Filing at a Glance

Company: World Corp Insurance Company

Product Name: 2010 Med Supp World Corp - Plan HdF

SERFF Tr Num: AMRP-126211688

State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010

SERFF Status: Closed-Approved-Closed

State Tr Num: 42829

Sub-TOI: MS08I.006 Plan F (High) 2010

Co Tr Num: 2010 MED SUPP WORLD CORP - PLAN HDF

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Stephanie Fowler

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

Disposition Date: 08/06/2009

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 World Corp - Plan HdF

Project Number: 2010 Med Supp World Corp - Plan HdF

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/06/2009

Deemer Date:

Submitted By: Sarah Shives

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/06/2009

Created By: Sarah Shives

Corresponding Filing Tracking Number: AMRP-126211605, AMRP-126211661

Filing Description:

Please see Cover Letter under 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

World Corp Insurance Company	CoCode: 79987	State of Domicile: Nebraska
11808 Grant Street	Group Code: 3527	Company Type: Life and Health
P O Box 3160	Group Name: American Enterprise	State ID Number:
Omaha, NE 68103-0160	FEIN Number: 56-0710065	
(402) 486-8289 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	$50 (policy) + $50 (rates) = $100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
World Corp Insurance Company	$100.00	07/01/2009	28916409

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	07/31/2009	07/31/2009	Sarah Shives	08/06/2009	08/06/2009

Disposition

Disposition Date: 08/06/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMRP-126211688*	*State:*	*Arkansas*
Filing Company:	*World Corp Insurance Company*	*State Tracking Number:*	*42829*
Company Tracking Number:	*2010 MED SUPP WORLD CORP - PLAN HDF*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.006 Plan F (High) 2010*
Product Name:	*2010 Med Supp World Corp - Plan HdF*		
Project Name/Number:	*2010 Med Supp World Corp - Plan HdF/2010 Med Supp World Corp - Plan HdF*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	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 HdF	Approved	Yes
Form	Plan HdF	Disapproved	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/31/2009
Submitted Date	07/31/2009
Respond By Date	08/31/2009

Dear Sarah Shives,

This will acknowledge receipt of the captioned filing.

Objection 1

- Plan HdF, A3112WC (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 2

- Plan HdF, A3112WC (Form)

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

Objection 3

- Outline of Coverage (Supporting Document)

Comment: Please remove the first sentence of the second paragraph under the "Premium Information" section. This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

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

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 sentence regarding attained age from page 1 of the policy as requested.

Related Objection 1

Applies To:

- Plan HdF, A3112WC (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 HdF	A3112WC		Policy/Contract/Fraternal Certificate	Initial		61.000	A3112WC -AR - Plan F-HD 8-6.pdf
Previous Version							
Plan HdF	*A3112WC*		*Policy/Contract/Fraternal*	*Initial*		*61.000*	A3112WC

	Certificate	- Plan F-HD.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: I have correct the typographical error within the bolding of the term "Benefit Period." Thank you for bringing this to my attention.

Related Objection 1

Applies To:

- Plan HdF, A3112WC (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 HdF	A3112WC		Policy/Contract/Fraternal Certificate	Initial		61.000	A3112WC -AR - Plan F-HD 8-6.pdf
Previous Version							
Plan HdF	*A3112WC*		*Policy/Contract/Fraternal Certificate*	*Initial*		*61.000*	A3112WC - Plan F-HD.pdf

No Rate/Rule Schedule items changed.

Response 3

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)

Comment:

Please remove the first sentence of the second paragraph under the "Premium Information" section. 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:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

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

Sincerely,

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

Form Schedule

Lead Form Number: A3112WC

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 08/06/2009	A3112WC	Policy/Contract/Fraternal Certificate	Plan HdF	Initial		61.000	A3112WC-AR - Plan F-HD 8-6.pdf

WORLD CORP INSURANCE COMPANY
P.O. Box 2115 • Omaha, Nebraska 68103-2115
A Stock Insurance Company

Medicare Supplement Policy – Benefit High Deductible 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, World Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

[Michael E Abbott — President | Mary K Durand — Secretary | Paul K Mikkelson — Countersignature]

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

Table of Contents

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Part A – 30-Day Right to Examine ..... [1]

Part B – Guaranteed Renewable; Premiums Subject to Change ..... [1]

Part C – Definitions ..... [4]

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Part F – Benefit Extension ..... [6]

Part G – Exclusions ..... [6]

Part H – Premium Provisions ..... [6]

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Part J – How to File a Claim ..... [7]

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Part L – General Provisions ..... [8]

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]

<u>PREMIUMS:</u>

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 World 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.

