

SERFF Tracking Number: AMRP-126211350 State: Arkansas  
Filing Company: American Republic Corp Insurance Company State Tracking Number: 42834  
Company Tracking Number: 2010 MED SUPP AR CORP - PLAN F  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010  
Standard Plans 2010  
Product Name: 2010 Med Supp AR Corp - Plan F  
Project Name/Number: 2010 Med Supp AR Corp - Plan F/2010 Med Supp AR Corp - Plan F

## Filing at a Glance

Company: American Republic Corp Insurance Company

Product Name: 2010 Med Supp AR Corp - Plan SERFF Tr Num: AMRP-126211350 State: ArkansasLH  
F

TOI: MS08I Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 42834  
Standard Plans 2010

Sub-TOI: MS08I.005 Plan F (Basic) 2010 Co Tr Num: 2010 MED SUPP AR State Status: Approved-Closed  
CORP - PLAN F

Filing Type: Form/Rate/Advertisement

Co Status: Reviewer(s): Stephanie Fowler

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

Falk, Sarah Shives, Jamie Mueller,

Michele Kulish, Kerin Overturf,

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 F

Status of Filing in Domicile: Not Filed

Project Number: 2010 Med Supp AR Corp - Plan F

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/06/2009

Explanation for Other Group Market Type:

State Status Changed: 08/06/2009

Deemer Date:

Corresponding Filing Tracking Number: AMRP-  
126211046, AMRP-126211392, AMRP-  
126211407

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**Filing Description:**

Please see Cover Letter under the Supporting Documentation 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  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$125.00  
 Retaliatory? Yes  
 Fee Explanation: \$50 (policy) + \$50 (rates) + \$25 (advertising) = \$125.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Republic Corp Insurance Company	\$125.00	07/01/2009	28916414

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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

*SERFF Tracking Number:* AMRP-126211350      *State:* Arkansas  
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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 F	Approved	Yes
Form	Brochure	Filed	Yes
Form	Plan F	Disapproved	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 F (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 F (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 F (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 taking the time to review this filing and bringing these items to my attention.

**Response 1**

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

**Related Objection 1**

Applies To:

- Outline of Coverage (Supporting Document)
- Plan F (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 F	A3101AC		Policy/Contract/Fraternal Certificate	Initial		61	A3101AC-AR - Plan F 8-6.pdf
<b>Previous Version</b>							
Plan F	A3101AC		Policy/Contract/Fraternal Certificate	Initial		61	A3101AC - Plan F.pdf

No Rate/Rule Schedule items changed.

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**Response 2**

Comments: I have removed the sentence on page 1 of the policy that referred to attained age as requested.

**Related Objection 1**

Applies To:

- Plan F (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.

**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 F	A3101AC		Policy/Contract/Fraternal Certificate	Initial		61	A3101AC-AR - Plan F 8-6.pdf
<i>Previous Version</i> Plan F	A3101AC		Policy/Contract/Fraternal Certificate	Initial		61	A3101AC - Plan F.pdf

No Rate/Rule Schedule items changed.

**Response 3**

Comments: I have correct the typographical error with the bolding on the term "Benefit Period." Thank you for bringing that to my attention.

**Related Objection 1**

Applies To:

SERFF Tracking Number: AMRP-126211350 State: Arkansas  
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 - Plan F (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 F	A3101AC		Policy/Contract/Fraternal Certificate	Initial		61	A3101AC-AR - Plan F 8-6.pdf
<b>Previous Version</b>							
Plan F	A3101AC		Policy/Contract/Fraternal Certificate	Initial		61	A3101AC - Plan F.pdf

No Rate/Rule Schedule items changed.

Thank you for reviewing this filing. Please feel free to contact me if you have any further questions. I can be reached at 800-247-2190 ext. 2083.

Sincerely,

Colletta Maddy, Jamie Mueller, Kerin Overturf, Michele Kulish, Norm Von Seggern, Sarah Shives, Susan Falk

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## Form Schedule

Lead Form Number: A3101AC

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	A3101AC	Policy/Cont	Plan F ract/Fratern al Certificate	Initial		61	A3101AC-AR - Plan F 8- 6.pdf
Filed	Z-2411	Advertising	Brochure	Initial			Z-2411 bracketed.pdf

**Medicare Supplement Policy – Benefit Plan F**  
**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 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.

