

SERFF Tracking Number: STLG-125912768 State: Arkansas  
Filing Company: Sterling Life Insurance Company State Tracking Number: 40996  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: AR OC (01/09) - Outline of Coverage Filing  
Project Name/Number: 2009 Outline of Coverage/

## Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: AR OC (01/09) - Outline of Coverage Filing

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement - Other

Filing Type: Form

Implementation Date Requested: 01/01/2009

State Filing Description:

SERFF Tr Num: STLG-125912768 State: ArkansasLH

SERFF Status: Closed

Co Tr Num:

Co Status:

Author: Jennifer Marinas

Date Submitted: 12/03/2008

State Tr Num: 40996

State Status: FEES PAID

Reviewer(s): Stephanie Fowler

Disposition Date: 12/11/2008

Disposition Status: Filed

Implementation Date:

## General Information

Project Name: 2009 Outline of Coverage

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/11/2008

State Status Changed: 12/03/2008

Corresponding Filing Tracking Number:

Filing Description:

December 3, 2008

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Re: Sterling Life Insurance Company Standard Medicare Supplement Insurance Filing

NAIC # 77399

*SERFF Tracking Number:* STLG-125912768 *State:* Arkansas  
*Filing Company:* Sterling Life Insurance Company *State Tracking Number:* 40996  
*Company Tracking Number:*  
*TOI:* MS06 Medicare Supplement - Other *Sub-TOI:* MS06.000 Medicare Supplement - Other  
*Product Name:* AR OC (01/09) - Outline of Coverage Filing  
*Project Name/Number:* 2009 Outline of Coverage/

## Outline of Coverage AR OC (01/09)

Dear Sir or Madam:

We are filing the above form for your consideration and approval. Please note that this is a previously approved Outline of Coverage that has been updated to reflect the 2009 Medicare deductible amounts. We have also added a revision number to the lower right hand corner so that when changes occur to the bracketed information (address, phone number, Medicare deductible amounts), we may be able to internally track our form without having the administrative burden of refiling the form with your department.

This revised form is intended to replace the form currently used in Arkansas((AR OC (01/08)(Rev. 10/07)). Sterling anticipates having this document available for use beginning January 1, 2009 when the new Medicare deductibles become effective.

If you have any questions, please do not hesitate to contact me at (360) 392-9201 or email [jennifer.marin@sterlingplans.com](mailto:jennifer.marin@sterlingplans.com).

Sincerely,

Jennifer Marinas  
Legal Assistant  
Compliance & Regulatory Affairs  
Sterling Life Insurance Company

## Company and Contact

### Filing Contact Information

Jennifer Marinas, Legal Assistant  
2219 Rimland Drive  
Bellingham, WA 98227

[jennifer.marin@sterlingplans.com](mailto:jennifer.marin@sterlingplans.com)  
(360) 392-9201 [Phone]  
(360) 647-8632[FAX]

### Filing Company Information

SERFF Tracking Number: STLG-125912768 State: Arkansas  
Filing Company: Sterling Life Insurance Company State Tracking Number: 40996  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: AR OC (01/09) - Outline of Coverage Filing  
Project Name/Number: 2009 Outline of Coverage/  
Sterling Life Insurance Company CoCode: 77399 State of Domicile: Illinois  
P.O. Box 5348 Group Code: Company Type: Insurance  
Bellingham, WA 98227 Group Name: Company - Life, Accident & Health  
(360) 647-9080 ext. [Phone] FEIN Number: 13-1867829 State ID Number:  
-----

SERFF Tracking Number: STLG-125912768 State: Arkansas  
Filing Company: Sterling Life Insurance Company State Tracking Number: 40996  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: AR OC (01/09) - Outline of Coverage Filing  
Project Name/Number: 2009 Outline of Coverage/

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: State of Domicile Illinois: \$50 per form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Life Insurance Company	\$50.00	12/03/2008	24298735

SERFF Tracking Number: STLG-125912768 State: Arkansas  
Filing Company: Sterling Life Insurance Company State Tracking Number: 40996  
Company Tracking Number:  
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
Product Name: AR OC (01/09) - Outline of Coverage Filing  
Project Name/Number: 2009 Outline of Coverage/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	12/11/2008	12/11/2008

