

SERFF Tracking Number: PLIS-127177619 State: Arkansas
Filing Company: Connecticut General Life Insurance Company State Tracking Number: 49083
Company Tracking Number: PPACA ENDORSEMENTS
TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
Expense
Product Name: PPACA Endorsements
Project Name/Number: /

Filing at a Glance

Company: Connecticut General Life Insurance Company

Product Name: PPACA Endorsements SERFF Tr Num: PLIS-127177619 State: Arkansas
TOI: H15G Group Health - Hospital/Surgical/Medical Expense SERFF Status: Closed-Approved- Closed State Tr Num: 49083
Sub-TOI: H15G.002 Large Group Only Co Tr Num: PPACA ENDORSEMENTS State Status: Approved-Closed

Filing Type: Form

Author: John Plisky Reviewer(s): Rosalind Minor
Date Submitted: 06/17/2011 Disposition Date: 06/30/2011
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: AR-Specific, not filed in CT.
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: 06/30/2011
State Status Changed: 06/30/2011 Deemer Date:
Created By: John Plisky Submitted By: John Plisky
Corresponding Filing Tracking Number:
PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms
PPACA Notes: null
Filing Description:
Please see attached cover letter.

Company and Contact

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Filing Contact Information

John Plisky, Consultant j.plisky@verizon.net
 Plisky Plisky & Co. LLC 732-223-0770 [Phone]
 617 Union Ave., Bldg. 1-2 732-223-1776 [FAX]
 Brielle, NJ 08730

Filing Company Information

(This filing was made by a third party - pliskypliskyandcollc)

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) 226-6255 ext. [Phone]	FEIN Number: 06-0303370	

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: \$50 ea. x 4 = \$200
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Connecticut General Life Insurance Company	\$200.00	06/17/2011	48827750

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2011	06/30/2011

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Disposition

Disposition Date: 06/30/2011

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	Cover Letter	Approved-Closed	Yes
Supporting Document	HHS Annual Limit Waiver	Approved-Closed	Yes
Supporting Document	Red-line of State-Specific Endorsements	Approved-Closed	Yes
Supporting Document	Explanation of Variable Material	Approved-Closed	Yes
Supporting Document	Authorization	Approved-Closed	Yes
Supporting Document	Previous Approval	Approved-Closed	Yes
Form	PPACA Endorsement-Grandfathered	Approved-Closed	Yes
Form	PPACA Endorsement-Non-Grandfathered	Approved-Closed	Yes
Form	Arkansas Endorsement	Approved-Closed	Yes
Form	Optional Arkansas Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SBCII-ENDRS-PPACA-01

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/30/2011	SBCII-ENDRS-PPACA-01-AR	Policy/Contract	Cont PPACA Fraternal Endorsement-Grandfathered	Initial			SBCII-ENDRS-PPACA-01-AR.pdf
Approved-Closed 06/30/2011	SBCII-ENDRS-PPACA-02-AR	Policy/Contract	Cont PPACA Fraternal Endorsement-Non-Grandfathered	Initial			SBCII-ENDRS-PPACA-02-AR.pdf
Approved-Closed 06/30/2011	SBCII-ENDRS-10-AR	Policy/Contract	Arkansas Fraternal Endorsement	Initial			SBCII-ENDRS-10-AR.pdf
Approved-Closed 06/30/2011	SCBII-OPT-10-AR	Policy/Contract	Optional Arkansas Fraternal Endorsement	Initial			SBCII-OPT-10-AR.pdf

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CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Mailing Address: 900 Cottage Grove Road

Hartford, CT 06152

Patient Protection and Affordable Care Act Endorsement

This endorsement is attached to and made a part of the Certificate provided to insureds covered under Group Policy [12345] issued by Connecticut General Life Insurance Company.

This Endorsement is for use with Grandfathered Plans.

The Certificate/Benefit Specifications are amended as stated below.

In the event of a conflict between the provisions of Your Certificate and the provisions of this Endorsement, the provisions that are more favorable to You shall apply.

Grandfathered Health Plan Disclosure

We believe your health plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to [CIGNA Customer Service] at [1-800-xxx-xxxx].

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Definitions

“Essential Health Benefits” means benefits covered under the plan 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. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

“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).

Lifetime Dollar Limits

This plan does not impose a lifetime dollar limit. Therefore, no amendment is necessary to comply with the Patient Protection and Affordable Care Act of 2010.

Annual Dollar Limits

The Secretary of Health and Human Services (“HHS”) has granted Connecticut General Life Insurance Company a waiver that permits Us to continue to impose an annual dollar limit for benefits provided under the terms of this plan. Therefore, any annual dollar limits included in Your Certificate continue to apply.

Rescissions

Your coverage may not be rescinded (retroactively terminated) unless: (1) the Policyholder 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 Policyholder or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact. We must provide at least 30 days advance written notice before your coverage may be rescinded. You have the right to appeal any such rescission.

Extension of Coverage to Dependents

Dependent children are eligible for coverage up to the age of 26. Any restrictions in the definition of Dependent in Your Certificate which require a child to be unmarried, a student, financially dependent on the employee, sharing a residence with the employee or unemployed, no longer apply. If the definition of Dependent in the Certificate provides coverage for a child beyond age 26 to comply with state law, such provision and all restrictions contained in the Certificate will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

Preexisting Condition Limitations

Any Preexisting Condition Limitation provision described in the Certificate does not apply to anyone who is under 19 years of age.

All provisions, definitions, limitations and conditions of the Policy and Certificate which are not inconsistent with these benefits and provisions apply to them.

Signed by:



Shermona S. Mapp
Corporate Secretary

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Mailing Address: 900 Cottage Grove Road

Hartford, CT 06152

Patient Protection and Affordable Care Act Endorsement

This endorsement is attached to and made a part of the Certificate provided to insureds covered under Group Policy [12345] issued by Connecticut General Life Insurance Company.

This Endorsement is for use with Non-Grandfathered Plans.

The Certificate/Benefit Specifications are amended as stated below.

In the event of a conflict between the provisions of Your Certificate and the provisions of this Endorsement, the provisions that are more favorable to You shall apply.

Definitions

“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: 1) 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; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

“Emergency Services” means, with respect to an Emergency Medical Condition: (a) 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; and (b) within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient.

“Essential Health Benefits” means benefits covered under the plan 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. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

“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).

“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.

Lifetime Dollar Limits

This plan does not impose a lifetime dollar limit. Therefore, no amendment is necessary to comply with the Patient Protection and Affordable Care Act of 2010.

Annual Dollar Limits

The Secretary of Health and Human Services (“HHS”) has granted Connecticut General Life Insurance Company a waiver that permits Us to continue to impose an annual dollar limit for benefits provided under the terms of this plan. Therefore, any annual dollar limits included in Your Certificate continue to apply.

Rescissions

Your coverage may not be rescinded (retroactively terminated) unless: (1) the Policyholder 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 Policyholder or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact. We must provide at least 30 days advance written notice before your coverage may be rescinded. You have the right to appeal any such rescission.

Extension of Coverage to Dependents

Dependent children are eligible for coverage up to the age of 26. Any restrictions in the definition of Dependent in Your Certificate which require a child to be unmarried, a student, financially dependent on the employee, sharing a residence with the employee or unemployed, no longer apply. If the definition of Dependent in the Certificate provides coverage for a child beyond age 26 to comply with state law, such provision and all restrictions contained in the Certificate will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

Preventive Services

In addition to any other benefits described in the Certificate, no Deductible, Co-payment, or Coinsurance shall apply to the following Covered Services:

- (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) with respect to Covered Persons who are 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) with respect to Covered Persons who are 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.

Preexisting Condition Limitations

Any Preexisting Condition Limitation provision described in the Certificate does not apply to anyone who is under 19 years of age.

Notice of Adverse Determination

In addition to any description provided in Your plan documents, a notice of adverse benefit determination will also include information sufficient for You to identify the claim, and information

about any office of health insurance consumer assistance or ombudsman available to assist You with the appeal process. In the case of a final adverse benefit determination, Your notice will include a discussion of the decision.

Right to Appeal

You have the right to appeal any decision or action taken to deny, reduce, or terminate the provision of or payment for health care services covered by Your plan or to rescind Your coverage. When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, You have the right to have the decision reviewed by an independent review organization not associated with Us.

Except where life or health would be seriously jeopardized, You must first exhaust the internal appeal process set forth in Your plan documents before your request for an external independent review will be granted. If We do not strictly adhere to all internal claim and appeals processes, You can be deemed to have exhausted the internal appeal process.

Your appeal rights are outlined in Your plan documents. In addition, before a final internal adverse benefit determination is issued, if applicable, You will be provided, free of charge, any new or additional evidence considered, or rationale relied upon, in sufficient time to allow You the opportunity to respond before the final notice is issued.

