supplement Plan L) and U3100ACAR (Outline of Coverage)

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

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

A handwritten signature in blue ink that reads "Christopher S. Aasland".

Christopher Aasland, FSA, MAAA
Vice President and Actuary

Date: July 1, 2009

American Republic Corp Insurance Company / National Headquarters, Des Moines, Iowa 50309

Outline of Medicare Supplement Coverage - Benefit Plans A, F, K & L

This chart shows 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.

BASIC BENEFITS included in A, B, C, D, F, F*, G, M and N. **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. **Medical Expenses:** Part B coinsurance (20% of Medicare approved expenses, or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments). **Blood:** First 3 pints of blood each year. **Hospice:** Part A coinsurance.

A	B	C	D	F	F*	G	K**	L**	M	N
Basic Benefits, including 100% Part B coinsurance	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 75%	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for Emergency Room						
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance				
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
		Part B Deductible		Part B Deductible						
				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
							Out-of-pocket limit*** [\$4,620]; paid at 100% after limit reached	Out-of-pocket limit*** [\$2,310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$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.

**Plans K and L cost share differently than Plans A, B, C, D, F, F*, G, M or N. 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.

PREMIUM INFORMATION

We guarantee to renew your policy as long as you live if you pay your premiums when due.

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 your state. No premium change may be made on an individual basis. We will notify you of the new premium at least 31 days before the next due date. You have a 31-day grace period to pay your premium. Please refer to the attached rate schedule.

Applicant's premium at issue age _____ for each plan available on _____ is:
Date

ANNUAL PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

Spouse's premium at issue age _____ for each plan available on _____ is: (if applying)
Date

ANNUAL PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

MODE FACTORS

Monthly Direct Bill: [0.087]
Quarterly: [0.25]
Semiannual: [0.50]
Annual: [0.08334]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

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

Please read this policy and the attached Application carefully. If you find that you are not satisfied with your policy, you may return it to American Republic Corp Insurance Company, [P.O. Box 2780, Omaha, Nebraska 68103-2780], together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid less the amount of any claims paid. If the amount of claims paid by us exceeds the amount of premiums paid by you, you shall reimburse us the difference. Then, the policy will be void from the beginning as if no policy had been issued.

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

The policy may not fully cover all of your medical costs. Neither American Republic Corp 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 the "Medicare & You" government publication 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. This paragraph does not apply to you if you are 65 or older and within 6 months of becoming eligible for Medicare. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN A								
A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	113.36	113.36	128.29	128.29	133.36	133.36	150.92	150.92
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	118.33	118.33	133.92	133.92	139.22	139.22	157.55	157.55
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	340.04	340.04	384.83	384.83	400.05	400.05	452.74	452.74
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	680.09	680.09	769.65	769.65	800.11	800.11	905.48	905.48
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,360.17	1,360.17	1,539.30	1,539.30	1,600.21	1,600.21	1,810.95	1,810.95	

Arkansas
Medicare Supplement Rates
Zip Codes 718, 723-725

Effective 6-1-2010

PLAN A								
A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	119.08	119.08	134.76	134.76	140.10	140.10	158.55	158.55
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	124.31	124.31	140.68	140.68	146.25	146.25	165.51	165.51
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	357.22	357.22	404.26	404.26	420.26	420.26	475.60	475.60
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	714.44	714.44	808.52	808.52	840.51	840.51	951.21	951.21
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,428.87	1,428.87	1,617.04	1,617.04	1,681.02	1,681.02	1,902.41	1,902.41	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN A								
A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	131.68	131.68	149.02	149.02	154.91	154.91	175.32	175.32
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	137.46	137.46	155.56	155.56	161.72	161.72	183.02	183.02
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	395.00	395.00	447.02	447.02	464.71	464.71	525.91	525.91
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	790.00	790.00	894.04	894.04	929.42	929.42	1,051.82	1,051.82
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,580.00	1,580.00	1,788.08	1,788.08	1,858.83	1,858.83	2,103.63	2,103.63	

Arkansas
Medicare Supplement Rates
Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN A								
A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	125.95	125.95	142.54	142.54	148.18	148.18	167.69	167.69
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	131.48	131.48	148.80	148.80	154.69	154.69	175.06	175.06
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	377.83	377.83	427.59	427.59	444.50	444.50	503.04	503.04
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	755.65	755.65	855.17	855.17	889.01	889.01	1,006.08	1,006.08
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,511.30	1,511.30	1,710.34	1,710.34	1,778.01	1,778.01	2,012.16	2,012.16	

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN F									
A3101AC									
Age 65 - 99	APP								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	155.51	155.51	176.00	176.00	182.96	182.96	207.05	207.05	
	MONTHLY								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	162.34	162.34	183.73	183.73	190.99	190.99	216.15	216.15	
QUARTERLY									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
466.50	466.50	527.95	527.95	548.83	548.83	621.11	621.11		
SEMI-ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
933.00	933.00	1,055.90	1,055.90	1,097.65	1,097.65	1,242.23	1,242.23		
ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
1,866.00	1,866.00	2,111.79	2,111.79	2,195.30	2,195.30	2,484.45	2,484.45		

