

SERFF Tracking Number: CCGH-125756697 State: Arkansas
 Filing Company: Connecticut General Life Insurance Company State Tracking Number: 39820
 Company Tracking Number: 20957299
 TOI: H10G Group Health - Dental Sub-TOI: H10G.000 Health - Dental
 Product Name: GM6000 09DEXL1, GM6000 09DEXL2
 Project Name/Number: Dental Exclusions & Limitations - 2008/20957299

Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: GM6000 09DEXL1, GM6000 09DEXL2 SERFF Tr Num: CCGH-125756697 State: ArkansasLH

TOI: H10G Group Health - Dental

SERFF Status: Closed

State Tr Num: 39820

Sub-TOI: H10G.000 Health - Dental

Co Tr Num: 20957299

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Kathryn Graywacz, Marilyn Wichroski
 Disposition Date: 08/16/2008

Date Submitted: 08/01/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Dental Exclusions & Limitations - 2008

Status of Filing in Domicile: Pending

Project Number: 20957299

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 08/16/2008

State Status Changed: 08/16/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The purpose of this filing is to seek approval of revised and reformatted dental exclusion and limitation provisions for use with CG's large group indemnity dental and dental PPO product portfolio. Form GM6000 09DEXL1 contains exclusions/limitations applicable to standard dental plans. Form GM6000 09DEXL2 contains exclusions/limitations applicable to lower cost dental plans.

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Dental exclusions and limitations provisions have been rewritten with the goal of improving member and provider satisfaction by clarifying benefit language and payment criteria. There are no material changes. This filing does not impact rates.

These forms are new and do not replace any forms currently on file with the Department. Upon approval, the proposed forms will be incorporated into dental certificates as they are issued going forward. Existing contracts will only be affected if and when new certificates are generated for those accounts.

Bracketed text may be deleted based on policyholder selections as noted in bold italicized text.

Company and Contact

Filing Contact Information

Marilyn Wichroski, HR Support Analyst Marilyn.Wichroski@CIGNA.com
 900 Cottage Grove Road (860) 226-0676 [Phone]
 Hartford, CT 06152 (860) 226-5400[FAX]

Filing Company Information

Connecticut General Life Insurance Company CoCode: 62308 State of Domicile: Connecticut
 900 Cottage Grove Road Group Code: 901 Company Type:
 Hartford, CT 06152 Group Name: State ID Number:
 (860) 226-5209 ext. [Phone] FEIN Number: 06-0303370

Filing Fees

Fee Required? Yes
 Fee Amount: \$40.00
 Retaliatory? No
 Fee Explanation: 2 forms @ \$20 each - \$40
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Connecticut General Life Insurance Company	\$40.00	08/01/2008	21732571

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/16/2008	08/16/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Exclusions- Expenses not Covered and General Limitations	Form	Marilyn Wichroski	08/06/2008	08/06/2008

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Disposition

Disposition Date: 08/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Exclusions-Expenses not Covered and General Limitations	Approved-Closed	Yes
Form (revised)	Exclusions-Expenses not Covered and General Limitations	Approved-Closed	Yes
Form	Exclusions-Expenses not Covered and General Limitations	Withdrawn	No

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Amendment Letter

Amendment Date:
 Submitted Date: 08/06/2008

Comments:

I am replacing form GM6000 09DEXL2 to correct a typographical error. I apologize if this change has interrupted the review process.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GM6000 09DEXL2	Certificate Amendment, Expenses Insert Page, not Covered Endorsemen and General t or Rider	Exclusions- Expenses Limitations	Initial				51	Generic - GM6000 09DEXL2.pdf

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Form Schedule

Lead Form Number: GM6000 09DEXL1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GM6000 09DEXL1	Certificate	Exclusions-Expenses	Initial		51	Generic - GM6000 09DEXL1.pdf
			Amendmen not Covered and t, Insert General Limitations Page, Endorseme nt or Rider				
Approved-Closed	GM6000 09DEXL2	Certificate	Exclusions-Expenses	Initial		51	Generic - GM6000 09DEXL2.pdf
			Amendmen not Covered and t, Insert General Limitations Page, Endorseme nt or Rider				

Exclusions – Expenses not Covered and General Limitations

Covered expenses will not include, and no payment will be made for:

- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect;
- replacement of a bridge, crown, onlay, post/post and core, partial denture, or complete denture within a 60 consecutive month period after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown, onlay, post/post and core, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown, partial denture or complete denture which is or can be made useable according to commonly accepted dental standards;
- the recementation and/or repair of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement by the same Dentist or a different Dentist in the same office. CG considers recementation and/or repair within this timeframe to be incidental to and part of the charges for the initial restoration;
- the replacement of any amalgam or resin-based composite filling involving the same surface(s) on the same tooth within a 12 consecutive month period of original placement by the same dentist or a different Dentist in the same office;

Bracketed text is deleted if the TMJ Option is accepted

- procedures, appliances or restorations (except complete dentures) whose main purpose is to: (a) change vertical dimension; or (b) [diagnose or treat conditions or disorders of the temporomandibular joint; or (c)] stabilize periodontally involved teeth; or (d) restore occlusion;
- porcelain, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture;
- fixed bridges and/or removable partial dentures with a cast metal framework for patients prior to their 16th birthday;
- fixed or removable space maintainers for patients on or after their 16th birthday;
- bite registrations or analysis; precision or semiprecision attachments; or splinting;
- oral hygiene, tobacco cessation and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water irrigation devices, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- dental services that do not meet commonly accepted dental standards;
- services to the extent you or your enrolled Dependent are compensated under any group medical plan. (Arizona and Pennsylvania residents: Coverage for covered services to the extent compensated under group medical plan, no fault auto insurance policies or uninsured motorist policies is not excluded. Kentucky and North Carolina residents: Services compensated under no-fault auto insurance policies or uninsured motorist policies are not excluded. Maryland residents: Services compensated under group medical plans are not excluded.)
- services that are deemed to be medical services;

Exclusions – Expenses not Covered and General Limitations (Continued)

- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- outpatient facility or hospital charges, services and supplies;
- Orthodontic Treatment, unless covered by your specific plan;
- services associated with the placement, repair, or removal of a dental implant, or any other services related to implants, unless covered by your specific plan. When covered by your plan, any prosthesis over an implant is subject to the same exclusions, limitations, alternate benefit provisions, time limitations, and missing tooth limitations as standard traditional restorative, fixed and removable prosthetics;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;
- treatment of jaw fractures and orthognathic surgery;
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control. CG considers this to be incidental to and part of the charges for services provided and not separately chargeable;
- therapeutic parenteral drug administration(s);
- Any localized delivery of antimicrobial agent procedures when more than eight (8) of these procedures are reported on the same date of service;
- charges for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- covered services to the extent that payment is unlawful where the person resides when the expenses are incurred;
- charges which the person is not legally required to pay;
- charges which would not have been made if the person had no insurance;
- covered services to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- charges for unnecessary care, treatment or surgery;
- covered services to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- general anesthesia or intravenous sedation, beyond a maximum of one hour, when general anesthesia or intravenous sedation is allowable;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;

Exclusions – Expenses not Covered and General Limitations (Continued)

- indirect pulp capping on the same date of service as a permanent restoration. CG considers this to be incidental to and part of the charges for services provided and not separately chargeable;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period;
- a combination of X-rays (such as ten or more periapical X-rays; or a panoramic X-ray with bite-wing X-rays) on the same date of service when the allowance meets or exceeds the allowance for an intraoral complete series of X-rays. Plan reimbursement will be based on an intraoral complete series;
- additional/incremental costs associated with optional/elective orthodontic materials including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement; appliances to correct harmful habits; and services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis. This limitation applies when orthodontics is covered under your plan;
- the same covered periodontal surgical service or procedure in the same site or area of the mouth in excess of once per any consecutive 36-month period;
- any covered periodontal scaling and root planing in the same area or quadrant of the mouth in excess of once per any consecutive 24 month period;
- periodontal (gum tissue and supporting bone) regenerative procedures and materials in excess of one per site (or per tooth, if applicable), when covered;
- localized delivery of antimicrobial agents in excess of eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered;
- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery;
- consultations and/or evaluations associated with services that are not covered;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure;
- localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy;
- charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- charges incurred due to injuries which are intentionally self-inflicted.

