

**State:** Arkansas **Filing Company:** The Order of United Commercial Travelers of America  
**TOI/Sub-TOI:** MS09 Medicare Supplement - Other 2010/MS09.000 Medicare Supplement Other 2010  
**Product Name:** Medicare Supplement Outline (2013)  
**Project Name/Number:** /

### Filing at a Glance

Company: The Order of United Commercial Travelers of America  
 Product Name: Medicare Supplement Outline (2013)  
 State: Arkansas  
 TOI: MS09 Medicare Supplement - Other 2010  
 Sub-TOI: MS09.000 Medicare Supplement Other 2010  
 Filing Type: Form  
 Date Submitted: 12/10/2012  
 SERFF Tr Num: UCTA-128802447  
 SERFF Status: Closed-Approved  
 State Tr Num:  
 State Status: Approved-Closed  
 Co Tr Num:  
 Implementation: 01/01/2013  
 Date Requested:  
 Author(s): Denise Sharif, Jane Visocan, Lyndsay Fields  
 Reviewer(s): Stephanie Fowler (primary)  
 Disposition Date: 01/09/2013  
 Disposition Status: Approved  
 Implementation Date:  
 State Filing Description:

**State:** Arkansas **Filing Company:** The Order of United Commercial Travelers of America  
**TOI/Sub-TOI:** MS09 Medicare Supplement - Other 2010/MS09.000 Medicare Supplement Other 2010  
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## General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Not required to be filed in domicile state.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/09/2013
	State Status Changed: 01/09/2013
Deemer Date:	Created By: Lyndsay Fields
Submitted By: Lyndsay Fields	Corresponding Filing Tracking Number:
Filing Description:	
SUBMISSION	
Medicare Supplement – Outline of Coverage – Form Number: MSIOC2013 AR	

We are requesting the review and approval of this form. 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 05/19/2010, under SERFF File WAKE-126588800.

We appreciate the Department's time and consideration with this filing. Thank you.

## Company and Contact

### Filing Contact Information

Denise Sharif, Compliance Supervisor	dsharif@uct.org
1801 Watermark Dr.	614-487-9680 [Phone] 103 [Ext]
Suite 100	614-487-9675 [FAX]
Columbus, OH 43215	

### Filing Company Information

The Order of United Commercial Travelers of America	CoCode: 56383	State of Domicile: Ohio
1801 Watermark Dr.	Group Code:	Company Type:
Suite 100	Group Name:	State ID Number:
Columbus, OH 43215	FEIN Number: 31-4273120	
(614) 487-9680 ext. 103[Phone]		

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	

State: Arkansas

Filing Company: The Order of United Commercial Travelers of America

TOI/Sub-TOI: MS09 Medicare Supplement - Other 2010/MS09.000 Medicare Supplement Other 2010

Product Name: Medicare Supplement Outline (2013)

Project Name/Number: /

Per Company: No

Company	Amount	Date Processed	Transaction #
The Order of United Commercial Travelers of America	\$50.00	12/10/2012	65589037

SERFF Tracking #:

UCTA-128802447

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

The Order of United Commercial Travelers of America

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	01/09/2013	01/09/2013

SERFF Tracking #:

UCTA-128802447

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

The Order of United Commercial Travelers of America

TOI/Sub-TOI:

MS09 Medicare Supplement - Other 2010/MS09.000 Medicare Supplement Other 2010

Product Name:

Medicare Supplement Outline (2013)

Project Name/Number:

/

## Disposition

Disposition Date: 01/09/2013

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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

SERFF Tracking #:

UCTA-128802447

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

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## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/09/2013	Outline of Coverage	MSIOC2013 AR	OUT	Initial		43.800	MSIOC2013 AR.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**The Order of United Commercial Travelers of America**  
**Outline of Medicare Supplement Coverage**  
**Benefit Plans A, B, 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.