Arkansas
Medicare Supplement Rates
Zip Codes 718, 723-725

Effective 6-1-2010

PLAN F								
A3101AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	163.37	163.37	184.88	184.88	192.20	192.20	217.51	217.51
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	170.54	170.54	193.00	193.00	200.64	200.64	227.06	227.06
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	490.06	490.06	554.61	554.61	576.54	576.54	652.48	652.48
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	980.12	980.12	1,109.22	1,109.22	1,153.09	1,153.09	1,304.97	1,304.97
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,960.24	1,960.24	2,218.44	2,218.44	2,306.17	2,306.17	2,609.93	2,609.93	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN F								
A3101AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	180.65	180.65	204.44	204.44	212.52	212.52	240.52	240.52
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	188.58	188.58	213.42	213.42	221.86	221.86	251.08	251.08
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	541.90	541.90	613.27	613.27	637.52	637.52	721.50	721.50
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,083.79	1,083.79	1,226.55	1,226.55	1,275.05	1,275.05	1,442.99	1,442.99
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
2,167.58	2,167.58	2,453.09	2,453.09	2,550.09	2,550.09	2,885.98	2,885.98	

Arkansas
Medicare Supplement Rates
Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN F									
A3101AC									
Age 65 - 99	APP								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	172.79	172.79	195.55	195.55	203.28	203.28	230.06	230.06	
	MONTHLY								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	180.38	180.38	204.14	204.14	212.21	212.21	240.16	240.16	
QUARTERLY									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
518.34	518.34	586.61	586.61	609.81	609.81	690.13	690.13		
SEMI-ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
1,036.67	1,036.67	1,173.22	1,173.22	1,219.61	1,219.61	1,380.26	1,380.26		
ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
2,073.34	2,073.34	2,346.43	2,346.43	2,439.22	2,439.22	2,760.51	2,760.51		

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	80.41	80.41	91.00	91.00	94.60	94.60	107.06	107.06
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	83.94	83.94	94.99	94.99	98.75	98.75	111.76	111.76
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	241.20	241.20	272.97	272.97	283.77	283.77	321.14	321.14
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	482.41	482.41	545.95	545.95	567.54	567.54	642.29	642.29
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
964.81	964.81	1,091.89	1,091.89	1,135.07	1,135.07	1,284.57	1,284.57	

Arkansas
Medicare Supplement Rates
Zip Codes 718, 723-725

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	84.47	84.47	95.59	95.59	99.37	99.37	112.46	112.46
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	88.18	88.18	99.79	99.79	103.74	103.74	117.40	117.40
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	253.39	253.39	286.76	286.76	298.10	298.10	337.36	337.36
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	506.77	506.77	573.52	573.52	596.20	596.20	674.73	674.73
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,013.54	1,013.54	1,147.04	1,147.04	1,192.40	1,192.40	1,349.45	1,349.45	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	93.40	93.40	105.71	105.71	109.89	109.89	124.36	124.36
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	97.50	97.50	110.35	110.35	114.71	114.71	129.82	129.82
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	280.19	280.19	317.09	317.09	329.63	329.63	373.05	373.05
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	560.37	560.37	634.18	634.18	659.26	659.26	746.09	746.09
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,120.74	1,120.74	1,268.36	1,268.36	1,318.52	1,318.52	1,492.18	1,492.18	

Arkansas
Medicare Supplement Rates
Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	89.34	89.34	101.11	101.11	105.11	105.11	118.95	118.95
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	93.27	93.27	105.55	105.55	109.72	109.72	124.18	124.18
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	268.01	268.01	303.30	303.30	315.30	315.30	356.83	356.83
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	536.01	536.01	606.61	606.61	630.60	630.60	713.66	713.66
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,072.02	1,072.02	1,213.21	1,213.21	1,261.19	1,261.19	1,427.31	1,427.31	

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN L									
A3105AC									
Age 65 - 99	APP								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	110.64	110.64	125.21	125.21	130.16	130.16	147.31	147.31	
	MONTHLY								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	115.50	115.50	130.71	130.71	135.88	135.88	153.78	153.78	
QUARTERLY									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
331.90	331.90	375.60	375.60	390.46	390.46	441.89	441.89		
SEMI-ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
663.79	663.79	751.20	751.20	780.93	780.93	883.77	883.77		
ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
1,327.58	1,327.58	1,502.40	1,502.40	1,561.85	1,561.85	1,767.54	1,767.54		

Arkansas
Medicare Supplement Rates
Zip Codes 718, 723-725

Effective 6-1-2010

PLAN L								
A3105AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	116.23	116.23	131.53	131.53	136.74	136.74	154.75	154.75
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	121.33	121.33	137.31	137.31	142.74	142.74	161.54	161.54
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	348.66	348.66	394.57	394.57	410.19	410.19	464.20	464.20
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	697.32	697.32	789.14	789.14	820.37	820.37	928.41	928.41
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,394.63	1,394.63	1,578.28	1,578.28	1,640.74	1,640.74	1,856.81	1,856.81	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN L								
A3105AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	128.52	128.52	145.45	145.45	151.20	151.20	171.11	171.11
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	134.17	134.17	151.83	151.83	157.84	157.84	178.63	178.63
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	385.54	385.54	436.31	436.31	453.57	453.57	513.30	513.30
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	771.07	771.07	872.61	872.61	907.14	907.14	1,026.60	1,026.60
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,542.14	1,542.14	1,745.22	1,745.22	1,814.27	1,814.27	2,053.20	2,053.20	

Arkansas
Medicare Supplement Rates
Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN L								
A3105AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	122.93	122.93	139.12	139.12	144.63	144.63	163.67	163.67
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	128.33	128.33	145.23	145.23	150.98	150.98	170.86	170.86
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	368.77	368.77	417.34	417.34	433.85	433.85	490.98	490.98
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	737.55	737.55	834.67	834.67	867.70	867.70	981.97	981.97
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,475.09	1,475.09	1,669.34	1,669.34	1,735.39	1,735.39	1,963.93	1,963.93	

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but [\$1,068]</p> <p>All but [\$267] a day</p> <p>All but [\$534]</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>[\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare Eligible expenses</p> <p>\$0</p>	<p>[\$1,068] (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$133.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$133.50] a day</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a physician's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

* 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.