Emergency Services

This plan does not require prior authorization for Emergency Services and does not utilize a preferred provider network. Therefore, Emergency Services are covered without the need for prior authorization and the level of benefits will be the same regardless of the participating status of the provider.

Direct Access to Obstetricians and Gynecologists

This plan does not require the selection of a primary care provider and does not require a referral in order to see an obstetrician or gynecologist. Therefore, no amendment is necessary to comply with the Patient Protection and Affordable Care Act of 2010.

Selection of a Primary Care Provider

This plan does not require the selection of a primary care provider. Therefore, no amendment is necessary to comply with the Patient Protection and Affordable Care Act of 2010.

All provisions, definitions, limitations and conditions of the Policy and Certificate which are not inconsistent with these benefits and provisions apply to them.

Signed by:



Shermona S. Mapp
Corporate Secretary

Arkansas Endorsement

This Endorsement is attached to and made a part of the Certificate provided under Group Policy [12345] issued by Connecticut General Life Insurance Company.

The Certificate is hereby amended for Arkansas by the following:

The following is added to the face page:

LIMITED HEALTH PLAN

V. Conditions and Effective Date

The provision **Effective Date of Health Insurance for Newborn or Adopted Children** is replaced with the following:

Effective Date of Health Insurance for Newborn or Adopted Children

A child born to the Insured Person or the Insured Person's insured dependent spouse is automatically insured as a Dependent. The effective date of insurance for the child will be the moment of birth. Coverage will be to the same extent as is provided for other covered Dependent children. Coverage includes:

1. The Necessary Care and Treatment of medically diagnosed congenital defects;
2. Birth abnormalities;
3. Prematurity;
4. Tests of any kind mandated by law; tests for hypothyroidism, phenylketonuria and galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants mandated by law;
5. Routine nursery care; and
6. Routine pediatric charges for a well newborn child for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

In the event additional premium is required for such child then the insurance will terminate 90 days from the date of birth unless written request to continue insurance is made to Us and the premium is paid within 90 days from the date of birth or before the next premium due date, whichever is later.

In the case of minor children under the Insured Person's charge, care and control for whom the Insured Person has filed a petition to adopt, coverage will be effective:

1. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
2. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage will be to the same extent as specified above. Any additional premium required for such child must be paid at the time application is made.

VI. Benefit Descriptions

Outpatient Medical Expense Benefit

The second paragraph is replaced with the following:

BENEFITS ARE PAYABLE AT THE APPLICABLE COINSURANCE PERCENTAGE AND ARE SUBJECT TO THE BENEFIT MAXIMUMS, DEDUCTIBLES AND CO-PAYMENTS STATED IN THE BENEFIT SPECIFICATIONS.

The following additional benefits are added to the **List of Covered Expenses – Out-Patient**, subject to the same terms and conditions:

1. Charges for Periodic Preventive Care Visits, provided by or under the supervision of a single Physician per visit, from the moment of birth through age 18 years. Periodic Preventive Care Visits include 20 visits at approximately the following intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.

Benefits for Periodic Preventive Care Visits, except for recommended immunization services, are subject to any Deductible, Insured Percent, Maximum Benefit and Copayment amounts shown in the Benefit Specifications.

For the purpose of this benefit:

"Children's Preventive Health Care" means Physician-delivered or Physician-supervised services for a covered Dependent child from the moment of birth through 18 years of age. Periodic Preventive Care Visits include medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

"Periodic Preventive Care Visits" means routine tests and procedures for the purpose of detection of abnormalities or malfunctions of the bodily systems and parts according to accepted medical practices.

2. Charges for medical equipment, medical supplies, and diabetes self-management training solely for the management and treatment of diabetes.

Benefits for self-management training include one per lifetime training program per Covered Person with diabetes for Necessary Treatment provided by a health care provider upon certification by such provider giving the training that the Covered Person has successfully completed the training.

In addition to the one lifetime training program provided above, additional diabetes self-management training will be covered in the event that a Physician prescribes additional training and it is Necessary Treatment because of a significant change in the Covered Person's symptoms or conditions.

The provider or diabetes educator shall only provide diabetes self-management training within his scope of practice after having demonstrated expertise in diabetes care and treatment. The provider or diabetes educator may only provide such training after having completed an education training program required by his licensing board when such program is in compliance with the National Standards for Diabetes Self-Management Education Program, developed by the American Diabetes Association. The Physician must issue a written prescription ordering the training for the Covered Person or his parent, spouse or legal guardian. The training must be successfully completed by the diabetic Covered Person and parent, spouse or legal guardian.

The provider must certify successful completion; and provide a written certification of such to the referring Physician and to Us. We will not pay benefits unless and until the provider provides certification that the Covered Person has successfully completed the diabetes self-management training.

The diabetes education process for self-management training must include the following standards:

- a. Needs Assessment. The health care provider must conduct an individualized educational needs assessment with the participation of the Covered Person, family, legal guardian, or support systems to be used in the development of the educational plan and interventions. The educational needs assessment shall include, but not be limited to, the following:
 - Health history;
 - Medical history;
 - Previous use of medication;
 - Diet history;
 - Current mental health status;
 - Use of health care delivery systems;
 - Life-style practices such as occupation, education, financial status, social and cultural and religious practices, health beliefs and attitudes or preventive behaviors;
 - Physical and psychological factors including age, mobility, visual acuity, manual dexterity, alertness, attention span, and ability to concentrate;
 - Barriers to learning such as education, literacy level, perceived learning needs, motivation to learn, and attitude;
 - Family and social support; and
 - Previous diabetes education, including actual knowledge and skills.
- b. Education Plan. The provider must develop a written education plan in collaboration with the Covered Person, his parent, spouse or legal guardian from information obtained in the needs assessment, including the following:
 - Desired patient outcomes;
 - Measurable, behaviorally-stated learner objectives; and
 - Instructional methods.
- c. Education Intervention. The provider must create an educational setting conducive to learning with adequate resources for space, teaching and audio-visual aids to facilitate the educational process. The provider must use a planned content outline. The content outline must be provided based on the needs assessment
- d. Evaluation of Learner Outcomes. The provider must review and evaluate the degree to which the Covered Person with diabetes is able to demonstrate diabetes self-management skills as identified by behavioral objectives.
- e. Plan for Follow-up for Continuing Learning Needs. The provider must review the educational plan and recommend any additional educational interventions to meet continuing learning needs.
- f. Documentation. The provider must maintain written files and thereby completely and accurately document the educational experiences provided, and communicate such to the referring Physician.

Diabetic equipment, supplies and appliances include the following which are prescribed by a Physician as Necessary Treatment of a Covered Person with diabetes:

- a. Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
- b. Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
- c. Test strips for glucose monitors, which include all test strips approved by the FDA, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
- d. Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method of monitoring.
- e. Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge.
- f. Injection aids, which include devices used to assist with insulin injection;
- g. Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
- h. Insulin pumps as prescribed by the Physician and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
- i. Oral agents for controlling the blood sugar level, which are prescription drugs;
- j. Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment.

For the purpose of this benefit:

"Diabetes Self-Management Training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalization and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

"Diabetes" means and includes Type 1, Type 2, or gestational diabetes, diabetes insipidus, and other specific types, and diabetes mellitus, a common chronic, serious systemic disorder of energy metabolism which includes a heterogeneous group of metabolic disorders which can be characterized by an elevated blood glucose level. The terms diabetes and diabetes mellitus are considered synonymous and defined to include Covered Persons using insulin and not using insulin and Covered Persons with elevated blood glucose levels induced by pregnancy, or Covered Persons with other medical conditions or medical therapies which wholly or partially consist of elevated blood glucose levels.

"Diabetes Educator or Health Care Provider" means only a person, licensed by and who has completed the Arkansas State Board's educational program that is in compliance with the National Standards for Diabetes Self-Management Educational Programs as developed by the American Diabetes Association, and only those duly certified to instruct in diabetes self-management.

3. Charges for amino acid modified preparations, low protein modified food products and formulas for therapeutic treatment of a Covered Person with phenylketonuria if:
 - a. The medical food or low protein modified food products are prescribed as Necessary Treatment for phenylketonuria;
 - b. The products are administered under the direction of a Physician; and
 - c. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year per person income tax credit allowed under Arkansas law.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry.

"Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per service and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

4. Charges for the Necessary Treatment for Loss or Impairment of Speech or Hearing. Covered Expenses for such treatment will be paid as they would for any other Sickness. No benefits will be paid for hearing instruments or devices.

"Loss or Impairment of Speech or Hearing" includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

5. [If a Prescription Benefit is shown in the Benefit Specifications, charges for any drug including the Necessary Treatment services associated with the administration of such drug to the extent they are covered expenses to treat the specific type of cancer for which the drug has been prescribed. Such drug must be:
 - a. Approved by the FDA;
 - b. Recognized as safe and effective for treatment of the specific type of cancer for which it was prescribed in any of the following standard reference compendia, unless the use is identified as not indicated in one or more such compendia:
 - the American Hospital Formulary Service drug information;
 - the United States Pharmacopoeia dispensing information; or
 - c. Recognized as safe and effective for treatment of the specific type of cancer in two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

We will not cover any drug that the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed.]