### **Additional Benefits**

- a. Medicare (Part A) Hospital Insurance Deductible – We will pay the Medicare (Part A) Initial Hospital Insurance Deductible.
- b. Skilled Nursing Facility Expenses – We will pay the actual billed charge up to the Medicare daily coinsurance charge (deductible) for days 21 through 100 of a Medicare-approved skilled nursing facility stay.
- c. Medicare (Part B) Medical Insurance Deductible – We will pay the Medicare (Part B) Medical Insurance Deductible.
- d. 100% Medicare Part B Excess Charges – We will pay up to 100% of the excess charge for eligible expenses approved but not paid by Medicare. **“Excess charge”** is the difference between the actual billed amount, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- e. Medically Necessary Emergency Care in a Foreign Country – We will provide coverage to the extent not covered by Medicare for 80% of billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country.

Benefits will be paid if the care would have been covered by Medicare if provided in the United States. Such care must begin during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250 and a lifetime maximum of \$50,000.

**“Emergency care”** means care needed immediately because of an injury or a sickness of sudden and unexpected onset.

## **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.

If applicable, place  
Affinity Group logo  
here otherwise place  
AR Corp logo here

# Freedom Solutions<sup>®</sup>

Medicare Supplement Insurance - Plan F

# Medicare Supplement Insurance

## Comprehensive Protection That Fits Your Needs and Your Budget

When you choose Plan F, you get more benefits than with *any other Medicare Supplement Insurance Plan*.

That's because Plan F is the most comprehensive Medicare supplement plan . . . period.

And because it's from American Republic Corp, you'll also get the right balance of cost, coverage and convenience.



### Affordable Rates - to help keep costs down

- Preferred rates for good health
- Couples discount simply for being part of a couple<sup>1</sup>



### Freedom to Choose

- Choose your doctors and hospitals – even when you travel
- Includes specialists - no referrals needed
- Centers of Excellence



### Convenient - we take care of the paperwork

- ExpressLane Automatic Claim Service<sup>SM</sup> means you won't waste time filing paperwork when you're sick or hurt

## Protection from a Financially Strong Company

American Republic Corp Insurance Company is a wholly-owned subsidiary of American Republic Insurance Company, a company that delivers customized health care solutions at an affordable price to individuals and families across the nation.

Founded in 1929, American Republic Insurance Company has established a proven track record in providing exceptional insurance solutions. Plus, our highly-respected [A- (Excellent) rating by A.M. Best Company] stands as further testimony to American Republic Insurance Company's financial strength and stability.\*

*\*Our [A- (Excellent) rating (January 2009) is the fourth highest of 15 possible ratings given by A.M. Best Company. As an independent non-government company, A.M. Best does not recommend products or services but does provide independent opinions of a company's overall financial strength.]*



# Freedom Solutions Plan F Benefit Highlights

- **Freedom to choose**  
You're free to visit the doctors and hospitals of your choice – even when you travel.
  - No referrals required
  - Includes specialists
  - Centers of Excellence
- **Preferred rates for good health**  
You may benefit from your good health by saving money. Plus, once you're approved for our preferred rate discount, you'll automatically keep that discount for however long you have your policy ... even if your health changes.
- **Couples discount to save even more**  
Additional savings simply for being part of a couple ... regardless of whether both of you request coverage.<sup>1</sup>
- **No waiting period for health conditions you have now**  
Any health conditions you have now are covered immediately once your application is issued — no waiting period.
- **Fast, accurate claims service**  
Thanks to our ExpressLane Automatic Claims Service<sup>SM</sup>, there are virtually no claim forms.
- **Guaranteed renewable for life**  
No matter what your health, as long as you pay premiums on time, your coverage will never be canceled.

If you have any questions about **Freedom Solutions Plan F**,  
be sure to ask your agent for details!

# Plan F Overview

Here's how Freedom Solutions Medicare Supplement PLAN F works with Medicare to help pay hospital and medical expenses that Medicare approves but doesn't pay...

