

SERFF Tracking Number: CEUL-126477107 State: Arkansas
Filing Company: Family Life Insurance Company State Tracking Number: 44749
Company Tracking Number:
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Medicare Supplement Outline
Project Name/Number: /

Filing at a Glance

Company: Family Life Insurance Company

Product Name: Medicare Supplement Outline SERFF Tr Num: CEUL-126477107 State: Arkansas

TOI: MS06 Medicare Supplement - Other SERFF Status: Closed-Approved- State Tr Num: 44749
Closed

Sub-TOI: MS06.000 Medicare Supplement - Other Co Tr Num: State Status: Approved-Closed
Other

Filing Type: Form

Author:

Reviewer(s): Stephanie Fowler

Date Submitted: 01/29/2010

Disposition Date: 03/10/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

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: 03/10/2010

Explanation for Other Group Market Type:

State Status Changed: 03/10/2010

Deemer Date:

Created By: Lloyd Kleiman

Submitted By: Lloyd Kleiman

Corresponding Filing Tracking Number:

Filing Description:

This is the Outline of Coverage for Family Life's Medicare Supplement.

Company and Contact

Filing Contact Information

Lloyd Kleiman,
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Houston, TX 77092

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Filing Company Information

Family Life Insurance Company CoCode: 63053 State of Domicile: Texas
 10700 Northwest Freeway Group Code: 1117 Company Type:
 Houston, TX 77092 Group Name: Manhattan Insurance State ID Number:
 Group
 (800) 877-7705 ext. [Phone] FEIN Number: 91-0550883

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	\$50.00	01/29/2010	33883236

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	03/10/2010	03/10/2010

SERFF Tracking Number: CEUL-126477107 *State:* Arkansas
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Disposition

Disposition Date: 03/10/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CEUL-126477107

State: Arkansas

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover letter	Accepted for Informational Purposes	Yes
Form	Outline of Coverage	Approved	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/10/2010	MSOCI200 810 AR	Outline of Coverage	Outline of Coverage	Initial		42.900	AR 1-1-10 OLD-R.NEW- D.pdf

FAMILY LIFE INSURANCE COMPANY
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. Family Life Insurance Company 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	
		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 B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		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	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				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 exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

FAMILY LIFE INSURANCE COMPANY
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		
Preventative Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit***	\$2310 Out of Policy 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 plans 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.

FAMILY LIFE INSURANCE COMPANY OF AMERICA

**PREFERRED PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

**722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,
72135, 72142, 72164, 72180, 72190, 72198, 72199**

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[1186]	[1444]	[1658]	[1514]	[1519]	[1696]	[1521]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[593]	[722]	[829]	[757]	[760]	[848]	[761]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[297]	[361]	[415]	[379]	[380]	[424]	[380]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[99]	[120]	[138]	[126]	[127]	[141]	[127]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY OF AMERICA

**STANDARD PREMIUM RATES
FOR USE IN ARKANSAS ZIP CODES**

**722, 72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,
72135, 72142, 72164, 72180, 72190, 72198, 72199**

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[1318]	[1604]	[1842]	[1681]	[1688]	[1885]	[1691]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[659]	[802]	[921]	[841]	[844]	[943]	[846]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[330]	[401]	[461]	[420]	[422]	[471]	[423]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[110]	[134]	[154]	[140]	[141]	[157]	[141]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY OF AMERICA

PREFERRED PREMIUM RATES

**FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 and 721 EXCEPT
72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,
72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199**

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[1127]	[1372]	[1575]	[1438]	[1443]	[1611]	[1445]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[564]	[686]	[788]	[719]	[722]	[806]	[723]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[282]	[343]	[394]	[360]	[361]	[403]	[361]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[94]	[114]	[131]	[120]	[120]	[134]	[120]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY OF AMERICA

STANDARD PREMIUM RATES

**FOR USE IN ALL ARKANSAS ZIP CODES BEGINNING WITH 720 and 721 EXCEPT
72002, 72053, 72065, 72076, 72078, 72099, 72103, 722113-72120, 72124,
72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199**

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[1252]	[1524]	[1750]	[1597]	[1604]	[1791]	[1606]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[626]	[762]	[875]	[799]	[802]	[896]	[803]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[313]	[381]	[438]	[399]	[401]	[448]	[402]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[104]	[127]	[146]	[133]	[134]	[149]	[134]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY OF AMERICA

**PREFERRED PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 720-722**

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[1008]	[1227]	[1409]	[1287]	[1291]	[1442]	[1293]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[504]	[614]	[705]	[644]	[646]	[721]	[647]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[252]	[307]	[352]	[322]	[323]	[361]	[323]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[84]	[102]	[117]	[107]	[108]	[120]	[108]