"Annual High Deductible" means the amount the covered person must satisfy each calendar year before we begin paying benefits under this contract. The annual high deductible includes Out-of-Pocket expenses, other than premiums, for service covered as benefits under this policy and shall be in addition to any other specific benefit deductibles. Expenses incurred before the Policy Date of this coverage will not be applied to this deductible.

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 after the covered person has satisfied their annual high deductible each calendar year. 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 Extension

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 reinstituted. 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 reinstitution:

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 is 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: World Corp Insurance Company, [P.O. Box 2155, Omaha, Nebraska 68103-2155], 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 Provisions

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.

Times 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 Actions – 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 Laws – 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.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	08/06/2009

Comments:

Attachment:

Compliance Certification - WCIC - AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	08/06/2009

Comments:

Attachments:

G3110WC.pdf

Supporting Doc - Terms US version.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	08/06/2009

Comments:

Attachment:

11-114-2758-XXXX AR (U3110WCAR) 8-6.pdf

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Accepted for Informational Purposes	08/06/2009

Comments:

Attachment:

World Corp Cover Letter Arkansas - Plan HdF.pdf

WORLD CORP
INSURANCE COMPANY
TM
P.O. Box 2155, Omaha, NE 68103-2155

To: Department of Insurance

RE: Forms A3110WC (Medicare Supplement Plan A), A3111WC (Medicare Supplement Plan F), A-3112WC (Medicare Supplement High Deductible Plan F) and U3110WCAR (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.

Christopher Aasland, FSA, MAAA
Vice President and Actuary

Date: July 1, 2009

WORLD CORP INSURANCE COMPANY℠
P.O. Box 2155, Omaha, NE 68103-2155

REQUEST FOR MEDICARE SUPPLEMENT COVERAGE

Plan Applied For: *(check one)*

[☐ Plan A ☐ Plan F ☐ High Deductible Plan F]

1 ABOUT YOU

First Name	M.I.	Last Name

Date of Birth	Sex	Social Security Number
MM / DD / YYYY	☐ M ☐ F	

Home Address	City	State	ZIP Code

Alternate Mailing Address	City	State	ZIP Code

Home Telephone Number	Alternate Telephone Number
Area Code	Area Code

Email Address ***(Your email address will never be shared or sold. It may be used to send you important notices.)***

2 YOU MAY BE GUARANTEED ACCEPTANCE

A. Did you enroll in Medicare Part B within the last 6 months? . . . . . ☐ YES ☐ NO

B. Are you within 6 months before your 65th birthday? . . . . . ☐ YES ☐ NO

C. What is your Medicare Part B effective date: *(See your red, white and blue Medicare card)* . . . . . MM / DD / YYYY

D. What is your Medicare Claim Number? *(See your red, white and blue Medicare card)*. . . . . .

If you answered "YES" TO QUESTIONS A and B, you are considered an OPEN ENROLLEE for Medicare supplement coverage. You can skip to Section 6.

E. If you lost or are losing other health insurance coverage:
Did you receive a notice from that health insurance company stating you were eligible for guaranteed issue of a Medicare supplement insurance policy OR that you had certain rights to buy a policy? .. . . . . ☐ YES ☐ NO

If you answered "YES" to QUESTION E, and are unable to provide a Termination Notice, please complete all sections of this application form.

F. Will you be providing us a copy of your Termination Notice? . . . . . ☐ YES ☐ NO

If you answered "YES" to QUESTION F, please FAX or mail a copy of your Termination Notice to the information listed below. Please skip to Section 6.

Fax Number
(402) 496-8377

Address	City	State	ZIP Code
World Corp Insurance Company P. O. Box 2155	Omaha	NE	68103-2155

If we do not receive a copy of your Termination Notice, we cannot process your application as a guaranteed issue applicant and you will be required to answer additional health questions.

3 GENERAL HEALTH

If you answer **"YES"** to questions A-C in this section, coverage is not available.

A. In the past 5 years, have you:
- been treated for or diagnosed as having diabetes requiring insulin;
- been treated for or advised to have a bone marrow or organ transplant;
- been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome *(AIDS)*? . . . . . ☐ YES ☐ NO

B. In the past 2 years have you:
- been treated for or diagnosed as having internal cancer, melanoma, leukemia, Hodgkin's Disease, or lymphoma;
- had heart surgery *(including bypass or balloon)*;
- been treated or diagnosed as having congestive heart failure, heart attack, peripheral vascular disease *(poor circulation in your extremities)*, or had angioplasty or stent placement of any vessel;
- used oxygen for any chronic lung disease *(for example, emphysema or chronic obstructive pulmonary disease (COPD))*;
- been treated for or diagnosed as having had a stroke or Transient Ischemic Attack *(TIA)*;
- been treated for or diagnosed as having disabling arthritis or connective tissue disease *(for example, lupus)*;
- been diagnosed as having cirrhosis of the liver, chronic renal failure, kidney failure, or have you had dialysis;
- been treated for or diagnosed as having Amyotrophic Lateral Sclerosis *(ALS)*, Parkinson's or Multiple Sclerosis;
- been treated for or diagnosed as having alcoholism or drug addiction;
- been or are now bedridden or confined to a wheelchair? . . . . . ☐ YES ☐ NO

C. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Organic Brain Syndrome or senile dementia? . . . . . ☐ YES ☐ NO

D. What is your height? . . . . . **Height** Ft. In.

E. What is your weight? . . . . . **Weight** lbs.

4 MEDICAL QUESTIONS

If you answer "**YES**" to any of the following questions, please provide details in the space allotted for each question.

A. Do you require assistance or supervision to perform any of the following everyday living activities: dressing, eating, bathing, toileting (including use of catheter), or walking *(including use of cane, walker or motorized scooter)*? . . . . . ☐ YES ☐ NO
If "**YES**", please provide details below.

Type of Assistance	For Which Activities

B. Have you been advised by a member of the medical profession to have surgery, including cataract surgery, that has not yet been performed? . . . . . ☐ YES ☐ NO
If "**YES**", please provide details below.

Condition	Type of Surgery Suggested	Dates of Treatment
		MM / DD / YYYY
		MM / DD / YYYY
		MM / DD / YYYY

C. Have you been hospitalized or confined to a nursing facility within the past 60 days or been hospitalized 3 or more times in the past 2 years? . . . . . ☐ YES ☐ NO
If "**YES**", please provide details below.

Condition	Type of Facility and Treatment Given	Dates of Treatment
		MM / DD / YYYY
		MM / DD / YYYY
		MM / DD / YYYY

4 MEDICAL QUESTIONS *(continued)*

D. Are you receiving or have you received treatment within the past 2 years for mental, nervous or seizure disorder? . . . . . ☐ YES ☐ NO
If "**YES**", please provide details below.

Condition	Type of Facility and Treatment Given	Dates of Treatment
		MM / DD / YYYY
		MM / DD / YYYY
		MM / DD / YYYY

E. Do you take prescription drugs? . . . . . ☐ YES ☐ NO
If "**YES**", please provide details below.

Your Medication (copy from label)	Reason	Dosage/Frequency

F. Please provide the date and reason for your last visit to a physician.

Physician's Name	Phone Number
	Area Code

Reason for Visit	Date of Visit
	MM / DD / YYYY

5 PREFERRED RATES

All questions must be answered "**NO**" to be eligible for Preferred Rates. If you answer "**YES**" to any of the following questions, Standard Rating will apply.

A. Have you used tobacco in any form in the last 2 years? . . . . . ☐ YES ☐ NO

B. Are you a diabetic controlled by diet or oral medication?. . . . . ☐ YES ☐ NO

C. Do you regularly take 3 or more maintenance prescription medications *(for example, medication for blood pressure, asthma or heart disease)*? . . . . . ☐ YES ☐ NO

6 COUPLE'S DISCOUNT

Complete the following section to determine eligibility for the Couple's Discount. If you answer "**NO**" to any of the questions in this section, you are not eligible for the Couple's Discount.

A. Are you part of a couple? *(Two people, regardless of sex, who are recognized as being legally married, married under common law, or having a civil union living at the same address)* . . . . . ☐ YES ☐ NO

B. Do you live at the same address as your significant other? . . . . . ☐ YES ☐ NO

Your significant other does not need to apply for you to receive the Couple's Discount, but the following information is required so that we can contact your significant other to confirm this relationship.

First Name	M.I.	Last Name

Home Address	City	State	ZIP Code

Date of Birth	Home Telephone Number
MM / DD / YYYY	Area Code

If your significant other has Medicare Supplement coverage, please complete the following.

Company

7 PRIOR OR EXISTING COVERAGE

A. Are you covered for medical assistance through the state **MEDICAID** program?
NOTE: If you are participating in a Spend-Down Program and have not met your Share of Cost, please answer "**NO**" to this question. . . . . ☐ YES ☐ NO

If "**YES**," will Medicaid pay your premium for this Medicare supplement policy? . . . . . ☐ YES ☐ NO

If "**YES**," do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?. . . . . ☐ YES ☐ NO

B. If you had coverage from any Medicare plan other than original Medicare within the past 63 days, fill in your start and end date. If you are still covered under this plan, leave "**END**" blank.
(Examples of other plans include a Medicare Advantage plan or a Medicare HMO or PPO.). . . . . .