## Medicare Part A–Hospital Expenses *(per benefit period)*

BENEFITS	MEDICARE PAYS	FREEDOM PLAN F PAYS	YOU PAY <sup>2</sup>
<b>Hospital Confinement</b>			
First 60 days	All but [ \$1,068 ] (Part A deductible)	[ \$1,068 ] (Part A deductible)	<b>Nothing</b>
Days 61-90	All but [ \$267 ] per day (Part A coinsurance)	[ \$267 per day ]	<b>Nothing</b>
Days 91-150 (lifetime reserve days)	All but [ \$534 ] per day	[ \$534 per day ]	<b>Nothing</b>
<i>After lifetime reserve days are used:</i> <ul style="list-style-type: none"> <li>• Additional 365 days lifetime</li> <li>• Beyond the additional 365 days</li> </ul>	Nothing Nothing	All costs Nothing	<b>Nothing<sup>3</sup></b> All costs
<b>Blood</b>			
First 3 pints (blood deductible)	Nothing	First 3 pints	<b>Nothing</b>
<b>Skilled Nursing Facility<sup>4</sup></b>			
First 20 days	100% of costs	Nothing	<b>Nothing</b>
Days 21-100	All but [ \$133.50 ] per day (skilled nursing coinsurance)	[ \$133.50 per day ]	<b>Nothing</b>
Beyond 100 days	Nothing	Nothing	All costs
<b>Hospice Care</b>			
Available for the terminally ill who elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare coinsurance	Nothing

## Medicare Part B—Medical Expenses *(per calendar year)*

BENEFITS	MEDICARE PAYS	FREEDOM PLAN F PAYS	YOU PAY <sup>2</sup>
<b>Physician Services and Other Medical Expenses In or Out of the Hospital</b>			
First [ \$135 ] of Medicare-approved expenses each calendar year	Nothing	[ \$135 ] (Part B deductible)	<b>Nothing</b>
Remainder of Medicare-approved amounts	Generally 80% (Part B coinsurance)	Generally 20%	<b>Nothing</b>
Covered charges in excess of Medicare approved amounts, up to any charge limitations established by state or federal law <sup>5</sup>	Nothing	100%	<b>Nothing</b>
<b>Blood</b>			
First 3 pints (blood deductible)	Nothing	First 3 pints	<b>Nothing</b>

## Medicare Parts A and B

BENEFITS	MEDICARE PAYS	FREEDOM PLAN F PAYS	YOU PAY <sup>2</sup>
<b>Home Health Care Medicare-Approved Services</b>			
Covered home care visits and medical supplies	100%	Nothing	<b>Nothing</b>
<b>Durable medical equipment</b>			
• First [ \$135 ] of Medicare-approved amounts (Part B deductible)	Nothing	[ \$135 ] (Part B deductible)	<b>Nothing</b>
• Remainder of Medicare-approved amounts	80%	20%	<b>Nothing</b>

## Freedom Medicare Supplement Plan F also pays these expenses not covered by Medicare...

ADDITIONAL BENEFITS of PLAN F	MEDICARE PAYS	FREEDOM PLAN F PAYS	YOU PAY <sup>2</sup>
<b>Foreign Travel</b>			
Medically necessary emergency hospital and medical care beginning during the first 60 days of each trip outside the USA	Nothing	[ 80% ] of covered charges after a [ \$250 ] deductible each calendar year, up to [ \$50,000 ] lifetime	Balance

# Questions and Answers about Freedom Solutions Plan F

## Q: I've applied for coverage. What happens next?

A: Once we receive your request for coverage, a representative may contact you to review the health questions you answered on the application.

## Q: I've been approved for coverage. What happens now?

A: You'll receive a kit that includes all the information you need to start using your plan – including your ID card.

## Q: With Freedom Solutions Plan F, can I see the same doctor I see now?

A: Yes, you can choose any doctor you wish. There are no networks, so you're free to use the doctors and hospitals of your choice – even when you travel.

