

SERFF Tracking Number: CCGH-127130904 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 48585
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: CGLIC filing for ACA
Project Name/Number: /

Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: CGLIC filing for ACA

SERFF Tr Num: CCGH-127130904 State: Arkansas

TOI: H16G Group Health - Major Medical

SERFF Status: Closed-Approved-
Closed State Tr Num: 48585

Sub-TOI: H16G.001C Any Size Group - Other

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Melissa Pine

Disposition Date: 05/02/2011

Date Submitted: 04/26/2011

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: Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 05/02/2011

State Status Changed: 05/02/2011

Deemer Date:

Created By: Melissa Pine

Submitted By: Melissa Pine

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

We are submitting for your approval the above-referenced Group Accident and Health certificate insert pages to be used with the certificate portion of our combined Policy/Certificate Document previously approved by your Department.

We are filing certificate insert pages containing changes compliant with the Affordable Care Act for Grandfathered and Non Grandfathered plans. We are also including text to describe Out of Pocket Expenses and their accumulation as well as text to describe payment for assistant and co-surgeons.

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We have included the PPACA Uniform Compliance Summary.

We consider any bracketed areas to be variable as shown. Please find the enclosed Description of Variable Material. A corresponding rate filing was [sent to][approved by] your Department on xx-xx-xxxx . This submission does not replace any certificate insert pages on file with your Department.

Thank you very much for your attention to this submission. If you have any questions or concerns, you can contact me directly at 860.226.7574. I can also be reached via e-mail at melissa.pine@cigna.com.

Company and Contact

Filing Contact Information

Melissa Pine, Compliance Sr. Associate Melissa.Pine@CIGNA.com
 900 Cottage Grove Road 860-226-7574 [Phone]
 B6LPA 860-226-5400 [FAX]
 Hartford, CT 06152

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? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Connecticut General Life Insurance Company	\$80.00	04/26/2011	46960861
Connecticut General Life Insurance Company	\$720.00	04/28/2011	47036370

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/02/2011	05/02/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	04/28/2011	04/28/2011	Melissa Pine	04/29/2011	04/29/2011
Pending Industry Response	Rosalind Minor	04/27/2011	04/27/2011	Melissa Pine	04/28/2011	04/28/2011

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Project Name/Number: /

Disposition

Disposition Date: 05/02/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Description of Variable	Approved-Closed	Yes
Supporting Document	Forms Listing	Approved-Closed	Yes
Form	Notice for PCP and OB/GYN	Approved-Closed	Yes
Form	LT and Annual Maximums - Schedule of Benefits	Approved-Closed	Yes
Form	Preventive Care Schedule	Approved-Closed	Yes
Form	Prescription Drug Schedule	Approved-Closed	Yes
Form	OOP Max (assistants and co-surgeons)	Approved-Closed	Yes
Form	Preventive Care	Approved-Closed	Yes
Form (revised)	Pre-existing condition limitation	Approved-Closed	Yes
Form	Pre-existing condition limitation	Replaced	Yes
Form	Rescissions	Approved-Closed	Yes
Form	Dependent Definition	Approved-Closed	Yes
Form	Emergency Medical Condition	Approved-Closed	Yes
Form	Emergency Service	Approved-Closed	Yes
Form	Essential Health Benefits	Approved-Closed	Yes
Form	PPACA of 2010	Approved-Closed	Yes
Form	Stabilize	Approved-Closed	Yes
Form	Appeals	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes

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Product Name: CGLIC filing for ACA
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/28/2011

Submitted Date 04/28/2011

Respond By Date

Dear Melissa Pine,

This will acknowledge receipt of the captioned filing.

Objection 1

- Pre-existing condition limitation, GM6000 INDEM303 (Form)

Comment:

With respect to coverage for minors for whom the insured has filed a petition to adopt, please refer to the 60-day period outlined under ACA 23-79-137.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 04/29/2011
 Submitted Date 04/29/2011

Dear Rosalind Minor,

Comments:

Thank you for your response.

Response 1

Comments: I have revised form GM6000 INDEM303 to reflect 60 days vs. 31. Redline and final version have been included for your review.