Start	End
MM / DD / YYYY	MM / DD / YYYY

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? . . . . . ☐ YES ☐ NO

Was this your first time in this type of Medicare plan?. . . . . ☐ YES ☐ NO

Did you drop a Medicare supplement policy to enroll in the Medicare plan? . . . . . ☐ YES ☐ NO

C. Do you have another Medicare supplement policy in force? . . . . . ☐ YES ☐ NO

If "**YES**," with what company, and what plan do you have?. . . . . .

COMPANY

PLAN

If "**YES**," do you intend to replace your current Medicare supplement policy with this policy?. . . . . ☐ YES ☐ NO

D. Have you had coverage under any other heath insurance within the past 63 days
(for example, an employer, union or individual plan)? . . . . . ☐ YES ☐ NO

If "**YES**," with what company, and what kind of policy?. . . . . .

COMPANY

PLAN

If "**YES**," what are your dates of coverage under the other policy?. . . . . .
If you are still covered under the other policy, leave "**END**" blank.

Start	End
MM / DD / YYYY	MM / DD / YYYY

8 PLEASE READ AND SIGN

You do not need more than one Medicare policy or certificate.

If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need Medicare supplement coverage.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later became covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You will be provided with an Outline of Coverage and The Guide to Health Insurance for People with Medicare and you understand your insurance will not become effective until you are eligible for Medicare.

I acknowledge that I have access to the World Corp Insurance Company Outline of Coverage and the Guide to Health Insurance for People with Medicare.

I have read the completed application, including Section 8, and I understand it.

I represent to the best of my knowledge and belief that I have answered the questions on this application truthfully and completely. I understand that my coverage will not begin until World Corp Insurance Company receives and accepts this application and applicable payment and assigns an effective date of coverage; that I understand that I will be informed whether or not my application has been accepted within 90 days (60 days in Missouri) or be given a reason for further delay.

WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive may be guilty of a crime and could be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Your Signature	Date
X	MM / DD / YYYY

Preferred Rates:
You may be eligible for preferred rates. The qualifications include the following:

- No tobacco use in any form in the last 2 years.
- No diagnosis of diabetes.
- You are on 2 or fewer maintenance prescription medication(s).

If all of these statements are true you may be eligible for preferred rates.

Standard Rates:
Anyone not eligible for preferred rate will be eligible, for standard rate.

Open Enrollment:
Open enrollment is the period of time when an applicant is guaranteed that coverage will be issued regardless of health history. The six-month period begins the first day of the month when the applicant turns 65 and enrolled in Medicare Part B. There are three situations under which an applicant can qualify for open enrollment:

- Applicant is age 65 or older and is first becoming enrolled in Medicare Part B.
- Applicant is already enrolled in Medicare Part B (usually due to disability) and is turning age 65. (Open enrollment regulations may vary by state.) During this time, an insurance company cannot deny coverage, make applicants wait for coverage to start, or charge more for policies because of health problems.
- Some states allow Medicare-eligible individuals under the age of 65 to apply for Medicare Supplement coverage.

Guaranteed Issue:
Federal law provides that certain individuals applying for Medicare Supplement coverage who are outside their normal open enrollment period and who may not otherwise medically qualify for coverage may, under certain situations, be eligible for guaranteed issue coverage without pre-existing limitations. The applicant must have had continuous creditable coverage (with no breaks in coverage greater than 63 days) and fall into one of the guaranteed issue categories (see chart).

An insurance company can't refuse to sell you a Medigap policy in the following situations:

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
#1: You are in a **Medicare Advantage Plan**, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area. **Note:** If you immediately join another Medicare Advantage Plan, you can stay in that plan for up to 1 year and still have the rights in situations #4 and #5.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company. You only have this right if you switch to Original Medicare rather than joining another Medicare Advantage Plan.	You can apply up to 60 calendar days before the date your health care coverage will end. You must apply no later than 63 calendar days after your health care coverage ends.
#2: You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending. **Note:** In this situation, state laws may vary.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until the COBRA coverage ends.	You must apply no later than 63 calendar days after the latest of these three dates: 1. Date the coverage ends 2. Date on the notice you get telling you that coverage is ending (if you get one) 3. Date on a claim denial, if this is the only way you know that your coverage ended
#3: You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. You can keep your Medigap policy or you may want to switch to another Medigap policy.	Medigap Plan A, B, C, F, K, or L that is sold by any insurance company in your state or the state you are moving to.	You can apply up to 60 calendar days before the date your health care coverage will end. You must apply no later than 63 calendar days after your health care coverage ends.

