

SERFF Tracking Number: HESS-126904193 State: Arkansas
Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 47683
Company Tracking Number: MLMUCTOC10/11 AR
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Medicare Supplement Outline 10/11
Project Name/Number: UCT/MLMUCTOC10/11

Filing at a Glance

Company: The Order of United Commercial Travelers of America

Product Name: Medicare Supplement Outline 10/11 SERFF Tr Num: HESS-126904193 State: Arkansas

TOI: MS06 Medicare Supplement - Other SERFF Status: Closed-Approved- Closed State Tr Num: 47683

Sub-TOI: MS06.000 Medicare Supplement - Other Co Tr Num: MLMUCTOC10/11 AR State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Stephanie Fowler

Authors: Antoinette Hess, Michelle Miller Disposition Date: 02/08/2011

Date Submitted: 01/11/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: UCT

Project Number: MLMUCTOC10/11

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Not required

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/08/2011

State Status Changed: 02/08/2011

Created By: Michelle Miller

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Michelle Miller

Filing Description:

RE: The Order of United Commercial Travelers of America

NAIC Number: 56383

FEIN Number: 31-4273120

SUBMISSION

Medicare Supplement – Outline of Coverage – Form Number: MSIOC2011 AR

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Hess Compliance Consulting, LLC has been retained by The Order of United Commercial Travelers of America to file the above-captioned form on their behalf. We are requesting the review and approval of these forms. A letter of authorization is included for reference.

All required filing documents have been completed and are included with the filing.

The filing of this Medicare Supplement Outline of Coverage represents the annual filing of this outline as required by your state. This outline will be used with the Medicare Supplement Plans approved on 5/20/2010, under SERFF File WAKE-126588800.

Hess Compliance Consulting, LLC appreciates the Department's time and consideration with this filing.

Company and Contact

Filing Contact Information

Toni Hess, Compliance Consultant Toni.Hess@HessCC.Com
931 Clarmont Avenue 215-485-2582 [Phone]
Bensalem, PA 19020

Filing Company Information

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

The Order of United Commercial Travelers of America CoCode: 56383 State of Domicile: Ohio
1801 Watermark Drive, Suite 100 Group Code: Company Type:
P.O. Box 159019 Group Name: State ID Number:
Columbus, OH 43215-8619 FEIN Number: 31-4273120
(800) 848-0123 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: Informational \$50
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Order of United Commercial Travelers of America	\$50.00	01/11/2011	43667370

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	02/08/2011	02/08/2011

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Disposition

Disposition Date: 02/08/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Authorization Letter	Accepted for Informational Purposes	Yes
Form	Outline of Coverage	Approved	Yes

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Form Schedule

Lead Form Number: MSIOC2011 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 02/08/2011	MSIOC201 1 AR	Outline of Coverage	Outline of Coverage	Initial		43.900	MSIOC2011 AR.pdf

The Order of United Commercial Travelers of America
Outline of Medicare Supplement Coverage
Benefit Plans A, B, C, D, F, G AND N

These charts show 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. The Order of United Commercial Travelers of America offers five of the eleven plans available.

[Plans E, H, I, and J are no longer available for sale. {This sentence shall not appear after June 1, 2011.}]

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 co-payments.

Blood: First three 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 coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit [\$4640]; paid at 100% after limit reached	Out-of-pocket limit [\$2320]; paid at 100% after limit reached		

***Plans F also have 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 [\$2000] deductible. Benefits from high deductible plan F 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.**

**ANNUAL PREMIUM RATES
FOR USE IN ARKANSAS**

All Ages	<u>Plan A</u>		<u>Plan B</u>		<u>Plan F</u>		<u>Plan G</u>		<u>Plan N</u>	
	Male	Female								
Non Tobacco Rates For Zip Codes 722	1,794.08	1,794.08	2,167.85	2,167.85	2,491.78	2,491.78	2,205.12	2,205.12	1,744.25	1,744.25
Tobacco Rates For Zip Codes 722	2,243.52	2,243.52	2,710.92	2,710.92	3,116.00	3,116.00	3,116.00	3,116.00	2,181.20	2,181.20
Non Tobacco Rates For Zip Codes 720-721	1,614.67	1,614.67	1,951.07	1,951.07	2,242.60	2,242.60	1,984.61	1,984.61	1,569.83	1,569.83
Tobacco Rates For Zip Codes 720-721	2,019.17	2,019.17	2,439.83	2,439.83	2,804.40	2,804.40	2,477.71	2,477.71	1,963.08	1,963.08
Non Tobacco Rates For Zip Codes 716-719 and 723-729	1,524.97	1,524.97	1,842.67	1,842.67	2,118.01	2,118.01	1,874.35	1,874.35	1,482.61	1,482.61
Tobacco Rates For Zip Codes 716-719 and 723-729	1,906.99	1,906.99	2,304.28	2,304.28	2,648.60	2,648.60	2,340.06	2,340.06	1,854.02	1,854.02

MODAL FACTORS

Semi-Annual – 0.51500

Quarterly – 0.26250

Direct Monthly – 0.10000

Monthly EFT – 0.08333

PREMIUM INFORMATION

We, The Order of United Commercial Travelers of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your issue age.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and The Order of United Commercial Travelers of America.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619, or to the representative through whom the policy was purchased. 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 The Order of United Commercial Travelers 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 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.