Related Objection 1

Applies To:

- Pre-existing condition limitation, GM6000 INDEM303 (Form)

Comment:

With respect to coverage for minors for whom the insured has filed a petition to adopt, please refer to the 60-day period outlined under ACA 23-79-137.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Pre-existing condition limitation	GM6000 INDEM303		Certificate Amendment, Insert Page, Endorsement or Rider	Initial		0.000	GM6000 INDEM303V1.pdf,GM6000 INDEM303

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 Product Name: CGLIC filing for ACA
 Project Name/Number: /

3V1
 Redline.pdf

Previous Version

Pre-existing condition	GM6000	Certificate Amendment,	Initial	0.000	INDEM30
limitation	INDEM30	Insert Page, Endorsement			3 Pre-
	3	or Rider			ex.pdf

No Rate/Rule Schedule items changed.

Please let me know if you need further information.

Sincerely,
 Melissa Pine

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Product Name: CGLIC filing for ACA
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/27/2011

Submitted Date 04/27/2011

Respond By Date

Dear Melissa Pine,

This will acknowledge receipt of the captioned filing.

Objection 1

- Notice for PCP and OB/GYN, NOT225 (Form)
- LT and Annual Maximums - Schedule of Benefits, GM6000 SCH188 (Form)
- Preventive Care Schedule, GM6000 SCH193 (Form)
- Prescription Drug Schedule, GM6000 SCH190 (Form)
- OOP Max (assistants and co-surgeons), GM6000 SCH192 (Form)
- Preventive Care, GM6000 FLX542 (Form)
- Pre-existing condition limitation, GM6000 INDEM303 (Form)
- Rescissions, GM6000 TRM414 (Form)
- Dependent Definition, GM6000 DFS2181 (Form)
- Emergency Medical Condition, GM6000 DFS2154 (Form)
- Emergency Service, GM6000 DFS2153 (Form)
- Essential Health Benefits, GM6000 DFS2155 (Form)
- PPACA of 2010, GM6000 DFS2156 (Form)
- Stabilize, GM6000 DFS2157 (Form)
- Appeals, GM6000 APL810 (Form)
- Policy Amendment, GM5800 34MD6 (Form)

Comment: Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$800.00. Please submit an additional \$720.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Product Name: CGLIC filing for ACA
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/28/2011
Submitted Date 04/28/2011

Dear Rosalind Minor,

Comments:

Thank you for the opportunity to submit the additional filing fees.

Response 1

Comments: I have submitted \$720 via EFT.

Related Objection 1

Applies To:

- Notice for PCP and OB/GYN, NOT225 (Form)
- LT and Annual Maximums - Schedule of Benefits, GM6000 SCH188 (Form)
- Preventive Care Schedule, GM6000 SCH193 (Form)
- Prescription Drug Schedule, GM6000 SCH190 (Form)
- OOP Max (assistants and co-surgeons), GM6000 SCH192 (Form)
- Preventive Care, GM6000 FLX542 (Form)
- Pre-existing condition limitation, GM6000 INDEM303 (Form)
- Rescissions, GM6000 TRM414 (Form)
- Dependent Definition, GM6000 DFS2181 (Form)
- Emergency Medical Condition, GM6000 DFS2154 (Form)
- Emergency Service, GM6000 DFS2153 (Form)
- Essential Health Benefits, GM6000 DFS2155 (Form)
- PPACA of 2010, GM6000 DFS2156 (Form)
- Stabilize, GM6000 DFS2157 (Form)
- Appeals, GM6000 APL810 (Form)
- Policy Amendment, GM5800 34MD6 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$800.00. Please submit an additional \$720.00 for this submission.

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Company Tracking Number:
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001C Any Size Group - Other*
Product Name: *CGLIC filing for ACA*
Project Name/Number: /

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you. Please let me know if you need further information.

Sincerely,
Melissa Pine

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 Product Name: CGLIC filing for ACA
 Project Name/Number: /

