Colby College

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2013

ACMEM13A
3332414

This document printed in December, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a Cigna company (called CG)

ANNUAL COMPLIANCE RIDER

Policyholder: Colby College
Rider Eligibility: Each Employee
Policy No. or Nos. 3332414-OPIN

EFFECTIVE DATE: January 1, 2013

You will become insured on the date you become eligible, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service. (This provision will not apply to any retiree benefits you may be eligible for.)

This Annual Compliance Rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

This Annual Compliance Rider replaces any other Annual Compliance Rider issued to you on a prior date. The provisions set forth in this Annual Compliance Rider comply with legislative requirements of the State of Maine regarding group insurance plans covering insureds. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

READ THE FOLLOWING

NOTE: The provisions identified in this rider are specifically applicable ONLY for:

(a) Benefit plans which have been made available by your Employer to you and/or your Dependents;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

Shermona Mapp, Corporate Secretary
Patient Protection and Affordable Care Act Endorsement

The group contract or certificate is amended as stated below. In the event of a conflict between the provisions of your plan documents and the provisions of this endorsement, the provisions that provide the better benefit 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) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

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

“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

Any lifetime limit on the aggregate dollar value of essential health benefits is deleted. Any lifetime limits on the dollar value of any essential health benefits are deleted.

Annual Dollar Limits

Any annual limits on the dollar value of essential health benefits are deleted.

Rescissions

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

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 plan document which require a child to be unmarried, a student, financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond age 26, the provision and all restrictions 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 preventive care services described in the plan documents, no deductible, copayment, or coinsurance shall apply to the following Covered Services. However, the covered services must be provided by a Participating Provider:

1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;

2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

3. for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
Notice of Adverse Determination

In addition to the 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 Cigna. 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.

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

Emergency Services, as defined above, are covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a participating provider. Emergency Services, as defined above, provided by a Non-participating Provider will be covered as if the services were provided by a Participating Provider.

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

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

The “Pharmacy Exclusions” in your Medical certificate are amended as follows:

The following bullet regarding contraceptives, if included, is hereby removed:

- any prescription contraceptive drug or device upon request of a religious employer for which contraceptives are contrary to its religious tenets. This exclusion will not apply to contraceptives prescribed for reasons other than contraception or to preserve the health or life of the person insured;

The following bullets are revised to read:

- drugs available over the counter that do not require a prescription by federal or state law, unless state or federal law requires coverage of such drugs; and unless the drug is determined to be Medically Necessary;
- prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products, unless state or federal law requires coverage of such drugs.

The Schedule

The following provision replaces the “Assistant Surgeon” section of The Schedule shown in your medical certificate:

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon’s allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

The Schedule

The following provision replaces the “Co-Surgeon” section of The Schedule shown in your medical certificate:

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

The Schedule

The existing “Family Planning” provisions in your Medical Schedule are replaced with the following provisions:

Women’s Family Planning

Women’s Family Planning provisions will be covered at “No charge”.

In addition, the following note shall apply:

Note:
Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician’s office.

Men’s Family Planning

Men’s Family Planning provisions will be covered the same as any other illness.

The Schedule

If your pharmacy plan includes coinsurance, the following provision is added to The Schedule for Pharmacy Benefits in your certificate:

Charges

The term Charges means the amount charged by CG to the plan when the Pharmacy is a Participating Pharmacy. If your plan covers out-of-network pharmacy benefits, it also means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.
The Schedule
The following text is added to your Pharmacy Schedule:
Medications required as part of preventive care services (detailed information is available at www.healthcare.gov/center/regulations/prevention/recommendations.html) are covered at 100% with no copayment or deductible.

Medicare Eligibles
If your certificate contains Medicare Eligibles provisions in the Coordination of Benefits section, the following is added and applies to your medical coverage.

Domestic Partners
Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CG is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules explained above will apply.

Federal Requirements
The following Federal Requirements replace any such provisions shown in your Certificate.

Notice of Provider Directory/Networks
Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks
If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

Women’s Health and Cancer Rights Act (WHCRA)
Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.
Claim Determination Procedures under ERISA

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a “preservice medical necessity determination.” The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider’s network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider’s network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, CG will notify you or your representative within 15 days after receiving your request. However, if more time is needed due to matters beyond CG’s control, CG will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG’s Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. CG will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, CG will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to CG within 48 hours after receiving the notice. CG will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow CG’s procedures for requesting a required preservice medical necessity determination, CG will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG’s control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving...
the request. However, if more time is needed to make a
determination due to matters beyond CG’s control, CG will
notify you or your representative within 30 days after
receiving the request. This notice will include the date a
determination can be expected, which will be no more than 45
days after receipt of the request. If more time is needed
because necessary information is missing from the request, the
notice will also specify what information is needed, and you or
your representative must provide the specified information
within 45 days after receiving the notice. The determination
period will be suspended on the date CG sends such a notice
of missing information, and resume on the date you or your
representative responds to the notice.

**Notice of Adverse Determination**
Every notice of an adverse benefit determination will be
provided in writing or electronically, and will include all of
the following that pertain to the determination: information
sufficient to identify the claim; the specific reason or reasons
for the adverse determination; reference to the specific plan
provisions on which the determination is based; a description
of any additional material or information necessary to perfect
the claim and an explanation of why such material or
information is necessary; a description of the plan’s review
procedures and the time limits applicable, including a
statement of a claimant’s rights to bring a civil action under
section 502(a) of ERISA following an adverse benefit
determination on appeal; upon request and free of charge, a
copy of any internal rule, guideline, protocol or other similar
criterion that was relied upon in making the adverse
determination regarding your claim; and an explanation of the
scientific or clinical judgment for a determination that is based
on a Medical Necessity, experimental treatment or other
similar exclusion or limit; information about any office of
health insurance consumer assistance or ombudsman available
to assist you with the appeal process; and in the case of a
claim involving urgent care, a description of the expedited
review process applicable to such claim.

**Trade Act of 2002**
The Trade Act of 2002 created a new tax credit for certain
individuals who become eligible for trade adjustment
assistance and for certain retired Employees who are receiving
pension payments from the Pension Benefit Guaranty
Corporation (PBGC) (eligible individuals). Under the new tax
provisions, eligible individuals can either take a tax credit or
get advance payment of 72.5% of premiums paid for qualified
health insurance, including continuation coverage. If you have
questions about these new tax provisions, you may call the
Health Coverage Tax Credit Customer Contact Center toll-free
at 1-866-628-4282. TDD/TTY callers may call toll-free at 1-
866-626-4282. More information about the Trade Act is also