# University of New England

**ANNUAL COMPLIANCE RIDER**

**EFFECTIVE DATE: January 1, 2017**

ACMEM17
3332272

This document printed in December, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

*Home Office: Bloomfield, Connecticut*

*Mailing Address: Hartford, Connecticut 06152*

**CIGNA HEALTH AND LIFE INSURANCE COMPANY,** a Cigna company (hereinafter called Cigna)

**ANNUAL COMPLIANCE RIDER**

No. ACMEM17

Policyholder: University of New England

Rider Eligibility: Each Employee

Policy No. or Nos. 3332272-HSAF, HSAI, OPINB, OPINE

EFFECTIVE DATE: January 1, 2017

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. If you are not insured for the benefits described in your certificate on that date, the effective date of this annual compliance rider will be the date you become insured.

This Annual Compliance Rider forms a part of the certificate issued to you by Cigna 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:

- Benefit plans which have been made available by your Employer to you and/or your Dependents;
- Benefit plans for which you and/or your Dependents are eligible;
- Benefit plans which you have elected for you and/or your Dependents;
- Benefit plans which are currently effective for you and/or your Dependents.

*Anna Krishtul, Corporate Secretary*

# Important Notices

**Important Information**

**Mental Health Parity and Addiction Equity Act**

**The Certificate is amended as stated below:**

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

**The Schedule and Mental Health and Substance Abuse Covered Expenses:**

Partial Hospitalization charges for Mental Health and Substance Abuse will be paid at the Outpatient level. Covered Expenses are changed as follows:

**Mental Health and Substance Abuse Services**

**Mental Health Services** are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

**Substance Abuse** is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

**Inpatient Mental Health Services**

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

**Mental Health Residential Treatment Services** are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

**Mental Health Residential Treatment Center** means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

**Outpatient Mental Health Services** are Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, or for Partial Hospitalization sessions, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

**Partial Hospitalization** sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

**Inpatient Substance Abuse Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment services.

**Substance Abuse Residential Treatment Services** are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

**Substance Abuse Residential Treatment Center** means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

**Outpatient Substance Abuse Rehabilitation Services**

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive

Outpatient Therapy Program and for Partial Hospitalization sessions.

**Partial Hospitalization** sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

**Substance Abuse Detoxification Services**

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

**Mental Health and Substance Abuse Exclusions:**

The following exclusion is hereby deleted and no longer applies:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.

**Terms within the agreement:**

The term "mental retardation" within your Certificate is hereby changed to "intellectual disabilities".

**Visit Limits:**

Any health care service billed with a Mental Health or Substance Abuse diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation/counseling.

HC-NOT69 12-14

# Important Notices

The following **Notice** page concerning Discrimination is Against the Law is added to your medical certificate

**Discrimination is Against the Law**

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on your ID card or send an email to ACAGrievance@cigna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HC-NOT76 10-16

AC

# Important Notices

The following **Notice** page concerning Proficiency of Language Assistance Services is added to your medical certificate:

**Proficiency of Language Assistance Services**

**ATTENTION**: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1-800-244-6224 (TTY: Dial 711).

Spanish

**ATENCIÓN:** tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1-800-244-6224 (los usuarios de TTY deben llamar al 711).

Chinese

**注意：**我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1-800-244-6224（聽障專線：請撥 711）。

Vietnamese

**CHÚ Ý:** Có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Dành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

주의**:** 언어 지원 서비스를 비용없이 이용하실 수 있습니다. 기존 Cigna 가입자의 경우, 가입자 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 아니면 1-800-244-6224번으로 연락해 **주십시오**(TTY: 711번으로 전화).

Tagalog

**PAUNAWA:** Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1-800-244-6224 (TTY: I-dial ang 711).

Russian

**ВНИМАНИЕ:** вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1-800-244-6224 (TTY: 711).

Arabic

برجاء الانتباة خدمات الترجمة المجانية متاحة لكم.لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1-800-244-6224(TTY: اتصل ب 711).

