Colby College

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2013

ACMEM13B
3332414

This document printed in December, 2012 takes the place of any documents previously issued to you which described your benefits.
CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a Cigna company (called CG)

ANNUAL COMPLIANCE RIDER

No. ACMEM13B

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

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
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.

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

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

Any section entitled “Federal Tax Implications for Dependent Coverage” is considered to be omitted from your certificate.

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 of the determination within 15 days after receiving the 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 reviewer,
in consultation with the treating Physician, will decide if 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: 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 criterion that was relied upon in making the adverse
determination.

**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 available at www.doleta.gov/tradeact.