** **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 (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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* (Part B deductible)	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next [\$135] of Medicare Approved Amounts* (Part B deductible)	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B) - Home Health Care

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

* 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.

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but [\$1,068] All but [\$267] a day All but [\$534] \$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 21st thru 100th day 101st 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 You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*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.

*** **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 (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER 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

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

* 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.

PLAN F (continued)
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	\$0	\$0	\$250
Remainder of charges	\$0	80% of a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,068]	[\$534] (50% of Part A deductible)	[\$534] (50% of Part A deductible)◆
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but [\$534]	[\$534] a day	\$0
• Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare Eligible expenses	\$0***
• Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	Up to [\$66.75] a day	Up to [\$66.75] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance◆

**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.

*** **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 K (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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	\$0	[\$135] (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
BLOOD First 3 pints	\$0	50%	50%◆
Next [\$135] of Medicare Approved Amounts****	\$0	\$0	[\$135] (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [\$4,620] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** 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.

PLAN K (continued)
MEDICARE (PARTS A AND B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First [\$135] of Medicare Approved Amounts*****	\$0	\$0	[\$135] (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	10%	10%◆

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,068]	[\$808.50] (75% of Part A Deductible)	[\$267] (25% of Part A Deductible)◆
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but [\$534]	[\$534] a day	\$0
• Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
• Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50 a day]	Up to [\$100.13] a day	Up to [\$33.38] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of Medicare copayment/coinsurance◆

** 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.

*** **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 L (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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	\$0	[\$135] (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
BLOOD First 3 pints	\$0	75%	25%◆
Next [\$135] of Medicare Approved Amounts****	\$0	\$0	[\$135] (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [\$2,310] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** 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.

PLAN L (continued)
MEDICARE (PARTS A & B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First [\$135] of Medicare Approved Amounts*****	\$0	\$0	[\$135] (Part B deductible)♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

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

NAIC: 67679

Date: July 1, 2009

Hon. Julie Benefield Bowman, Commissioner of Insurance
Insurance Division
1200 W. Third St.
Little Rock, AR 72201-1904

Attention: John Shields

RE: Individual Medicare Supplement Plans
Plan A - A3100AC
Outline of Coverage – U3100ACAR
Replacement Form – M3100AC

Dear Mr. Shields:

In this filing we are enclosing Medicare Supplement forms for your Departments review. These forms are new and do not replace any previously approved forms. These forms were developed in accordance with the NAIC Medicare Supplement Model Regulation, as amended. Please see Attachment A for specific information on each form.

These Medicare Supplement forms will be marketed to Arkansas residents who are eligible for Medicare and will be marketed through face to face contact as well as telephone solicitation. The forms employ easy to read language. Our certification as to the Flesch Readability Score of the policy forms is included in this filing.

These forms will use application C-1031 previously approved February 27, 2008 for these products. You will note that the form is co-branded and will be used by American Republic Insurance Company in the marketing of Medicare Supplement, Short- Term Convalescent Care, and Life insurance coverage. Both American Republic Insurance Company and American Republic Corp Insurance Company are subsidiaries of the mutual insurance holding company, American Enterprise Group Inc.

The Actuarial Memorandum and rates are also included in this filing.

Variable material is bracketed to indicate that they are subject to change. The forms are in final print subject only to minor modification in paper size, stock, color, border, font, company logo and adaptation to computer printing. Depending on printer capabilities, the application will be printed as either simplex or duplex.

Your earliest acknowledgement of this filing would be appreciated. If you have any questions or comments, please contact me. I can be reached at our toll-free number, 1-800-247-2190, ext 2083, by fax at 515-875-4391, or you can email me at sarah.shives@americanenterprise.com.

Sincerely,

A handwritten signature in cursive script that reads "Sarah A. Shives".

Sarah Shives
Compliance Analyst
American Republic Corp Insurance Company

Enc.

ATTACHMENT A

FORM	DESCRIPTION
Policy Form A3100AC	Medicare Supplement Plan A
U3100ACAR	Outline of Coverage
American Republic Corp Rates and Actuarial Memorandums	Medicare Supplement Memorandums and Rates
M3100AC	Replacement Form

SERFF Tracking Number: AMRP-126211046 State: Arkansas
 Filing Company: American Republic Corp Insurance Company State Tracking Number: 42835
 Company Tracking Number: 2010 MED SUPP AR CORP - PLAN A
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: 2010 Med Supp AR Corp - Plan A
 Project Name/Number: 2010 Med Supp AR Corp - Plan A/2010 Med Supp AR Corp - Plan A

Superseded Attachments

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.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Plan A	06/30/2009	A3100AC - Plan A.pdf
No original date	Supporting Document	Outline of Coverage	06/30/2009	12-114-2758-XXXX AR (U3100ACAR).pdf

Medicare Supplement Policy – Benefit Plan A
Benefits Provided by this Policy Are Subject to Changes Made in Medicare.