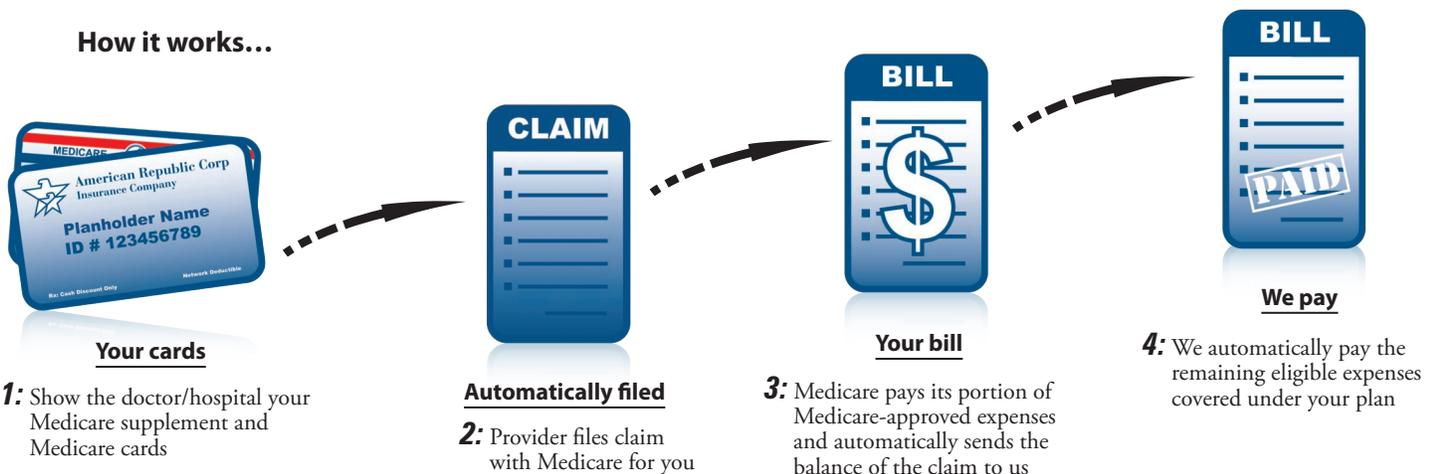
## Q: Do we both have to have Freedom Solutions Plan F coverage to get the couples discount?

A: No, you can get additional savings just for being part of a couple<sup>1</sup> – regardless of whether you both sign up for coverage with American Republic Corp.

## Q: How does the ExpressLane Automatic Claim Service work?

A: ExpressLane Automatic Claim Service is a free service that works with Medicare to make sure your claims get paid quickly and accurately with no paperwork on your part in most cases. ExpressLane is available in all 50 states, so it will take care of your claims no matter where you receive treatment.

### How it works...



# Disclosures and Important Information

**PREMIUMS AND RENEWABILITY.** Your coverage may be renewed for life so long as the policy remains in force and your premiums are paid on time. Your benefits and premiums will vary depending on the plan selected. Your premium could change if you move to a different area. Should a necessary premium change be made, it will only be made on a renewal date and only if it is made on all policies in the same class as determined by us. Premiums will increase because a person is one year older (except in AZ, AR, GA and MO).

**READ YOUR POLICY CAREFULLY.** This booklet provides a very brief description of the important policy features; it is not the insurance contract. Your policy contains all of the provisions with which both you and the Company must comply. It sets forth in detail the rights and obligations of both you and your insurance company. THIS IS A LIMITED POLICY DESIGNED TO COVER ONLY THOSE EXPENSES WHICH MEDICARE APPROVES BUT DOES NOT PAY. You will have a 30-day free-look period to review your policy. If you decide to send the policy back to us within this period, we will return all premiums.

In Colorado, Kansas, Mississippi, Missouri, North Carolina, New Hampshire, Oklahoma, Oregon and South Dakota, coverage is available to qualified Medicare beneficiaries under age 65.

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. For Medicare Supplement plans, the Outline of Medicare Supplement Coverage form is provided.

This is a solicitation of insurance and an agent may contact you.

Not connected with or endorsed by the United States government or the federal Medicare program.

1 A couple is defined as two people living in the same household, regardless of sex, who are recognized as being legally married, married under common law, or having a civil union.