Form Schedule

Lead Form Number: NOT225

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/02/2011	NOT225	Certificate	Notice for PCP and Amendmen OB/GYN t, Insert Page, Endorseme nt or Rider	Initial		0.000	NOT225 OBGYN PCP.pdf
Approved-Closed 05/02/2011	GM6000 SCH188	Certificate	LT and Annual Amendmen Maximums - t, Insert Schedule of Benefits Page, Endorseme nt or Rider	Initial		0.000	GM6000 SCH188 LT and Annual Maximum.pdf
Approved-Closed 05/02/2011	GM6000 SCH193	Certificate	Preventive Care Amendmen Schedule t, Insert Page, Endorseme nt or Rider	Initial		0.000	GM6000 SCH193.pdf
Approved-Closed 05/02/2011	GM6000 SCH190	Certificate	Prescription Drug Amendmen Schedule t, Insert Page, Endorseme nt or Rider	Initial		0.000	SCH190 Prescription Drug Schedule.pdf
Approved-Closed 05/02/2011	GM6000 SCH192	Certificate	OOP Max (assistants and co-surgeons) t, Insert Page, Endorseme nt or Rider	Initial		0.000	SCH192 Out of Pocket Expenses Assistant and Cosurgeons.pdf
Approved-	GM6000	Certificate	Preventive Care	Initial		0.000	FLX542

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TOI:	H16G Group Health - Major Medical	Sub-TOI:	H16G.001C Any Size Group - Other
Product Name:	CGLIC filing for ACA		
Project Name/Number:	/		
Closed	FLX542	Amendmen	Preventive
05/02/2011		t, Insert	Care.pdf
		Page,	
		Endorseme	
		nt or Rider	
Approved-	GM6000	Certificate	0.000
Closed	INDEM303	Pre-existing condition	GM6000
05/02/2011		Amendmen limitation	INDEM303V1
		t, Insert	.pdf
		Page,	GM6000
		Endorseme	INDEM303V1
		nt or Rider	Redline.pdf
Approved-	GM6000	Certificate	0.000
Closed	TRM414	Rescissions	TRM414
05/02/2011		Amendmen	Rescissions.p
		t, Insert	df
		Page,	
		Endorseme	
		nt or Rider	
Approved-	GM6000	Certificate	0.000
Closed	DFS2181	Dependent Definition	GM6000
05/02/2011		Amendmen	DFS2181 (AR
		t, Insert	Dependent).p
		Page,	df
		Endorseme	
		nt or Rider	
Approved-	GM6000	Certificate	0.000
Closed	DFS2154	Emergency Medical	DFS2154
05/02/2011		Amendmen	Emergency
		t, Insert	Medical
		Page,	Condition.pdf
		Endorseme	
		nt or Rider	
Approved-	GM6000	Certificate	0.000
Closed	DFS2153	Emergency Service	DFS2153
05/02/2011		Amendmen	Emergency
		t, Insert	Services.pdf
		Page,	
		Endorseme	
		nt or Rider	
Approved-	GM6000	Certificate	0.000
Closed	DFS2155	Essential Health	DFS2155
05/02/2011		Amendmen	Essential
		t, Insert	Health

<i>SERFF Tracking Number:</i>	<i>CCGH-127130904</i>	<i>State:</i>	<i>Arkansas</i>		
<i>Filing Company:</i>	<i>Connecticut General Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48585</i>		
<i>Company Tracking Number:</i>					
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>		
<i>Product Name:</i>	<i>CLIC filing for ACA</i>				
<i>Project Name/Number:</i>	<i>/</i>				
	Page,				Benefits.pdf
	Endorseme				
	nt or Rider				
Approved- GM6000	Certificate	PPACA of 2010	Initial	0.000	DFS2156
Closed DFS2156	Amendmen				PPACA of
05/02/2011	t, Insert				2010.pdf
	Page,				
	Endorseme				
	nt or Rider				
Approved- GM6000	Certificate	Stabilize	Initial	0.000	DFS2157
Closed DFS2157	Amendmen				Stabilize.pdf
05/02/2011	t, Insert				
	Page,				
	Endorseme				
	nt or Rider				
Approved- GM6000	Certificate	Appeals	Other	Other Explanation:	0.000
Closed APL810	Amendmen				GM6000
05/02/2011	t, Insert				APL810.pdf
	Page,				
	Endorseme				
	nt or Rider				
Approved- GM5800	Policy/Cont	Policy Amendment	Initial	0.000	GM5834-MD6
Closed 34MD6	ract/Fratern				Pol
05/02/2011	al				Amend.pdf
	Certificate:				
	Amendmen				
	t, Insert				
	Page,				
	Endorseme				
	nt or Rider				

[Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.]

[Selection of a Primary Care Provider

This plan generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, CIGNA designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.]

For children, you may designate a pediatrician as the primary care provider.