We have issued this policy based on: (a) your application for it; and (b) your payment of the first premium on or before the Policy Date. The first premium and the Policy Date are shown on Schedule of Benefits.

Read your Policy Carefully! This policy is a legal document between you and us.

Part A – 30-Day Right to Examine Policy

Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

Part B – Guaranteed Renewable; Premiums Subject to Change

We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may change the premiums on your policy from time to time. We may not change the premiums unless we do so on all policies of this form issued to persons of your class. We will notify you of the new premium at least 31 days before the first premium due date after which the changes take effect. Premiums are based on your attained age.

Medicare Changes – The benefits of your policy change when the Medicare deductibles and copayment amounts you are required to pay are changed. We may also change the premiums (with state insurance department approval) when the benefits change.

The provisions on the following pages are part of this policy.

In witness whereof, American Republic Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

[  
President Secretary Countersignature]

Notice to Buyer – This Policy may not cover all of your Medical Expenses.

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Schedule of Benefits

COVERED PERSON (S):

[John A. Doe, age 65, the Insured]

POLICY NUMBER: [12345678]

DATE OF ISSUE: [JANUARY 1, 2010]

FIRST RENEWAL DATE: [varies, based on premium mode selected]

INITIAL PREMIUM AND FEES (if applicable): \$ [#####]

FORM NUMBER(S):

POLICY NUMBER:

POLICY DATE:

FIRST POLICY ANNIVERSARY:

COVERED PERSONS:

INSURED [John A. Doe] ISSUE AGE: [-age 65]

COVERED SPOUSE [Jane B. Doe] ISSUE AGE: [65]

PREMIUMS:

FIRST PREMIUM PAID: \$ [XXX.XX]

PREMIUM FREQUENCY: [Monthly, Quarterly, Semi-Annually, Annually]

CLASSIFICATION: [John A. Doe] [Standard, Preferred]
[Jane B. Doe] [Standard, Preferred]

Part C – Definitions

Some words used in your policy have a special meaning. We have defined them below. Also, the words “we,” “our” and “us” refer to American Republic Corp Insurance Company. The words “you” and “your” refer to the insured person named on the Schedule of Benefits.

“**Age**” means your age on your last birthday.

A “**Benefit Period**” starts the first time a covered person enters a hospital on or after the Policy Date. A new benefit period starts the next time that covered person enters a hospital after being out of a hospital and skilled nursing facility for at least 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods allowed.

A “**Calendar Year**” begins January 1 and ends December 31 each year.

“**Class**” means the factors that went into making up the premium rate when coverage was issued. In addition to the plan of insurance, those factors include age and geographic region.

“**Covered Person(s)**” means you and/or your covered spouse as approved by us, or added to coverage by endorsement, provided coverage has not been terminated.

“**Covered Spouse**” means your lawful spouse, as named in the application and approved by us, or as added to coverage by endorsement, provided coverage has not been terminated.

“**Hospice Care**” means treatment in a hospice program as defined by Medicare.

“**Hospital**” means an institution which meets Medicare’s definition of a hospital.

“**Injury**” means accidental bodily injury which occurs while this policy is in force.

“**Loss**” means the Medicare eligible expenses incurred by a covered person resulting from a covered sickness or injury.

“**Medicaid**” means the “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as amended.

“**Medicare**” means Title XVIII (Health Insurance for the Aged) of the Social Security Act as added by the Social Security Amendments of 1965 as then constituted or later amended.

“**Medicare Eligible Expenses**” shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

“**Physician**” is a physician meeting Medicare’s definition of physician.

“**Respite Care**” is treatment that meets Medicare’s definition of respite care.

“**Sickness**” means a condition, a state of ill health, or an illness, first manifested by a covered person while this policy is in force.

Part D – Benefits

We will pay benefits for the following items of expense a covered person incurs and that are approved but not paid for by Medicare Parts A and B. In determining benefits to be paid, we will consider the covered person to be enrolled in and eligible for Medicare Parts A and B. Medicare eligible expenses must be incurred during the benefit period while this policy is in force.

Basic (Core) Plan Benefits

- a. Medicare Part A Hospital Services and Supplies Expenses
 1. Part A Medicare eligible expenses for hospitalization from the 61st to the 90th day in any Medicare benefit period;
 2. Part A Medicare eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used; and
 3. When all Medicare hospital inpatient coverage and lifetime reserve days are used up, we will pay 100% of the Part A Medicare eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the covered person for any balance.
- b. Medicare Part A and Part B Blood Deductibles – Coverage under Medicare Parts A and B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.
- c. Medicare Part B Medical Insurance – After the Medicare Part B Deductible, we will pay the Medicare Part B coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) for eligible expenses approved but not paid for by Medicare.
- d. Hospice Care – We will provide coverage of cost sharing (Medicare copayment or coinsurance amounts) for all Part A Medicare eligible expenses for hospice care and respite care. In order to receive this benefit, you must meet Medicare's requirements including a physician's certification of terminal illness.