An insurance company can't refuse to sell you a Medigap policy in the following situations: (continued)

You have a guaranteed issue right if...	You have the right to buy...	You can/must apply for a Medigap policy...
#4: (**Trial Right**) You joined a **Medicare Advantage Plan** or PACE when you were first eligible for Medicare Part A at age 65, and within the first year of joining, you decide you want to switch to Original Medicare.	Any Medigap policy that is sold in your state by any insurance company.	You can apply up to 60 calendar days before the date your coverage will end. You must apply no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
#5: (**Trial Right**) You dropped a Medigap policy to join a **Medicare Advantage Plan** (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan less than a year, and you want to switch back.	The Medigap policy you had before you joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company you had before still sells it. If it included drug coverage, you can still get that same policy, but without the drug coverage. If your former Medigap policy **isn't** available, you can buy a Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.	You can apply up to 60 calendar days before the date your coverage will end. You must apply no later than 63 calendar days after your coverage ends. **Note:** Your rights may last for an extra 12 months under certain circumstances.
#6: Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage otherwise ends through no fault of your own.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.	You must apply no later than 63 calendar days from the date your coverage ends.
#7: You leave a **Medicare Advantage Plan** or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.	You must apply no later than 63 calendar days from the date your coverage ends.

Source: *2009 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* "published by Center for Medicare & Medicaid Services (CMS)"

World Corp Insurance Company

P. O. Box 2155, Omaha, Nebraska 68103-2155

Outline of Medicare Supplement Coverage - Benefit Plans A, F, F*

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	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	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	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	Part A Deductible	Part A Deductible	Part A Deductible	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.

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

NOTICE TO BUYER: This policy may not cover all of your **medical** expenses.

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 _____ (Age) for each plan available on _____ (Date) is:

ANNUAL PREMIUMS

Plan A	Plan F	Plan HDF
_____	_____	_____

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

ANNUAL PREMIUMS

Plan A	Plan F	Plan HDF
_____	_____	_____

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 World Corp Insurance Company, [P. O. Box 2155, Omaha, Nebraska 68103-2155], 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 World 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

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 717, 726-729

PLAN A A3110WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	100.49	100.49	113.73	113.73	118.23	118.23	133.80	133.80
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	104.91	104.91	118.73	118.73	123.42	123.42	139.68	139.68
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	301.46	301.46	341.17	341.17	354.66	354.66	401.37	401.37
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	602.92	602.92	682.33	682.33	709.32	709.32	802.74	802.74
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,205.84	1,205.84	1,364.66	1,364.66	1,418.64	1,418.64	1,605.47	1,605.47

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 718, 723-725

PLAN A A3110WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	105.57	105.57	119.47	119.47	124.20	124.20	140.56	140.56
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	110.21	110.21	124.72	124.72	129.66	129.66	146.73	146.73
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	316.69	316.69	358.40	358.40	372.57	372.57	421.64	421.64
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	633.37	633.37	716.79	716.79	745.15	745.15	843.28	843.28
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,266.74	1,266.74	1,433.58	1,433.58	1,490.29	1,490.29	1,686.56	1,686.56

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 722

PLAN A A3110WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	116.74	116.74	132.11	132.11	137.34	137.34	155.42	155.42
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	121.86	121.86	137.91	137.91	143.37	143.37	162.25	162.25
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	350.18	350.18	396.30	396.30	411.98	411.98	466.24	466.24
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	700.36	700.36	792.61	792.61	823.96	823.96	932.47	932.47
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,400.72	1,400.72	1,585.21	1,585.21	1,647.92	1,647.92	1,864.94	1,864.94

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes ALL OTHERS

PLAN A A3110WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	111.66	111.66	126.37	126.37	131.37	131.37	148.67	148.67
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	116.56	116.56	131.92	131.92	137.14	137.14	155.20	155.20
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	334.96	334.96	379.07	379.07	394.07	394.07	445.97	445.97
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	669.91	669.91	758.14	758.14	788.14	788.14	891.93	891.93
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,339.82	1,339.82	1,516.28	1,516.28	1,576.27	1,576.27	1,783.86	1,783.86

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 717, 726-729

PLAN F A3111WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	135.93	135.93	153.83	153.83	159.92	159.92	180.98	180.98
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	141.90	141.90	160.59	160.59	166.94	166.94	188.92	188.92
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	407.75	407.75	461.45	461.45	479.71	479.71	542.89	542.89
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	815.51	815.51	922.91	922.91	959.42	959.42	1,085.77	1,085.77
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,631.01	1,631.01	1,845.81	1,845.81	1,918.83	1,918.83	2,171.54	2,171.54

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 718, 723-725

PLAN F A3111WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	142.79	142.79	161.60	161.60	167.99	167.99	190.12	190.12
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	149.06	149.06	168.70	168.70	175.37	175.37	198.47	198.47
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	428.35	428.35	484.76	484.76	503.94	503.94	570.30	570.30
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	856.69	856.69	969.52	969.52	1,007.87	1,007.87	1,140.61	1,140.61
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,713.38	1,713.38	1,939.03	1,939.03	2,015.74	2,015.74	2,281.21	2,281.21