*SERFF Tracking Number:*      *STLG-125912768*                      *State:*                      *Arkansas*  
*Filing Company:*              *Sterling Life Insurance Company*                      *State Tracking Number:*      *40996*  
*Company Tracking Number:*  
*TOI:*                      *MS06 Medicare Supplement - Other*                      *Sub-TOI:*                      *MS06.000 Medicare Supplement - Other*  
*Product Name:*              *AR OC (01/09) - Outline of Coverage Filing*  
*Project Name/Number:*      *2009 Outline of Coverage/*

## **Disposition**

Disposition Date: 12/11/2008

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:*      *STLG-125912768*                      *State:*                      *Arkansas*  
*Filing Company:*              *Sterling Life Insurance Company*                      *State Tracking Number:*      *40996*  
*Company Tracking Number:*  
*TOI:*                      *MS06 Medicare Supplement - Other*                      *Sub-TOI:*                      *MS06.000 Medicare Supplement - Other*  
*Product Name:*              *AR OC (01/09) - Outline of Coverage Filing*  
*Project Name/Number:*      *2009 Outline of Coverage/*

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Accepted for Informational Purposes	Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Health - Actuarial Justification		Yes
<b>Supporting Document</b>	Outline of Coverage		Yes
<b>Form</b>	Medicar Supplement Standard/Select Outline of Coverage	Approved	Yes

SERFF Tracking Number: STLG-125912768 State: Arkansas  
 Filing Company: Sterling Life Insurance Company State Tracking Number: 40996  
 Company Tracking Number:  
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other  
 Product Name: AR OC (01/09) - Outline of Coverage Filing  
 Project Name/Number: 2009 Outline of Coverage/

## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	AR OC (01/09)	Outline of Coverage	Medicar Supplement Standard/Select Outline of Coverage	Revised	Replaced Form #: AR OC (01/08)(Rev. 10/07) Previous Filing #: OLYM-125387078		AR 2009 OC (Rev. 10.08).pdf

## STERLING LIFE INSURANCE COMPANY

Medicare Supplement Administrative Offices/Customer Service [P.O. Box 5348, Bellingham, WA 98227-5348]

### Outline of Medicare SELECT and Medicare Supplement Coverage - Cover Page 1 of 2

**\*Standard Medicare Supplement Plans and Medicare SELECT Plans A, B, C, F, G and K are Available**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Standard Plan "A". Some plans may not be available in Your state.

**The starred (\*) plans (A, B, C, F, G and K) are Medicare SELECT Plans.** Medicare SELECT plans contain restrictions on Your use of hospitals.

**See Outlines of Coverage sections for details about ALL plans**

**BASIC BENEFITS** for Plans A-J

**Hospitalization:** Part A coinsurance plus coverage for 365 additional days in Your lifetime after Medicare benefits end. **Medical Expenses:** Part B coinsurance (Generally 20% of Medicare Approved expenses), or co-payments for hospital outpatient services. **Blood:** First three pints of blood each year.

*A*	*B*	*C*	D	E	*F*	F#	*G	H	I
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery
				Preventive Care NOT covered by Medicare					

**#Plans F and J** also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after the policyholder has paid a calendar year [\$2,000] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. The expenses include the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

**The starred (\*) plans (A, B, C, F, G and K) are Medicare SELECT Plans.** Medicare SELECT plans contain restrictions on Your use of providers.

**STERLING LIFE INSURANCE COMPANY**  
**Outline of Medicare SELECT and Medicare Supplement Coverage - Cover Page 2**

**Basic Benefits for Plans K and L include similar services as Plans A-J, but cost sharing for the basic benefits is at different levels.**

<b>J</b>	<b>*K**</b>	<b>L**</b>
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End  50% Hospice cost-sharing  50% of Medicare-eligible expenses for the first three pints of blood  50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End  75% Hospice cost-sharing  75% of Medicare-eligible expenses for the first three pints of blood  75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4,620] Out of Pocket Annual Limit***	[\$2,310] Out of Pocket Annual Limit***

**\*\*Plans K and L provide for different cost-sharing for items and services than Plans A-J.**

**Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.**

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

**See Outlines of Coverage for details and exceptions.**

## PREMIUM INFORMATION

Sterling Life Insurance Company may raise Your premium if it raises the premium for all policies in Your class. Premiums are community rated and based on the mode of the premium payment selected. **Premium in the chart below is subject to change.**

**(INSERT PAGE 3)**

## **OUTLINE OF MEDICARE SUPPLEMENT COVERAGE DISCLOSURES**

**DISCLOSURES** Use this outline to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY** This is only an outline describing Your policy's most important features. The policy is Your insurance contract. You must read the policy itself to understand all of the rights and duties of both You and Your insurance company.