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 [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	\$0 [\$283] a day [\$566] a day 100% of Medicare eligible expenses \$0	[\$1132] (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 [\$141.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$141.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

****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 [\$162] 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 [\$162] of Medicare Approved Amounts*	\$0	\$0	[\$162] (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 [\$162] of Medicare Approved Amounts*	\$0	\$0	[\$162] (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 [\$162] of Medicare Approved Amounts*	\$0	\$0	[\$162] (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 [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	[\$1132] (Part A deductible) [\$283] a day [\$566] 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 [\$141.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$141.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

****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 [\$162] 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 [\$162] of Medicare Approved Amounts*	\$0	\$0	[\$162] (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 [\$162] of Medicare Approved Amounts*	\$0	\$0	[\$162] (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 [\$162] of Medicare Approved Amounts*	\$0	\$0	[\$162] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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 [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	[\$1132] (Part A deductible) [\$283] a day [\$566] 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 [\$141.50] a day \$0	\$0 Up to [\$141.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

****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 [\$162] 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 [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	[\$162] (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$162] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs [\$162] (Part B deductible) 20%	\$0 \$0 \$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 [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 [\$162] (Part B deductible) 20%	\$0 \$0 \$0

OTHER SERVICES – 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>

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 [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	[\$1132] (Part A deductible) [\$283] a day [\$566] 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 [\$141.50] a day \$0	\$0 Up to [\$141.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

****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 [\$162] 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 [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 [\$162] (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 [\$162] (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 [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 [\$162] (Part B deductible) \$0

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</p>			
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 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 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 [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	[\$1132] (Part A deductible) [\$283] a day [\$566] 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 [\$141.50] a day \$0	\$0 Up to [\$141.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

****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 N

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

*Once you have been billed [\$162] 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 [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 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 the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	[\$162] (Part B deductible) Up to [\$20] per office visit and up to {\$50} per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	\$0
BLOOD First 3 pints Next [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$162] (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 [\$162] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$162] (Part B deductible) \$0

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</p>			
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: HESS-126904193 State: Arkansas
 Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 47683
 Company Tracking Number: MLMUCTOC10/11 AR
 TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
 Product Name: Medicare Supplement Outline 10/11
 Project Name/Number: UCT/MLMUCTOC10/11

Supporting Document Schedules

		Item Status:	Status
			Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	02/08/2011

Comments:

Attachments:

AR RuleReg 19.pdf
 AR RuleReg 49.pdf
 AR Readability.pdf
 AR Consumer Notice.pdf

		Item Status:	Status
			Date:

Bypassed - Item: Application
Bypass Reason: Outline of Coverage filing only
Comments:

		Item Status:	Status
			Date:

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: Outline of Coverage filing only
Comments:

		Item Status:	Status
			Date:

Bypassed - Item: Outline of Coverage
Bypass Reason: Outline of Coverage filing only, Outline is in Form Schedule Tab
Comments:

		Item Status:	Status
			Date:

SERFF Tracking Number: HESS-126904193 State: Arkansas
Filing Company: The Order of United Commercial Travelers of America State Tracking Number: 47683
Company Tracking Number: MLMUCTOC10/11 AR
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Medicare Supplement Outline 10/11
Project Name/Number: UCT/MLMUCTOC10/11
Satisfied - Item: Authorization Letter Accepted for Informational Purposes 02/08/2011

Comments:

Attachment:

UCT Hess Authorization 112010.pdf

ARKANSAS

RULE AND REGULATION 19 CERTIFICATION

FORM(S)

Outline of Coverage

FORM NUMBER

MSIOC2011 AR

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the State of Insurance.

Signature

Michelle Miller

Name

Compliance Consultant

Title

ARKANSAS

RULE AND REGULATION 49 CERTIFICATION

FORM(S)

Outline of Coverage

FORM NUMBER

MSIOC2011 AR

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Michelle Miller

Name

Compliance Consultant

Title

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

**The Order of United Commercial Travelers of America
1801 Watermark Drive, Suite 100
P.O. Box 159019
Columbus, OH 43215-8619**

I hereby certify that the Flesch Reading Ease Test Score of the listed form is as follows:

<u>Form Number</u>	<u>Type and/or Title of Form</u>	<u>Flesch Score</u>
MSIOC2011 AR	Outline of Coverage	43.9

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.

Signature

Michelle Miller
Name

Compliance Consultant
Title

CONSUMER NOTICE
THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA

Policyholder Service Office of Company: **The Order of United Commercial Travelers of America**
Address: **1801 Watermark Drive, Suite 100, Columbus OH 43215-8619**
Telephone Number: **(800) 848-0123**

Agent: **[Fred Smith]**
Address: **[123 First Street, Any Town, Arkansas]**
Telephone Number: **[555-555-1234]**

If we at The Order of United Commercial Travelers of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Tird Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494

Please direct your inquiries as to this bulletin to the Legal Division of this Department at (501) 371-2820.



1801 Watermark Drive, Suite 100
Columbus, Ohio 43215-8619

Tel: 614.487.9680
Toll-free: 800.848.0123
Fax: 614.487.9675

November 10, 2010

Toni Hess
Hess Compliance Consulting, LLC
931 Clarmont Avenue
Bensalem, PA 19020

Dear Ms. Hess:

The firm of Hess Compliance Consulting, LLC is hereby authorized to submit form filings for approval to the Department of Insurance on behalf of The Order of United Commercial Travelers of America. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Thank you.

Sincerely,

A handwritten signature in blue ink, appearing to read 'J. Hoffman', is written over a horizontal line.

Joseph H. Hoffman
Chief Executive Officer