

SERFF Tracking Number: CCGH-126498880 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 44842
Company Tracking Number: GM6000 SCH165
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: Group Retiree Medical Benefit
Project Name/Number: /

Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: Group Retiree Medical Benefit SERFF Tr Num: CCGH-126498880 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 44842
Closed

Sub-TOI: H16G.001C Any Size Group - Other Co Tr Num: GM6000 SCH165 State Status: Approved-Closed

Filing Type: Form

Author: Karen Martocci

Reviewer(s): Rosalind Minor

Date Submitted: 02/12/2010

Disposition Date: 02/12/2010

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

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: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 02/12/2010

Explanation for Other Group Market Type:

State Status Changed: 02/12/2010

Deemer Date:

Created By: Karen Martocci

Submitted By: Karen Martocci

Corresponding Filing Tracking Number:

Filing Description:

Connecticut General Life Insurance Company

NAIC Company ID#: 62308-046

NAIC Group #: 901

FEIN: 06-0303370

Group Accident and Health Insurance

Certificate Insert pages GM6000 SCH165, GM6000 MEL87, GM6000 MEL88, GM6000 CLA62

Dear Sir or Madam:

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We are submitting for your approval the above-referenced Group Accident and Health certificate insert pages to be used with our retiree medical plan for Medicare eligible retirees and their dependents. We received approval from your Department for our retiree medical plan certificate form GM6000 MEL80 et al on September 15, 2006.

The purpose of this submission is to obtain your approval of certificate text which updates benefit descriptions, provides new product features and clarifies administration. Included in this submission are the following updates:

- Schedule- an updated and more detailed schedule that includes new deductible/copayment features. The term “deductible” or “copayment” will be used to reference this new feature.
- New vision and hearing buy up benefits
- outpatient short-term rehabilitation unlimited buy-up benefits for certain therapies.
- Covered Expenses- revised to reflect any new buy-up options or descriptive text shown in the schedule.
- Claim page –updated to clarify the claim submission process.

We have filed simultaneously for approval in Connecticut, our state of domicile.

These forms are new and do not replace any on file with your Department.

Bracketed text is considered variable. Descriptions of variability are found on the certificate insert pages and in the Description of Variable Material that is included.

Thank you very much for your attention to this submission. If you have any questions or concerns, you can contact me directly at 860.226.5631. I can also be reached via e-mail at karen.martocci@cigna.com.

Sincerely,

Karen Martocci
Compliance Manager

Company and Contact

Filing Contact Information

June Goddard, Healthcare Compliance Analyst june.goddard@cigna.com
CIGNA Companies 303-729-8469 [Phone]
8505 E. Orchard Road 303-729-8433 [FAX]
Greenwood Village, CO 80111

Filing Company Information

Connecticut General Life Insurance Company CoCode: 62308 State of Domicile: Connecticut

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Product Name: Group Retiree Medical Benefit

Project Name/Number: /
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? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Connecticut General Life Insurance Company	\$50.00	02/12/2010	34161451

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/12/2010	02/12/2010

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Disposition

Disposition Date: 02/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	variability	Approved-Closed	Yes
Form	schedule	Approved-Closed	Yes
Form	covered expenses	Approved-Closed	Yes
Form	covered expenses	Approved-Closed	Yes
Form	claim	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GM6000 SCH165

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 02/12/2010	GM6000 SCH165	Schedule	schedule	Initial			GM6000SCH165.pdf
Approved- Closed 02/12/2010	GM6000 MEL87	Certificate	covered expenses	Initial			GM6000MEL87.pdf
Approved- Closed 02/12/2010	GM6000 MEL88	Certificate	covered expenses	Initial			GM6000MEL88.pdf
Approved- Closed 02/12/2010	GM6000 CLA62	Certificate	claim	Initial			GM6000CLA62.pdf

[CIGNA Medicare Surround] (Part A [and Part B])

Remove text for Part A only plans

The Schedule

If plan does not include a deductible, copayments, Part B coverage, or dependent coverage modify to remove references.

For You [and Your Dependents]

Part A benefits cover the same benefits covered under Medicare Part A. [Part B benefits cover the same benefits covered under Medicare Part B.] Unless otherwise noted, the benefits covered under this plan are limited to expenses approved by Medicare but not paid by Medicare. To receive benefits, you [and your Dependents] must pay a portion of the Covered Expenses. That portion is the [Deductible][Copayment] [and] Coinsurance].