**RIGHT TO RETURN POLICY** If You are not satisfied with Your policy, You may return it to us within thirty (30) days after You receive it. You may return it to us or to the agent who sold it. We will refund to You any premium paid and this policy will be void.

**POLICY REPLACEMENT** If You are replacing another health insurance policy, do NOT cancel it until You have actually received Your new policy and are sure You want to keep it.

**NOTICE** This policy may not fully cover all of Your medical costs. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult "Medicare & You" for more details. Neither Sterling Life Insurance Company nor its agents are connected with Medicare.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

Review the application carefully before You sign it. Be certain that all information has been properly recorded.

### **REFUND OF PREMIUM**

If termination is due to You ceasing to be eligible for this plan or We receive written notice that You wish to terminate Your coverage, the date of termination will be the first day of the month following the event. Any premium paid beyond the termination date will be refunded to You.

### **LIMITATIONS AND EXCLUSIONS**

Your coverage is conditional on Medicare's approval of Medicare Eligible Expenses. Services eligible for coverage must therefore be deemed as medically necessary by Medicare. If Medicare does not consider services rendered or expenses incurred as medically necessary, no benefits will be paid. We will not place any limitations on benefits that are more restrictive than Medicare's limitations and restrictions, except as noted in the Network Hospital Restrictions.

No benefits will be paid under Medicare Part A which duplicates payments under Medicare Part B. No benefits will be paid under Medicare Part B which duplicates payments under Medicare Part A. No benefits will duplicate payment made directly by Medicare.

### **NETWORK HOSPITAL RESTRICTIONS – MEDICARE SELECT PRODUCTS ONLY**

Except as specified below, Part A and Part B (hospital or facility) benefits will not be paid for services provided at a Hospital which is not a Network Hospital and Part B (hospital or facility) benefits for outpatient surgery will only be provided if performed at a doctor's office, Network Hospital, or outpatient surgery clinic which is owned, operated by or has a written agreement with a Network Hospital to provide services. Full benefits of Your coverage will be paid when:

1. Services are provided in the following places: a Physician's office; in another office setting (other than an outpatient surgery clinic); in a Skilled Nursing Facility;

2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, Injury or a condition, and it is not reasonable to obtain such services through the Network Hospital;
3. While Traveling outside the Service Area, services will be covered from the 1<sup>st</sup> day through the 90<sup>th</sup> day of each trip, travel must be for purposes other than the receipt of medical care; or
4. Required services are not available at a Network Hospital in Your Service Area.

### **Network Hospitals**

---

A Network Hospital is one that has a written agreement with Sterling and has been designated by Sterling to provide hospital services insured under this policy. You may use any Network Hospital, which is listed, on Your current Sterling Medicare SELECT Supplement Insurance **Network Hospital Directory**. This directory is updated periodically. To verify the status of a hospital please call [1-800-688-0010] between the hours of 5AM and 5PM Pacific Time, Monday through Friday.

### **Non-Network Hospital Admission Procedures**

---

Prior to admission to a non-Network Hospital, You, either directly or through Your physician, should contact Sterling's Customer Service Center. The Customer Service Center will confirm whether the required services are available from a Network Hospital, and if not available, will assist You in locating a hospital that provides the necessary service. **Utilizing Sterling's Customer Service Center prior to use of a non-Network Hospital eliminates the need for retrospective inquiry as to the legitimacy of the filed claim.**

These non-Network Hospital Admission Procedures do not apply in emergency situations or while You are traveling outside of the service area during the 1<sup>st</sup> through 90<sup>th</sup> day of travel. Travel must be for purposes other than the receipt of medical care.

### **CONTINUATION OF COVERAGE**

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. However, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable.

If the authority to issue Medicare SELECT policies is discontinued for whatever reason or the Service Area no longer exists, Your coverage can continue. Coverage will be continued under any other Medicare Supplement policy We have available containing comparable or lesser benefits and which does not contain Restricted Network Provisions. You will not need to provide evidence of insurability.

### **CONVERSION PRIVILEGE – MEDICARE SELECT PRODUCTS ONLY**

You may request to convert this policy to a policy that does not contain Restricted Network Provisions without submission of evidence of insurance at anytime. Your request must be received by Sterling on or before the 20<sup>th</sup> day of the month, and will be effective the 1<sup>st</sup> day of the following month. The conversion will be to any Medicare Supplement plan You choose which is offered by Sterling for sale in Your State.

