

SERFF Tracking Number: AMLC-126602608 State: Arkansas
Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 45518
Company Tracking Number: F2704 R10
TOI: MS09 Medicare Supplement - Other 2010 Sub-TOI: MS09.000 Medicare Supplement Other 2010
Product Name: Individual Medicare Supplement
Project Name/Number: Summary of Benefits/F2704 R10

Filing at a Glance

Company: Globe Life and Accident Insurance Company

Product Name: Individual Medicare Supplement SERFF Tr Num: AMLC-126602608 State: Arkansas

TOI: MS09 Medicare Supplement - Other 2010 SERFF Status: Closed-Filed State Tr Num: 45518

Sub-TOI: MS09.000 Medicare Supplement Co Tr Num: F2704 R10 State Status: Filed-Closed
Other 2010

Filing Type: Advertisement

Reviewer(s): Stephanie Fowler

Author: Diane Breeding

Disposition Date: 04/28/2010

Date Submitted: 04/27/2010

Disposition Status: Filed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Summary of Benefits

Status of Filing in Domicile: Pending

Project Number: F2704 R10

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed via SERFF 4-26-10 domicile state Nebraska

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/28/2010

Explanation for Other Group Market Type:

State Status Changed: 04/28/2010

Deemer Date:

Created By: Diane Breeding

Submitted By: Diane Breeding

Corresponding Filing Tracking Number:

Filing Description:

NAIC: 290-91472

FEIN: 63-0782739

RE: Medicare Supplement Summary of Benefits F2704 R10

NAIC Transmittal

Filing Fee: \$25.00

Attached for your review and approval is one (1) laser print copy of the above mentioned Summary of Benefits F2704 R10 which is being submitted for use with our Individual Medicare Supplement portfolio.

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The Summary of Benefits does not contain any unusual or unorthodox provisions or wording. The Summary of Benefits has been filed in states where the company is authorized to do business, and in our domicile state Nebraska.

I hereby certify that I have carefully reviewed the attached Summary of Benefits and to the best of my knowledge and ability find:

1. The Summary of Benefits conforms to all insurance statutes and department requirements of your jurisdiction.
2. The Summary of Benefits contains no provisions previously disapproved by your department.

Your early review and approval of this submission will be greatly appreciated. If you have any questions, please feel free to call (972) 569-3295 Collect, or e-mail me at dbreeding@torchmarkcorp.com.

Company and Contact

Filing Contact Information

Diane Breeding, Assistant Analyst dbreeding@torchmarkcorp.com
 3700 S. Stonebridge Drive 972-569-3295 [Phone]
 McKinney, TX 75070 972-569-3728 [FAX]

Filing Company Information

Globe Life and Accident Insurance Company CoCode: 91472 State of Domicile: Nebraska
 204 North Robinson Avenue Group Code: 290 Company Type: Life and Health
 Oklahoma City, OK 73102 Group Name: Liberty National State ID Number:
 (405) 270-1400 ext. [Phone] FEIN Number: 63-0782739

Filing Fees

Fee Required? Yes
 Fee Amount: \$25.00
 Retaliatory? No
 Fee Explanation: Your filing fee.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Globe Life and Accident Insurance Company	\$25.00	04/27/2010	35989141
Globe Life and Accident Insurance Company	\$25.00	04/27/2010	35990249

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Stephanie Fowler	04/28/2010	04/28/2010

SERFF Tracking Number: *AMLC-126602608* *State:* *Arkansas*
Filing Company: *Globe Life and Accident Insurance Company* *State Tracking Number:* *45518*
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Disposition

Disposition Date: 04/28/2010

Implementation Date:

Status: Filed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMLC-126602608 State: Arkansas
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Form Schedule

Lead Form Number: F2704 R10

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed 04/28/2010	F2704 R10	Advertising	Summary of Benefits	Initial		0.000	F2704 R10.pdf

SUMMARY OF BENEFITS

The chart below outlines the benefits included in each standardized Medicare supplement plan. Every company must make Plan "A" available. Globe Life offers Plans A, B, C and F (highlighted below) - the features and benefits of each of those plans are outlined in the chart on the reverse side.

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 the Part B coinsurance or copayments.

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	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	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance					
	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 Deductible					
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Part B Excess (100%)			Foreign Travel Emergency	Foreign Travel Emergency
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)	Out-of-pocket limit [\$4620]; paid at 100% after limit reached	Out-of-pocket limit [\$2310]; 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 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.



MEDICARE SUPPLEMENT LIMITATIONS AND EXCLUSIONS

We will NOT pay benefits under this policy for:

- 1) Any expense that you are not legally obligated to pay; or
- 2) Any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a physician; or
- 3) Any portion of any expense for which payment is made by Medicare; or
- 4) Custodial or intermediate-level care or rest cures; or
- 5) Any type of expense not eligible for coverage under Medicare.

Globe Life And Accident Insurance Company • Globe Life Center • Oklahoma City, OK 73184

Globe Life And Accident Insurance Company is not affiliated with Medicare, Social Security or any other government agency. Policy Forms: [GMSA10, GMSB10, GMSC10, GMSF10]

F6774 R10

MEDICARE SUPPLEMENT

PLANS & BENEFITS



Get The Most For Your Money With A Globe Life Policy

F2704 R10

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an in-patient 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.