2 This is your liability for covered charges. You are responsible for all other non-covered charges.

3 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 the balance based on any difference between its billed charges and the amount Medicare would have paid for Medicare-covered items or services.

4 Medicare only covers approved skilled nursing care in a Medicare-approved facility. Facility licensing terminology may vary by state and may not use "skilled nursing facility" terminology (i.e. nursing facility in Iowa). Freedom Medicare Supplement pays the skilled nursing coinsurance for Medicare-approved stays in facilities certified to provide Medicare skilled care.

5 Under federal law, doctors who do not accept assignment can charge up to 115% of the fee schedule amount for nonparticipating physicians. The patient does not have to pay charges that exceed that amount. Laws in Ohio prohibit medical providers from balance billing for charges above the Medicare-approved amount. Therefore, Ohio policies provide benefits for Part B excess charges only when services are rendered in another state.

Offered Through:  
**Place Affinity Group  
logo here**

[ Underwritten by: ]  
 **American Republic Corp  
Insurance Company**

A wholly owned subsidiary of American Republic  
Insurance Company of Des Moines, Iowa

**Your Affinity Group Agent is:**

We have additional Medicare supplement plans for you. Ask your agent for details.

### **30-Day Free Look Period**

Take 30 days to review your coverage. If for any reason at all you decide this is not what you had in mind, just return your Certificate or policy. We will promptly cancel your coverage and refund any money you are owed.

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SM ExpressLane Claim Service is a servicemark of American Republic Insurance Company

Plan availability varies by state.

Forms: A3101AC; in MO, A3101AC-MO; in OK, A3101AC-OK; in PA, A3101AC-PA

*SERFF Tracking Number:* AMRP-126211350      *State:* Arkansas  
*Filing Company:* American Republic Corp Insurance Company      *State Tracking Number:* 42834  
*Company Tracking Number:* 2010 MED SUPP AR CORP - PLAN F  
*TOI:* MS08I Individual Medicare Supplement -      *Sub-TOI:* MS08I.005 Plan F (Basic) 2010  
Standard Plans 2010  
*Product Name:* 2010 Med Supp AR Corp - Plan F  
*Project Name/Number:* 2010 Med Supp AR Corp - Plan F/2010 Med Supp AR Corp - Plan F

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: AMRP-126211350 State: Arkansas  
Filing Company: American Republic Corp Insurance Company State Tracking Number: 42834  
Company Tracking Number: 2010 MED SUPP AR CORP - PLAN F  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010  
Standard Plans 2010  
Product Name: 2010 Med Supp AR Corp - Plan F  
Project Name/Number: 2010 Med Supp AR Corp - Plan F/2010 Med Supp AR Corp - Plan F

## 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 F.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

<b>PLAN A</b>									
<b>A3100AC</b>									
<b>Age 65 - 99</b>	<b>APP</b>								
	<b>PREFERRED</b>				<b>STANDARD</b>				
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
		113.36	113.36	128.29	128.29	133.36	133.36	150.92	150.92
	<b>MONTHLY</b>								
	<b>PREFERRED</b>				<b>STANDARD</b>				
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
		118.33	118.33	133.92	133.92	139.22	139.22	157.55	157.55
	<b>QUARTERLY</b>								
	<b>PREFERRED</b>				<b>STANDARD</b>				
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
		340.04	340.04	384.83	384.83	400.05	400.05	452.74	452.74
	<b>SEMI-ANNUAL</b>								
	<b>PREFERRED</b>				<b>STANDARD</b>				
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
		680.09	680.09	769.65	769.65	800.11	800.11	905.48	905.48
<b>ANNUAL</b>									
<b>PREFERRED</b>				<b>STANDARD</b>					
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>			
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>		
	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

<b>PLAN A</b>								
<b>A3100AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	119.08	119.08	134.76	134.76	140.10	140.10	158.55	158.55
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	124.31	124.31	140.68	140.68	146.25	146.25	165.51	165.51
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	357.22	357.22	404.26	404.26	420.26	420.26	475.60	475.60
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	714.44	714.44	808.52	808.52	840.51	840.51	951.21	951.21
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