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY OF AMERICA

**STANDARD PREMIUM RATES
FOR USE IN ALL ARKANSAS ZIP CODES
EXCEPT 720-722**

ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[1120]	[1363]	[1566]	[1429]	[1435]	[1602]	[1437]

SEMI-ANNUAL

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[560]	[682]	[783]	[715]	[718]	[801]	[719]

QUARTERLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[280]	[341]	[392]	[357]	[359]	[401]	[359]

MONTHLY

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G
All Ages	[93]	[114]	[131]	[119]	[120]	[134]	[120]

Spousal Discount Factor: .93

PREMIUM INFORMATION

Family Life Insurance Company may change your premium if a new table of rates is applicable to the policy. 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 state and zip code of residence.

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 Family Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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. Neither Family Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

This policy does not contain a pre-existing condition limitation and this policy does not pay benefits for (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section; (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions; (e) Services for which a charge is not normally made in the absence of insurance; or (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

Please refer to your policy 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.

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

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 outpatient 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.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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**

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.

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

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.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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**

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.

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

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.

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

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%	[\$155] (Part B deductible) Generally 20%	\$0** \$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 [\$155] (Part B deductible) 20%	\$0** \$0** \$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 [\$155] (Part B deductible) 20%	\$0** \$0** \$0**
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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 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.
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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.

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

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.

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

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

*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.

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

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	Balance
— Calendar Year maximum	\$0	[\$1,600]	Balance

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.

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

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.

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

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

*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.

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

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 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.
†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	\$0 \$0	[\$120] \$0	\$0** All costs

†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.

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

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 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.

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

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%	[\$155] (Part B deductible) Generally 20%	\$0** \$0**
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0**
BLOOD First 3 pints Next \$155 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs [\$155] (Part B deductible) 20%	\$0** \$0** \$0**
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0**

(continued)

PLAN F
PARTS A & B

*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.

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

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.

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

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.

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

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**

*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.

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

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	Balance
— Calendar Year maximum	\$0	[\$1600]	Balance

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: CEUL-126477107

State: Arkansas

Filing Company: Family Life Insurance Company

State Tracking Number: 44749

Company Tracking Number:

TOI: MS06 Medicare Supplement - Other

Sub-TOI: MS06.000 Medicare Supplement - Other

Product Name: Medicare Supplement Outline

Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status
			Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	03/10/2010
Comments:			
Attachment:			
flesch cert_001.pdf			

		Item Status:	Status
			Date:
Bypassed - Item:	Application		
Bypass Reason:	not an application		
Comments:			

		Item Status:	Status
			Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	in the form schedule		
Comments:			

		Item Status:	Status
			Date:
Satisfied - Item:	Cover letter	Accepted for Informational Purposes	03/10/2010
Comments:			
Attachment:			
Cover LetterAR.pdf			

FAMILY LIFE

Lloyd Kleiman
Compliance Analyst

January 28, 2010

CERTIFICATION

I, Mary Lou Rainey, Secretary for The Manhattan Life Insurance Company, hereby certify that the following form(s) has the following readability score as calculated by the Flesch Reading Ease Test set forth by your state, and meets the minimum reading ease requirements set forth by the state of Arkansas.

FORM

Readability Score

MSOCI200810 AR

42.9

DATE: 1/28/10



Mary Lou Rainey, Secretary

10700 Northwest Freeway
Houston, Texas 77092
Email: lkleiman@manhattanlife.com

Phone: 713-529-0045, ext. 5184
Toll Free: 800-669-9030 ext. 5184
Fax: 713-821-6551



FAMILY LIFE

Lloyd Kleiman
Compliance Analyst

January 28, 2010

Arkansas Insurance Department

RE: Family Life Insurance Company
NAIC #: 63053 FEIN: 91-0550883
Medicare Supplement – Outline of Coverage filing

Dear Sir/Madam:

The following form is submitted for your information.

MSOCI200810 AR Outline of Coverage
edition date – 01-01-2010

This revised Outline of Coverage reflects the standard revisions to benefit levels taking effect January 1, 2010. The corresponding change to the rates is also reflected.

If you have any questions regarding this form or need additional information regarding this submission, please call or contact me at the numbers/addresses below.

Sincerely,



10700 Northwest Freeway
Houston, Texas 77092
Email: lkleiman@manhattanlife.com

Phone: 713-529-0045, ext. 5184
Toll Free: 800-669-9030 ext. 5184
Fax: 713-821-6551