6. [If a Prescription Benefit is shown in the Benefit Specifications, charges for prescribed drugs or devices approved by the FDA for use as a contraceptive. If We use a Formulary, it shall include oral, implant, and injectible contraceptive drugs, intrauterine devices, and prescription barrier methods. Coverage is not provided for an abortion, an abortifacient or any FDA-approved emergency contraception.]

7. Charges for colorectal screenings for Covered Persons who are over fifty (50), or who are under fifty (50) and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines.

Persons defined to be at high risk include persons who: face high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; have a family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; have genetic alterations of hereditary nonpolyposis; have colon cancer or familial adenomatous polyposis; a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any additional or expanded definition of "persons at high risk for colorectal cancer" as recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests:

- a. An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- b. A double-contrast barium enema every five (5) years; or
- c. A colonoscopy every ten (10) years; and
- d. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, as determined in consultation with appropriate health care organizations.

The covered person shall determine the choice of screening strategies in consultation with a health care provider.

8. Charges for prostate cancer exams and lab tests for any male Covered Person forty (40) years of age or older in accordance with the National Comprehensive Cancer Guidelines. Coverage related to the examination and tests is covered the same as any Sickness under the Policy except that it is not subject to a Deductible.

If a medical practitioner recommends that the Covered Person undergo a prostate specific antigen blood test, coverage shall not be denied on the ground that the Covered Person has already had a digital rectal examination and the examination result was negative.

9. Charges up to a maximum of 80% of Medicare allowables as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System for:

- (A) An orthotic device;
- (B) An orthotic service;
- (C) A prosthetic device; and
- (D) A prosthetic service.

Coverage for an orthotic device, an orthotic service, a prosthetic device, or a prosthetic service for a replacement is limited to one every three years unless Medically Necessary or indicated by other coverage criteria.

The orthotic device, an orthotic service, a prosthetic device, or a prosthetic service must be prescribed by a licensed doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine and provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

10. Charges for the diagnosis and treatment of autism spectrum disorders. Such disorders include, but are not limited to, autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified in the current edition of the "Diagnostic and Statistical Manual of Mental Disorders."

The following additional benefits are added to the **List of Covered Expenses – Out-Patient** [and the **List of Covered Expenses – In-Patient** contained on the **In-Patient Hospital Expense Benefit Rider**, if included in the Benefit Specifications], subject to the same terms and conditions:

1. Charges for in vitro fertilization services, including cryopreservation, subject to the following:
 - a. Participants must be interspousal with respect to donor and recipient; and
 - b. There must be a documented two year history of unexplained infertility; or
 - c. Infertility is associated with one or more of the following conditions:
 - (1) Endometriosis;
 - (2) DES;
 - (3) Blockage or removal of one or both fallopian tubes not a result of voluntary sterilization;
 - (4) Contributing abnormal male factors.

Expenses incurred for in vitro fertilization services are covered to the same extent and subject to the same policy provisions as any other maternity related expenses. The Lifetime Maximum Benefit is \$15,000.

2. Charges for the following Out-Patient services provided they would be covered if performed on an In-Patient basis:
 - a. Laboratory and pathological tests, including machine tests, ordered by the attending Physician when necessary to and rendered in conjunction with the medical or surgical diagnosis or treatment of a Sickness or Injury.
 - b. Renal dialysis when ordered by the attending Physician for treatment of chronic renal disease. "Renal dialysis" is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semipermeable membrane, including hemodialysis and peritoneal dialysis.
3. Charges for anesthesia and hospitalization services or ambulatory surgical facility charges performed in connection with dental procedures when a treating provider certifies that the services are required to effectively perform the procedures and the patient is:

- a. under 7 years of age and it is determined by 2 dentists that treatment in a hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition; or
- b. a person with a serious diagnosed mental or physical condition; or
- c. a person with a significant behavioral problem as determined by the Covered Person's Physician.

This benefit does not apply to treatment rendered for temporomandibular joint disorders.

VIII. Termination of Insurance

The 31 day requirement for due proof of a child's incapacity is deleted. We will require notice of the child's incapacity and dependency. In no event, however, will this requirement preclude eligible Dependents regardless of age. If dependency or incapacity is removed or terminated the Insured Person must notify Us.

The **Extension of Benefits** provision is replaced with the following:

If an In-Patient Hospital Expense Benefit Rider and/or an In-Hospital Indemnity Benefit Rider is in force as shown on in the Benefit Specifications and the policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the policy will continue for any Covered Person who is Hospital confined on the date the policy ends. Continuation of such benefits are subject to all the terms and conditions of the policy, except those relating to termination of benefits. Such benefits will continue until the Hospital confinement ends or until the Maximum Benefit available under the policy are paid, whichever occurs first.

The following provision is added:

State Continuation of Coverage

If the Insured Person or the Insured Person's spouse, while insured, ceases to be eligible for insurance for medical care and treatment on a expense incurred basis for himself or herself and his or her Dependents because he or she is no longer a member of a class eligible for insurance he or she may continue such insurance.

An insured Dependent spouse, whose coverage would cease because of a change in marital status, may continue such coverage under the policy. The spouse may include any Dependent children whose insurance would cease as a result of the change in marital status. Continuation shall not be available to a Covered Person who is eligible for:

1. Federal Medicare coverage; or
2. Full coverage under any other group health plan. This coverage must provide benefits for all pre-existing conditions to be considered full coverage.

Continuation of coverage is available only to those who have been covered continuously under the policy during the 3 month period just prior to termination of membership or change in marital status.

If such person wants to continue coverage he or she must notify Us to that effect within 10 days after termination of membership or change in marital status. The notice must be in writing and the required premium paid when due. The premium shall be the total premium for such coverage including any portion thereof formerly paid by the Employer. Such coverage will cease on the earliest of:

1. A period of 120 days from the date insurance would have ceased;
2. The date the Insured Person qualifies for:
 - a. Medicare; or

- b. Other group coverage whether insured or uninsured;
3. The date the policy terminates;
4. Failure to make timely premium payments; or
5. The date the person chooses to use the Conversion Privilege.

IX. Conversion Privilege

The following is added:

If hospital and surgical insurance on an expense incurred basis stops because of termination of the policy, the right to convert such insurance is, nevertheless, available to such persons if:

1. The policy is not replaced by similar group coverage within 31 days;
2. The person is not eligible for Medicare coverage;
3. The person is not fully covered (i.e., all Pre-Existing Conditions are covered) under any other group medical policy or contract. Conversion will be allowed for a person not otherwise eligible for conversion under this provision until all Pre-Existing Conditions are covered or would be covered under another group policy or contract.

All other provisions and conditions of the conversion provision still apply.

[Item 2.b) under the Conversion Privilege on the **Term Life Insurance Rider**, if included in the Benefit Specifications, is amended to be \$10,000.00.]

XI. General Provisions

The **Time of Payment of Claims** provision is replaced with the following:

1. We shall pay or deny a Clean Claim within 30 days after We receive it if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.
2. We shall notify the claimant within 30 days after receipt of the claim if We determine that more information is needed to resolve one or more issues. Our notice shall give an explanation of the additional information that is required. We may suspend the claim until We receive the requested information. We shall reopen and pay or deny a previously suspended claim within 30 days after We receive all the information We requested.
3. If We fail to pay or deny a Clean Claim in accordance with item 1. above or give notice in accordance with item 2. above, We shall pay a penalty to the claimant for the period beginning on the sixty-first day after receipt of the Clean Claim and ending on the Clean Claim payment date (the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.
4. If We fail to pay or deny a claim in accordance with item 2. above which is not already subject to the penalty for the claim imposed by item 3. above, We shall pay a penalty to the claimant for the period beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period), calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.

“Clean Claim” means a claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by HIPAA, or on Our standard claim form with all required

fields completed in accordance with Our published claim filing requirements. A Clean Claim shall not include a claim: (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve one or more issues.

All provisions, definitions, limitations and conditions of the Policy, Certificate and attached Riders which are not inconsistent with these benefits apply to them.

Signed by:

A handwritten signature in cursive script that reads "Susan L. Cooper".

Corporate Secretary
Susan L. Cooper

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Mailing Address: 900 Cottage Grove Road
Hartford, CT 06152

OPTIONAL ARKANSAS ENDORSEMENT

This Endorsement is attached to and made a part of the Certificate provided under Group Policy [12345] issued by Connecticut General Life Insurance Company.