Part E – Benefit Changes

Benefits will change automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors.

Part F – Benefit Extensions

Termination of coverage shall be without prejudice to a continuous loss which commenced while this policy was in force. Extension of benefits beyond the period this policy was in force is:

- a. subject to the covered person's continuous total disability;
- b. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
- c. limited to the duration benefits would have been paid had this policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Part G - Exclusions

We will not pay benefits for:

- a. services for which a charge is normally not made when there is no insurance;
- b. expense incurred before the Policy Date; or
- c. that portion of expense incurred which is paid for by Medicare.

Part H – Premium Provisions

Premium Payment – The premium must be paid on or before the date it is due or during the grace period.

Grace Period – The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

Lapse – This policy will go out of force if the premium is not paid by the end of the grace period.

Reinstatement – If this policy should lapse, we, or an agent we specifically authorize to accept premiums, may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other rights of ours or yours will be the same as they were before this policy lapsed. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid.

Suspension and Reinstitution of Coverage

Suspension of Coverage

Eligibility for Medicaid – Benefits and premiums under this policy shall be suspended at a covered person's request for a period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). The covered person must notify us within 90 days after becoming entitled to such assistance. Upon receipt of timely notice, we will return that portion of the premium for the period of time the covered person is eligible for Medicaid. The refunded premiums will be reduced by the amount of claims paid for the period the covered person is eligible.

Group Health Plan – Benefits and premiums under this policy shall be suspended, at a covered person's request, (for any period that may be provided by federal regulation) if the covered person is entitled to benefits under section 226(b) of the Social Security Act as amended; and covered under a group health plan (as defined in section 1862(b) (1) (A) (v) of the Social Security Act, as amended).

Reinstitution

If a covered person loses entitlement to medical assistance (Medicaid) during a period of suspension, this policy will be automatically reinstated. This will be effective the date of termination of the entitlement. The covered person must provide us with notice of the loss of the entitlement within 90 days after the date of the loss and pay the premium attributed to the period effective as of the date of termination of entitlement. Upon reinstatement:

- a. there will be no additional waiting period with respect to treatment of preexisting conditions;
- b. coverage will be substantially equivalent to coverage in effect before the date of the suspension; and
- c. premiums will be classified on terms that are at least as favorable to the covered person as the premium classification terms that would have applied to the covered person had the coverage not been suspended.

Part I – How Your Covered Spouse May Convert to His/Her Own Policy

If you and your spouse get divorced from each other, you may both continue your insurance. Either you or your covered spouse may obtain a separate policy without having to provide us evidence of insurability. The request for the new policy must be made within 31 days after you or your spouse are removed from the coverage of this policy. The new policy will be effective on the date coverage ended under this policy. We will not issue a new policy to anyone who is not a permanent resident of the United States.

Part J – How to File a Claim

Notice of Claim – We must be notified of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may provide us with the notice, or you can have someone provide it for you. The notice should include your name and either your policy number or identification number. The notice should be sent to us at: American Republic Corp Insurance Company, [P.O. Box 2780, Omaha, Nebraska 68103-2780], or to any of our agents.

Claim Forms – When we receive your notice of claim for benefits, we will send you any necessary forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of claim if you notify us in writing about the expenses for which you are making a claim for benefits within 90 days after the expenses are incurred.

Proof of Your Claim – We must have proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be provided to us within 1 year after the time proof is otherwise required, unless you are not legally competent to act.

Part K – Payment of Claims Provision

Payment of Claims – Benefits are paid to the covered person. Any benefits unpaid at the covered person's death we may pay to their beneficiary (if one is named); otherwise, we may pay them to the covered person's estate. We may also pay up to \$1,000 of unpaid benefits to any of the covered person's relatives we deem properly qualified to receive them. We will be discharged of liability for payments we make in good faith to the covered person's relatives.

Time of Payment of Claims – All benefits due are paid as soon as we receive the covered person's proper written proof of loss.

Subrogation – To the extent allowed by law, we will be subrogated to all rights of recovery that a covered person may have against another party or insurer (including an uninsured or underinsured motorist carrier or workers' compensation) for all benefits paid by us that were incurred by the covered person as a result of acts or omissions of a third party for which a third party or insurer is or may be responsible to the covered person. Medicare claims or liens take priority over our subrogation rights. However, following Medicare, our right to repayment shall be a first priority lien against any recovery by the covered person and is to be paid regardless of whether the covered person is fully compensated. Our right to repayment is enforceable regardless of whether the recovery is by judgment, settlement or otherwise, and regardless of how the recovery proceeds are allocated. The amount of any repayment will be no more than the total amount of benefits we paid to the covered person, but no more than the amount paid by the other party. No attorney fees may be deducted, unless prior written approval is obtained from us. The covered person agrees to provide us with all necessary and requested information, and to complete all documents required by us to assist us in the enforcement of our right of subrogation recovery.

Part L – General Provisions

Entire Contract; Changes – This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of ours may make a change and the change must appear in writing as a part of this policy.

Time Limit on Certain Defenses – Unless based on fraudulent misstatement by you on the application, we will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the Policy Date because of misstatements.

Physical Examination – We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require.