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
[Lifetime Maximum for essential benefits	Unlimited] [10,000-Unlimited]**	
[Lifetime Maximum for non-essential benefits	[\$10,000-Unlimited]	[\$10,000-Unlimited]]
[Lifetime Maximum for non-essential benefits	[\$10,000-Unlimited]]	
[Annual Maximum for essential benefits [including !]	[\$750,000 - Unlimited]] [\$1,000-\$750,000] *	
[Annual Maximum for essential benefits [including !]	[\$750,000 - Unlimited] [\$1,000-\$750,000] *	[\$750,000 - Unlimited]] [\$1,000-\$750,000] *
[Annual Maximum for non-essential benefits	[\$10,000-Unlimited]]	
[Annual Maximum for non-essential benefits	[Not Applicable] [\$10,000-Unlimited]	[\$10,000-Unlimited]

* For use with approved client request to the U.S. Department of Health and Human Services for a waiver of the PPACA limit.

** For use with plans exempt from PPACA only.

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>[Preventive Care] <u>Routine Preventive Care</u> Unlimited Maximum [[Contract] [Calendar] Year Maximum: [\$250-2,000]]** [Note: Well-woman OB/GYN visits will be considered [either] a [PCP or] Specialist visit [depending on how the provider contracts with CIGNA].]</p>		
Physician's Office Visit	No charge	[No charge] [30-80]% after plan deductible]
Immunizations	No charge	No charge [30-80]% after plan deductible]
Preventive Care Related Services (i.e. "routine" services)	[50-100]% [after plan deductible]	[30-80]% [after plan deductible]
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service
	<p>Note: The associated wellness exam will be covered at no charge [after the \$[0-100] PCP or \$[0-150] Specialist per visit copay].*</p>	

*Variables Applicable to Exempt and Grandfathered Plans only.

** Variables Applicable to plans Exempt from PPACA only.

Note: The benefit differential level between services rendered In-Network and Out-of-Network shall not exceed 25% of the allowable charge for the service rendered.

**Prescription Drug Benefits
The Schedule**

For You and Your Dependents

[Medications required as part of evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force are covered at 100% with no copayment or deductible.]

The Schedule

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for [In-Network][and][Out-of-Network] charges that are not paid by the benefit plan. The following [In-Network] [and] [Out-of-Network] Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%. [Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, In-Network copayments and Out-of-Network deductibles are no longer required]

- [Coinsurance]
- [Plan Deductible]
- [coinsurance][and][copayments][and][Per Day][deductibles] [for the following:]
 - [inpatient hospital facility]
 - [outpatient facility]
 - [Advanced Radiological Imaging]
 - [emergency room]
 - [office visit]
 - [urgent care]
 - [bariatric [surgery] [treatment]]
 - [External Prosthetic Appliances]
 - [[Medical] [and] [Pharmacy] [CIGNA Pharmacy]][Mail Order Pharmacy]
 - [Mental Health] [and] [Substance Abuse]

The following Out-of-Pocket [In-Network] [and] [Out-of-Network] Expenses and charges do not contribute to the Out-of-Pocket Maximum and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached.

- [non-compliance penalties]
- [provider charges in excess of the Maximum Reimbursable Charge]
- [Coinsurance]
- [Plan Deductible]
- [coinsurance][and][copayments][and][deductibles] [for the following:]
 - [inpatient hospital facility]
 - [outpatient facility]
 - [Advanced Radiological Imaging]
 - [emergency room]
 - [office visit]
 - [urgent care]
 - [bariatric [surgery] [treatment]]
 - [External Prosthetic Appliances]
 - [[Medical] [and] [Pharmacy] [CIGNA Pharmacy]][Mail Order Pharmacy]
 - [Mental Health] [and] [Substance Abuse]

[Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed [16-20] percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to 62.5 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)]

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 CG. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- [charges made for the following preventive care services (detailed information is available at www.healthcare.gov/center/regulations/prevention/recommendations.html):
 - (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
 - (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
 - (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
 - (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.]

[Pre-existing Condition Limitations

(Not applicable to anyone under age 19)

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

An adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 60 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.]

[Pre-existing Condition Limitations

(Not applicable to anyone under age 19)

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

An adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within ~~60~~³¹ days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.]

