

SERFF Tracking Number: MUTM-127786875 State: Arkansas  
Filing Company: Government Personnel Mutual Life Insurance Company State Tracking Number: 50152  
Company Tracking Number: ROBYN GONZALES  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010  
Product Name: 2012 Copay Deductible Filing- DP2.T04-AR 00-12 (GPM)  
Project Name/Number: 2012 Copay Deductible Filing/DP2.T04-AR 00-12

## Filing at a Glance

Company: Government Personnel Mutual Life Insurance Company

Product Name: 2012 Copay Deductible Filing- SERFF Tr Num: MUTM-127786875 State: Arkansas  
DP2.T04-AR 00-12 (GPM)

TOI: MS08I Individual Medicare Supplement - SERFF Status: Closed-Approved State Tr Num: 50152  
Standard Plans 2010

Sub-TOI: MS08I.001 Plan A 2010

Co Tr Num: ROBYN GONZALES

State Status: Approved-Closed  
Reviewer(s): Stephanie Fowler,  
Donna Lambert

Filing Type: Form

Authors: Shelly Kaipust, Jan  
Serafini, Jaime Mosqueda, Ellen  
Cochrane, Melanie Worth, Robyn  
Gonzales, Neil Sandhoefner

Disposition Date: 11/07/2011

Date Submitted: 11/01/2011

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 12/07/2011

State Filing Description:

## General Information

Project Name: 2012 Copay Deductible Filing

Project Number: DP2.T04-AR 00-12

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Ellen Cochrane

Filing Description:

NAIC # 63967

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 11/07/2011

State Status Changed: 11/07/2011

Created By: Ellen Cochrane

Corresponding Filing Tracking Number:

Individual Medicare Supplement Insurance

Outline of Coverage Modules CP25 00-12, DP2.T04-AR 00-12, and BC25 00-12

SERFF Tracking Number: MUTM-127786875 State: Arkansas  
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Enclosed for your review and approval are the above-captioned Medicare supplement outline of coverage module forms. This filing is being made to comply with the changes in the Federal Medicare coinsurance and deductible amounts. The only changes in these modules from the previously approved modules are the coinsurance and deductible amounts effective January 1, 2012.

Outline of coverage module forms CP25 00-12 and BC24 00-12 will replace forms CP25 09-11 and BC25 00-11, which your Department approved on August 16, 2011 and November 23, 2010, respectively. Outline of coverage module form DP2.T04-AR 00-12 is also included with minor grammatical changes. This form will replace form DP2.T01-AR 09-11, also approved on August 16, 2011.

Your review and approval of this submission will be most appreciated. If you have any questions, please do not hesitate to contact me.

Sincerely,

Robyn Gonzales  
Senior Product and Advertising Compliance Analyst  
Corporate Compliance and Ethics Division  
Phone: 402-351-6748  
Fax: 402-351-5298  
E-mail: Robyn.Gonzales@mutualofomaha.com

## Company and Contact

### Filing Contact Information

Robyn Gonzales - Admin, robyn.gonzales@mutualofomaha.com  
Mutual of Omaha 402-351-6748 [Phone]  
Mutual of Omaha Plaza 402-351-5298 [FAX]  
Omaha, NE 68175

### Filing Company Information

Government Personnel Mutual Life Insurance CoCode: 63967 State of Domicile: Texas  
Company  
PO Box 659567 Group Code: Company Type: Life & Health  
San Antonio, TX 99999 Group Name: State ID Number:

SERFF Tracking Number: MUTM-127786875 State: Arkansas  
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Project Name/Number: 2012 Copay Deductible Filing/DP2.T04-AR 00-12  
(800) 929-4765 ext. [Phone] FEIN Number: 74-0651020  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$150.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Government Personnel Mutual Life Insurance Company	\$150.00	11/01/2011	53370589

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/07/2011	11/07/2011

*SERFF Tracking Number:* MUTM-127786875      *State:* Arkansas  
*Filing Company:* Government Personnel Mutual Life Insurance      *State Tracking Number:* 50152  
*Company*  
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*Standard Plans 2010*  
*Product Name:* 2012 Copay Deductible Filing- DP2.T04-AR 00-12 (GPM)  
*Project Name/Number:* 2012 Copay Deductible Filing/DP2.T04-AR 00-12