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Include appropriate text below when plan has copayments but no deductible, or deductibles but no copayments. For Employee only plans, remove references "or your Dependent" and "and your family".

[Copayments

Copayments are expenses to be paid by you or your Dependent for the services received. Copayments are in addition to any Coinsurance.]

[Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.]

Include the following box only if the plan includes both a deductible and Copayment. For Employee only plans, remove references "or your Dependent" and "and your family".

[Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.]

Out-of-Pocket Expenses: Include the following box if OOP is included. Modify based on plan design.

[Out of Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Part A or Part B expenses for:

- Coinsurance
- Deductible
- per admission Copayment/ Deductible
- per day Copayment/ Deductible
- per trip Copayment/ Deductible
- per visit Copayment / Deductible

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100%.

Except for: Provider charges in excess of Maximum Reimbursable Charge].

Contract Year: Use for when Contract Year is elected as the accumulation type.

[Contract Year

Contract Year means a twelve month period beginning on each [MM/DD].]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p><i>Include text based on the plan selection</i></p> <p>Lifetime Maximum Applies to Part [A and B] expenses</p>	<p><i>Include based on the plan selection</i></p> <p>[\$ 250,000- unlimited]</p>	
<p>Coinsurance Levels Part A</p>	<p>Coinsurance as shown below of the amount approved by Medicare but not paid by Medicare</p>	<p>Not Applicable</p>
<p><i>Include text boxes below when part B is covered and modify based upon plan design to include coverage for Part B deductible, include coverage for Remainder of expenses after the Part B deductible or include coverage for both. Vary to include/exclude plan deductible and vary coinsurance within the ranges shown.</i></p>		
<p>[Part B Deductible]</p>	<p>[Not Applicable]</p>	<p>[25-100%after plan deductible of the amount approved by Medicare but not paid by Medicare] or [Not covered]</p>
<p>[Remainder of expenses after the Part B Deductible]</p>	<p>[Not Applicable]</p>	<p>[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] or [Not covered]</p>
<p>Part B Excess Charges – <i>Include the following box if the Part B Excess Charges Buy-up is selected. Modify to include/exclude plan deductible and vary coinsurance within the ranges shown.</i></p>		
<p>[Part B Excess Charges Charges above approved Medicare amounts for providers that do not accept Medicare assignment]</p>	<p>[Not Applicable]</p>	<p>[25-100% , after plan deductible, up to the Medicare limiting charge or, the Maximum Reimbursable Charge whichever is less.]</p>
<p>Maximum Reimbursable Charge: <i>If the plan elects Option 1 or Option 2 for Maximum Reimbursable Charge, include the following box and modify accordingly.</i></p>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Maximum Reimbursable Charge</p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply;] or</p> <p><i>Use the following if the plan selection is either Option 1 (Percentile)</i></p> <p>[A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.]</p>	<p><i>Use the following if plan is Option 1</i> [Not Applicable]</p>	<p><i>Use the following if plan is Option 1</i> <i>Add the percentile amount</i> [80th] [90th] Percentile]</p>
<p><i>Use the following if the plan selection is Option 2 (Percentage)</i></p> <p>[A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:</p> <ul style="list-style-type: none"> • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CG. <p>Note:</p> <ul style="list-style-type: none"> • The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.] 	<p><i>Use the following if plan is Option 2</i> [Not Applicable]</p>	<p><i>Use the following if plan is Option 2</i> <i>Add the percentage amount</i> [110-200%]</p>
<p>Calendar/Contract Year Maximum: <i>Include text and vary based on plan design..</i></p>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Calendar/ Contract Year Maximum Applies to Part A and Part B expenses]	[\$20,000-unlimited]	
<i>Deductible : Include text and vary based on plan design.</i>		
[Contract/Calendar Year Deductible (Applies to Part A and Part B expenses]		
[Individual] [Family Maximum]	[\$1-\$5000 per person] or [Not Applicable] [\$1-\$10,000 per family] or [Not Applicable]	[\$ 1-\$5000 per person] or [Not Applicable] [\$1-\$10,000 per family] or [Not Applicable]
[Family Maximum Calculation Individual Calculation Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance. (after any other applicable deductibles or copayments).]		
<i>Standard box: Always use this box for plans with OOP Maximum and modify according to plan design.</i>		
[Out-of-Pocket Maximum (Applies to Part A and Part B expenses)]		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Individual] [Family Maximum]	[\$1-\$5000 per person] or [Not Applicable] [\$-\$10,000 per family] or [Not Applicable]	[\$1-\$5000 per person] or [Not Applicable] [\$-\$10,000 per family] or [Not Applicable]
[Family Maximum Calculation Individual Calculation: Family members meet only their individual out-of-pocket and then their claims will be covered at 100%; if the family out-of-pocket has been met prior to their individual out-of-pocket being met, their claims will be paid at 100%.]		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>Inpatient Hospital - Facility Services</p> <p>Semi-private room and board, general nursing and miscellaneous services and supplies.</p> <p>A new benefit period begins each time the member is out of the hospital more than [30-180] days</p>		
<p><i>Add the following if the plan includes days 1- 150 (using 60 lifetime reserve days) and vary based on plan design to include/not include plan deductible, per admission deductible/copayment, per day deductible/copayment and vary coinsurance.</i></p>		
<p>[Days 1- 150 (using 60 lifetime reserve days)]</p>	<p>[\$25-3000 per admission deductible/copayment: then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p> <p>or</p> <p>[\$25-1500 per day deductible/copayment: then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p>	<p>[Not applicable]</p>
