

<i>SERFF Tracking Number:</i>	<i>IASL-126355825</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Royal Neighbors of America</i>	<i>State Tracking Number:</i>	<i>43867</i>
<i>Company Tracking Number:</i>	<i>RN AR 2010 OC</i>		
<i>TOI:</i>	<i>MS06 Medicare Supplement - Other</i>	<i>Sub-TOI:</i>	<i>MS06.000 Medicare Supplement - Other</i>
<i>Product Name:</i>	<i>RN AR 2010 OC</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Royal Neighbors of America

Product Name: RN AR 2010 OC

TOI: MS06 Medicare Supplement - Other

SERFF Tr Num: IASL-126355825 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 43867

Sub-TOI: MS06.000 Medicare Supplement - Other

Co Tr Num: RN AR 2010 OC

State Status: Approved-Closed

Filing Type: Form

Author: Karen Nowlan

Reviewer(s): Stephanie Fowler

Date Submitted: 10/23/2009

Disposition Date: 11/30/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/30/2009

Explanation for Other Group Market Type:

State Status Changed: 11/30/2009

Deemer Date:

Created By: Karen Nowlan

Submitted By: Karen Nowlan

Corresponding Filing Tracking Number:

Filing Description:

The attached outline of coverage has been revised to comply with the 2010 Medicare Supplement Deductibles and Copayments. It replaces 3511-AR; Rev. 01-2009 approved by your department on 11/07/2008, state tracking # 40500.

This outline will be used with policy form numbers 20049AA-AR et al. These certificate forms were approved by your Department on July 6, 2004.

Company and Contact

SERFF Tracking Number: IASL-126355825 State: Arkansas
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 Company Tracking Number: RN AR 2010 OC
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
 Product Name: RN AR 2010 OC
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Filing Contact Information

Karen Nowlan, Compliance analyst karen.nowlan@iasadmin.com
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 Largo, FL 33773-1502

Filing Company Information

(This filing was made by a third party - insuranceadministrativesolutions)

Royal Neighbors of America CoCode: 57657 State of Domicile: Illinois
 230 16th Street Group Code: -99 Company Type: Fraternal Benefit Society
 Rock Island, IL 61201-8645 Group Name: State ID Number:
 (309) 788-4561 ext. [Phone] FEIN Number: 36-1711198

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Royal Neighbors of America	\$20.00	10/23/2009	31506971

SERFF Tracking Number: IASL-126355825 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	11/30/2009	11/30/2009

SERFF Tracking Number: IASL-126355825 *State:* Arkansas
Filing Company: Royal Neighbors of America *State Tracking Number:* 43867
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Product Name: RN AR 2010 OC
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Disposition

Disposition Date: 11/30/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: IASL-126355825

State: Arkansas

Filing Company: Royal Neighbors of America

State Tracking Number: 43867

Company Tracking Number: RN AR 2010 OC

TOI: MS06 Medicare Supplement - Other

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Product Name: RN AR 2010 OC

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Authorization Letter		Yes
Form	Outline of Coverage	Approved	Yes

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Form Schedule

Lead Form Number: 3511-AR; Rev. 1-2010

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/30/2009	3511-AR; Rev. 1- 2010	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: 3511-AR; Rev. 1- 2009 Previous Filing #: 40500		3511-AR Rev 01-2010 Eff 01-01- 2010.pdf



Royal Neighbors of America
Outline of Medicare Supplement Coverage-Cover Page 1 of 2
Benefit Plans A, B, C, D, E, F and G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A.” Some plans may not be available in your state. Royal Neighbors of America offers seven of the fourteen plans available.

See Outlines of Coverage sections for details about ALL plans.

Basic Benefits: For Plans A-J.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or, copayments for hospital outpatient services.

Blood: First three pints of blood each year.

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

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

Royal Neighbors of America
Outline of Medicare Supplement Coverage-Cover Page 2 of 2

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

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100 %)		
Foreign Travel Emergency		
At Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit***	\$2310 Out of Pocket Annual Limit***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.**

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

See Outlines of Coverage for details and exceptions.

**ROYAL NEIGHBORS OF AMERICA
ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

722-723

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	2,853	3,168	3,222	3,578	3,778	4,197	3,130	3,479	3,270	3,628	3,889	4,323	3,212	3,569

**ROYAL NEIGHBORS OF AMERICA
SEMI-ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

722-723

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	1,426.50	1,584.00	1,611.00	1,789.00	1,889.00	2,098.50	1,565.00	1,739.50	1,635.00	1,814.00	1,944.50	2,161.50	1,606.00	1,784.50

**ROYAL NEIGHBORS OF AMERICA
QUARTERLY PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

722-723

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
All	713.25	792.00	805.50	894.50	944.50	1,049.25	782.50	869.75	817.50	907.00	972.25	1,080.75	803.00	892.25

**ROYAL NEIGHBORS OF AMERICA
MONTHLY PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

722-723

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	237.65	263.89	268.39	298.05	314.71	349.61	260.73	289.80	272.39	302.21	323.95	360.11	267.56	297.30

**ROYAL NEIGHBORS OF AMERICA
ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

727

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	2,536	2,816	2,864	3,180	3,358	3,730	2,782	3,093	2,906	3,225	3,457	3,842	2,855	3,173