SERVICE	MEDICARE PAYS	PLAN A PAYS	YOU PAY	PLAN B PAYS	YOU PAY	PLAN C PAYS	YOU PAY	PLAN F PAYS	YOU PAY
HOSPITALIZATION * Semiprivate room and board, general nursing and miscellaneous services and supplies									
First 60 days	All but [\$1100]	\$0	[\$1100] (Part A Deductible)	[\$1100](Part A Deductible)	\$0	[\$1100] (Part A Deductible)	\$0	[\$1100] (Part A Deductible)	\$0
61st thru 90th day	All but [\$275] a day	[\$275] a day	\$0	[\$275] a day	\$0	[\$275] a day	\$0	[\$275] a day	\$0
91st day and after: –While using 60 lifetime reserve days	All but [\$550] a day	[\$550] a day	\$0	[\$550] a day	\$0	[\$550] a day	\$0	[\$550] a day	\$0
Once lifetime reserve days are used: –Additional 365 days (lifetime) –Beyond the additional 365 days	\$0 \$0	100% of Medicare eligible expenses \$0	\$0 All costs	100% of Medicare eligible expenses \$0	\$0 All costs	100% of Medicare eligible expenses \$0	\$0 All costs	100% of Medicare eligible expenses \$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	\$0	\$0	\$0	\$0	\$0	\$0
21st thru 100th day	All but [\$137.50] a day	\$0	Up to [\$137.50] a day	\$0	Up to [\$137.50] a day	Up to [\$137.50] a day	\$0	Up to [\$137.50] a day	\$0
101st day and after	\$0	\$0	All costs	\$0	All costs	\$0	All costs	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0	3 pints \$0	\$0 \$0	3 pints \$0	\$0 \$0	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 outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0

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.

SERVICE	MEDICARE PAYS	PLAN A PAYS	YOU PAY	PLAN B PAYS	YOU PAY	PLAN C PAYS	YOU PAY	PLAN F 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* (the Part B Deductible)	\$0	\$0	[\$155] (Part B Deductible)	\$0	[\$155] (Part B Deductible)	[\$155] (Part B Deductible)	\$0	[\$155] (Part B Deductible)	\$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0	Generally 20%	\$0	Generally 20%	\$0
Part B Excess Charges (Above Medicare approved amounts)	\$0	\$0	All costs	\$0	All costs	\$0	All costs	100%	\$0
BLOOD First 3 pints Next [\$155] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$155] (Part B Deductible) \$0	All costs \$0 20%	\$0 [\$155] (Part B Deductible) \$0	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0	All costs [\$155] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

MEDICARE (PARTS A & B)

SERVICE	MEDICARE PAYS	PLAN A PAYS	YOU PAY	PLAN B PAYS	YOU PAY	PLAN C PAYS	YOU PAY	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Durable medical equipment: –First [\$155] of Medicare approved amounts * –Remainder of Medicare approved amounts	\$0 80%	\$0 20%	[\$155] (Part B Deductible) \$0	\$0 20%	[\$155] (Part B Deductible) \$0	[\$155] (Part B Deductible) 20%	\$0 \$0	[\$155] (Part B Deductible) 20%	\$0 \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICE	MEDICARE PAYS	PLAN A PAYS	YOU PAY	PLAN B PAYS	YOU PAY	PLAN C PAYS	YOU PAY	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE – Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA									
First \$250 each calendar year	\$0	\$0	\$250	\$0	\$250	\$0	\$250	\$0	\$250
Remainder of charges	\$0	\$0	Balance	\$0	Balance	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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Supporting Document Schedules

	Item Status:	Status
Satisfied - Item: NAIC	Accepted for Informational Purposes	Date: 04/28/2010
Comments:		
Attachment:		
AR F2704 R10 NAIC Transmittal.pdf		

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	ARKANSAS
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Globe Life & Accident Ins. Co. P.O. Box 2440 McKinney, TX 75070	Nebraska	Life & Health	290	91472	63-0782739	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Diane M. Breeding	(972) 569-3295	(972) 569-3728	dbreeding@torchmarkcorp.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	F2704 R10
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7.	<input checked="" type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual	<input type="checkbox"/> Franchise			
		Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____			

9.	Type of Insurance (TOI)	MS09
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10.	Sub-Type of Insurance (Sub-TOI)	MS09.000
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11.	Submitted Documents	<div style="margin-bottom: 10px;"> <input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input checked="" type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other </div> <div style="margin-bottom: 10px;"> Rates <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ </div> <div> SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____ </div>
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12.	Filing Submission Date	April 27, 2010
13	Filing Fee (If required)	Amount <u> \$25.00 </u> Check Date <u> 4-27-10 </u>
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u> EFT </u>
14.	Date of Domiciliary Approval	PENDING
15.	Filing Description:	
<p>NAIC: 290-91472 FEIN: 63-0782739 RE: Medicare Supplement Summary of Benefits F2704 R10 NAIC Transmittal Filing Fee: \$25.00</p> <p>Attached for your review and approval is one (1) laser print copy of the above mentioned Summary of Benefits F2704 R10 which is being submitted for use with our Individual Medicare Supplement portfolio.</p> <p>The Summary of Benefits does not contain any unusual or unorthodox provisions or wording. The Summary of Benefits has been filed in states where the company is authorized to do business, and in our domicile state Nebraska.</p> <p>I hereby certify that I have carefully reviewed the attached Summary of Benefits and to the best of my knowledge and ability find:</p> <ol style="list-style-type: none"> 1. The Summary of Benefits conforms to all insurance statutes and department requirements of your jurisdiction. 2. The Summary of Benefits contains no provisions previously disapproved by your department. <p>Your early review and approval of this submission will be greatly appreciated. If you have any questions, please feel free to call (972) 569-3295 Collect, or e-mail me at dbreeding@torchmarkcorp.com.</p>		

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>ARKANSAS</u>.</p>		
Print Name <u> Diane M. Breeding </u>		Title <u> Analyst </u>
		Date: <u> April 27, 2010 </u>
Signature _____		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		F2704 R10
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Individual Medicare Supplement	F2704 R10	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	N/A
	Summary of Benefits			
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1