<p><i>Add the following boxes if the plan does not include coverage for the first 60 days but includes coverage for the 61st through 150th day. Vary based on plan design to include/not include plan deductible /copayment , per day deductible/copayment and vary coinsurance within the ranges shown.</i></p>		
<p>[First 60 days per benefit period (Medicare Part A deductible)]</p>	<p>[Not covered]</p>	<p>[Not applicable]</p>
<p>61st – 150th day per benefit period (using 60 lifetime reserve days)]</p>	<p>[\$25-1500 per day deductible/copayment: then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p>	<p>[Not applicable]</p>
<p><i>Add the following boxes if the plan includes coverage for only the first 60 days and vary based on plan design to include/not include plan deductible, per admission deductible/copayment, per day deductible/copayment and vary coinsurance within the ranges shown.</i></p>		
<p>[First 60 days per benefit period (Medicare Part A deductible)]</p>	<p>[\$25-3000 per admission deductible/copayment]</p> <p>or</p> <p>[\$25-1500 per day deductible/copayment: then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p>	<p>[Not applicable]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
61 st – 150 th day per benefit period (using 60 lifetime reserve days)]	[Not Covered]	[Not applicable]
<i>Add the following when the benefit level varies for days 1- 150. Modify coinsurance within the ranges shown and vary to include/not include plan deductible include per day deductible/copayment., per admission deductible/copayment</i>		
[First 60 days per benefit period (Medicare Part A deductible)	[\$25-3000 per admission deductible/copayment then or [\$25-1500 per day deductible/copayment: then] [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]	[Not applicable]
61 st – 90 th day per benefit period (using 60 lifetime reserve days)	[\$25-1500 per day deductible/copayment: then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]	[Not applicable]
91 st -150 th day per benefit period (using 60 lifetime reserve days)]	[\$25-1500 per day deductible/copayment: then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]	[Not applicable]
Inpatient Hospital- Facility Charges Buy-up: <i>Use the following box if the plan includes the Buy-up for additional days and vary based on plan design to include/not include per day deductible/copayment, plan deductible and vary coinsurance.</i>		
[Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime Days 1-365]	[\$25-1500 per day deductible/copayment: then 25-100% after plan deductible.]	[Not Applicable]
<i>Include if coverage at Inpatient Services at Other Health care Facilities is included and vary based upon plan design to include/not include per day deductible/copayment, plan deductible and vary coinsurance.</i>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Inpatient Services at Other Health Care Facilities] Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>First 20 days</p> <p>21st – 100th day]</p>	<p>[Not Covered by plan. Medicare pays in full.]</p> <p>[\$1-250 per day deductible/copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p>	<p>[Not Applicable]</p> <p>Not Applicable]</p>
<p><i>Inpatient Services at Other Health Care Facilities Buy-up: Use the following box if the plan includes additional days for Other Health Care Facilities for the 101st to the 365th day and vary based on plan design to include/not include plan deductible, per day maximum, per day deductible/copayment, and vary coinsurance within the ranges shown.</i></p>		
<p>[101st – 365th day]</p>	<p>[\$1-250 per day deductible /copayment then 25-100% after plan deductible]</p> <p>[25-100% after plan deductible up to \$0-\$250 per day]</p>	<p>[Not Applicable]</p>
<p><i>Inpatient Services at Other Health Care Facilities Buy-up: Use the following box if the plan includes additional days for Other Health Care Facilities for the 101st to the 120th day and vary based on plan design to include/not include plan deductible, per day maximum, per day deductible/copayment, and vary coinsurance within the ranges shown.</i></p>		
<p>[101 thru 120]</p>	<p>[\$1-250 per day deductible /copayment then 25-100% after plan deductible]</p> <p>[25-100% after plan deductible up to \$0-\$250 per day]</p>	<p>[Not Applicable]</p>
<p><i>Inpatient Services at Other Health Care Facilities Buy-up: Use the following box if the plan includes additional days for Other Health Care Facilities for the 101st to the 180th day and vary based on plan design to include/not include plan deductible, per day maximum, per day deductible/copayment, and vary coinsurance within the ranges shown.</i></p>		
<p>[101 through 180]</p>	<p>[\$1-250 per day deductible /copayment then 25-100% after plan deductible]</p> <p>[25-100% after plan deductible up to \$0-\$250 per day]</p>	<p>[Not Applicable]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p><i>Include text if plan covers Part A expenses only and modify accordingly.</i> [*Inpatient Facility Services include, but are not limited to, expenses incurred for Advance Radiological Imaging, Maternity, Abortion, Family Planning, Organ Transplants, Dental Care and Mental Health and Substance Abuse.]</p>		
<p><i>Include the following box if Hospice is included and vary text based on plan design to include/not include plan deductible and vary coinsurance within the ranges shown.</i></p>		
<p>[Hospice/Inpatient Respite Care (includes Bereavement Counseling)]</p>	<p>[25-100% after plan deductible of of the amount approved by Medicare but not paid by Medicare]</p>	<p>[Not Applicable]</p>
<p><i>Include all of the following boxes (except for buy-ups) when Part B Expenses are covered. Only include boxes labeled as buy-ups if elected by the policyholder.</i></p>		
<p><i>Vary to include/not include plan deductible, per office visit deductible/copayment and vary coinsurance</i></p> <p>[Physician's Services</p>		<p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]</p>
<p>Primary Care Physician's Office visit</p>	<p>[Not Applicable]</p>	
<p>Specialty Care Physician's Office Visits</p>	<p>Not Applicable</p>	
<p>Surgery Performed In the Physician's Office</p>	<p>Not Applicable</p>	
<p>Second Opinion Consultations (provided on a voluntary basis)</p>	<p>Not Applicable</p>	
<p>Allergy Treatment/Injections]</p>	<p>Not Applicable]</p>	