French Creole

**ATANSYON:** Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1-800-244-6224 (TTY: Rele 711).

French

**ATTENTION :** des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1-800-244-6224 (ATS : composez le numéro 711).

Portuguese

**ATENÇÃO:** Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1-800-244-6224 (Dispositivos TTY: marque 711).

Polish

**UWAGA:** W celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1-800-244-6224 (TTY: wybierz 711).

Japanese

**お知らせ：**無料の日本語サポートサービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号におかけ下さい。その他の方は、1-800-244-6224におかけください。（文字電話: 番号711）。

Italian

**ATTENZIONE:** sono disponibili servizi di assistenza linguistica gratuiti. Per i clientI Cigna attuali, chiamare il numero sul retro della tessera ID. In caso contrario, chiamare il numero 1-800-244-6224 (utenti TTY: chiamare il numero 711).

German

**Achtung:** Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Für gegenwärtige Cigna-Kunden, Bitte rufen Sie die Nummer auf der Rückseite Ihres Personalausweises. Sonst, rufen Sie 1-800-244-6224 (TTY: Wählen Sie 711).

Persian (Farsi)

**توجه**: خدمات کمکی زبان، رایگان در دسترس شما است. **برای مشتریان فعلی** Cigna، لطفا با شماره ای که در پشت کارت شناسایی شما است تماس بگیرید. **در غیر اینصورت، با شماره** 1-800-244-6224 **تماس بگیرید** (TTY: 711 را شماره گیری کنید).

HC-NOT77 10-16 AC

## Certification Requirements – Out-of-Network

The following replaces any existing bullet regarding a registered bed patient in the **Pre-Admission Certification/Continued Stay Review for Hospital Confinement** section of your medical certificate when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;

HC-PAC14 11-14
V2 AC

## Certification Requirements – Out-of-Network

The following replaces any existing similar paragraphs regarding Covered Expenses incurred in the **Pre-Admission Certification/Continued Stay Review for Hospital Confinement** section of your medical certificate:

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

The following replaces any existing similar paragraphs regarding Covered Expenses incurred in the **Outpatient Certification Requirements - Out-of-Network** section of your medical certificate:

**Outpatient Certification Requirements – Out-of-Network**

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

HC-PAC27 01-15
V1 AC

## Prior Authorization/Pre-Authorized

The following replaces any existing bullet regarding inpatient Hospital services in the **Prior Authorization/Pre-Authorized** section of your medical certificate for services that require Prior Authorization:

- inpatient Hospital services, except for 48/96 hour maternity stays;

HC-PRA5 11-14
V3 AC

## Covered Expenses

The paragraph regarding Hearing Aids shown in the **Covered Expenses** section of your medical certificate is replaced with the following:

- charges made for the purchase of a hearing aid for each ear, every 36 months (not subject to plan deductible or coinsurance) for children through age 18 as shown in The Schedule. The plan deductible and coinsurance can be applied to the services necessary to assess, select, and fit the hearing aid for each hearing-impaired ear, in accordance with the following requirements:
  - The hearing loss must be documented by a Physician or a licensed audiologist.
  - The hearing aid must be purchased from a licensed audiologist or a licensed hearing aid dealer.

HC-COV109 04-10
V2 AC

# Exclusions, Expenses Not Covered and General Limitations

The bullet regarding an Institutional Review Board under the experimental, investigational or unproven services exclusion found in the **Exclusions, Expenses Not Covered and General Limitations** section of your medical certificate is revised as follows:

- the subject of review or approval by an Institutional Review Board for the proposed use except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

HC-EXC34 10-13
V2 AC

## The Schedule

If you are enrolled in a medical plan with In- and Out-of-Network features and subject to Out-of-Pocket maximums, the following provision is added to **The Schedule** shown in your medical certificate:

**Out-of-Pocket Expenses – For In-Network Charges Only**
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. When the Out-of-Pocket Maximum shown in The Schedule is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

In addition, any existing "Out-of-Pocket Expenses" heading in **The Schedule** of your In- and Out-of-Network medical certificate is revised to read as follows:

**Out of Pocket Expenses – For Out-of-Network Charges Only**

SCHED AC4

## The Schedule

If you are enrolled in a Comprehensive medical plan or an In-Network only medical plan and subject to Out-of-Pocket maximums, the following provision is added to **The Schedule** shown in your medical certificate:

**Out-of-Pocket Expenses**
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. When the Out-of-Pocket Maximum shown in The Schedule is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

In addition, any existing "Out-of-Pocket Expenses" paragraph in **The Schedule** of your Comprehensive medical plan or In-Network only medical plan certificate is hereby removed.