The Certificate and attached Riders are amended for Arkansas by the following:

If elected, the following optional benefits are added to the **List of Covered Expenses – Out-Patient**, subject to the same terms and conditions:

FOR SCREENING MAMMOGRAPHY

If this benefit is elected, Covered Expenses will include the following mammogram screening for occult breast cancer for women covered under the policy:

- A baseline mammogram for ages 35 to 40;
- A mammogram every one or two years based on the recommendation of a woman’s Physician for ages 40 to 49;
- A mammogram every year for ages 50 and over;
- Upon recommendation of a woman’s Physician, without regard to age, where such woman has had a prior history of breast cancer or where such woman’s mother or sister has had a history of breast cancer.

Benefits are limited to \$50 for each screening mammography, which includes payment of both the professional and technical components. In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

Benefits for screening mammography will not prejudice coverage under the policy for diagnostic mammography as recommended by a woman’s Physician.

"Screening Mammography" is a radiologic procedure provided to a woman who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two views of each breast and includes a Physician’s interpretation of results of the procedure.

"Diagnostic Mammography" is a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the Physician interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Physician to correlate the radiologic findings is often performed as part of the study.

Accepted by Policyholder Declined by Policyholder _____
Policyholder’s Signature

FOR HEARING AIDS

If this benefit is elected, Covered Expenses will include charges for a hearing aid or hearing instrument sold by a professional licensed by the state of Arkansas to dispense a hearing aid or hearing instrument. Coverage is limited to \$1,400 per ear for each three-year period and is not subject to Policy Deductibles or Co-payment requirements.

"Hearing aid" means an instrument or device, including repair and replacement parts, that:

- (A) Is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;
- (B) Is worn in or on the body; and
- (C) Is generally not useful to a person in the absence of a hearing impairment.

Accepted by Policyholder Declined by Policyholder _____
Policyholder's Signature

FOR HOSPICE CARE

If this benefit is elected, Covered Expenses will include charges for terminally ill patients for Hospice care and Hospice Programs on the same basis as any other Sickness under the Policy.

"Hospice" or "Hospice Program", as defined under Arkansas law, means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, and which employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. The care shall be available 24 hours a day, 7 days a week, and provided on the basis of need, regardless of ability to pay.

Accepted by Policyholder Declined by Policyholder _____
Policyholder's Signature

If elected, the following optional benefits are added to the **List of Covered Expenses – Out-Patient** [and the **List of Covered Expenses – In-Patient** contained on the **In-Patient Hospital Expense Benefit Rider**, if included in the Benefit Specifications], subject to the same terms and conditions:

FOR DIAGNOSIS AND TREATMENT OF MUSCULOSKELETAL DISORDERS OF BONE OR JOINT IN FACE, NECK OR HEAD

If this benefit is elected, Covered Expenses will include the Necessary Treatment and diagnosis of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect or pathology.

Rejection of this optional benefit means that temporomandibular joint disorders and craniomandibular disorders will NOT BE COVERED.

Accepted by Policyholder Declined by Policyholder _____
Policyholder's Signature

FOR TREATMENT OF ALCOHOL OR DRUG DEPENDENCY

If this benefit is elected, Covered Expenses will include the Necessary Treatment for a Covered Person with alcohol or drug dependency in a Hospital or an Alcohol and Drug Dependency Treatment Center.

Benefits for such treatment will be paid as they would for any other Sickness subject to the following limits for each Covered Person:

- A maximum of \$6,000 for each 24 month period;
- No more than \$3,000.00 will be paid in any 30 consecutive day period.
- A lifetime maximum of \$12,000 while insured under the policy.

For the purpose of this benefit:

An "Alcohol and Drug Dependency Treatment Center" is a public or private facility or unit of a facility engaged in providing 24 hour treatment for substance abuse, and which provides a program for treatment of such abuse pursuant to a written treatment plan approved and monitored by a Physician, properly licensed or accredited by the Department of Human Services/Office on Alcohol and Drug Abuse Prevention.

The facility or unit may be: a) within a Hospital or psychiatric hospital or attached to or be a freestanding unit of a general Hospital or psychiatric hospital; or b) a freestanding facility specializing in such treatment, but it does not include halfway houses or recovery farms.

"Alcohol or Drug Dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

___ Accepted by Policyholder ___ Declined by Policyholder _____
Policyholder's Signature

FOR TREATMENT OF MENTAL OR NERVOUS DISORDERS

If this benefit is elected, Covered Expenses will include the Necessary Treatment of mental or nervous disorders. Benefits for such treatment will be paid as they would for any other Sickness. All benefits are subject to the following:

1. Inpatient confinement including partial hospitalization must be in a Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Services, Division of Mental Health Services. Partial hospitalization means continuous treatment for at least 4 hours but not less than 16 hours in any 24 hour period.
2. Outpatient benefits will be provided for services furnished by a:
 - a. Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Service, Division of Mental Health Services;
 - b. Physician licensed under the Medical Practices Act;
 - c. licensed psychologist; or
 - d. community mental health center or other mental health clinic certified by the Department of Human Service, Division of Mental Health Services.

Benefits are limited for each Covered Person per calendar year to 8 inpatient/partial hospitalization days; and 40 outpatient visits.

Accepted by Policyholder Declined by Policyholder _____
Policyholder's Signature

All provisions, definitions, limitations and conditions of the Policy and Certificate which are not inconsistent with these benefits apply to them.

Signed by:

Susan L. Cooper

Corporate Secretary
Susan L. Cooper

SERFF Tracking Number: PLIS-127177619 State: Arkansas
 Filing Company: Connecticut General Life Insurance Company State Tracking Number: 49083
 Company Tracking Number: PPACA ENDORSEMENTS
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: PPACA Endorsements
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: readability.pdf	Approved-Closed	06/30/2011
Satisfied - Item: Application Comments: SBCII-APP-H-02 and SBCII-APP-02 both approved 7/18/06.	Approved-Closed	06/30/2011
Satisfied - Item: PPACA Uniform Compliance Summary Comments: Attachment: PPACA-UCS-AR.pdf	Approved-Closed	06/30/2011
Satisfied - Item: Cover Letter Comments: Attachment: cover letter.pdf	Approved-Closed	06/30/2011
Satisfied - Item: HHS Annual Limit Waiver	Approved-Closed	06/30/2011

SERFF Tracking Number: PLIS-127177619 State: Arkansas
 Filing Company: Connecticut General Life Insurance Company State Tracking Number: 49083
 Company Tracking Number: PPACA ENDORSEMENTS
 TOI: H15G Group Health - Hospital/Surgical/Medical Sub-TOI: H15G.002 Large Group Only
 Expense
 Product Name: PPACA Endorsements
 Project Name/Number: /

Comments:

Attachment:

HHS annual limit waiver.pdf

	Item Status:	Status
		Date:
Satisfied - Item: Red-line of State-Specific Endorsements	Approved-Closed	06/30/2011

Comments:

Attachments:

red-line 6-17-11 SBCII-ENDRS-10-AR.pdf
 red-line SBCII-OPT-10-AR.pdf

	Item Status:	Status
		Date:
Satisfied - Item: Explanation of Variable Material	Approved-Closed	06/30/2011

Comments:

Attachment:

explanation of variables.pdf

	Item Status:	Status
		Date:
Satisfied - Item: Authorization	Approved-Closed	06/30/2011

Comments:

Attachment:

CGLIC authorization.pdf

	Item Status:	Status
		Date:
Satisfied - Item: Previous Approval	Approved-Closed	06/30/2011

Comments:

Attachment:

previous approval.pdf

Connecticut General Life Insurance Company

READABILITY CERTIFICATION

The policy forms listed below have been Flesch scored. The following items were deleted before the scoring was done:

- (1) the name and address of the insurer;
- (2) the name, number and title of the policy form;
- (3) captions and subcaptions;
- (4) specification pages, schedules and tables; and
- (5) words that are defined in the policy forms.

<u>Form #</u>	<u>Flesch Score</u>
SBCII-ENDRS-PPACA-01-AR	50.3
SBCII-ENDRS-PPACA-02-AR	50.1
SBCII-ENDRS-10-AR	45.6
SBCII-OPT-10-AR	46.2



John M. Plisky
Consultant

June 17, 2011

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 H15G.002 Large Group Hospital/Surgical/Medical Expense	62308-046	PLIS-127177619	SBCII-GMP-02 et al. approved in Arkansas on 6/18/06.	<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
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	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 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:			
	Page Number: Grandfathered page 2 & Non-Grandfathered page 2			
	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>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If no , please explain.
	Explanation: Please see submitted HHS annual limit waiver.			
	Page Number: Grandfathered page 2 & Non-Grandfathered page 2			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 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:			
	Page Number: Grandfathered page 2 & Non-Grandfathered page 2			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of 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:			
	Page Number: Grandfathered page 2 & Non-Grandfathered page 2			

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 Explanation: Page Number: Non-Grandfathered page 2	<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.
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇ Explanation: Page Number: Grandfathered page 2 & Non-Grandfathered page 2	<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.
	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number: Non-Grandfathered page 3	<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.