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Routine Preventive Care other than the One time "Welcome to Medicare" routine physical and early cancer detection benefits</p> <p>Contract/ Calendar Year Maximum: \$100-unlimited</p> <p>All outpatient x-ray/lab benefits in connection with preventive care accumulate to the maximum]</p>	<p>[Not Applicable]</p>	<p>[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible up to the Maximum Reimbursable Charge]</p>

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p><i>Include for plans without a per visit deductible/copay. Vary to include/not include plan deductible, and vary coinsurance</i></p> <p>[Outpatient Facility Services Operating Room, Recovery Room, Procedures Room and Treatment Room]</p>	[Not Applicable]	[25-100%,after plan deductible, of the amount approved by Medicare but not paid by Medicare]
<p><i>Include next 2 boxes for plans with a per visit deductible/copay. Vary to include/not include plan deductible, per visit deductible/copayment and vary coinsurance</i></p> <p>[Outpatient Facility Services-Surgical Facility and Free Standing Ambulatory Surgery Center Operating Room, Recovery Room, Procedures Room and Treatment Room</p>	[Not Applicable]	[\$1-1500 per visit deductible./copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
<p>Outpatient Facility Services Non-Surgical Facility Including but not limited to radiation therapy, chemotherapy, x-ray, MRI, CT Scan, Pet Scan or lab services when done in an outpatient hospital facility]</p>	Not Applicable]	[\$1-150 per visit deductible/copayment then 25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
<p><i>The following Part B benefit text can be varied (as shown) to include/not include plan deductible, to include/not include per visit deductible/copayment, to include/not include maximums and vary coinsurance:</i></p> <p><i>Inpatient Hospital Physician's Visits/Consultations, Inpatient Hospital Professional Services, Outpatient Professional Services, Emergency and Urgent Care Services, Laboratory and Radiology Service and Advanced Radiological Imaging, Outpatient Short-Term Rehabilitative Therapy, Home Health Care, Maternity, Abortion, infertility, Family Planning, Organ T ransplant, DME, EPA, Diabetic Supplies and Services, Clinical Trials, Dental Care, Routine Foot Disorders, Blood, Part B Covered Prescription Drugs, At Home Recovery, Smoking Cessation Counseling, Mental Health And Substance Abuse, foreign travel, hearing and vision.</i></p>		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Inpatient Hospital Physician's Visits/Consultations	[Not Applicable	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	Not Applicable	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist]	Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Emergency and Urgent Care Services		
Physician's Office Visit	[Not Applicable	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Hospital Emergency Room	Not Applicable	[\$1-500 per visit deductible/copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare. Deductible is waived if the patient is admitted to the hospital]
Emergency Room Physician	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
Urgent Care Facility or Outpatient Facility	Not Applicable	[\$1-150 per visit deductible/copayment then 25- 100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Independent x-ray and/or Lab Facility in conjunction with an ER visit	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Ambulance]	Not Applicable]	<i>Vary to remove per trip deductible/copayment.</i> [per trip deductible/copayment \$1-100 then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Laboratory and Radiology Services and Advanced Radiological Imaging (includes pre-admission testing. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office	[Not Applicable	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Hospital Facility-non- surgical facility	Not Applicable	[\$1-150 per visit deductible/copayment then 25- 100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Independent X-ray and/or Lab Facility]	Not Applicable]	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services Maximum: Unlimited up to Medicare limits</p> <p>Includes:</p> <ul style="list-style-type: none"> Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy Cardiac Rehab] 	[Not Applicable]	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
<p><i>Include if Short-term Rehabilitative Therapy buy up is selected.</i></p>		
<p>[Outpatient Short-Term Rehabilitative Therapy (above Medicare limits) Maximum: Unlimited Includes:</p> <ul style="list-style-type: none"> • Physical Therapy • Speech Therapy • Occupational Therapy • Pulmonary Therapy • Cognitive Therapy] 	[Not Applicable]	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible up to theMaximum Reimbursable Charge]
<p>[Home Health Care (includes private duty nursing)</p> <p>Maximum: Unlimited]</p>	[Not Covered by plan. Medicare pays in full.]	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
<p>[Maternity Care Services</p>		