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 722

PLAN F A3111WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	157.90	157.90	178.69	178.69	185.76	185.76	210.22	210.22
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	164.83	164.83	186.54	186.54	193.92	193.92	219.46	219.46
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	473.65	473.65	536.03	536.03	557.24	557.24	630.62	630.62
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	947.30	947.30	1,072.06	1,072.06	1,114.47	1,114.47	1,261.25	1,261.25
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,894.60	1,894.60	2,144.12	2,144.12	2,228.94	2,228.94	2,522.49	2,522.49

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes ALL OTHERS

PLAN F A3111WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	151.03	151.03	170.92	170.92	177.68	177.68	201.08	201.08
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	157.66	157.66	178.43	178.43	185.49	185.49	209.92	209.92
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	453.06	453.06	512.73	512.73	533.01	533.01	603.21	603.21
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	906.12	906.12	1,025.45	1,025.45	1,066.02	1,066.02	1,206.41	1,206.41
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,812.23	1,812.23	2,050.90	2,050.90	2,132.03	2,132.03	2,412.82	2,412.82

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 717, 726-729

PLAN HIGH DEDUCTIBLE F A3112WC								
	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
Age 65 - 99	56.81	56.81	64.29	64.29	66.84	66.84	75.64	75.64
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	59.31	59.31	67.12	67.12	69.77	69.77	78.96	78.96
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	170.42	170.42	192.86	192.86	200.49	200.49	226.89	226.89
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	340.84	340.84	385.72	385.72	400.99	400.99	453.79	453.79
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	681.67	681.67	771.44	771.44	801.97	801.97	907.57	907.57

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 718, 723-725

PLAN HIGH DEDUCTIBLE F A3112WC								
	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
Age 65 - 99	59.68	59.68	67.54	67.54	70.21	70.21	79.46	79.46
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	62.30	62.30	70.50	70.50	73.29	73.29	82.95	82.95
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	179.03	179.03	202.60	202.60	210.62	210.62	238.35	238.35
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	358.05	358.05	405.20	405.20	421.24	421.24	476.71	476.71
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	716.10	716.10	810.40	810.40	842.47	842.47	953.41	953.41

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes 722

PLAN HIGH DEDUCTIBLE F A3112WC								
	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
Age 65 - 99	65.99	65.99	74.68	74.68	77.64	77.64	87.86	87.86
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	68.89	68.89	77.96	77.96	81.05	81.05	91.72	91.72
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	197.96	197.96	224.03	224.03	232.90	232.90	263.56	263.56
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	395.92	395.92	448.06	448.06	465.79	465.79	527.13	527.13
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	791.84	791.84	896.11	896.11	931.58	931.58	1,054.25	1,054.25

Arkansas

Effective 6-1-2010

Medicare Supplement Rates
Zip Codes ALL OTHERS

PLAN HIGH DEDUCTIBLE F A3112WC								
	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
Age 65 - 99	63.12	63.12	71.43	71.43	74.26	74.26	84.04	84.04
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	65.90	65.90	74.57	74.57	77.52	77.52	87.73	87.73
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	189.36	189.36	214.29	214.29	222.77	222.77	252.10	252.10
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	378.71	378.71	428.58	428.58	445.54	445.54	504.21	504.21
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	757.42	757.42	857.15	857.15	891.08	891.08	1,008.41	1,008.41

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$534]	[$534] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PLAN A (continued)

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

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

Medicare (Parts A and B) - Home Health Care

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

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

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$534]	[$534] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PLAN F (continued)

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

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

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

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

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

PLAN F (continued)

OTHER BENEFITS NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$534]	[$534] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	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.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

***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.

HIGH DEDUCTIBLE PLAN F (continued)

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% of a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

WORLD CORP
INSURANCE COMPANY
TM
P.O. Box 2155, Omaha, NE 68103-2155

NAIC: 79987 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 High Deductible F – A3112WC

Dear Mr. Shields:

In this filing we are enclosing Medicare Supplement forms and advertisement brochure 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 contact us for coverage through the internet and apply on-line on our website. We also included a supporting document in our filing to define some terms in our application. These same terms will be used in conjunction with our application.

These forms will use application G3110WC. The application form will be completed on-line by the consumer through our website.

Our certification as to the Flesch Readability Score of the policy forms is included in this filing.

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 515-245-2083, or you can email me at sarah.shives@americanenterprise.com.

Sincerely,

Sarah Shives
Compliance Analyst
World Corp Insurance Company

Enc.

