

SERFF Tracking Number: MUTM-126350574 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43845
Company Tracking Number: NEIL SANDHOEFNER
TOI: MS05I Individual Medicare Supplement - Sub-TOI: MS05I.001 Plan A
Standard Plans
Product Name: Medicare Supplement Outline of Coverage - UBCPAR 00-10
Project Name/Number: Medicare Supplement Outline of Coverage/UBCPAR 00-10

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Medicare Supplement Outline of SERFF Tr Num: MUTM-126350574 State: Arkansas
Coverage - UBCPAR 00-10

TOI: MS05I Individual Medicare Supplement - SERFF Status: Closed-Approved State Tr Num: 43845
Standard Plans

Sub-TOI: MS05I.001 Plan A

Filing Type: Form

Co Tr Num: NEIL SANDHOEFNER State Status: Approved-Closed

Reviewer(s): Stephanie Fowler

Authors: Mary Cleasby, Shelly

Disposition Date: 11/19/2009

Kaipust, Stacey Payton, Jan

Serafini, Mary Gregg, Krysia

Gannon, Ellen Cochrane, Melanie

Schultz, Kristin Miller, Neil

Sandhoefner

Date Submitted: 10/20/2009

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Medicare Supplement Outline of Coverage

Project Number: UBCPAR 00-10

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 11/19/2009

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 11/19/2009

Created By: Shelly Kaipust

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Shelly Kaipust

Filing Description:

October 20, 2009

Arkansas Department of Insurance

SERFF Tracking Number: MUTM-126350574 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43845
Company Tracking Number: NEIL SANDHOEFNER
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
Standard Plans
Product Name: Medicare Supplement Outline of Coverage - UBCPAR 00-10
Project Name/Number: Medicare Supplement Outline of Coverage/UBCPAR 00-10

Attn: Compliance - Life & Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: NAIC # 261-69868 FEIN 47-0322111
United of Omaha Life Insurance Company
Individual Medicare Supplement Insurance
Outline of Coverage Module Form UBCPAR 00-10

Enclosed for your review and approval is the above captioned Medicare Supplement outline of coverage module form. This form is new and will replace previously approved module form UBCPAR effective January 1, 2010. This filing is being made to comply with the annual change in the Federal copay and deductible amounts for 2010.

UBCPAR 00-10 is the benefit charts for the outline and will replace UBCPAR, approved by your Department on October 29, 2008.

The only changes in this new form reflect the 2010 copay and deductible amounts effective January 1, 2010. This form will not be used in your state before January 1, 2010.

Your consideration and approval of this filing will be most appreciated. If I may be of additional assistance as you complete your review, please do not hesitate to contact me. Thank you.

Sincerely,

Neil Sandhoefner
Product and Advertising Compliance Analyst
Regulatory Affairs
Phone: 402-351-6969
Fax: 402-351-5298
E-mail: Neil.Sandhoefner@mutualofomaha.com

Company and Contact

Filing Contact Information

Neil Sandhoefner, Product & Advertising Compliance Analyst neil.sandhoefner@mutualofomaha.com

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Mutual of Omaha 402-351-6969 [Phone]
 Mutual of Omaha Plaza 402-351-5298 [FAX]
 Omaha, NE 68175

Filing Company Information

United of Omaha Life Insurance Company CoCode: 69868 State of Domicile: Nebraska
 Mutual of Omaha Plaza Group Code: 261 Company Type: Life Insurance
 Omaha, NE 68175 Group Name: State ID Number:
 (402) 351-6420 ext. [Phone] FEIN Number: 47-0322111

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$20.00	10/20/2009	31414300

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	11/19/2009	11/19/2009

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Disposition

Disposition Date: 11/19/2009

Implementation Date:

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	Accepted for Informational Purposes	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	AR Fee Schedule Cert	Accepted for Informational Purposes	Yes
Form	Outline of Coverage Benefits Chart	Approved	Yes

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Form Schedule

Lead Form Number: UBCPAR 00-10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 11/19/2009	UBCPAR 00-10	Outline of Coverage	Outline of Coverage Benefits Chart	Initial			UBCPAR 00- 10.pdf

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 A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,100	\$0	\$1,100 (Part A Deductible)
61 st through 90 th day	All but \$275 a day	\$275 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$550 a day	\$550 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
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	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$137.50 a day	\$0	Up to \$137.50 a day
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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 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 \$155 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$155 of Medicare Approved Amounts*	\$0	\$0	\$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

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

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,100	\$1,100 (Part A Deductible)	\$0	\$1,100 (Part A Deductible)	\$0
61 st through 90 th day	All but \$275 a day	\$275 a day	\$0	\$275 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$550 a day	\$550 a day	\$0	\$550 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
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	All approved amounts	\$0	\$0	\$0	\$0
21 st through 100 th day	All but \$137.50 a day	Up to \$137.50 a day	\$0	Up to \$137.50 a day	\$0
101 st day and after	\$0	\$0	All costs	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$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	\$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 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.

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

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

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B Deductible)	\$0	\$0	\$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
Part B Excess Charges (above Medicare Approved Amounts)	\$0	100%	\$0	80%	20%
BLOOD First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$155 of Medicare Approved Amounts*	\$0	\$155 (Part B Deductible)	\$0	\$0	\$155 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0	\$0	\$0

PARTS A AND B

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

PLANS F and G
PARTS A and B (continued)

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOME HEALTH CARE—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	N/A	All costs	Actual charges to \$40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	N/A	All costs	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
Calendar year maximum	\$0	N/A	All costs	\$1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250	\$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

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	11/19/2009
Comments:			
Attachment:			
AR Read Cert.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	Not applicable for this Medicare Supplement Outline of Coverage filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not applicable for this Medicare Supplement Outline of Coverage filing.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage		
Comments:	See Form Schedule tab for this Outline of Coverage.		

		Item Status:	Status Date:
Satisfied - Item:	AR Fee Schedule Cert	Accepted for Informational Purposes	11/19/2009
Comments:			

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Attachment:

AR Fee Schedule Cert .pdf

CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form</u>	<u>Description</u>	<u>Score</u>
UBCPAR 00-10	Outline of Coverage Benefit Charts	N/A*

* This form is for an outline of coverage and should not be subject to the readability requirements.

United of Omaha Life Insurance Company

Date: October 20, 2009



Daniel J. Kennelly
Vice President & Chief Compliance Officer

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868

Company Contact Person & Phone: Neil Sandhoefner

402-351-6969

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* _____ X \$50 = \$ _____

**Retaliatory \$ _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.

* _____ X \$50 = _____

**Retaliatory \$ _____

Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.

* 1 X \$20 = 20

**Retaliatory \$ _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* _____ X \$25 = \$ _____

**Retaliatory \$ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority

* _____ X \$400 = _____

Filing to amend Certificate of Authority.

*** _____ X \$100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**