Termination of Insurance**Rescissions**

Your coverage may not be rescinded (retroactively terminated) by CG or the plan sponsor unless: (1) the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

DEFINITIONS

Dependent

Dependents are:

- your lawful spouse; or
- [your Domestic Partner;]and
- any child of yours who is
 - less than [26-99] years old.[and not eligible for another employer-sponsored group health plan other than that of a parent.]
 - [26-99] years old, but less than [27-99], unmarried, enrolled in school as a full-time student and primarily supported by you.]
 - [26] or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild. [If your Domestic Partner has a child, that child will also be included as a Dependent.]

[Benefits for a Dependent child [or student] will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.]

[Benefits for a Dependent child [or student] will continue until the last day of the calendar month in which the limiting age is reached.]

[Benefits for a Dependent child [or student] will continue until the last day of the calendar year in which the limiting age is reached.]

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DEFINITIONS

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

DEFINITIONS

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; or a health care item or service furnished or required to evaluate and treat the emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

DEFINITIONS

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

DEFINITIONS

Patient Protection and Affordable Care Act of 2010 (“PPACA”)

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152.)

DEFINITIONS

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within [365 days] of receipt of a denial notice, to the following address:

[CIGNA HealthCare Inc.
National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422]

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

[If CG fails to strictly adhere to all the requirements of the internal claims and appeals process, you may initiate an external Independent Review and/or pursue any available remedies under applicable law.]

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.]

CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of medical necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, CG's review will be completed within 15 calendar days. For postservice claims, CG's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by CG in connection with the level-two appeal, CG will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by CG, CG will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if CG does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG's level two appeal review denial. CG will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

Appeal to the State of Arkansas

You have the right to contact the Arkansas Insurance Department for assistance at any time. The Consumer Services Division may be contacted at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
501-371-2640
501-371-2749 Fax
or call: 1-800-852-5494

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.]

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

PREMIUMS (Continued)

CHANGES IN PREMIUM RATES (Continued)

The Insurance Company may change rates immediately if in its opinion its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance. In addition, the Insurance Company may change the rates if at any time the enrollment or employee contribution level is less than assumed by the Insurance Company in underwriting the coverage or if the Insurance Company: (i) is required to pay any fee or assessment, or (ii) incurs any additional costs in administering the policy; as a result of requirements of federal or state law.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by interaction with an HMO.

SERFF Tracking Number: CCGH-127130904 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 48585
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: CGLIC filing for ACA
Project Name/Number: /

Rate data does NOT apply to filing.

SERFF Tracking Number: CCGH-127130904 State: Arkansas
 Filing Company: Connecticut General Life Insurance Company State Tracking Number: 48585
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: CGLIC filing for ACA
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR Certif of Compliance with Rule 19.pdf AR NAIC Readability.pdf	Approved-Closed	05/02/2011
Bypassed - Item: Application Bypass Reason: N/A Comments:	Approved-Closed	05/02/2011
Satisfied - Item: PPACA Uniform Compliance Summary Comments: Attachment: AR Final PPACA Uniform Compliance Summary - 01-11.pdf	Approved-Closed	05/02/2011
Satisfied - Item: Description of Variable Comments: Attachment: AR Description of Variable Material.pdf	Approved-Closed	05/02/2011
Satisfied - Item: Forms Listing	Approved-Closed	05/02/2011

SERFF Tracking Number: CCGH-127130904 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 48585
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: CGLIC filing for ACA
Project Name/Number: /

Comments:

Attachment:

AR List of Forms.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Connecticut General Life Insurance Company

Form Number(s): NOT225 et al (See attached forms listing)

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

Signature of Company Officer

Edmund J. Skowronek, Jr.

Name

Director

Title

April 26, 2011

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

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 Number</u>	<u>Flesch Score</u>
NOT225 et. al.	46.9