## **COMPLAINT PROCEDURE – MEDICARE SELECT PRODUCTS ONLY**

### **Complaints While Staying At A Network Hospital.**

If, while confined at a Network Hospital, You have a complaint regarding the hospital's services being provided, You may contact Sterling's Customer Service Center by phone [1-800-688-0010] 5AM to 5PM Pacific Time, Monday through Friday, to express the complaint. Sterling's Customer Service representatives will relay the complaint within twenty-four (24) hours, to the hospital's Administrator for response within twenty (20) days. Calls received between 5PM and 5AM, weekends and holidays, will be transferred to automated voice-mail, where You may leave Your name, policyholder identification number, telephone number and comment, request or complaint. Return phone calls will be placed the following business day.

**Other Complaints.** If You have questions or are dissatisfied with the quality of care received from a Network Hospital, have a complaint or want to contest the disposition of a claim, You may direct such inquiries to the Customer Service Center, [P.O. Box 5348, Bellingham, WA 98227-5348], [1-800-688-0010] without initiating a formal grievance.

Questions or complaints regarding any of these areas which are presented shall receive acknowledgment within three (3) business days of receipt. A response will be sent to You within thirty (30) business days of the complaint. If after thirty (30) business days a response is unavailable, we will provide a status update to You every ten (10) business days.

## **GRIEVANCE PROCEDURE – MEDICARE SELECT PRODUCTS ONLY**

In the event You are dissatisfied with the response received to a complaint or with the disposition of a claim, You may submit a formal grievance by writing to the Claims Administrator at [P.O. Box 5348, Bellingham, WA 98227-5348]. Formal grievances in all other areas should be submitted to Us in writing at the same address. A grievance must clearly state "This is a grievance", or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure. Written acknowledgment of receipt of the grievance will be mailed within three (3) business days and the grievance will be investigated. A response will be sent within thirty (30) days following the date the grievance is received and shall explain in detail the reasons for the determination.

If Sterling upholds the grievance, corrective action will be taken promptly to remedy the situation.

**Grievance Appeal Committee.** In the event You are not satisfied with the results of Our determination, You have the right to file an appeal by written request with Sterling. The appeal should be submitted to the Grievance Appeal Committee of Sterling within sixty (60) days from the date You are notified of the complaint procedure results. The Grievance Appeal Committee shall be made up of individuals not involved in the decision making process of the original grievance or request for determination. The Grievance Appeal Committee shall schedule a hearing on the grievance within sixty (60) days of its receipt. Both You and the person or organization against whom the complaint has been made shall be notified of the time and place of the Grievance Appeal Committee hearing at which time such individuals shall have the right to appear in person or by telephone and present any information which supports their position. At the close of the hearing, the Grievance Appeal Committee shall make findings and issue a written decision within fifteen (15) days after the hearing is held unless additional information is needed.

If You are dissatisfied with the decision, You should submit a written complaint to the Arkansas Insurance Department, [1200 West Third Street, Little Rock, AR 72201-1904] or call [1-800-852-5494 or (501) 371-2640].

## PLAN A - BENEFITS CHART

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy, page 5 or 6 for details of coverage.) -Beyond the Additional 365 days</p>	<p>All but [\$1,068] All but [\$267] a day  All but [\$534] a day  \$0  \$0</p>	<p>\$0 [\$267] a day  [\$534] a day  100% of Medicare Eligible Expenses  \$0</p>	<p>[\$1,068] (Part A Deductible) \$0**  \$0**  \$0 ✓See NOTICE below  All Costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0** Up to [\$133.50] a day All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0** \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance of Expenses</p>

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 “Basic 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 - BENEFITS CHART**

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

\* 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.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$135] (Part B Deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0** [\$135] (Part B Deductible) \$0**
<b>CLINICAL LABORATORY SERVICES</b> Blood Tests For Diagnostic Services	100%	\$0	\$0**

**PARTS A & B**

<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0** [\$135] (Part B Deductible) \$0
--	--------------------	-------------------	---

## PLAN B - BENEFITS CHART

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

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

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy, page 5 or 6 for details of coverage.) -Beyond the Additional 365 days</p>	<p>All but [\$1,068] All but [\$267] a day  All but [\$534] a day  \$0  \$0</p>	<p>[\$1,068] (Part A Deductible) [\$267] a day  [\$534] a day  100% of Medicare Eligible Expenses \$0</p>	<p>\$0** \$0**  \$0**  \$0** ✓See NOTICE below  All Costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0** Up to [\$133.50] a day All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0** \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance of Expenses</p>