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

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

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

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

Age 65 - 99

**Arkansas**  
**Medicare Supplement Rates**  
**Zip Codes 722**

Effective 6-1-2010

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

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

<b>PLAN K A3104AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	80.41	80.41	91.00	91.00	94.60	94.60	107.06	107.06
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	83.94	83.94	94.99	94.99	98.75	98.75	111.76	111.76
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	241.20	241.20	272.97	272.97	283.77	283.77	321.14	321.14
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	482.41	482.41	545.95	545.95	567.54	567.54	642.29	642.29
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN K A3104AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	84.47	84.47	95.59	95.59	99.37	99.37	112.46	112.46
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	88.18	88.18	99.79	99.79	103.74	103.74	117.40	117.40
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	253.39	253.39	286.76	286.76	298.10	298.10	337.36	337.36
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	506.77	506.77	573.52	573.52	596.20	596.20	674.73	674.73
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN K A3104AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	93.40	93.40	105.71	105.71	109.89	109.89	124.36	124.36
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	97.50	97.50	110.35	110.35	114.71	114.71	129.82	129.82
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	280.19	280.19	317.09	317.09	329.63	329.63	373.05	373.05
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	560.37	560.37	634.18	634.18	659.26	659.26	746.09	746.09
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN K A3104AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	89.34	89.34	101.11	101.11	105.11	105.11	118.95	118.95
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	93.27	93.27	105.55	105.55	109.72	109.72	124.18	124.18
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	268.01	268.01	303.30	303.30	315.30	315.30	356.83	356.83
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	536.01	536.01	606.61	606.61	630.60	630.60	713.66	713.66
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN L</b>								
<b>A3105AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	110.64	110.64	125.21	125.21	130.16	130.16	147.31	147.31
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	115.50	115.50	130.71	130.71	135.88	135.88	153.78	153.78
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	331.90	331.90	375.60	375.60	390.46	390.46	441.89	441.89
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	663.79	663.79	751.20	751.20	780.93	780.93	883.77	883.77
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN L</b>								
<b>A3105AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	116.23	116.23	131.53	131.53	136.74	136.74	154.75	154.75
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	121.33	121.33	137.31	137.31	142.74	142.74	161.54	161.54
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	348.66	348.66	394.57	394.57	410.19	410.19	464.20	464.20
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	697.32	697.32	789.14	789.14	820.37	820.37	928.41	928.41
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

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

<b>PLAN L</b>								
<b>A3105AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	122.93	122.93	139.12	139.12	144.63	144.63	163.67	163.67
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	128.33	128.33	145.23	145.23	150.98	150.98	170.86	170.86
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	368.77	368.77	417.34	417.34	433.85	433.85	490.98	490.98
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	737.55	737.55	834.67	834.67	867.70	867.70	981.97	981.97
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,068]  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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital First 20 days 21st thru 100th day  101st day and after	All approved amounts All but [\$133.50] a day  \$0	\$0 \$0  \$0	\$0 Up to [\$133.50] a day  All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts* (Part B deductible) Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	[\$135] (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Medicare (Parts A and B) - Home Health Care**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul> First [\$135] of Medicare Approved Amounts* 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,068]  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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital First 20 days 21st thru 100th day  101st day and after	All approved amounts All but [\$133.50] a day  \$0	\$0 Up to [\$133.50] a day  \$0	\$0 \$0  All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
• 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
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$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*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,068]  All but [\$267] a day  All but [\$534]  \$0  \$0	[\$534] (50% of Part A deductible)  [\$267] a day  [\$534] a day  100% of Medicare Eligible expenses  \$0	[\$534] (50% of Part A deductible)◆  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE**</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$66.75] a day \$0	\$0 Up to [\$66.75] a day◆ All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	50% \$0	50%◆ \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts****	\$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%◆
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
<b>BLOOD</b> 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%◆
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	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
<b>HOME HEALTH CARE</b>			
<b>MEDICARE-APPROVED SERVICES</b>			
<ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul>	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*
<b>HOSPITALIZATION**</b>			
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
<b>SKILLED NURSING FACILITY CARE**</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50 a day]	Up to [\$100.13] a day	Up to [\$33.38] a day◆
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts**** 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%◆
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
<b>BLOOD</b> 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%◆
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	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
<b>HOME HEALTH CARE</b>			
<b>MEDICARE-APPROVED SERVICES</b>			
<ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul>	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 F – A3101AC

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 Outline of Coverage and the Replacement form to be used with this form has been submitted under SERFF number AMRP-126211046.