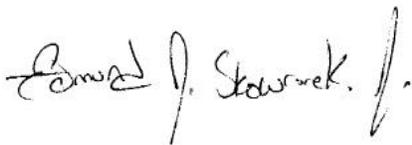
B. Test Option Selected

Test was applied to 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

April 21, 2011
Date

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)
 SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Connecticut General Life Insurance Company	62308-046		GM5800/GM6000 Combined Policy Certificate Series	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</p> <p>Explanation: Text has been added to note that any Pre-existing Condition Limitation is "Not applicable to anyone under age 19."</p> <p>Page Number: Form GM6000 INDEM303</p>	<p><i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.</p> <p>Explanation: Schedule text accommodates different Annual Maximums for essential vs. non-essential benefits</p> <p>Page Number: GM6000 SCH188</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Lifetime Dollar Limits on Essential Benefits</p> <p>Explanation: Schedule text accommodates different Lifetime Maximums for essential vs. non-essential benefits</p> <p>Page Number: GM6000 SCH188</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.</p> <p>Explanation: Rescissions may occur only due to fraud or intentional misrepresentation of fact.</p> <p>Page Number: GM6000 TRM414</p>	<p><i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i></p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Schedule provides for no cost-sharing for preventive services. Covered Expense text describes benefit.			
	Page Number: GM6000 SCH193, GM6000 SCH190, GM6000 FLX542			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Revisions have been made to the Dependent definition to provide for coverage for dependents until age 26 (at a minimum).			
	Page Number: GM6000 DFS2181			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: CGLIC provides for both an internal appeal and external review process.			
	Page Number: GM6000 APL810			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation: CGLIC provides coverage for emergency services without a prior authorization requirement, at the In-Network cost-sharing level.</p> <p>Page Number: Previously Approved</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation: CIGNA standardly allows pediatricians to be designated PCPs.</p> <p>Page Number: NOT225</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation: Generally, CGLIC’s products are "open access" and do not require prior authorization or referral to see and OB/GYN. If a product does require a referral to a specialist, CGLIC standardly permits direct access to OB/GYNs.</p> <p>Page Number: NOT225</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

Description of Variable Material
GM6000 SCH188 et al

NOT225 – we wish to vary text based on product specifications.

GM6000 SCH188 – we wish to vary text based on Lifetime Maximums applying to non essential benefits, Combined or Separate maximums based on client selection, to list essential benefits upon client request, to reflect an annual aggregate maximum approved by waiver from the U.S. Department of Health and Human Services, and allow a dollar Lifetime Maximum for plans exempt from PPACA only. Specific annual dollar maximums would be applies to Exempt plans only.

GM6000 SCH193 – we wish to vary text to reflect product specifications to include or exclude Out of Network coverage and reflect coinsurance percentage per client selection from the ranges shown; include wellness exam copayment reference and In Network cost share with Grandfathered plans per client request; and include an annual maximum for plans exempt from PPACA.

GM6000 SCH190 – we wish to include this in the Schedule when preventive care drugs are covered under a Pharmacy benefit.

GM6000 DFS2181 – we wish to vary text to include coverage of Domestic Partner and their dependents; reflect coverage of students 26 and over when applicable; reflect when coverage ends for dependents and or students; include a caveat upon request for Grandfathered plans, that coverage applies unless other employer sponsored group health coverage is available; reflect expanded age ranges per client request; and omit proof of handicapped status if CG no longer requires proof.

GM6000 INDEM303 – we wish to omit this page if PCL is not applied to the plan.

GM6000 FLX542 – we wish to omit text for Grandfathered plans using previously approved covered expense text.

GM6000 SCH192 – We will edit the bracketed text of Out of Pocket Expenses to show items which accumulate to the Out of Pocket Maximum and those which do not and for which payment does not increase. Inclusion of mental health and substance abuse charges will be accumulated in compliance with parity requirements.

Connecticut General Life Insurance Company

LISTING OF NEW FORMS

Description :	Form Number:
Notice for PCP/OBGYN	NOT225
LT and Annual Maximums – Schedule of Benefits	GM6000 SCH188
Preventive Care	GM6000 SCH193
Rx Schedule	GM6000 SCH190
OOP text (assistants & co-surgeons)	GM6000 SCH192
Preventive Care	GM6000 FLX542
Pre-existing Limitation	GM6000 INDEM303
Rescissions	GM6000 TRM414
Definition of Dependent	GM6000 DFS2181
Emergency Medical Condition	GM6000 DFS2154
Emergency Service	GM6000 DFS2153
Essential Health Benefits	GM6000 DFS2155
PPACA of 2010	GM6000 DFS2156
Stabilize	GM6000 DFS2157
Amendment	GM5800 34MD6
Appeals	GM6000 APL810

SERFF Tracking Number: CCGH-127130904 State: Arkansas
 Filing Company: Connecticut General Life Insurance Company State Tracking Number: 48585
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: CGLIC filing for ACA
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/26/2011	Form	Pre-existing condition limitation	04/29/2011	INDEM303 Pre-ex.pdf (Superseded)

[Pre-existing Condition Limitations

(Not applicable to anyone under age 19)

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

An adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.]