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a “no-fault” insurance law; or
- an uninsured motorist insurance law.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

***Standard Exclusions/Limitations
For Calendar year plans, references to consecutive months are replaced with the calendar year equivalent.***

Exclusions – Expenses not Covered and Limitations

Covered Expenses do not include expenses incurred for:

- procedures which are not included in the list of Covered Dental Expenses;
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards;
- procedures for which a charge would not have been made if the person had no insurance or for which the person is not legally required to pay;
- any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension;

Deleted if the TMJ coverage option is elected

- [procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;]
- occlusal adjustment or the alteration or restoration of occlusion;
- the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
- bite registration or bite analysis;
- cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- porcelain, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;

Deleted if Plan has coverage for Missing Teeth

- [the initial placement of a full denture or partial denture unless it includes the replacement of a functioning Natural Tooth extracted while the person is covered under this plan. The removal of only a permanent third molar will not qualify a full or partial denture as a benefit under this provision);]

Deleted if Plan has coverage for Missing Teeth

- [the initial placement of a fixed bridge, unless it includes the replacement of a functioning Natural Tooth extracted while the person is covered under this plan. If a bridge replaces teeth that were missing prior to the date the person's coverage became effective and also teeth that are extracted after the person's effective date, benefits are payable only for the pontics replacing those teeth which are extracted while the person was insured under this plan. The removal of only a permanent third molar will not qualify a fixed bridge as a benefit under this provision;]
- services associated with the placement, repair, or removal of a dental implant, or any other services related to implants, unless covered by your specific plan. When covered by your plan, any prosthesis over an implant is subject to the same exclusions, limitations, alternate benefit provisions, time limitations, and missing tooth limitations as standard traditional restorative, fixed and removable prosthetics;
- crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture;
- fixed bridges and/or removable partial dentures with a cast metal framework for patients prior to their 16th birthday;
- core build-ups;

Lower Cost Plan Exclusions/Limitations

For Calendar year plans, references to consecutive months are replaced with the calendar year equivalent.

Exclusions – Expenses not Covered and Limitations

- replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
 - (a) replacement occurs at least 84 consecutive months after the initial date of insertion of the existing full or partial denture; or
 - (b) the partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning Natural Tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
 - (c) replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge. (If the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional Necessary extraction of a functioning Natural Tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- the replacement of posts/posts and cores, crowns, cast restorations, inlays, onlays or other laboratory prepared restorations within 84 consecutive months of the date of insertion;
- the replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth;
- the recementation and/or repair of any inlay, onlay, crown, post and core, or fixed bridge within 12 consecutive months of initial placement by the same Dentist or a different Dentist in the same office. CG considers recementation and/or repair within this timeframe to be incidental to and part of the charges for the initial restoration;
- replacement of a partial denture or full denture which can be made serviceable;
- replacement of lost or stolen appliances;
- prescription drugs;
- any procedure, service, supply or appliance used primarily for the purpose of splinting;
- athletic mouth guards;
- occlusal guards (night guards);
- myofunctional therapy;
- precision or semiprecision attachments;
- labial veneers (laminates);
- treatment of jaw fractures and orthognathic surgery;
- services to correct congenital malformations, including the replacement of congenitally missing teeth;
- Orthodontic Treatment, unless covered by your specific plan;
- charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control. CG considers this to be incidental to and part of the charges for services provided and not separately chargeable;
- charges for travel time; transportation costs; or professional advice given on the phone;
- temporary, transitional or interim dental services;
- diagnostic casts, diagnostic models, or study models;
- any charge for any treatment performed outside of the United States other than for emergency treatment (any benefits for emergency treatment which is performed outside of the United States will be limited to a maximum of (\$100 - \$200) per consecutive 12-month period;

Lower Cost Plan Exclusions/Limitations

For Calendar year plans, references to consecutive months are replaced with the calendar year equivalent.