**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 \$4800; paid at 100% after limit reached	Out-of-pocket limit \$2400; 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 \$2110 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2110. 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	Plan A		Plan B		Plan F		Plan G		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
<b>Non Tobacco Rates For Zip Codes 722</b>	\$1,865.84	\$1,865.84	\$2,254.56	\$2,254.56	\$2,591.45	\$2,591.45	\$2,293.32	\$2,293.32	\$1,814.02	\$1,814.02
<b>Tobacco Rates For Zip Codes 722</b>	\$2,333.26	\$2,333.26	\$2,819.35	\$2,819.35	\$3,240.64	\$3,240.64	\$2,863.13	\$2,863.13	\$2,268.44	\$2,268.44
<b>Non Tobacco Rates For Zip Codes 720-721</b>	\$1,679.26	\$1,679.26	\$2,029.10	\$2,029.10	\$2,332.31	\$2,332.31	\$2,063.99	\$2,063.99	\$1,632.62	\$1,632.62
<b>Tobacco Rates For Zip Codes 720-721</b>	\$2,099.93	\$2,099.93	\$2,537.42	\$2,537.42	\$2,916.58	\$2,916.58	\$2,576.82	\$2,576.82	\$2,041.60	\$2,041.60
<b>Non Tobacco Rates For Zip Codes 716-719 and 723-729</b>	\$1,585.96	\$1,585.96	\$1,916.38	\$1,916.38	\$2,202.73	\$2,202.73	\$1,949.32	\$1,949.32	\$1,541.92	\$1,541.92
<b>Tobacco Rates For Zip Codes 716-719 and 723-729</b>	\$1,983.27	\$1,983.27	\$2,396.45	\$2,396.45	\$2,754.54	\$2,754.54	\$2,433.66	\$2,433.66	\$1,928.17	\$1,928.17
<b>MODAL FACTORS</b>										
<b>Semi-Annual – 0.51500</b>		<b>Quarterly – 0.26250</b>			<b>Direct Monthly – 0.10000</b>			<b>Monthly EFT – 0.08333</b>		

## **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. The premium may change 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 the change. Class is defined as underwriting class, state and zip code of residence.

## **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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1184 All but \$296 a day  All but \$592 a day  \$0 \$0	\$0 \$296 a day  \$592 a day  100% of Medicare eligible expenses \$0	\$1184 (Part A deductible) \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$148.00 a day \$0	\$0 \$0 \$0	\$0 Up to \$148.00 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$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 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 an additional 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 \$147 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      \$0  Generally 80%	      \$0  Generally 20%	        \$147 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	  \$0 \$147 (Part B deductible) \$0
<b>CLINICAL LABORATORY                      SERVICES – TESTS FOR                      DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	   100%  \$0  80%	   \$0  \$0  20%	     \$0 \$147 (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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1184 All but \$296 a day All but \$592 a day \$0 \$0	\$1184 (Part A deductible) \$296 a day \$592 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$148.00 a day \$0	\$0 \$0 \$0	\$0 Up to \$148.00 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$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 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 an additional 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 \$147 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      \$0   Generally 80%	      \$0   Generally 20%	         \$147 (Part B deductible)   \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0  \$0  80%	 All costs  \$0  20%	 \$0  \$147 (Part B deductible)  \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	   100%   \$0  80%	   \$0   \$0  20%	   \$0   \$147 (Part B deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1184 All but \$296 a day  All but \$592 a day  \$0  \$0	\$1184 (Part A deductible) \$296 a day  \$592 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$148.00 a day \$0	\$0 Up to \$148.00 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 an additional 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 \$147 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$147 (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$147 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$147 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$147 (Part B deductible) 20%	\$0 \$0 \$0

**OTHER SERVICES – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>                      Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                      First \$250 each calendar year                      Remainder of charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1184 All but \$296 a day  All but \$592 a day  \$0  \$0	\$1184 (Part A deductible) \$296 a day  \$592 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$148.00 a day \$0	\$0 Up to \$148.00 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 an additional 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 \$147 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$147 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$147 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$0 20%	\$0  \$147 (Part B deductible) \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>                      Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA                      First \$250 each calendar year                      Remainder of Charges</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000.</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</p>

**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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1184 All but \$296 a day  All but \$592 a day  \$0  \$0	\$1184 (Part A deductible) \$296 a day  \$592 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$148.00 a day \$0	\$0 Up to \$148.00 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 an additional 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 \$147 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$147 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.	\$147 (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.
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	\$0
<b>BLOOD</b> First 3 pints Next \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$147 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$147 (Part B deductible) \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>                      Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</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 #:

UCTA-128802447

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

The Order of United Commercial Travelers of America

TOI/Sub-TOI: MS09 Medicare Supplement - Other 2010/MS09.000 Medicare Supplement Other 2010

Product Name: Medicare Supplement Outline (2013)

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Read Cert 12-10-12.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	Not applicable.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not applicable.		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage		
Comments:	Please see the Form Schedule tab.		

**ARKANSAS  
Flesch Readability Certification**

Name and Address of Insurer:

The Order of United Commercial Travelers of America  
1801 Watermark Dr., Suite 100  
Columbus, OH 43215

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

<u>Title of Form(s)</u>	<u>Form Number</u>	<u>Flesch Score</u>
Medicare Supplement Outline of Coverage	MSIOC2013 AR	43.8



Signature

Joseph Hoffman

Name

Chief Executive Officer

Title