SCHED AC5

## The Schedule

If **The Schedule** in your medical certificate contains an entry for "Rx cap contribution to the combined Medical/Pharmacy Out-of-Pocket Maximum" the text for "Option 2" found in that section is replaced as follows:

Option 2: Pharmacy paid at Pharmacy Program levels until the total Out-of-Pocket Maximum has been met, then paid at 100% for In-Network charges.

SCHED AC8

## The Schedule

If you are enrolled in a medical plan which is subject to Health Care Reform, any "Early Intervention Services" dollar maximum shown in **The Schedule** of your medical certificate no longer applies and is hereby NULL and VOID.

SCHED AC28

## The Schedule

If you are enrolled in a medical plan which is subject to Health Care Reform, any dollar maximum shown in the "Hearing Aid Maximum" entry of **The Schedule** of your medical certificate no longer applies and is hereby NULL and VOID.

SCHED AC27

## The Schedule

The following paragraph, if included in your **Pharmacy Schedule**, is hereby revised to read as follows:

**Out-of-Pocket Expenses**
Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drugs and Related Supplies for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits are payable at 100%.

SCHEDPHARM AC4

## The Schedule

The following paragraph, found in your **Pharmacy Schedule**, is hereby revised to read as follows:

Certain medications covered under this plan and required as part of preventive care services (detailed information is

available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Participating Pharmacy. A written prescription is required.

SCHEDPHARM AC8

## Exclusions, Expenses Not Covered and General Limitations

The following exclusion regarding "transsexual surgery" under the **Exclusions, Expenses Not Covered and General Limitations** section of your medical certificate is hereby NULL and VOID:

- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

HC-EXC228 10-16 AC

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.

HC-FED1 10-10 AC

## Notice of Provider Directory/Networks

**Notice Regarding Provider Directories and Provider Networks**

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

**Notice Regarding Pharmacy Directories and Pharmacy Networks**

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 10-10 AC

## Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.

HC-FED71 12-14
AC

## Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

**Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.**

HC-FED71 12-14
V1 AC

## Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

### A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

### B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

### C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

### D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

### E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

### F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

### G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

**H. Enrollment in Qualified Health Plan (QHP)**

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70 12-14
AC1

## Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14
AC

## 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.

HC-FED12 10-10
AC

## Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)

Any Pre-existing Condition Limitation under this plan will no longer be imposed.

HC-FED32 04-11
AC1

## Obtaining a Certificate of Creditable Coverage Under This Plan

The section entitled "Obtaining a Certificate of Creditable Coverage Under This Plan" shown under the **Federal Requirements** provision of your medical certificate is hereby removed.

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your Dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

HC-FED15 10-10
AC

## Claim Determination Procedures under ERISA

**The following complies with federal law. Provisions of applicable 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 a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in

the booklet, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, 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 as applicable, and in the determination notices.

**Preservice Determinations**

When you or your representative requests a required prior authorization, Cigna 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 Cigna's control, Cigna 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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna 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 health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna 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, Cigna 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 Cigna within 48 hours after receiving the notice. Cigna 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 Cigna's procedures for requesting a required preservice determination, Cigna 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 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 coverage 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, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

**Postservice Determinations**

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna 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 Cigna's control, Cigna 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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will 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 including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; 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, (if applicable); 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; a description of any available internal appeal and/or external review process(es); 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.

HC-FED79 03-13
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## COBRA Continuation Rights Under Federal Law

### For You and Your Dependents

### Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

HC-FED54 12-13
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## COBRA Continuation Rights Under Federal Law

### For You and Your Dependents

The following paragraphs regarding the "Trade Act of 2002" are hereby rendered NULL and VOID:

### 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/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

HC-FED66 07-14
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## Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be

appropriate based upon the individual meeting the conditions described in paragraph (a); or

- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, device, item, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

HC-FED53 10-13
AC

## ERISA Required Information

The following bullet under "**C**ontinue Group Health Plan Coverage" section found under the **ERISA Required Information** provision in your certificate is being amended to read as follows:

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

The following paragraph under "Enforce Your Rights" section found under the **ERISA Required Information** provision in your certificate is being amended to read as follows:

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

HC-FED72 05-15
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## ERISA Required Information

The following paragraph is being removed from the "Continue Group Health Plan Coverage" section found under the **ERISA Required Information** provision of your medical certificate:

- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of

creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

HC-FED68 08-14
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