ATTACHMENT A

FORM	DESCRIPTION
Policy Form A3112WC	Medicare Supplement Plan F- High Deductible
American Republic Corp Rates and Actuarial Memorandums	Medicare Supplement Memorandums and Rates

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/30/2009	Form	Plan HdF	08/06/2009	A3112WC - Plan F-HD.pdf (Superceded)
06/30/2009	Supporting Document	Outline of Coverage	08/06/2009	11-114-2758-XXXX AR (U3110WCAR).pdf (Superceded)

WORLD CORP INSURANCE COMPANY™
P.O. Box 2115 • Omaha, Nebraska 68103-2115
A Stock Insurance Company

Medicare Supplement Policy – Benefit High Deductible 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, World Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

[Michael E Abbott — President | Mary K Durand — Secretary | Paul K Mikkelson — 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]

<u>PREMIUMS:</u>

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 World 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.

"Annual High Deductible" means the amount the covered person must satisfy each calendar year before we begin paying benefits under this contract. The annual high deductible includes Out-of-Pocket expenses, other than premiums, for service covered as benefits under this policy and shall be in addition to any other specific benefit deductibles. Expenses incurred before the Policy Date of this coverage will not be applied to this deductible.

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 after the covered person has satisfied their annual high deductible each calendar year. 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 Extension

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 reinstituted. 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 reinstitution:

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 is 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: World Corp Insurance Company, [P.O. Box 2155, Omaha, Nebraska 68103-2155], 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 Provisions

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.

Times 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 Actions – 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 Laws – 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.

World Corp Insurance Company

P. O. Box 2155, Omaha, Nebraska 68103-2155

Outline of Medicare Supplement Coverage - Benefit Plans A, F, F*

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	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	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	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	Part A Deductible	Part A Deductible	Part A Deductible	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.

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

NOTICE TO BUYER: This policy may not cover all of your **medical** expenses.

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 _____ (Age) for each plan available on _____ (Date) is:

ANNUAL PREMIUMS

Plan A	Plan F	Plan HDF
_____	_____	_____

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

ANNUAL PREMIUMS

Plan A	Plan F	Plan HDF
_____	_____	_____

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.

U3110WCAR

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 World Corp Insurance Company, P. O. Box 2155, Omaha, Nebraska 68103-2155, 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 World 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
A3110WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
100.49	100.49	113.73	113.73	118.23	118.23	133.80	133.80

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
104.91	104.91	118.73	118.73	123.42	123.42	139.68	139.68

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
301.46	301.46	341.17	341.17	354.66	354.66	401.37	401.37

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
602.92	602.92	682.33	682.33	709.32	709.32	802.74	802.74

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,205.84	1,205.84	1,364.66	1,364.66	1,418.64	1,418.64	1,605.47	1,605.47

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN A A3110WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	105.57	105.57	119.47	119.47	124.20	124.20	140.56	140.56
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	110.21	110.21	124.72	124.72	129.66	129.66	146.73	146.73
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	316.69	316.69	358.40	358.40	372.57	372.57	421.64	421.64
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	633.37	633.37	716.79	716.79	745.15	745.15	843.28	843.28
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,266.74	1,266.74	1,433.58	1,433.58	1,490.29	1,490.29	1,686.56	1,686.56

Arkansas

Medicare Supplement Rates

Zip Codes 722

Effective 6-1-2010

PLAN A A3110WC								
Age 65 - 99	APP							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	116.74	116.74	132.11	132.11	137.34	137.34	155.42	155.42
	MONTHLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	121.86	121.86	137.91	137.91	143.37	143.37	162.25	162.25
	QUARTERLY							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	350.18	350.18	396.30	396.30	411.98	411.98	466.24	466.24
	SEMI-ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	700.36	700.36	792.61	792.61	823.96	823.96	932.47	932.47
	ANNUAL							
	PREFERRED				STANDARD			
	COUPLE		SINGLE		COUPLE		SINGLE	
	Female	Male	Female	Male	Female	Male	Female	Male
	1,400.72	1,400.72	1,585.21	1,585.21	1,647.92	1,647.92	1,864.94	1,864.94

Arkansas

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Effective 6-1-2010

PLAN A
A3110WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
111.66	111.66	126.37	126.37	131.37	131.37	148.67	148.67

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
116.56	116.56	131.92	131.92	137.14	137.14	155.20	155.20

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
334.96	334.96	379.07	379.07	394.07	394.07	445.97	445.97

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
669.91	669.91	758.14	758.14	788.14	788.14	891.93	891.93

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,339.82	1,339.82	1,516.28	1,516.28	1,576.27	1,576.27	1,783.86	1,783.86

Arkansas

Medicare Supplement Rates

Zip Codes 717, 726-729

Effective 6-1-2010

PLAN F
A3111WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
135.93	135.93	153.83	153.83	159.92	159.92	180.98	180.98

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
141.90	141.90	160.59	160.59	166.94	166.94	188.92	188.92

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
407.75	407.75	461.45	461.45	479.71	479.71	542.89	542.89