◇ 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:</p> <p>Page Number: Non-Grandfathered page 3</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:</p> <p>Page Number: Non-Grandfathered page 3</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:</p> <p>Page Number: Non-Grandfathered page 3</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>

PLISKY PLISKY & CO. LLC

617 UNION AVENUE, UNIT 1-21 ♦ BRIELLE, NJ 08730 ♦ PHONE: (732) 223-0770 ♦ FAX: (732) 223-1776

June 17, 2011

Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

Re: Connecticut General Life Insurance Company
NAIC#: 62308-046 FEIN#: 06-0303370
H15G.002 Large Group Hospital/Surgical/Medical Expense

Policy Forms:

SBCII-ENDRS-PPACA-01-AR	PPACA Endorsement (Grandfathered)
SBCII-ENDRS-PPACA-02-AR	PPACA Endorsement (Non-Grandfathered)
SBCII-ENDRS-10-AR	Arkansas Endorsement
SBCII-OPT-10-AR	Optional Arkansas Endorsement

Dear Sir/Madam:

New Submission. This is a new submission of two PPACA Endorsements to be used with policy forms SBCII-GMP-02 et al. that were approved in Arkansas on July 18, 2006.

These policy forms are for issuance to a trustee group policyholder situated in Delaware. The trust documents were reviewed and filed when the base policy forms were approved.

Marketing is licensed agents and brokers to participating large employers with 51⁺ employees. These forms are new and do not replace any forms currently on file with your office.

Arkansas Endorsements. We have also taken this opportunity to update your state's mandated benefits on the Arkansas Endorsement and the Optional Arkansas Endorsement that are attached to certificates delivered to residents of your state.

To facilitate your review, we have included "red-line" versions that show all updates.

Variable Material. Variable material is shown in brackets. An *Explanation of Variable Material* has been included which explains the very limited use of variable material.

Flesch Test. A *Readability Certification* is attached indicating that these forms meet your state's minimum requirements.

Filing Authority. This filing is being made by Plisky Plisky & Co. LLC on behalf of Connecticut General Life Insurance Company. A letter of filing authorization is attached.

Sincerely,

A handwritten signature in black ink, appearing to read "J. M. Plisky". The signature is written in a cursive style with a large, sweeping initial "J" and "P".

John M. Plisky, Consultant



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: October 2010
From: Steve Larsen, Director, Office of Oversight *slh*
Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR § 147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning September 26, 2010. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR § 147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIOOversight@hhs.gov.

Arkansas Endorsement

This Endorsement is attached to and made a part of the Certificate provided under Group Policy [12345] issued by Connecticut General Life Insurance Company.

The Certificate is hereby amended for Arkansas by the following:

The following is added to the face page:

LIMITED HEALTH PLAN

V. Conditions and Effective Date

The provision **Effective Date of Health Insurance for Newborn or Adopted Children** is replaced with the following:

Effective Date of Health Insurance for Newborn or Adopted Children

A child born to the Insured Person or the Insured Person's insured dependent spouse is automatically insured as a Dependent. The effective date of insurance for the child will be the moment of birth. Coverage will be to the same extent as is provided for other covered Dependent children. Coverage includes:

1. The Necessary Care and Treatment of medically diagnosed congenital defects;
2. Birth abnormalities;
3. Prematurity;
4. Tests of any kind mandated by law; tests for hypothyroidism, phenylketonuria and galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants mandated by law;
5. Routine nursery care; and
6. Routine pediatric charges for a well newborn child for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

In the event additional premium is required for such child then the insurance will terminate 90 days from the date of birth unless written request to continue insurance is made to Us and the premium is paid within 90 days from the date of birth or before the next premium due date, whichever is later.

In the case of minor children under the Insured Person's charge, care and control for whom the Insured Person has filed a petition to adopt, coverage will be effective:

1. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
2. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage will be to the same extent as specified above. Any additional premium required for such child must be paid at the time application is made.

VI. Benefit Descriptions

Outpatient Medical Expense Benefit

The second paragraph is replaced with the following:

BENEFITS ARE PAYABLE AT THE APPLICABLE COINSURANCE PERCENTAGE AND ARE SUBJECT TO THE BENEFIT MAXIMUMS, DEDUCTIBLES AND CO-PAYMENTS STATED IN THE BENEFIT SPECIFICATIONS.

The following additional benefits are added to the **List of Covered Expenses – Out-Patient**, subject to the same terms and conditions:

1. Charges for Periodic Preventive Care Visits, provided by or under the supervision of a single Physician per visit, from the moment of birth through age 18 years. Periodic Preventive Care Visits include 20 visits at approximately the following intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.

Benefits for Periodic Preventive Care Visits, ~~(a) will be reimbursed at levels that will not exceed those established for the same services under the Medicaid program of the State of Arkansas; and (b) except for recommended immunization services,~~ are subject to any Deductible, Insured Percent, Maximum Benefit and Copayment amounts shown in the Benefit Specifications.

For the purpose of this benefit:

"Children's Preventive Health Care" means Physician-delivered or Physician-supervised services for a covered Dependent child from the moment of birth through 18 years of age. Periodic Preventive Care Visits include medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

"Periodic Preventive Care Visits" means routine tests and procedures for the purpose of detection of abnormalities or malfunctions of the bodily systems and parts according to accepted medical practices.

2. Charges for medical equipment, medical supplies, and diabetes self-management training solely for the management and treatment of diabetes.

Benefits for self-management training include one per lifetime training program per Covered Person with diabetes for Necessary Treatment provided by a health care provider upon certification by such provider giving the training that the Covered Person has successfully completed the training.

In addition to the one lifetime training program provided above, additional diabetes self-management training will be covered in the event that a Physician prescribes additional training and it is Necessary Treatment because of a significant change in the Covered Person's symptoms or conditions.

The provider or diabetes educator shall only provide diabetes self-management training within his scope of practice after having demonstrated expertise in diabetes care and treatment. The provider or diabetes educator may only provide such training after having completed an education training program required by his licensing board when such program is in compliance with the National Standards for Diabetes Self-Management Education Program, developed by the American Diabetes Association. The Physician must issue a written prescription ordering the training for the Covered Person or his parent, spouse or legal guardian. The training must be successfully completed by the diabetic Covered Person and parent, spouse or legal guardian.

The provider must certify successful completion; and provide a written certification of such to the referring Physician and to Us. We will not pay benefits unless and until the provider provides certification that the Covered Person has successfully completed the diabetes self-management training.

The diabetes education process for self-management training must include the following standards:

- a. Needs Assessment. The health care provider must conduct an individualized educational needs assessment with the participation of the Covered Person, family, legal guardian, or support systems to be used in the development of the educational plan and interventions. The educational needs assessment shall include, but not be limited to, the following:
 - Health history;
 - Medical history;
 - Previous use of medication;
 - Diet history;
 - Current mental health status;
 - Use of health care delivery systems;
 - Life-style practices such as occupation, education, financial status, social and cultural and religious practices, health beliefs and attitudes or preventive behaviors;
 - Physical and psychological factors including age, mobility, visual acuity, manual dexterity, alertness, attention span, and ability to concentrate;
 - Barriers to learning such as education, literacy level, perceived learning needs, motivation to learn, and attitude;
 - Family and social support; and
 - Previous diabetes education, including actual knowledge and skills.
- b. Education Plan. The provider must develop a written education plan in collaboration with the Covered Person, his parent, spouse or legal guardian from information obtained in the needs assessment, including the following:
 - Desired patient outcomes;
 - Measurable, behaviorally-stated learner objectives; and
 - Instructional methods.
- c. Education Intervention. The provider must create an educational setting conducive to learning with adequate resources for space, teaching and audio-visual aids to facilitate the educational process. The provider must use a planned content outline. The content outline must be provided based on the needs assessment
- d. Evaluation of Learner Outcomes. The provider must review and evaluate the degree to which the Covered Person with diabetes is able to demonstrate diabetes self-management skills as identified by behavioral objectives.
- e. Plan for Follow-up for Continuing Learning Needs. The provider must review the educational plan and recommend any additional educational interventions to meet continuing learning needs.
- f. Documentation. The provider must maintain written files and thereby completely and accurately document the educational experiences provided, and communicate such to the referring Physician.

Diabetic equipment, supplies and appliances include the following which are prescribed by a Physician as Necessary Treatment of a Covered Person with diabetes:

- a. Blood glucose monitors, which include all commercially available blood glucose monitors designed for patient use and for persons who have been diagnosed with diabetes;
- b. Blood glucose monitors for the legally blind, which include all commercially available blood glucose monitors designed for patient use with adaptive devices and for persons who are legally blind and have been diagnosed with diabetes;
- c. Test strips for glucose monitors, which include all test strips approved by the FDA, glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
- d. Visual reading and urine testing strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones. Urine test strips for glucose only are not acceptable as the sole method of monitoring.
- e. Insulin, which includes all commercially available insulin preparations including insulin analog preparations available in either vial or cartridge.
- f. Injection aids, which include devices used to assist with insulin injection;
- g. Syringes, which include insulin syringes, pen-like insulin injection devices, pen needles for pen-like insulin injection devices;
- h. Insulin pumps as prescribed by the Physician and appurtenances thereto, which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
- i. Oral agents for controlling the blood sugar level, which are prescription drugs;
- j. Podiatric appliances for prevention of complications associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment.