Legal Action – Before you can bring a legal action to recover under this policy, you must wait for at least 60 days after you have given us due proof, in writing, of the particular claim for benefits. Any legal action under this section must be brought by you within three years of the date we receive your proof of the claim on which you intend to pursue the legal action.

Other Insurance With Us – The insurance in force at any one time on a covered person under a policy or policies with us specifically supplementing any part of Medicare (Part A and/or Part B) will be limited to the policy with the greatest benefit. The premium for any such excess insurance will be returned.

Conformity With State Law – If this policy does not comply with the laws of the state where you live on the Policy Date shown on the Schedule of Benefits, we will treat it as if it had been amended to comply.

Misstatement of Age – If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

Premium Refund at Death – If the covered person dies while this policy is in force, we will refund part of your premium. The refund will be the unused premium beginning with the first policy month after the covered person's date of death.

Change of Beneficiary – The covered person may change the beneficiary at any time by providing us written notice. The covered person does not need the consent of the beneficiary to make this or any other change, unless the covered person has made a designation that cannot be changed.

Assignment – If the covered person assigned the benefits to someone else, we will pay them to the assignee instead of to the covered person, the covered person's beneficiary, or the covered person's estate. We will not be bound to an assignment until we receive a valid written assignment.

Annual Meeting Information – The annual meeting of the members of American Enterprise Mutual Holding Company will be held at the mutual holding company's principal office at nine o'clock a.m. on the first Tuesday in March of each year. Each such meeting will be for the purpose of electing a director or directors and transacting any other business properly coming before the annual meeting. At every annual meeting, each member of the mutual holding company who is a member as of the record date fixed by the board of directors which record date shall not be more than 90 days prior to the date of the meeting, shall have one vote upon any proposition coming before such meeting, which vote may only be cast in person or by ballot furnished by the mutual holding company. In order to vote by ballot, a member as of the record date must request a ballot from the Secretary of the mutual holding company at least 15 days prior to the annual meeting.

American Republic Corp Insurance Company / National Headquarters, Des Moines, Iowa 50309

Outline of Medicare Supplement Coverage - Benefit Plans A, F, K & L

This chart shows 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.

BASIC BENEFITS included in A, B, C, D, F, F*, G, M and N. **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. **Medical Expenses:** Part B coinsurance (20% of Medicare approved expenses, or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments). **Blood:** First 3 pints of blood each year. **Hospice:** Part A coinsurance.

A	B	C	D	F	F*	G	K**	L**	M	N
Basic Benefits, including 100% Part B coinsurance	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 75%	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for Emergency Room						
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance				
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
		Part B Deductible		Part B Deductible						
				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
							Out-of-pocket limit*** [\$4,620]; paid at 100% after limit reached	Out-of-pocket limit*** [\$2,310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$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.

**Plans K and L cost share differently than Plans A, B, C, D, F, F*, G, M or N. 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.

PREMIUM INFORMATION

We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may change the premiums on your policy from time to time. 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 your state. No premium change may be made on an individual basis. We will notify you of the new premium at least 31 days before the next due date. You have a 31-day grace period to pay your premium. Please refer to the attached rate schedule.

Applicant's premium at issue age _____ for each plan available on _____ is:
Date

ANNUAL PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

Spouse's premium at issue age _____ for each plan available on _____ is: (if applying)
Date

ANNUAL PREMIUMS

Plan A	Plan F	Plan K	Plan L
_____	_____	_____	_____

MODE FACTORS

Monthly Direct Bill: [0.087]
Quarterly: [0.25]
Semiannual: [0.50]
Annual: [0.08334]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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

Please read this policy and the attached Application carefully. If you find that you are not satisfied with your policy, you may return it to American Republic Corp Insurance Company, P.O. Box 2780, Omaha, Nebraska 68103-2780, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid less the amount of any claims paid. If the amount of claims paid by us exceeds the amount of premiums paid by you, you shall reimburse us the difference. Then, the policy will be void from the beginning as if no policy had been issued.

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

The policy may not fully cover all of your medical costs. Neither American Republic Corp 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 the "Medicare & You" government publication 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. This paragraph does not apply to you if you are 65 or older and within 6 months of becoming eligible for Medicare. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Arkansas

Medicare Supplement Rates

Zip Codes 717, 726-729

Effective 6-1-2010

PLAN A A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	113.36	113.36	128.29	128.29	133.36	133.36	150.92	150.92
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	118.33	118.33	133.92	133.92	139.22	139.22	157.55	157.55
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	340.04	340.04	384.83	384.83	400.05	400.05	452.74	452.74
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	680.09	680.09	769.65	769.65	800.11	800.11	905.48	905.48
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,360.17	1,360.17	1,539.30	1,539.30	1,600.21	1,600.21	1,810.95	1,810.95	

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN A A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	119.08	119.08	134.76	134.76	140.10	140.10	158.55	158.55
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	124.31	124.31	140.68	140.68	146.25	146.25	165.51	165.51
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	357.22	357.22	404.26	404.26	420.26	420.26	475.60	475.60
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	714.44	714.44	808.52	808.52	840.51	840.51	951.21	951.21
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,428.87	1,428.87	1,617.04	1,617.04	1,681.02	1,681.02	1,902.41	1,902.41	