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](mailto: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 A3101AC	Medicare Supplement Plan F
American Republic Corp Rates and Actuarial Memorandums	Medicare Supplement Memorandums and Rates

SERFF Tracking Number: AMRP-126211350 State: Arkansas  
 Filing Company: American Republic Corp Insurance Company State Tracking Number: 42834  
 Company Tracking Number: 2010 MED SUPP AR CORP - PLAN F  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010  
 Standard Plans 2010  
 Product Name: 2010 Med Supp AR Corp - Plan F  
 Project Name/Number: 2010 Med Supp AR Corp - Plan F/2010 Med Supp AR Corp - Plan F

## 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	Supporting Document	Outline of Coverage	06/30/2009	12-114-2758-XXXX AR (U3100ACAR).pdf
No original date	Form	Plan F	06/30/2009	A3101AC - Plan F.pdf

**Medicare Supplement Policy – Benefit Plan F**  
**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.

### **Additional Benefits**

- a. Medicare (Part A) Hospital Insurance Deductible – We will pay the Medicare (Part A) Initial Hospital Insurance Deductible.
- b. Skilled Nursing Facility Expenses – We will pay the actual billed charge up to the Medicare daily coinsurance charge (deductible) for days 21 through 100 of a Medicare-approved skilled nursing facility stay.
- c. Medicare (Part B) Medical Insurance Deductible – We will pay the Medicare (Part B) Medical Insurance Deductible.
- d. 100% Medicare Part B Excess Charges – We will pay up to 100% of the excess charge for eligible expenses approved but not paid by Medicare. “**Excess charge**” is the difference between the actual billed amount, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- e. Medically Necessary Emergency Care in a Foreign Country – We will provide coverage to the extent not covered by Medicare for 80% of billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country.

Benefits will be paid if the care would have been covered by Medicare if provided in the United States. Such care must begin during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250 and a lifetime maximum of \$50,000.

“**Emergency care**” means care needed immediately because of an injury or a sickness of sudden and unexpected onset.

## **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 }

<b>PLAN A A3100AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	119.08	119.08	134.76	134.76	140.10	140.10	158.55	158.55
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	124.31	124.31	140.68	140.68	146.25	146.25	165.51	165.51
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	357.22	357.22	404.26	404.26	420.26	420.26	475.60	475.60
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	714.44	714.44	808.52	808.52	840.51	840.51	951.21	951.21
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

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

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

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

<b>PLAN F</b>								
<b>A3101AC</b>								
<b>APP</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
180.65	180.65	204.44	204.44	212.52	212.52	240.52	240.52	
<b>MONTHLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
188.58	188.58	213.42	213.42	221.86	221.86	251.08	251.08	
<b>QUARTERLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
541.90	541.90	613.27	613.27	637.52	637.52	721.50	721.50	
<b>SEMI-ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
1,083.79	1,083.79	1,226.55	1,226.55	1,275.05	1,275.05	1,442.99	1,442.99	
<b>ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN F</b>								
<b>A3101AC</b>								
<b>APP</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
172.79	172.79	195.55	195.55	203.28	203.28	230.06	230.06	
<b>MONTHLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
180.38	180.38	204.14	204.14	212.21	212.21	240.16	240.16	
<b>QUARTERLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
518.34	518.34	586.61	586.61	609.81	609.81	690.13	690.13	
<b>SEMI-ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
1,036.67	1,036.67	1,173.22	1,173.22	1,219.61	1,219.61	1,380.26	1,380.26	
<b>ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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	