<p>Initial Visit to Confirm Pregnancy Note: OB/GYNs are considered Specialists</p>	[Not Applicable]	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Office Visits in addition to the global maternity fee when performed by an OBGYN or specialist	Not Applicable	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Delivery - Facility (Inpatient Hospital) (Birthing Center)]	Same as plan's Inpatient Hospital Facility benefit Not Applicable]	[Not Applicable] [Same as Outpatient Surgical Facility]
[Abortion] Includes non-elective procedures only		
Physician's Office Visit	[Not Applicable	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	[Same as Outpatient Facility]
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Physician's Services]	Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Family Planning Services		
Family Planning: Always use the following item when Preventive Care Buy-up is elected.		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Office Visits (tests and counseling)</p> <p>Maximum: subject to plan's Preventive Care dollar maximum</p> <p>The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.]</p>	[Not Applicable]	[Per visit deductible /copayment \$1-150 then 25-100% up to the Maximum Reimbursable Charge]
<p><i>The following boxes for Surgical related services are standardly covered and do not require offering the optional Preventive Care benefit. Services are not subject to the Preventive Care dollar maximum..</i></p>		
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation Limited to Medicare covered services (excludes reversals)		
Inpatient Facility	[Same as plan's Inpatient Hospital Facility benefit	[Not Applicable]
Outpatient Facility	Not Applicable	[Same as Outpatient Facility]
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Physician's Services	Not Applicable	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
Physician's Office]	Not Applicable]	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Infertility Treatment Services Not Covered include:</p> <ul style="list-style-type: none"> • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). <p>Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.]</p>	[Not Covered]	[Not Covered]
<p>[Organ Transplant Includes all medically appropriate, non-experimental transplants</p>		
Inpatient Facility	[Same as plan’s Inpatient Hospital Facility benefit	[Not Applicable]
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Physician's Services	Not Applicable	[25-100%, % after plan deductible of the amount approved by Medicare but not paid by Medicare]
Travel Services]	Not Covered]	[Not Covered]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Durable Medical Equipment] Maximum: Unlimited]	[Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[External Prosthetic Appliances] Maximum: Unlimited]	[Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Diabetic Supplies and Services]	[Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Clinical Trials]		
Inpatient Facility	[Same as plan's Inpatient Hospital Facility benefit	[Not Applicable]
Outpatient Facility	Not Applicable	[Same as Outpatient Facility]
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Physician's Services	Not Applicable	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
Physician's Office]	Not Applicable]	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[Dental Care Limited to Medicare covered dental services		
Physician's Office Visit	[Not Applicable	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100 after plan deductible of the amount approved by Medicare but not paid by Medicare]
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	[Not Applicable]
Outpatient Surgical Facility	Not Applicable	[Same as Outpatient Facility]
Inpatient Physician's Services	Not Applicable	[25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
Outpatient Physician's Services]	Not Applicable	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
[TMJ Surgical and Non-surgical]	[Not Covered]	[Not Covered]
[Routine Foot Disorders] Includes services associated with foot care for diabetes and peripheral vascular disease.]	[Not Applicable]	[\$1-150 PCP or \$1-150 Specialist per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Part B Covered Prescription Drugs]	[Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Smoking Cessation Counseling]	[Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Blood] First 3 pints in a calendar year Additional amounts per calendar year]	[Not Applicable Not Applicable]	[25-100%, after plan deductible of the amount approved by Medicare but not paid by Medicare.] [25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]
[Mental Health and Substance Abuse]		
Inpatient <i>Federal parity-limit is permitted only if the hospital buy-up is not selected.</i> [Psychiatric hospital Lifetime max: 190 days]	[Same as plan's Inpatient Hospital Facility benefit]	[Not Applicable]
Outpatient Individual Therapy Group Therapy]	Not Applicable Not Applicable]	[\$1-150 per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare] [\$1-150 per office visit deductible /copayment then 25-100% after plan deductible of the amount approved by Medicare but not paid by Medicare]