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
815.51	815.51	922.91	922.91	959.42	959.42	1,085.77	1,085.77

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,631.01	1,631.01	1,845.81	1,845.81	1,918.83	1,918.83	2,171.54	2,171.54

Arkansas

Medicare Supplement Rates

Zip Codes 718, 723-725

Effective 6-1-2010

PLAN F
A3111WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
142.79	142.79	161.60	161.60	167.99	167.99	190.12	190.12

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
149.06	149.06	168.70	168.70	175.37	175.37	198.47	198.47

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
428.35	428.35	484.76	484.76	503.94	503.94	570.30	570.30

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
856.69	856.69	969.52	969.52	1,007.87	1,007.87	1,140.61	1,140.61

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,713.38	1,713.38	1,939.03	1,939.03	2,015.74	2,015.74	2,281.21	2,281.21

Arkansas

Medicare Supplement Rates

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PLAN F
A3111WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
157.90	157.90	178.69	178.69	185.76	185.76	210.22	210.22

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
164.83	164.83	186.54	186.54	193.92	193.92	219.46	219.46

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
473.65	473.65	536.03	536.03	557.24	557.24	630.62	630.62

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
947.30	947.30	1,072.06	1,072.06	1,114.47	1,114.47	1,261.25	1,261.25

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,894.60	1,894.60	2,144.12	2,144.12	2,228.94	2,228.94	2,522.49	2,522.49

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PLAN F
A3111WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
151.03	151.03	170.92	170.92	177.68	177.68	201.08	201.08

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
157.66	157.66	178.43	178.43	185.49	185.49	209.92	209.92

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
453.06	453.06	512.73	512.73	533.01	533.01	603.21	603.21

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
906.12	906.12	1,025.45	1,025.45	1,066.02	1,066.02	1,206.41	1,206.41

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
1,812.23	1,812.23	2,050.90	2,050.90	2,132.03	2,132.03	2,412.82	2,412.82

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PLAN HIGH DEDUCTIBLE F
A3112WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
56.81	56.81	64.29	64.29	66.84	66.84	75.64	75.64

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
59.31	59.31	67.12	67.12	69.77	69.77	78.96	78.96

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
170.42	170.42	192.86	192.86	200.49	200.49	226.89	226.89

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
340.84	340.84	385.72	385.72	400.99	400.99	453.79	453.79

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
681.67	681.67	771.44	771.44	801.97	801.97	907.57	907.57

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PLAN HIGH DEDUCTIBLE F
A3112WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
59.68	59.68	67.54	67.54	70.21	70.21	79.46	79.46

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
62.30	62.30	70.50	70.50	73.29	73.29	82.95	82.95

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
179.03	179.03	202.60	202.60	210.62	210.62	238.35	238.35

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
358.05	358.05	405.20	405.20	421.24	421.24	476.71	476.71

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
716.10	716.10	810.40	810.40	842.47	842.47	953.41	953.41

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PLAN HIGH DEDUCTIBLE F
A3112WC

Age 65 - 99

APP							
PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
65.99	65.99	74.68	74.68	77.64	77.64	87.86	87.86

MONTHLY							
PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
68.89	68.89	77.96	77.96	81.05	81.05	91.72	91.72

QUARTERLY							
PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
197.96	197.96	224.03	224.03	232.90	232.90	263.56	263.56

SEMI-ANNUAL							
PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
395.92	395.92	448.06	448.06	465.79	465.79	527.13	527.13

ANNUAL							
PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
791.84	791.84	896.11	896.11	931.58	931.58	1,054.25	1,054.25

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PLAN HIGH DEDUCTIBLE F
A3112WC

Age 65 - 99

APP

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
63.12	63.12	71.43	71.43	74.26	74.26	84.04	84.04

MONTHLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
65.90	65.90	74.57	74.57	77.52	77.52	87.73	87.73

QUARTERLY

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
189.36	189.36	214.29	214.29	222.77	222.77	252.10	252.10

SEMI-ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
378.71	378.71	428.58	428.58	445.54	445.54	504.21	504.21

ANNUAL

PREFERRED				STANDARD			
COUPLE		SINGLE		COUPLE		SINGLE	
Female	Male	Female	Male	Female	Male	Female	Male
757.42	757.42	857.15	857.15	891.08	891.08	1,008.41	1,008.41

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$534]	[$534] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PLAN A (continued)

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

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

Medicare (Parts A and B) - Home Health Care

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

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

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$534]	[$534] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

PLAN F (continued)

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

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

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

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

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

PLAN F (continued)

OTHER BENEFITS NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but [$534]	[$534] a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	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.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

***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.

HIGH DEDUCTIBLE PLAN F (continued)

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2,000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2,000] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% of a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.