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 "Basic Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN B - BENEFITS CHART

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

\* 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.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally, 80%	\$0 Generally, 20%	[\$135] (Part B Deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0** [\$135] (Part B Deductible) \$0**
<b>CLINICAL LABORATORY SERVICES</b> Blood Tests For Diagnostic Services	100%	\$0	\$0**

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0** [\$135] (Part B Deductible) \$0**
--	--------------------	-------------------	---

## PLAN C - BENEFITS CHART

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

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

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy, page 5 or 6 for details of coverage.) -Beyond the Additional 365 days</p>	<p>All but [\$1,068] All but [\$267] a day All but [\$534] a day \$0 \$0</p>	<p>[\$1,068] (Part A Deductible) [\$267] a day [\$534] a day 100% of Medicare Eligible Expenses \$0</p>	<p>\$0** \$0** \$0** \$0** ✓See NOTICE below All Costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 Up to [\$133.50] a day \$0</p>	<p>\$0** \$0** All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0** \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance of Expenses</p>

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 "Basic 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 C - BENEFITS CHART

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

\* 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.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally, 80%	[\$135] (Part B Deductible) Generally, 20%	\$0** \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs [\$135] (Part B Deductible) 20%	\$0** \$0** \$0**
<b>CLINICAL LABORATORY SERVICES</b> Blood Tests For Diagnostic Services	100%	\$0	\$0**

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b> -Medically Necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$135] (Part B Deductible) 20%	\$0** \$0** \$0**
--	--------------------	---	-------------------------

**PLAN C - BENEFITS CHART**

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA                      First \$250 each Calendar Year                      Remainder of Charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a Lifetime Maximum Benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 Lifetime Maximum Benefit</p>

## PLAN F - BENEFITS CHART

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

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

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy, page 5 or 6 for details of coverage.) -Beyond the Additional 365 days	All but [\$1,068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1,068] (Part A Deductible) [\$267] a day  [\$534] a day  100% of Medicare Eligible Expenses  \$0	\$0** \$0**  \$0**  \$0** ▼See NOTICE below  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance of Expenses

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 "Basic 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 - BENEFITS CHART

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

\* 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.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally, 80%	[\$135] (Part B Deductible) Generally, 20%	\$0** \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs [\$135] (Part B Deductible) 20%	\$0** \$0** \$0**
<b>CLINICAL LABORATORY SERVICES</b> Blood Tests For Diagnostic Services	100%	\$0	\$0**

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b> -Medically Necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  [\$135] (Part B Deductible) 20%	\$0**  \$0** \$0**
--	------------------------	---	-----------------------------

**PLAN F - BENEFITS CHART**

OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                      Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA                      First \$250 each Calendar Year                      Remainder of Charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a Lifetime Maximum Benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 Lifetime Maximum Benefit</p>

## PLAN G - BENEFITS CHART

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

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

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days (✓See your policy, page 5 or 6 for details of coverage.) -Beyond the Additional 365 days	All but [\$1,068] All but [\$267] a day  All but [\$534] a day  \$0  \$0	[\$1,068] (Part A Deductible) [\$267] a day  [\$534] a day  100% of Medicare Eligible Expenses  \$0	\$0** \$0**  \$0**  \$0** ✓See NOTICE below  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$133.50] a day \$0	\$0 Up to [\$133.50] a day \$0	\$0** \$0** All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance of Expenses

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 "Basic 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 G - BENEFITS CHART

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

- \* 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.
- \*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 80% Generally	\$0 20% Generally	[\$135] (Part B Deductible) \$0**
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0** [\$135] (Part B Deductible) \$0**
<b>CLINICAL LABORATORY SERVICES</b> Tests For Diagnostic Services	100%	\$0	\$0**

### PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b> -Medically Necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0** [\$135] (Part B Deductible) \$0**
<b>AT HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan -Benefit for each visit -Number of visits covered (must be received within 8 weeks of first Medicare-approved visit) -Calendar year maximum	\$0 \$0 \$0	Actual charges to \$40 a visit Up to the number of Medicare-approved visits, not to exceed 7 each week \$1,600	Balance Balance Balance

**PLAN G - BENEFITS CHART**  
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically Necessary Emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a Lifetime Maximum Benefit of \$50,000	\$250 20% and amounts over the \$50,000 Lifetime Maximum Benefit