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
At Home Recovery – Include the following if the Buy-up for At Home Recovery is selected..		
[At Home Recovery] Non Medicare covered activities to assist with daily living during recovery from an illness, injury or surgery (these visits have to follow Medicare approved/covered home health visits)		
Benefit for each visit: Contract/Calendar Year Maximum: \$ 500-unlimited]	[Not Applicable]	[\$1-40 per visit]
Foreign Travel – Include the following if selected.		
[Foreign Travel] Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: Calendar year deductible: \$ 1-250 Lifetime Maximum: \$ 5,000-unlimited]	[Not Applicable]	[25-100% after plan deductible]
Include the following if Hearing Buy-u.p is selected.		
[Routine Hearing Exam] Contract/Calendar Year Maximum: 1 routine exam per year]	[Not Applicable]	[25-100% , after plan deductible, up to the Maximum Reimbursable Charge] or [Per visit deductible /copayment \$1-150 then 25-100% after plan deductible up to the Maximum Reimbursable Charge]
Include the following if the Vision Buy-up is selected .		

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	[PART B EXPENSES PLAN PAYS] <i>Remove column when Part B expenses are not covered under the plan design.</i>
<p>[Routine Vision Exam Contract/Calendar Year Maximum: 1 routine exam per year]</p>	<p>[Not Applicable]</p>	<p>[25-100% , after plan deductible, up to Maximum Reimbursable Charge] or [Per visit deductible /copayment \$1-150 then 100% after plan deductible up to the Maximum Reimbursable Charge]</p>
<p>[Vision Hardware Contract/Calendar Year Maximum: 1 every 2 years]</p>	<p>[Not Applicable]</p>	<p>[25-100% , after plan deductible, up to the Maximum Reimbursable Charge] or [25-100% up to \$50-unlimited maximum for all hardware combined including but not limited to eyeglasses, frames and contact lenses]</p>

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Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Medicare or CG. **Any applicable [Copayments,] [Deductibles] [or limits] are shown in The Schedule.**

Covered Expenses

Add text if policyholder selects coverage for Medicare Part A for the first 60 days per benefit period

- [charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 60th day in any Medicare Benefit Period (Medicare Part A Deductible).]