For the purpose of this benefit:

"Diabetes Self-Management Training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalization and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

"Diabetes" means and includes Type 1, Type 2, or gestational diabetes, diabetes insipidus, and other specific types, and diabetes mellitus, a common chronic, serious systemic disorder of energy metabolism which includes a heterogeneous group of metabolic disorders which can be characterized by an elevated blood glucose level. The terms diabetes and diabetes mellitus are considered synonymous and defined to include Covered Persons using insulin and not using insulin and Covered Persons with elevated blood glucose levels induced by pregnancy, or Covered Persons with other medical conditions or medical therapies which wholly or partially consist of elevated blood glucose levels.

"Diabetes Educator or Health Care Provider" means only a person, licensed by and who has completed the Arkansas State Board's educational program that is in compliance with the National Standards for Diabetes Self-Management Educational Programs as developed by the American Diabetes Association, and only those duly certified to instruct in diabetes self-management.

3. Charges for amino acid modified preparations, low protein modified food products and formulas for therapeutic treatment of a Covered Person with phenylketonuria if:
 - a. The medical food or low protein modified food products are prescribed as Necessary Treatment for phenylketonuria;
 - b. The products are administered under the direction of a Physician; and
 - c. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the \$2,400 per year per person income tax credit allowed under Arkansas law.

For purposes of this benefit:

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry.

"Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per service and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

4. Charges for the Necessary Treatment for Loss or Impairment of Speech or Hearing. Covered Expenses for such treatment will be paid as they would for any other Sickness. No benefits will be paid for hearing instruments or devices.

"Loss or Impairment of Speech or Hearing" includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology that fall within the scope of his area of certification.

5. [If a Prescription Benefit is shown in the Benefit Specifications, charges for any drug including the Necessary Treatment services associated with the administration of such drug to the extent they are covered expenses to treat the specific type of cancer for which the drug has been prescribed. Such drug must be:

- a. Approved by the FDA;
- b. Recognized as safe and effective for treatment of the specific type of cancer for which it was prescribed in any of the following standard reference compendia, unless the use is identified as not indicated in one or more such compendia:
 - the American Hospital Formulary Service drug information;
 - the United States Pharmacopoeia dispensing information; or
- c. Recognized as safe and effective for treatment of the specific type of cancer in two articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

We will not cover any drug that the FDA has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed.]

6. [If a Prescription Benefit is shown in the Benefit Specifications, charges for prescribed drugs or devices approved by the FDA for use as a contraceptive. If We use a Formulary, it shall include oral, implant, and injectible contraceptive drugs, intrauterine devices, and prescription barrier methods. Coverage is not provided for an abortion, an abortifacient or any FDA-approved emergency contraception.]

7. Charges for colorectal screenings for Covered Persons who are over fifty (50), or who are under fifty (50) and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines.

Persons defined to be at high risk include persons who: face high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; have a family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; have genetic alterations of hereditary nonpolyposis; have colon cancer or familial adenomatous polyposis; a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any additional or expanded definition of "persons at high risk for colorectal cancer" as recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests:

- a. An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
- b. A double-contrast barium enema every five (5) years; or
- c. A colonoscopy every ten (10) years; and
- d. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, as determined in consultation with appropriate health care organizations.

The covered person shall determine the choice of screening strategies in consultation with a health care provider.

8. Charges for prostate cancer exams and lab tests for any male Covered Person forty (40) years of age or older in accordance with the National Comprehensive Cancer Guidelines. Coverage related to the examination and tests is covered the same as any Sickness under the Policy except that it is not subject to a Deductible.

If a medical practitioner recommends that the Covered Person undergo a prostate specific antigen blood test, coverage shall not be denied on the ground that the Covered Person has already had a digital rectal examination and the examination result was negative.

9. Charges up to a maximum of 80% of Medicare allowables as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System for:

- (A) An orthotic device;
- (B) An orthotic service;
- (C) A prosthetic device; and
- (D) A prosthetic service.

Coverage for an orthotic device, an orthotic service, a prosthetic device, or a prosthetic service for a replacement is limited to one every three years unless Medically Necessary or indicated by other coverage criteria.

The orthotic device, an orthotic service, a prosthetic device, or a prosthetic service must be prescribed by a licensed doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine and provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

10. Charges for the diagnosis and treatment of autism spectrum disorders. Such disorders include, but are not limited to, autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified in the current edition of the "Diagnostic and Statistical Manual of Mental Disorders."

The following additional benefits are added to the **List of Covered Expenses – Out-Patient** [and the **List of Covered Expenses – In-Patient** contained on the **In-Patient Hospital Expense Benefit Rider**, if included in the Benefit Specifications], subject to the same terms and conditions:

1. Charges for in vitro fertilization services, including cryopreservation, subject to the following:
 - a. Participants must be interspousal with respect to donor and recipient; and
 - b. There must be a documented two year history of unexplained infertility; or
 - c. Infertility is associated with one or more of the following conditions:
 - (1) Endometriosis;
 - (2) DES;
 - (3) Blockage or removal of one or both fallopian tubes not a result of voluntary sterilization;
 - (4) Contributing abnormal male factors.

Expenses incurred for in vitro fertilization services are covered to the same extent and subject to the same policy provisions as any other maternity related expenses. The Lifetime Maximum Benefit is \$15,000.

2. Charges for the following Out-Patient services provided they would be covered if performed on an In-Patient basis:
 - a. Laboratory and pathological tests, including machine tests, ordered by the attending Physician when necessary to and rendered in conjunction with the medical or surgical diagnosis or treatment of a Sickness or Injury.
 - b. Renal dialysis when ordered by the attending Physician for treatment of chronic renal disease. "Renal dialysis" is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semipermeable membrane, including hemodialysis and peritoneal dialysis.

3. Charges for anesthesia and hospitalization services or ambulatory surgical facility charges performed in connection with dental procedures when a treating provider certifies that the services are required to effectively perform the procedures and the patient is:

- a. under 7 years of age and it is determined by 2 dentists that treatment in a hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition; or
- b. a person with a serious diagnosed mental or physical condition; or
- c. a person with a significant behavioral problem as determined by the Covered Person's Physician.

This benefit does not apply to treatment rendered for temporomandibular joint disorders.

VIII. Termination of Insurance

The 31 day requirement for due proof of a child's incapacity is deleted. We will require notice of the child's incapacity and dependency. In no event, however, will this requirement preclude eligible Dependents regardless of age. If dependency or incapacity is removed or terminated the Insured Person must notify Us.

The **Extension of Benefits** provision is replaced with the following:

If an In-Patient Hospital Expense Benefit Rider and/or an In-Hospital Indemnity Benefit Rider is in force as shown on in the Benefit Specifications and the policy ends and is replaced by a group health insurance plan issued by another insurer or self-funded health care plan, coverage under the policy will continue for any Covered Person who is Hospital confined on the date the policy ends. Continuation of such benefits are subject to all the terms and conditions of the policy, except those relating to termination of benefits. Such benefits will continue until the Hospital confinement ends or until the Maximum Benefit available under the policy are paid, whichever occurs first.

The following provision is added:

State Continuation of Coverage

If the Insured Person or the Insured Person's spouse, while insured, ceases to be eligible for insurance for medical care and treatment on an expense incurred basis for himself or herself and his or her Dependents because he or she is no longer a member of a class eligible for insurance he or she may continue such insurance.

An insured Dependent spouse, whose coverage would cease because of a change in marital status, may continue such coverage under the policy. The spouse may include any Dependent children whose insurance would cease as a result of the change in marital status. Continuation shall not be available to a Covered Person who is eligible for:

1. Federal Medicare coverage; or
2. Full coverage under any other group health plan. This coverage must provide benefits for all pre-existing conditions to be considered full coverage.

Continuation of coverage is available only to those who have been covered continuously under the policy during the 3 month period just prior to termination of membership or change in marital status.

If such person wants to continue coverage he or she must notify Us to that effect within 10 days after termination of membership or change in marital status. The notice must be in writing and the required premium paid when due. The premium shall be the total premium for such coverage including any portion thereof formerly paid by the Employer. Such coverage will cease on the earliest of:

1. A period of 120 days from the date insurance would have ceased;
2. The date the Insured Person qualifies for:
 - a. Medicare; or
 - b. Other group coverage whether insured or uninsured;
3. The date the policy terminates;
4. Failure to make timely premium payments; or
5. The date the person chooses to use the Conversion Privilege.