**ROYAL NEIGHBORS OF AMERICA
SEMI-ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

727

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	1,268.00	1,408.00	1,432.00	1,590.00	1,679.00	1,865.00	1,391.00	1,546.50	1,453.00	1,612.50	1,728.50	1,921.00	1,427.50	1,586.50

**ROYAL NEIGHBORS OF AMERICA
QUARTERLY PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

727

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	634.00	704.00	716.00	795.00	839.50	932.50	695.50	773.25	726.50	806.25	864.25	960.50	713.75	793.25

**ROYAL NEIGHBORS OF AMERICA
MONTHLY PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

727

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	211.25	234.57	238.57	264.89	279.72	310.71	231.74	257.65	242.07	268.64	287.97	320.04	237.82	264.31

**ROYAL NEIGHBORS OF AMERICA
ANNUAL PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 722-723, 727**

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	2,378	2,640	2,685	2,981	3,149	3,497	2,609	2,900	2,725	3,023	3,241	3,602	2,677	2,975

**ROYAL NEIGHBORS OF AMERICA
SEMI-ANNUAL PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 722-723, 727**

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	1,189.00	1,320.00	1,342.50	1,490.50	1,574.50	1,748.50	1,304.50	1,450.00	1,362.50	1,511.50	1,620.50	1,801.00	1,338.50	1,487.50

**ROYAL NEIGHBORS OF AMERICA
QUARTERLY PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 722-723, 727**

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	594.50	660.00	671.25	745.25	787.25	874.25	652.25	725.00	681.25	755.75	810.25	900.50	669.25	743.75

**ROYAL NEIGHBORS OF AMERICA
MONTHLY PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 722-723, 727**

Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Non-Smoker	Smoker												
All	198.09	219.91	223.66	248.32	262.31	291.30	217.33	241.57	226.99	251.82	269.98	300.05	222.99	247.82

PREMIUM INFORMATION

Royal Neighbors of America may change your premium if a new table of rates is applicable to the certificate. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as underwriting class, state and zip code of residence.

Premiums will change on your certificate anniversary date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and Royal Neighbors of America.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to: Royal Neighbors of America, Medicare Supplement Administration, P.O. Box 10851, Clearwater, Florida 33757-8851. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

POLICY OR CERTIFICATE REPLACEMENT

If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

This certificate may not fully cover all of your medical costs. Neither Royal Neighbors of America nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. Royal Neighbors of America may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

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

Please refer to your certificate for details.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$0 \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$1100 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

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

PLAN A

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

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

PLAN B

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 C

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

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

PLAN D

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D
PARTS A & B

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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	\$0	\$1,600	

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% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 E

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$155 (Part B deductible) \$0
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(continued)

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First 250 each calendar year Remainder of charges</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.</p>
<p>*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional Charges</p>	<p>\$0 \$0</p>	<p>\$120 \$0</p>	<p>\$0 All costs</p>

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

(continued)

****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 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$155 of Medicare Approved amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN F
PARTS A & B

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 \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER SERVICES – 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% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 G

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

*Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$155 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G
PARTS A & B

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 \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	\$0	\$1600	

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% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum

SERFF Tracking Number: IASL-126355825 State: Arkansas
 Filing Company: Royal Neighbors of America State Tracking Number: 43867
 Company Tracking Number: RN AR 2010 OC
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
 Product Name: RN AR 2010 OC
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Flesch Certification Bypass Reason: NA - Filing an Outline of Coverage Comments:		
Bypassed - Item: Application Bypass Reason: NA - Filing an Outline of Coverage Comments:		
Bypassed - Item: Health - Actuarial Justification Bypass Reason: NA - Filing an Outline of Coverage Comments:		
Bypassed - Item: Outline of Coverage Bypass Reason: Outline of Coverage is on the form schedule tab. Comments:		
Satisfied - Item: Authorization Letter Comments: Attachment: 2009 08 RNA IAS Authorization.pdf		



Brian W. Haynes
Treasurer and Chief Financial Officer

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August 4, 2009

Ms. Darcey Shaffer, ACS, FLMI
Compliance Manager
Insurance Administrative Solutions, L.L.C.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

Re: Filing/Reporting Requirements for RNA Medicare Supplement Insurance
Certificates

Dear Ms. Shaffer:

This letter authorizes Insurance Administrative Solutions, L.L.C. "IAS" to file on behalf of Royal Neighbors of America, various reports and forms for the Medicare Supplement Insurance Certificates with the State Insurance Departments. Prior to submission of any reports or forms including any advertising materials, IAS will obtain written approval of the documents to be filed from the Medicare Supplement Line of Business Manager or CFO of Royal Neighbors. IAS may correspond with the State Insurance Departments regarding any questions they may have concerning the filings, but will notify Royal Neighbors and obtain their consent before making any changes to the submission.

IAS will keep Royal Neighbors fully advised of all such filings submitted on behalf of Royal Neighbors and furnish copies of approved submissions to the attention of John Fleming, Medicare Supplement Line of Business Manager and Deb Zemo, Compliance Assistant

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,

Brian W. Haynes
CFO and Treasurer

BWH:jag