Add text if policyholder selects coverage for Medicare part A for the first day through the 150th day per benefit period while using 60 lifetime reserve days

- [charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).]

Add text if policyholder selects coverage for Medicare Part A for the 61st day through the 150th^h day per benefit period while using 60 lifetime reserve days

- [charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the 61st day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).]

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Covered Expenses (continued)

Add text if buy up for Inpatient Hospital-Facility Services is elected for an additional 365 days once lifetime reserve days are used

- [charges made by a Hospital for a Hospital Confinement for an additional 365 days per benefit period per person per lifetime once the lifetime reserve days are used (or would have ended if used).]

Add text for Inpatient Services at Other Health Care Facilities for coverage from the 21st day through the 100th day.

- [charges made by a Skilled Nursing Facility, rehabilitation hospital and sub-acute facilities for Part A Medicare Eligible Expenses from the 21st day through the 100th day in any Medicare Benefit Period. A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for buy-up for Inpatient services at Other Health Care Facilities for coverage from the 101st day through the 365th day

- [charges made by a Skilled Nursing Facility from the 101st day through 365th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for buy-up for Inpatient services at Other Health Care Facilities for coverage from the 101st day through the 120th day

- [charges made by a Skilled Nursing Facility from the 101st day through 120th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for buy-up for Inpatient services at Other Health Care Facilities for coverage from the 101st day through the 180th day

- [charges made by a Skilled Nursing Facility from the 101st day through 180th day (days in excess of those covered by Medicare). A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.]

Add text for Hospice/Inpatient Respite Care, including bereavement counseling

- [charges made for Hospice/Inpatient Respite Care for Part A Medicare Eligible Expenses which includes bereavement counseling for a terminally ill person.]

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Covered Expenses (Continued)

Add text if policyholder selects Medicare Part B Deductible coverage

- [charges made for the Medicare Part B Deductible.]

Add text if policyholder selects remainder of Part B expenses.

- [charges made for the Medicare Approved Amounts remaining for Part B Medicare Eligible Expenses including but not limited to:
 - charges made for Inpatient and Outpatient Physicians services.
 - charges made for laboratory and radiology services.
 - charges for Medicare Eligible Expenses for preventive care for a one time "Welcome to Medicare" routine physical.
 - charges made for immunizations.
 - charges for the following Early Cancer Detection Screenings including but not limited to:
 - pap test and pelvic examination;
 - prostate cancer screening and digital exam;
 - mammogram screening;
 - colonoscopy ;
 - sigmoidoscopy;
 - fecal blood test;
 - barium enema.
 - charges made for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
 - charges made for additional amounts of blood after the first 3 pints in a calendar year.
 - charges made for outpatient short-term rehabilitative therapy.
 - charges made for home health care services.
 - charges made for maternity.
 - charges made for family planning surgical related services.
 - charges made for durable medical equipment and external prosthetic appliances.

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Covered Expenses (Continued)

- charges made for diabetic supplies, including but not limited to: blood glucose test strips, blood glucose monitor, lancet devices and lancets, glucose control solutions for checking accuracy of test strips and monitors and therapeutic shoes or inserts.
- charges made for clinical trials.
- charges made in an outpatient facility, emergency room or urgent care facility.
- charges made for ambulance services;
- charges made for routine foot disorders for diabetes and peripheral vascular disease when Medically Necessary.
- charges made for prescription drugs including but not limited to: antigens, osteoporosis drugs, erythropoiesis, blood clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs and oral anti-nausea drugs.
- charges for smoking cessation counseling.
- charges made for mental health and substance abuse.
- charges made for organ transplants.
- charges made for dental care.]

Add text if policyholder selects Buy-up for Preventive Care coverage

- [charges for preventive care after the one time "Welcome to Medicare" routine physical.
- charges for early cancer screenings not covered by Medicare.
- charges made for family planning office visits, tests and counseling.]

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Covered Expenses (Continued)

Add text if policyholder selects buy-up for At Home Recovery Benefits

- [charges made for At Home Recovery Services when a) you require assistance with activities of daily living during recovery from an illness, injury, or surgery; b) the total number of at-home recovery visits do not exceed the total number of Medicare-covered Home Care visits for this illness, injury, or surgery; c) the at-home recovery visits are received within eight weeks following the date of the last home visit that is covered by Medicare.]