## PLAN K - BENEFITS CHART

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

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

\* 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. \*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after:</p> <ul style="list-style-type: none"> <li>-While using 60 lifetime reserve days</li> <li>-Once lifetime reserve days are used:</li> <li>-Additional 365 days</li> </ul> <p>(✓See your policy, page 5 or 6 for details of coverage.)</p> <ul style="list-style-type: none"> <li>-Beyond the Additional 365 days</li> </ul>	<p>All but [\$1,068] All but [\$267] a day</p> <p>All but [\$534] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$534] (50% of Part A Deductible) [\$267] a day</p> <p>[\$534] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>[\$534] (50% of Part A Deductible)◆ \$0**</p> <p>\$0**</p> <p>\$0** ▼See NOTICE below</p> <p>All Costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but [\$133.50] a day \$0</p>	<p>\$0 Up to [\$66.75] a day \$0</p>	<p>\$0** Up to [\$66.75] a day◆ All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>50% \$0</p>	<p>50%◆ \$0**</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>Generally, most Medicare-eligible expenses for outpatient drugs and inpatient respite care</p>	<p>50% of coinsurance or copayments</p>	<p>50% of coinsurance or copayments◆</p>

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 “Basic Benefits”. During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN K - BENEFITS CHART

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

\* 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.

\*\* \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First [\$135] of Medicare Approved Amounts*  Preventive Benefits for Medicare covered services  Remainder of Medicare Approved Amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 10%	[\$135] (Part B Deductible)*◆  All costs above Medicare approved amounts  Generally 10%◆
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4,620])***
<b>BLOOD</b> First 3 pints Next [\$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ [\$135] (Part B Deductible)*◆ Generally 10%◆
<b>CLINICAL LABORATORY SERVICES</b> Tests For Diagnostic Services	100%	\$0	\$0**

### PARTS A & B

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES -Medically Necessary skilled care services and medical supplies -Durable medical equipment First [\$135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$0 10%	\$0**  [\$135] (Part B Deductible)*◆ 10%◆
--	------------------------	-----------------------	--

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

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

*SERFF Tracking Number:*      *STLG-125912768*                      *State:*                      *Arkansas*  
*Filing Company:*              *Sterling Life Insurance Company*                      *State Tracking Number:*      *40996*  
*Company Tracking Number:*  
*TOI:*                      *MS06 Medicare Supplement - Other*                      *Sub-TOI:*                      *MS06.000 Medicare Supplement - Other*  
*Product Name:*              *AR OC (01/09) - Outline of Coverage Filing*  
*Project Name/Number:*      *2009 Outline of Coverage/*

## **Rate Information**

Rate data does NOT apply to filing.

*SERFF Tracking Number:* STLG-125912768      *State:* Arkansas  
*Filing Company:* Sterling Life Insurance Company      *State Tracking Number:* 40996  
*Company Tracking Number:*  
*TOI:* MS06 Medicare Supplement - Other      *Sub-TOI:* MS06.000 Medicare Supplement - Other  
*Product Name:* AR OC (01/09) - Outline of Coverage Filing  
*Project Name/Number:* 2009 Outline of Coverage/

## Supporting Document Schedules

<p><b>Satisfied -Name:</b> Certification/Notice</p> <p><b>Comments:</b></p> <p><b>Attachment:</b> AR Cert of Compliance 2009.pdf</p>	<p><b>Review Status:</b> Accepted for Informational Purposes      12/11/2008</p>
<p><b>Bypassed -Name:</b> Application</p> <p><b>Bypass Reason:</b> N/A - this is only an outline of coverage filing.</p> <p><b>Comments:</b></p>	<p><b>Review Status:</b> 11/20/2008</p>
<p><b>Bypassed -Name:</b> Health - Actuarial Justification</p> <p><b>Bypass Reason:</b> N/A - this is only an outline of coverage filing.</p> <p><b>Comments:</b></p>	<p><b>Review Status:</b> 11/20/2008</p>
<p><b>Satisfied -Name:</b> Outline of Coverage</p> <p><b>Comments:</b> Outline of Coverage form located under the Forms Schedule tab.</p>	<p><b>Review Status:</b> 11/20/2008</p>

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: Sterling Life Insurance Company

Form Number(s): AR OC (01/09)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

\_\_\_\_\_  
Signature of Company Officer

Craig A. Bodway  
\_\_\_\_\_  
Name

Assistant Secretary  
\_\_\_\_\_  
Title

\_\_\_\_\_  
Date