Arkansas
Medicare Supplement Rates
Zip Codes 722

Effective 6-1-2010

PLAN A A3100AC									
Age 65 - 99	APP								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	131.68	131.68	149.02	149.02	154.91	154.91	175.32	175.32	
	MONTHLY								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	137.46	137.46	155.56	155.56	161.72	161.72	183.02	183.02	
	QUARTERLY								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	395.00	395.00	447.02	447.02	464.71	464.71	525.91	525.91	
	SEMI-ANNUAL								
	PREFERRED				STANDARD				
	COUPLE		SINGLE		COUPLE		SINGLE		
	Female	Male	Female	Male	Female	Male	Female	Male	
	790.00	790.00	894.04	894.04	929.42	929.42	1,051.82	1,051.82	
ANNUAL									
PREFERRED				STANDARD					
COUPLE		SINGLE		COUPLE		SINGLE			
Female	Male	Female	Male	Female	Male	Female	Male		
1,580.00	1,580.00	1,788.08	1,788.08	1,858.83	1,858.83	2,103.63	2,103.63		

Arkansas

Medicare Supplement Rates

Zip Codes ALL OTHERS

Effective 6-1-2010

PLAN A A3100AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	125.95	125.95	142.54	142.54	148.18	148.18	167.69	167.69
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	131.48	131.48	148.80	148.80	154.69	154.69	175.06	175.06
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	377.83	377.83	427.59	427.59	444.50	444.50	503.04	503.04
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	755.65	755.65	855.17	855.17	889.01	889.01	1,006.08	1,006.08
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,511.30	1,511.30	1,710.34	1,710.34	1,778.01	1,778.01	2,012.16	2,012.16	

Arkansas
Medicare Supplement Rates
Zip Codes 717, 726-729

Effective 6-1-2010

PLAN F								
A3101AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
155.51	155.51	176.00	176.00	182.96	182.96	207.05	207.05	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
162.34	162.34	183.73	183.73	190.99	190.99	216.15	216.15	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
466.50	466.50	527.95	527.95	548.83	548.83	621.11	621.11	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
933.00	933.00	1,055.90	1,055.90	1,097.65	1,097.65	1,242.23	1,242.23	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,866.00	1,866.00	2,111.79	2,111.79	2,195.30	2,195.30	2,484.45	2,484.45	

Age 65 - 99

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PLAN F A3101AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	163.37	163.37	184.88	184.88	192.20	192.20	217.51	217.51
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	170.54	170.54	193.00	193.00	200.64	200.64	227.06	227.06
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	490.06	490.06	554.61	554.61	576.54	576.54	652.48	652.48
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	980.12	980.12	1,109.22	1,109.22	1,153.09	1,153.09	1,304.97	1,304.97
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,960.24	1,960.24	2,218.44	2,218.44	2,306.17	2,306.17	2,609.93	2,609.93	

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PLAN F								
A3101AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
180.65	180.65	204.44	204.44	212.52	212.52	240.52	240.52	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
188.58	188.58	213.42	213.42	221.86	221.86	251.08	251.08	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
541.90	541.90	613.27	613.27	637.52	637.52	721.50	721.50	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,083.79	1,083.79	1,226.55	1,226.55	1,275.05	1,275.05	1,442.99	1,442.99	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
2,167.58	2,167.58	2,453.09	2,453.09	2,550.09	2,550.09	2,885.98	2,885.98	

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PLAN F								
A3101AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
172.79	172.79	195.55	195.55	203.28	203.28	230.06	230.06	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
180.38	180.38	204.14	204.14	212.21	212.21	240.16	240.16	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
518.34	518.34	586.61	586.61	609.81	609.81	690.13	690.13	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,036.67	1,036.67	1,173.22	1,173.22	1,219.61	1,219.61	1,380.26	1,380.26	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
2,073.34	2,073.34	2,346.43	2,346.43	2,439.22	2,439.22	2,760.51	2,760.51	

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PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	80.41	80.41	91.00	91.00	94.60	94.60	107.06	107.06
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	83.94	83.94	94.99	94.99	98.75	98.75	111.76	111.76
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	241.20	241.20	272.97	272.97	283.77	283.77	321.14	321.14
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	482.41	482.41	545.95	545.95	567.54	567.54	642.29	642.29
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
964.81	964.81	1,091.89	1,091.89	1,135.07	1,135.07	1,284.57	1,284.57	

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PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	84.47	84.47	95.59	95.59	99.37	99.37	112.46	112.46
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	88.18	88.18	99.79	99.79	103.74	103.74	117.40	117.40
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	253.39	253.39	286.76	286.76	298.10	298.10	337.36	337.36
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	506.77	506.77	573.52	573.52	596.20	596.20	674.73	674.73
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,013.54	1,013.54	1,147.04	1,147.04	1,192.40	1,192.40	1,349.45	1,349.45	

PLAN K A3104AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	93.40	93.40	105.71	105.71	109.89	109.89	124.36	124.36
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	97.50	97.50	110.35	110.35	114.71	114.71	129.82	129.82
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	280.19	280.19	317.09	317.09	329.63	329.63	373.05	373.05
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	560.37	560.37	634.18	634.18	659.26	659.26	746.09	746.09
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,120.74	1,120.74	1,268.36	1,268.36	1,318.52	1,318.52	1,492.18	1,492.18	

