University Corporation for Atmospheric Research

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2013

ACASOM13
3153744

This document printed in April, 2013 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna)

ANNUAL COMPLIANCE RIDER

No. ACASOM13

Policyholder: University Corporation for Atmospheric Research

Rider Eligibility: Each Employee

Policy No. or Nos. 3153744-HDHP

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. 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 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 Krishul, Corporate Secretary
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. 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.
How To File Your Claim
The following paragraph replaces the “Timely Filing” section shown under How To File Your Claim in your medical certificate:

Timely Filing of Out-of-Network Claims
Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

The Schedule
The following note is added to the “Preventive Care” section in your Medical Schedule:

Preventive Care
Note:
Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.

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 following provision replaces the “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-Network.
Out-of-Network Women’s Family Planning provisions will be covered the same as any other illness Out-of-Network.
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
The following provision is added to your Medical Schedule and covered In-Network at “No charge”; Out-of-Network is covered subject to the Out-of-Network coinsurance and plan deductible (if applicable):

Breast Feeding Equipment and Supplies
Note:
Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.
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.

Prescription Drug Benefits
The following text is added to the Prescription Drug Benefits section of your medical certificate shown under “Your Payments”:

Your Payments
In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the plan to the Pharmacy, or the Pharmacy’s Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer’s payment source.

Exclusions
The “Pharmacy Exclusions” in your Medical certificate are amended as follows:
The following bullet regarding contraceptives, if included, is hereby removed:
• contraceptive drugs, and prescription appliances for contraception;

Medicare Eligibles
If your certificate contains Medicare Eligibles provisions in the Coordination of Benefits section and covers Domestic Partners, 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 coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules explained above will apply.

Termination of Insurance
The following text is added to the Termination of Insurance section of your certificate:

Termination of Insurance - Rescissions
Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless 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 the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Definitions
If the plan includes Dependent coverage, any references to a “child who lives with you” shown in the definition of Dependent in your medical certificate are hereby removed.

Definitions
The following definition of Essential Health Benefits is hereby added to your certificate under the Definitions section:

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

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

Definitions

The following definition of Patient Protection and Affordable Care Act of 2010 ("PPACA") is hereby added to the Definitions section of your certificate:

Patient Protection and Affordable Care Act of 2010 ("PPACA")

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

Definitions

The following definition of Stabilize is hereby added to the Definitions section of your certificate:

Stabilize

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

Federal Requirements

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.

COBRA Continuation Rights Under Federal Law

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.
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, 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 Physician 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’s Physician will defer to the determination of the treating Physician, 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 medical necessity 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 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, Cigna 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, 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.

**Postservice Claim Determinations**

When you or your representative requests payment for services which have been rendered, Cigna 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 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 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.

Medical - When You Have a Complaint or an Appeal

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

“Physician Reviewers” are licensed Physicians depending on the care, service or treatment under review.

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

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal

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

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

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

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

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

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal. Requests for a level-two appeal regarding the medical necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician reviewer. You may present your situation to the Committee in person or by conference call.
For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the Committee’s decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the Committee’s decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee’s decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna’s level-two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant’s rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna’s level-two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna’s Physician reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

**Notice of Benefit Determination on Appeal**

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

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

**Relevant Information**

Relevant information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
Legal Action
If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.