## **Disposition**

Disposition Date: 11/07/2011

Implementation Date: 12/07/2011

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Form	Individual Medicare Supplement Insurance Outline of Coverage-Disclosure Page	Approved	Yes
Form	Individual Medicare Supplement Insurance Outline of Coverage - Cover Page	Approved	Yes
Form	Individual Medicare Supplement Insurance Outline of Coverage - Benefit Charts	Approved	Yes

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## Form Schedule

**Lead Form Number: DP2.T04-AR 00-12**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/07/2011	DP2.T04-AR 00-12	Outline of Coverage	Individual Medicare Supplement Insurance Outline of Coverage-Disclosure Page	Initial			DP2.T04-AR 00-12.pdf
Approved 11/07/2011	CP25 00-12	Outline of Coverage	Individual Medicare Supplement Insurance Outline of Coverage - Cover Page	Initial			CP25 00-12.pdf
Approved 11/07/2011	BC25 00-12	Outline of Coverage	Individual Medicare Supplement Insurance Outline of Coverage - Benefit Charts	Initial			BC25 00-12.pdf

**Disclosures**

Use this outline to compare benefits and premiums among policies.

**Premium Information**

We, Government Personnel Mutual Life, can only raise your premium if we raise the premium for all policies like yours in the same geographic area of the state where you live.

**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 us.

**Right to Return Policy**

If you find that you are not satisfied with your policy, you may return it to us at our administrative office, 3316 Farnam Street, Omaha, NE 68175. 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**

The policy may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

**Complete Answers Are Very Important**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. We 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.

**GOVERNMENT PERSONNEL MUTUAL LIFE INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE**  
**BENEFIT PLANS A, C, F, G, AND N**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

**Basic Benefits:**

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. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Co-insurance *		Basic, including 100% Part B Co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance		Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4,660; paid at 100% after limit reached	Out-of-pocket limit \$2,330; paid at 100% after limit reached		

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/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.

**PLANS A AND 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 A Pays	You Pay	Plan C Pays	You Pay
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but \$1,156	\$0	\$1,156 (Part A deductible)	\$1,156 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$289 a day	\$289 a day	\$0	\$289 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0	\$578 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	\$0	\$0	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$144.50 a day	\$0	Up to \$144.50 a day	Up to \$144.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs	\$0	All costs
<b>BLOOD</b>					
First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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.

**PLANS A AND C**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$140 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 A Pays	You Pay	Plan C 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 \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)	\$140 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs	\$0	All costs
<b>BLOOD</b>					
First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)	\$140 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE—MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment					
First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)	\$140 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0	20%	\$0

**PLANS A AND C**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan A Pays</b>	<b>You Pay</b>	<b>Plan C Pays</b>	<b>You Pay</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First \$250 each calendar year	\$0	N/A	All Costs	\$0	\$250
Remainder of charges	\$0	N/A	All Costs	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit

**PLANS F AND 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 F Pays	You Pay	Plan G Pays	You Pay
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0	\$1,156 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$289 a day	\$289 a day	\$0	\$289 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0	\$578 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	\$0	\$0	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$144.50 a day	Up to \$144.50 a day	\$0	Up to \$144.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs	\$0	All costs
<b>BLOOD</b>					
First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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.

**PLANS F AND G**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$140 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 F Pays	You Pay	Plan G 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 \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0	100%	\$0
<b>BLOOD</b>					
First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE—MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment					
First \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0	20%	\$0

**PLANS F AND G  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan F Pays</b>	<b>You Pay</b>	<b>Plan G Pays</b>	<b>You Pay</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First \$250 each calendar year	\$0	\$0	\$250	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit

**PLAN N**  
**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 N Pays	You Pay
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$289 a day	\$289 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$144.50 a day	Up to \$144.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate'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 N**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$140 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 N 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 \$140 of Medicare-approved amounts*	\$0	<b>\$0</b>	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE—MEDICARE- APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

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

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan N Pays</b>	<b>You Pay</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit

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 Standard Plans 2010  
 Product Name: 2012 Copay Deductible Filing- DP2.T04-AR 00-12 (GPM)  
 Project Name/Number: 2012 Copay Deductible Filing/DP2.T04-AR 00-12

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Flesch Certification	Approved	11/07/2011
<b>Bypass Reason:</b>	Not required for this filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved	11/07/2011
<b>Bypass Reason:</b>	Not required for this filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved	11/07/2011
<b>Bypass Reason:</b>	Not required for this filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Outline of Coverage	Approved	11/07/2011
<b>Comments:</b>	Please see the Outline of Coverages attached under the Forms Schedule Tab.		