IX. Conversion Privilege

The following is added:

If hospital and surgical insurance on an expense incurred basis stops because of termination of the policy, the right to convert such insurance is, nevertheless, available to such persons if:

1. The policy is not replaced by similar group coverage within 31 days;
2. The person is not eligible for Medicare coverage;
3. The person is not fully covered (i.e., all Pre-Existing Conditions are covered) under any other group medical policy or contract. Conversion will be allowed for a person not otherwise eligible for conversion under this provision until all Pre-Existing Conditions are covered or would be covered under another group policy or contract.

All other provisions and conditions of the conversion provision still apply.

[Item 2.b) under the Conversion Privilege on the **Term Life Insurance Rider**, if included in the Benefit Specifications, is amended to be \$10,000.00.]

XI. General Provisions

The **Time of Payment of Claims** provision is replaced with the following:

1. We shall pay or deny a Clean Claim within 30 days after We receive it if the claim was submitted electronically, or within 45 days after receipt if the claim was submitted by other means.
2. We shall notify the claimant within 30 days after receipt of the claim if We determine that more information is needed to resolve one or more issues. Our notice shall give an explanation of the additional information that is required. We may suspend the claim until We receive the requested information. We shall reopen and pay or deny a previously suspended claim within 30 days after We receive all the information We requested.
3. If We fail to pay or deny a Clean Claim in accordance with item 1. above or give notice in accordance with item 2. above, We shall pay a penalty to the claimant for the period beginning on the sixty-first day after receipt of the Clean Claim and ending on the Clean Claim payment date (the delinquent payment period), calculated as follows: the amount of the Clean Claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.
4. If We fail to pay or deny a claim in accordance with item 2. above which is not already subject to the penalty for the claim imposed by item 3. above, We shall pay a penalty to the claimant for the period beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period), calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquent payment period, divided by 365. Such payment shall be paid without any action by the claimant.

“Clean Claim” means a claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by HIPAA, or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim shall not include a claim: (1) for payment of expenses incurred during a period of time for which premiums are delinquent; or (2) for which We need additional information in order to resolve one or more issues.

All provisions, definitions, limitations and conditions of the Policy, Certificate and attached Riders which are not inconsistent with these benefits apply to them.

Signed by:



Corporate Secretary
Susan L. Cooper

OPTIONAL ARKANSAS ENDORSEMENT

This Endorsement is attached to and made a part of the Certificate provided under Group Policy [12345] issued by Connecticut General Life Insurance Company.

The Certificate and attached Riders are amended for Arkansas by the following:

If elected, the following optional benefits are added to the **List of Covered Expenses – Out-Patient**, subject to the same terms and conditions:

FOR SCREENING MAMMOGRAPHY

If this benefit is elected, Covered Expenses will include the following mammogram screening for occult breast cancer for women covered under the policy:

- A baseline mammogram for ages 35 to 40;
- A mammogram every one or two years based on the recommendation of a woman’s Physician for ages 40 to 49;
- A mammogram every year for ages 50 and over;
- Upon recommendation of a woman’s Physician, without regard to age, where such woman has had a prior history of breast cancer or where such woman’s mother or sister has had a history of breast cancer.

Benefits are limited to \$50 for each screening mammography, which includes payment of both the professional and technical components. In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

Benefits for screening mammography will not prejudice coverage under the policy for diagnostic mammography as recommended by a woman’s Physician.

"Screening Mammography" is a radiologic procedure provided to a woman who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two views of each breast and includes a Physician’s interpretation of results of the procedure.

"Diagnostic Mammography" is a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the Physician interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Physician to correlate the radiologic findings is often performed as part of the study.

Accepted by Policyholder

Declined by Policyholder

Policyholder’s Signature

FOR HEARING AIDS

If this benefit is elected, Covered Expenses will include charges for a hearing aid or hearing instrument sold by a professional licensed by the state of Arkansas to dispense a hearing aid or hearing instrument. Coverage is limited to \$1,400 per ear for each three-year period and is not subject to Policy Deductibles or Co-payment requirements.

“Hearing aid” means an instrument or device, including repair and replacement parts, that:

(A) Is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;

(B) Is worn in or on the body; and

(C) Is generally not useful to a person in the absence of a hearing impairment.

Accepted by Policyholder

Declined by Policyholder

Policyholder’s Signature

FOR HOSPICE CARE

If this benefit is elected, Covered Expenses will include charges for terminally ill patients for Hospice care and Hospice Programs on the same basis as any other Sickness under the Policy.

“Hospice” or “Hospice Program”, as defined under Arkansas law, means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, and which employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. The care shall be available 24 hours a day, 7 days a week, and provided on the basis of need, regardless of ability to pay.

Accepted by Policyholder

Declined by Policyholder

Policyholder’s Signature

If elected, the following optional benefits are added to the **List of Covered Expenses – Out-Patient** [and the **List of Covered Expenses – In-Patient** contained on the **In-Patient Hospital Expense Benefit Rider**, if included in the Benefit Specifications], subject to the same terms and conditions:

{FOR DIAGNOSIS AND TREATMENT OF MUSCULOSKELETAL DISORDERS OF BONE OR JOINT IN FACE, NECK OR HEAD

If this benefit is elected, Covered Expenses will include the Necessary Treatment and diagnosis of musculoskeletal disorders affecting any bone or joint in the face, neck or head. This includes temporomandibular joint disorder and craniomandibular disorder. Treatment includes both surgical and nonsurgical procedures. Benefits are provided for these conditions whether they are the result of accident, trauma, congenital defect, developmental defect or pathology.

Rejection of this optional benefit means that temporomandibular joint disorders and craniomandibular disorders will NOT BE COVERED.}

Accepted by Policyholder

Declined by Policyholder

Policyholder’s Signature

{FOR TREATMENT OF ALCOHOL OR DRUG DEPENDENCY

If this benefit is elected, Covered Expenses will include the Necessary Treatment for a Covered Person with alcohol or drug dependency in a Hospital or an Alcohol and Drug Dependency Treatment Center.

Benefits for such treatment will be paid as they would for any other Sickness subject to the following limits for each Covered Person:

- A maximum of \$6,000 for each 24 month period;
- No more than \$3,000.00 will be paid in any 30 consecutive day period.
- A lifetime maximum of \$12,000 while insured under the policy.

For the purpose of this benefit:

An "Alcohol and Drug Dependency Treatment Center" is a public or private facility or unit of a facility engaged in providing 24 hour treatment for substance abuse, and which provides a program for treatment of such abuse pursuant to a written treatment plan approved and monitored by a Physician, properly licensed or accredited by the Department of Human Services/Office on Alcohol and Drug Abuse Prevention.

The facility or unit may be: a) within a Hospital or psychiatric hospital or attached to or be a freestanding unit of a general Hospital or psychiatric hospital; or b) a freestanding facility specializing in such treatment, but it does not include halfway houses or recovery farms.

"Alcohol or Drug Dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.}

Accepted by Policyholder

Declined by Policyholder

Policyholder's Signature

{FOR TREATMENT OF MENTAL OR NERVOUS DISORDERS

If this benefit is elected, Covered Expenses will include the Necessary Treatment of mental or nervous disorders. Benefits for such treatment will be paid as they would for any other Sickness. All benefits are subject to the following:

1. Inpatient confinement including partial hospitalization must be in a Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Services, Division of Mental Health Services. Partial hospitalization means continuous treatment for at least 4 hours but not less than 16 hours in any 24 hour period.
2. Outpatient benefits will be provided for services furnished by a:
 - a. Hospital, psychiatric hospital, outpatient psychiatric center licensed by the State Health Department or a community mental health center certified by the Department of Human Service, Division of Mental Health Services;
 - b. Physician licensed under the Medical Practices Act;
 - c. licensed psychologist; or

- d. community mental health center or other mental health clinic certified by the Department of Human Service, Division of Mental Health Services.

Benefits are limited for each Covered Person per calendar year to 8 inpatient/partial hospitalization days; and 40 outpatient visits.}

Accepted by Policyholder Declined by Policyholder Policyholder's Signature

All provisions, definitions, limitations and conditions of the Policy and Certificate which are not inconsistent with these benefits apply to them.

Signed by:



Corporate Secretary
Susan L. Cooper

Connecticut General Life Insurance Company

EXPLANATION OF VARIABLE MATERIAL

This is a supplement to the submission and provides an explanation as to the use of variable material. Variable material is signified by brackets throughout the rider and allows it to be tailored to the actual plan selected by the policyholder.

SBCII-ENDRS-PPACA-01-AR

Appropriate Group Policy # will be inserted.

The name of the department that will be handling calls regarding grandfathered plans will be inserted along with their phone number.

SBCII-ENDRS-PPACA-02-AR

Appropriate Group Policy # will be inserted.

SBCII-ENDRS-10-AR

SBCII-OPT-10-AR

Appropriate Group Policy # will be inserted.