<b>PLAN K A3104AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	93.40	93.40	105.71	105.71	109.89	109.89	124.36	124.36
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	97.50	97.50	110.35	110.35	114.71	114.71	129.82	129.82
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	280.19	280.19	317.09	317.09	329.63	329.63	373.05	373.05
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	560.37	560.37	634.18	634.18	659.26	659.26	746.09	746.09
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN K A3104AC</b>								
<b>Age 65 - 99</b>	<b>APP</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	89.34	89.34	101.11	101.11	105.11	105.11	118.95	118.95
	<b>MONTHLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	93.27	93.27	105.55	105.55	109.72	109.72	124.18	124.18
	<b>QUARTERLY</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	268.01	268.01	303.30	303.30	315.30	315.30	356.83	356.83
	<b>SEMI-ANNUAL</b>							
	<b>PREFERRED</b>				<b>STANDARD</b>			
	<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>
	536.01	536.01	606.61	606.61	630.60	630.60	713.66	713.66
<b>ANNUAL</b>								
<b>PREFERRED</b>				<b>STANDARD</b>				
<b>COUPLE</b>		<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>		
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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

<b>PLAN L</b>								
<b>A3105AC</b>								
<b>APP</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
110.64	110.64	125.21	125.21	130.16	130.16	147.31	147.31	
<b>MONTHLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
115.50	115.50	130.71	130.71	135.88	135.88	153.78	153.78	
<b>QUARTERLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
331.90	331.90	375.60	375.60	390.46	390.46	441.89	441.89	
<b>SEMI-ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
663.79	663.79	751.20	751.20	780.93	780.93	883.77	883.77	
<b>ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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	

<b>PLAN L</b>								
<b>A3105AC</b>								
<b>APP</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
128.52	128.52	145.45	145.45	151.20	151.20	171.11	171.11	
<b>MONTHLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
134.17	134.17	151.83	151.83	157.84	157.84	178.63	178.63	
<b>QUARTERLY</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
385.54	385.54	436.31	436.31	453.57	453.57	513.30	513.30	
<b>SEMI-ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
771.07	771.07	872.61	872.61	907.14	907.14	1,026.60	1,026.60	
<b>ANNUAL</b>								
<b>PREFERRED</b>					<b>STANDARD</b>			
<b>COUPLE</b>			<b>SINGLE</b>		<b>COUPLE</b>		<b>SINGLE</b>	
<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>	<b>Male</b>	
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><b>HOSPITALIZATION*</b></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"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	<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><b>SKILLED NURSING FACILITY CARE*</b></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><b>BLOOD</b></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><b>HOSPICE CARE</b></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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts* (Part B deductible)	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**Medicare (Parts A and B) - Home Health Care**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
• 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,068]  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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital First 20 days 21st thru 100th day  101st day and after	All approved amounts All but [\$133.50] a day  \$0	\$0 Up to [\$133.50] a day  \$0	\$0 \$0  All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [\$135] of Medicare Approved Amounts*	\$0	[\$135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b>			
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
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>			
• 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
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$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*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:                             <ul style="list-style-type: none"> <li>• Additional 365 days</li> </ul> </li> <li>• Beyond the additional 365 days</li> </ul>	All but [\$1,068]  All but [\$267] a day  All but [\$534]  \$0  \$0	[\$534] (50% of Part A deductible)  [\$267] a day  [\$534] a day  100% of Medicare Eligible expenses  \$0	[\$534] (50% of Part A deductible)◆  \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE**</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$66.75] a day \$0	\$0 Up to [\$66.75] a day◆ All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	50% \$0	50%◆ \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts****	\$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%◆
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])*
<b>BLOOD</b> 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%◆
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	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
<b>HOME HEALTH CARE</b>			
<b>MEDICARE-APPROVED SERVICES</b>			
<ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul>	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*
<b>HOSPITALIZATION**</b>			
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
<b>SKILLED NURSING FACILITY CARE**</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50 a day]	Up to [\$100.13] a day	Up to [\$33.38] a day◆
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts****	\$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%◆
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2,310])*
<b>BLOOD</b> 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%◆
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	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
<b>HOME HEALTH CARE</b>			
<b>MEDICARE-APPROVED SERVICES</b>			
<ul style="list-style-type: none"> <li>• Medically necessary skilled care services and medical supplies</li> <li>• Durable medical equipment</li> </ul>	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.