Add text if policyholder selects buy-up for Foreign Travel Emergency Services

- [charges made for the Foreign Travel Emergency Services deductible and for the charges remaining after the deductible. Covered Expenses will include any Emergency Services that begin within the first 60 days of travel outside the United States in a calendar year.]

Add text if policyholder selects buy-up for Part B excess charges above approved Medicare amounts

- [Part B Excess charges for provider's who do not accept Medicare assignment after the Medicare Part B Deductible is met. Coverage will be provided for the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.]

Add text if policyholder selects buy-up for routine hearing exam.

- [charges made for a routine hearing exam.]

Add text if policyholder selects buy-up for routine vision exam and hardware.

- [charges made for a routine vision exam and vision hardware, including eyeglasses, frames and contact lenses.]

Add text if policyholder selects buy-up for routine vision exam

- [charges made for a routine vision exam]

Add text if policyholder selects buy-up for Short-term Rehabilitation

- charges made for outpatient short-term rehabilitative therapy above Medicare limits.

HOW TO FILE YOUR CLAIM

Upon enrollment, for smoother claim payment, you should provide CG with your Medicare Claim Number as it appears on your Medicare I.D. card. You can:

- Enter it at **myCIGNA.com** or
- Call CG Customer Service at the number on the back of your CG I.D. card.

You must submit expenses covered by this plan to Medicare before they can be considered for payment under this plan. Hospitals, Skilled Nursing Facilities, home health agencies, and Physicians are required by law to file Medicare claims for covered services and supplies that you receive.

If you visit your doctor or hospital, your doctor or hospital will send a claim directly to Medicare. Medicare will pay their part and will send the claim to CG. You will receive a Medicare Summary Notice (MSN) from Medicare. The Summary Notice will list your Medicare claims information including a note if the information was sent to your private insurer (CG) for additional benefits.

For services not covered by Medicare but covered by this plan, you will need to send a claim form to CG. You may get the required claim forms from your Benefit Plan Administrator, by calling customer service or from our website at www.CIGNA.com. All fully completed claim forms and bills should be mailed directly to the claim address that appears on the back of your CG ID card.

CGCLAIM REMINDERS:

- BE SURE TO USE YOUR CG MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL CG Customer Service.

YOUR MEMBER ID IS THE ID SHOWN ON YOUR CG IDENTIFICATION CARD.

YOUR CG ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR CG IDENTIFICATION CARD.

PROVIDE YOUR MEDICARE CLAIM IDENTIFICATION NUMBER AS IT APPEARS ON YOUR MEDICARE ID CARD

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

SERFF Tracking Number: CCGH-126498880 State: Arkansas
 Filing Company: Connecticut General Life Insurance Company State Tracking Number: 44842
 Company Tracking Number: GM6000 SCH165
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: Group Retiree Medical Benefit
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/12/2010
Comments:			
Attachment:			
ARReadability.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/12/2010
Bypass Reason:	n/a		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	variability	Approved-Closed	02/12/2010
Comments:			
Attachment:			
Variability.pdf			

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Group Forms

This is to certify that the forms listed below are in compliance with the readability laws in your state.

A. Option Selected

Policy and related forms are scored collectively for the Flesch reading ease test. The collective score for the policy forms and each related form is indicated below:

Form and Form Numbers to Which Certification is Applicable:

<u>Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Certificate insert pages	GM6000 MEL87, GM6000MEL88, GM6000CLA62	45

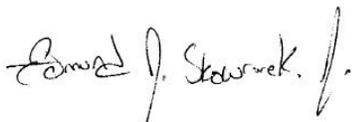
B. Test Option Selected

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 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

2/11/10
Date

Connecticut General Life Insurance Company

Statement of Variability forms GM6000 SCH165 et. al.

General

1. To the extent that variable changes are made they will not be ambiguous or deceptive.
2. Titles or names such as Product Name may change but their relation to the matter to which they pertain will not be ambiguous or deceptive.
3. Connective words and phrases that only serve the grammatical purpose of meaningful continuity may vary as the sense demands.
4. Text may be varied to include text that is approved by your Department for use with CG medical plans.
5. Text may vary in accordance with changes in Medicare.
6. Wording may vary in order to facilitate and/or to clarify the meaning of terms and benefits conveyed in the coverage. Examples of such changes include but are not limited to:
 - benefit provisions may be re-written at the request of our customers to clarify the policyholder's understanding of benefits and/or administration.