Any mandated benefits/provisions that are bracketed because they are only required if certain benefits are included in the base Certificate will be in-or-out, meaning they will be included as shown when required or omitted entirely when not required.

Edmund J. Skowronek, Jr.
Director
State Filing
Legal & Public Affairs



January 21, 2011

**Re: Connecticut General Life Insurance Company
Bloomfield, Connecticut
NAIC Company ID#: 62308-046
NAIC Group #: 901
FEIN: 06-0303370**

Routing B6LPA
900 Cottage Grove Road
Hartford, CT 06152-1038
Telephone 860.226.6255
Facsimile 860.226.5400
edmund.skowronek@cigna.com

To Whom It May Concern:

Please be advised that until this authority is revoked in writing, John M. Plisky of Plisky Plisky & Co. LLC of Brielle, New Jersey are hereby authorized to act as our agent and to perform each and every act necessary in connection with the filing of policy forms and rate information on our behalf.

By: Edmund J. Skowronek, Jr.

Name: Edmund J. Skowronek, Jr.

Title: Director - State Filing

Date: 01/21/2011

June 30, 2006

Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RECEIVED

JUL - 7 2006

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Re: Connecticut General Life Insurance Company
NAIC#: 62308-046 FEIN#: 06-0303370
Group Policy Form SBCII-GMP-02 et al.

APPROVED
JUL 18 2006
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Dear Sir/Madam:

Submission. These group limited benefit health insurance policy forms will be issued to a group policyholder situated in Delaware called the Starbridge Employer Trust. Participating employer groups will be large employers (51+ employees).

This trust has already been registered in Arkansas during the review of a different policy form for another company (The MEGA Life and Health Insurance Company) which was approved November 5, 2002. Enclosed is a copy of the original Trust Agreement, Addendum and a new Exhibit Q which allows Connecticut General Life Insurance Company to be an insurer under the trust.

Submitted Materials. The forms in the attached *List of Forms* are submitted in final printed form for your review and approval. However, the certificate may be printed in booklet form (or other appropriate format) instead of as shown in this submission. This alternative will adhere to the same guidelines as required for the submitted forms and will not give undue prominence to any portion of the text. These forms are new and do not replace any forms currently on file in your state.

Arkansas Endorsements. Your state's mandated benefits are included on the enclosed Endorsement and Optional Endorsement which will be attached to certificates delivered to residents of your state.

Variable Material. Variable material is shown in brackets. An *Explanation of Variable Material* has been included which explains the very limited use of variable material.

Flesch Test. A *Readability Certification* is attached indicating that these forms meet your state's minimum requirements.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Mailing Address: 900 Cottage Grove Road
Hartford, CT 06152

Arkansas Endorsement

This Endorsement is attached to and made a part of the Certificate provided under Group Policy [12345] issued by Connecticut General Life Insurance Company.

The Certificate is hereby amended for Arkansas by the following:

The following is added to the face page:

LIMITED HEALTH PLAN

V. Conditions and Effective Date

The provision **Effective Date of Health Insurance for Newborn or Adopted Children** is replaced with the following:

Effective Date of Health Insurance for Newborn or Adopted Children

A child born to the Insured Person or the Insured Person's insured dependent spouse is automatically insured as a Dependent. The effective date of insurance for the child will be the moment of birth. Coverage will be to the same extent as is provided for other covered Dependent children. Coverage includes:

1. The Necessary Care and Treatment of medically diagnosed congenital defects;
2. Birth abnormalities;
3. Prematurity;
4. Tests of any kind mandated by law; tests for hypothyroidism, phenylketonuria and galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia, as well as any testing of newborn infants mandated by law;
5. Routine nursery care; and
6. Routine pediatric charges for a well newborn child for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

In the event additional premium is required for such child then the insurance will terminate 90 days from the date of birth unless written request to continue insurance is made to Us and the premium is paid within 90 days from the date of birth or before the next premium due date, whichever is later.

In the case of minor children under the Insured Person's charge, care and control for whom the Insured Person has filed a petition to adopt, coverage will be effective:

1. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
2. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage will be to the same extent as specified above. Any additional premium required for such child must be paid at the time application is made.

APPROVED
JUL 18 2006
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

**Mailing Address: 900 Cottage Grove Road
Hartford, CT 06152**

OPTIONAL ARKANSAS ENDORSEMENT

This Endorsement is attached to and made a part of the Certificate provided under Group Policy [12345] issued by Connecticut General Life Insurance Company.

The Certificate and attached Riders are amended for Arkansas by the following:

If elected, the following optional benefits are added to the **List of Covered Expenses – Out-Patient**, subject to the same terms and conditions:

[FOR SCREENING MAMMOGRAPHY

If this benefit is elected, Covered Expenses will include the following mammogram screening for occult breast cancer: for women covered under the policy:

- A baseline mammogram for ages 35 to 40;
- A mammogram every one or two years based on the recommendation of a woman's Physician for ages 40 to 49;
- A mammogram every year for ages 50 and over;
- Upon recommendation of a woman's Physician, without regard to age, where such woman has had a prior history of breast cancer or where such woman's mother or sister has had a history of breast cancer.

Benefits are limited to \$50 for each screening mammography, which includes payment of both the professional and technical components. In cases of Hospital outpatient screening mammography, and comparable situations, where professional services are billed separate from technical services, the professional component will not be less than 40% of the total fee.

Benefits for screening mammography will not prejudice coverage under the policy for diagnostic mammography as recommended by a woman's Physician.

"Screening Mammography" is a radiologic procedure provided to a woman who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two views of each breast and includes a Physician's interpretation of results of the procedure.

"Diagnostic Mammography" is a problem-solving radiologic procedure of higher intensity than screening mammography provided to women who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the Physician interpreting the study, and additional views are obtained as needed. Physical exam of the breast by the interpreting Physician to correlate the radiologic findings is often performed as part of the study.]

APPROVED

JUL 18 2006

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

**Mailing Address: 900 Cottage Grove Road
Hartford, CT 06152**

Policy Holder: [XYZ Trust Company,
Trustee for ABC Employers Trust]
Policy Number: [12345]
Policy Date: [July 1, 2006]
Anniversary Date: [July 1, of each year]

We agree to insure certain individuals and to pay the benefits provided by this Policy in accordance with its provisions.

This Policy is issued in consideration of statements made in the application and the payment of premiums by the Holder. A copy of the signed application will be attached and made a part of this Policy.

This Policy is effective on the Policy Date. The Policy Date will be the date of issue. The first Policy Year will end on the anniversary date shown above. Each Policy Year after that will end on the same date of each year. All periods will begin and end at 12:01 A.M. Standard Time at the Holder's main address.

Signed by:

Susan L. Cooper

Corporate Secretary
Susan L. Cooper

APPROVED
JUL 18 2006
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

**Group Insurance Policy
Renewable with the Consent of the Company**

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

**Mailing Address: 900 Cottage Grove Road
Hartford, CT 06152**

CERTIFICATE OF COVERAGE

Issued under the terms of

Group Insurance Policy Number: [12345]

Issued to: [DEF Company]

**a Participating Employer in the [ABC Employers Trust]
(herein called the Holder)**

Policy Date: [July 1, 2006]

Connecticut General Life Insurance Company hereby certifies that members of the class(es) eligible for insurance are insured under the above Policy as determined by the Eligibility and Effective Date provisions.

This Certificate and attached riders, if any, is evidence of insurance provided under the Policy. Applicable benefits are shown in the Benefit Specifications page. All benefits are paid according to the terms of the Policy. This Certificate and attached riders, if any, describes the essential features of the insurance coverage.

The male pronoun includes the female whenever used.

Signed by:

Susan L. Cooper

Corporate Secretary
Susan L. Cooper

APPROVED
JUL 18 2006
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

STARBRIDGE EMPLOYER TRUST

FILED
AUG 25 2005
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

THIS AGREEMENT, effective January 1, 2002, is made and entered into between the Participating Employers, herein collectively called "Trustor", and Wilmington Trust Company, hereinafter called "Trustee".

WITNESSETH:

WHEREAS, the Trustor has established a plan for providing group medical expense, life, disability and accidental death insurance for those Participants and Participating Employers that desire such coverage and who meet the requirements for obtaining such coverage; and

WHEREAS, the Trustor hereby desires to create and continue a Trust for such purposes; and

WHEREAS, Wilmington Trust Company has consented to act as Trustee in accordance with the provisions hereof;

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

ARTICLE I
GENERAL PROVISIONS

A. NAME OF TRUST

The Trust shall be known as the Starbridge Employer Trust.

B. DEFINITIONS

The following words as used in this Trust shall have the meaning indicated unless otherwise required by context:

1. Beneficiary -- Any person or persons designated by a Participant or the Policy to receive any benefits which may be payable under the provisions of such Policy.
2. Insurer -- The MEGA Life and Health Insurance Company, Oklahoma City, OK.