Exclusions – Expenses not Covered and Limitations

- oral hygiene, tobacco cessation and diet instruction; broken appointments; completion of claim forms; personal supplies (e.g., water irrigation devices, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;
- outpatient facility or hospital charges, services and supplies;
- charges for or in connection with an injury or illness arising out of, or in the course of any employment for wage or profit;
- charges for or in connection with an injury or illness which is covered under any workers' compensation or similar law;
- charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- covered services to the extent that payment is unlawful where the person resides when the expenses are incurred;
- charges which the person is not legally required to pay;
- charges which would not have been made if the person had no insurance;
- covered services to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- charges for unnecessary care, treatment or surgery;
- covered services to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- charges for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- charges incurred due to injuries which are intentionally self-inflicted;
- general anesthesia or intravenous sedation, beyond a maximum of one hour, when general anesthesia or intravenous sedation is allowable;
- general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;
- tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;
- a combination of X-rays (such as ten or more periapical X-rays; or a panoramic X-ray with bite-wing X-rays) on the same date of service when the allowance meets or exceeds the allowance for an intraoral complete series of X-rays. Plan reimbursement will be based on an intraoral complete series;
- additional/incremental costs associated with optional/elective orthodontic materials including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement; appliances to correct harmful habits; and services which are not typically included in Orthodontic Treatment. These services will be identified on a case-by-case basis. This limitation applies when orthodontics is covered under your plan;
- periodontal (gum tissue and supporting bone) regenerative procedures and materials in excess of one per site (or per tooth, if applicable), when covered;

Lower Cost Plan Exclusions/Limitations

For Calendar year plans, references to consecutive months are replaced with the calendar year equivalent.

Exclusions – Expenses not Covered and Limitations

- bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction; or when performed in conjunction with an apicoectomy or periradicular surgery;
- consultations and/or evaluations associated with services that are not covered;
- endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;
- intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure;

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a “no-fault” insurance law; or
- an uninsured motorist insurance law.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

Lower Cost Plan Exclusions/Limitations
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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 08/16/2008
Comments:
Attachments:
Compliance Certification.pdf
Readability Certification.pdf

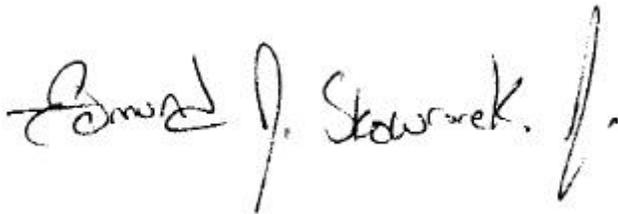
Bypassed -Name: Application **Review Status:** Approved-Closed 08/16/2008
Bypass Reason: not applicable
Comments:

Certification of Compliance
Arkansas Rule and Regulation 19
&
Arkansas Rule and Regulation 49

Insurer: Connecticut General Life Insurance Company

Form Number(s): GM6000 09DEXL1
GM6000 09DEXL2

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19 and Rule and Regulation 49.



Signature of Company Officer

Edmund J. Skowronek, Jr.

Name

Director

Title

August 1, 2008

Date

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Group Forms

This is to certify that the forms listed below are in compliance with state readability laws and regulations and the NAIC Life and Health Insurance Policy Language Simplification Model Act.

A. Option Selected

Certificate pages are scored as a group for the Flesch reading ease test.

Form and Form Numbers to Which Certification is Applicable:

<u>Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Standard Dental Plan Exclusions – Expenses not Covered and General Limitations	GM6000 09DEXL1	51
Lower Cost Dental Plan Exclusions – Expenses not Covered and General Limitations	GM6000 09DEXL2	50.7

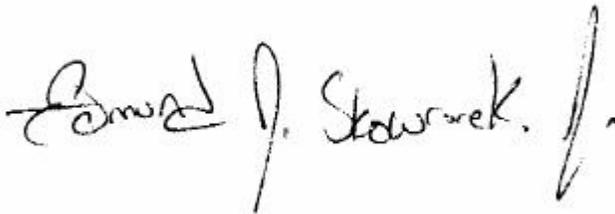
B. Test Option Selected

Test was applied to individual policy insert pages(s) and individual certificate insert pages(s).

C. Standards for Certification

The following standards have been achieved:

1. The text achieved the minimum score of 40 on the Flesch reading ease test in accordance with section A above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs, or constructions are not used.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy.
8. Any words which are defined in the policy(ies) and any medical terminology have been excluded from the Flesch test score.



Edmund J. Skowronek, Jr.

Director
Officer's Title

July 31, 2008
Date