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Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	89.34	89.34	101.11	101.11	105.11	105.11	118.95	118.95
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	93.27	93.27	105.55	105.55	109.72	109.72	124.18	124.18
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	268.01	268.01	303.30	303.30	315.30	315.30	356.83	356.83
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	536.01	536.01	606.61	606.61	630.60	630.60	713.66	713.66
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,072.02	1,072.02	1,213.21	1,213.21	1,261.19	1,261.19	1,427.31	1,427.31	

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PLAN L								
A3105AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
110.64	110.64	125.21	125.21	130.16	130.16	147.31	147.31	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
115.50	115.50	130.71	130.71	135.88	135.88	153.78	153.78	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
331.90	331.90	375.60	375.60	390.46	390.46	441.89	441.89	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
663.79	663.79	751.20	751.20	780.93	780.93	883.77	883.77	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,327.58	1,327.58	1,502.40	1,502.40	1,561.85	1,561.85	1,767.54	1,767.54	

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PLAN L								
A3105AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
116.23	116.23	131.53	131.53	136.74	136.74	154.75	154.75	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
121.33	121.33	137.31	137.31	142.74	142.74	161.54	161.54	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
348.66	348.66	394.57	394.57	410.19	410.19	464.20	464.20	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
697.32	697.32	789.14	789.14	820.37	820.37	928.41	928.41	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,394.63	1,394.63	1,578.28	1,578.28	1,640.74	1,640.74	1,856.81	1,856.81	

Age 65 - 99

PLAN L								
A3105AC								
APP								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
128.52	128.52	145.45	145.45	151.20	151.20	171.11	171.11	
MONTHLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
134.17	134.17	151.83	151.83	157.84	157.84	178.63	178.63	
QUARTERLY								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
385.54	385.54	436.31	436.31	453.57	453.57	513.30	513.30	
SEMI-ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
771.07	771.07	872.61	872.61	907.14	907.14	1,026.60	1,026.60	
ANNUAL								
PREFERRED					STANDARD			
COUPLE			SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male	
1,542.14	1,542.14	1,745.22	1,745.22	1,814.27	1,814.27	2,053.20	2,053.20	

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PLAN L A3105AC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	122.93	122.93	139.12	139.12	144.63	144.63	163.67	163.67
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	128.33	128.33	145.23	145.23	150.98	150.98	170.86	170.86
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	368.77	368.77	417.34	417.34	433.85	433.85	490.98	490.98
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	737.55	737.55	834.67	834.67	867.70	867.70	981.97	981.97
ANNUAL								
PREFERRED				STANDARD				
COUPLE		SINGLE		COUPLE		SINGLE		
Female	Male	Female	Male	Female	Male	Female	Male	
1,475.09	1,475.09	1,669.34	1,669.34	1,735.39	1,735.39	1,963.93	1,963.93	

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but [\$1,068] All but [\$267] a day All but [\$534] \$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 21st thru 100th day 101st 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 You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* 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.

** **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 (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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* (Part B deductible) 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* (Part B deductible) 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

Medicare (Parts A and B) - Home Health Care

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • 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

* 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.

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but [\$1,068] All but [\$267] a day All but [\$534] \$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 21st thru 100th day 101st 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 You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*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.

*** **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 (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER 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

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

* 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.

PLAN F (continued)
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	\$0	\$0	\$250
Remainder of charges	\$0	80% of a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<p>HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but [\$1,068]</p> <p>All but [\$267] a day</p> <p>All but [\$534]</p> <p>\$0</p> <p>\$0</p>	<p>[\$534] (50% of Part A deductible)</p> <p>[\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare Eligible expenses</p> <p>\$0</p>	<p>[\$534] (50% of Part A deductible)◆</p> <p>\$0</p> <p>\$0</p> <p>\$0***</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$133.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$66.75] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$66.75] a day◆</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>50%</p> <p>\$0</p>	<p>50%◆</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare’s requirements, including a physician’s certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>50% of copayment/coinsurance</p>	<p>50% of Medicare copayment/coinsurance◆</p>

**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.

*** **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 K (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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	\$0	[\$135] (Part B deductible)****◆
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
BLOOD First 3 pints	\$0	50%	50%◆
Next [\$135] of Medicare Approved Amounts****	\$0	\$0	[\$135] (Part B deductible)◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [\$4,620] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** 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.

PLAN K (continued)
MEDICARE (PARTS A AND B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First [\$135] of Medicare Approved Amounts*****	\$0	\$0	[\$135] (Part B deductible)♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [\$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,068]	[\$808.50] (75% of Part A Deductible)	[\$267] (25% of Part A Deductible)◆
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but [\$534]	[\$534] a day	\$0
• Once lifetime reserve days are used:			
• Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
• Beyond the additional 365 days	\$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	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50 a day]	Up to [\$100.13] a day	Up to [\$33.38] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a physician’s certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of Medicare copayment/coinsurance◆

** 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.

*** **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 L (continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER 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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	[\$135] (Part B deductible)****◆ All costs above Medicare approved amounts 5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
BLOOD First 3 pints Next [\$135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ [\$135] (Part B deductible)◆ Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare Approved Amounts to [\$2,310] per year. However, this limit does NOT include charges from your provider that exceed Medicare Approved Amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** 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.

PLAN L (continued)
MEDICARE (PARTS A & B) - HOME HEALTH SERVICES

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First [\$135] of Medicare Approved Amounts*****	\$0	\$0	[\$135] (Part B deductible)♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

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