Monroe Board of Education

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2013

ACCTMSURR13
3333054

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.

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

a Cigna company (called CG)

ANNUAL COMPLIANCE RIDER

No. ACCTMSURR13

Policyholder: Monroe Board of Education

Rider Eligibility: Each Eligible Person

Policy No. or Nos. 3333054-MEDG1

EFFECTIVE DATE: January 1, 2013

You will become insured on the date you become eligible, if you are in a class of Eligible Persons on that date.

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 provision set forth in this Annual Compliance Rider comply with legislative requirements of the State of Connecticut 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

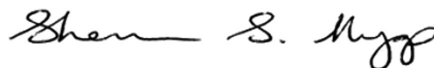
NOTE: The provisions identified in this rider are specifically applicable ONLY for:

(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

The following provisions will apply to the **Certificate Rider** for the state of Connecticut that is part of your certificate.

The following bullets for "Autism Spectrum Disorders", "Hypodermic Needles or Syringes", "Anesthesia for Dental Procedures", "Pain Management", "Lyme Disease", "Ostomy Supplies" and "Accidental Consumption of a Controlled Drug" are added to the **Covered Expenses** section of your certificate rider:

- charges made for physical therapy, speech therapy and occupational therapy services for the treatment of autism spectrum disorders, as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders."

  Such services are available in connection with treatment for autism spectrum disorders to the same extent that such services are available for other conditions covered under the plan.
- Charges for hypodermic needles or syringes prescribed by a practitioner, for the purposes of administering medication for medical conditions, provided that the medications are covered under the plan.
- Coverage for general anesthesia, nursing and related hospital services provided in conjunction with inpatient, outpatient or one-day dental services shall be provided if: (a) the services are deemed medically necessary by the treating dentist or oral surgeon and the insured's Primary Care Physician (if election of a Primary Care Physician is required under the plan); and (b) the patient is either:
  - determined by a dentist, in conjunction with a Primary Care Physician (if election of a Primary Care Physician is required under the plan) to have a dental condition that requires procedures performed in a hospital; or
  - a person who has a developmental disability determined by the Primary Care Physician (if election of a Primary Care Physician is required under the plan) to place the person at serious risk.
- charges for pain treatment procedures and medications, including all means medically necessary to make a diagnosis and treatment plan. Such procedures or medications must be ordered by a pain management specialist Physician who is credentialed by the American Academy of Pain Management or who is a board certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management. Pain means any sensation in which a person experiences severe discomfort, distress or suffering due to provocation.
- for treatment of Lyme disease to include 30 days of intravenous antibiotic therapy and 60 days of oral antibiotic therapy. Further treatment will be covered if recommended by a board certified rheumatologist, infectious disease specialist or neurologist;
- Medically Necessary appliances and supplies related to an ostomy; colostomy; ileostomy; or urostomy surgery, such as collection devices, irrigation equipment and supplies, skin barriers, and skin protectors;
- charges made for emergency medical care arising from accidental ingestion or consumption of a controlled drug for at least: (1) thirty days in any calendar year for confinement as an inpatient in a hospital; and (2) $500 per calendar year for expenses incurred outside a hospital.

If your plan covers Part B expenses, the following bullets for "Specialized Formulas", "Colonoscopy", "Prostate-specific Antigens", "Epidermolysis Bullosa", and "Contraceptive Drugs, Devices and Supplies" are added to the **Covered Expenses** section of your certificate rider:

- charges for specialized formulas for children up to age twelve who are entitled to Medicare by reason of disability, when Medically Necessary for treatment of a specific disease or condition and administered under the supervision of a Physician. Specialized formula means nutritional formula for children up to age twelve, who are entitled to Medicare by reason of disability, that is exempt from FDA nutritional labeling requirements and is intended for use solely under medical supervision in the dietary management of specific diseases.
- Covered screening shall include, but not be limited to: (1) an annual fecal occult blood test; (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with American Collage of Gastroenterology recommendations after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.
- For laboratory and diagnostic tests including prostate-specific antigen (PSA) tests to screen for prostate cancer for men who are asymptomatic, but whose biological father or brother has been diagnosed with prostate cancer and for all men age fifty and over.
- Charges made for Medically Necessary wound-care supplies for the treatment of epidermolysis bullosa when administered under the direction of a Physician.
- For prescription contraception methods approved by the U.S. Food and Drug Administration, including prescription drugs and devices.

The section of your certificate rider entitled **Medical Benefits Extension** is replaced with the following:

Medical Benefits Extension for Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent are hospital or facility confined on that date due to an Injury or Sickness covered by the policy, Medical Benefits will be paid for covered professional services, supplies and facility charge expenses incurred in connection with the confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are discharged from the hospital or facility in which you are confined on the policy cancellation date;
- 12 months from the date the policy is canceled.

Claim for coverage must be submitted within one year of the policy cancellation.

The section of your certificate rider entitled **When You Have a Complaint or an Appeal** is replaced with the following:

The Following Will Apply to Residents of Connecticut

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; and "Physician reviewers" are licensed Physicians depending on the care, treatment or service 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, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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 can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing 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 to register your appeal by telephone. Call or write to us at the toll-free number or address 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 Physician in the field related to the care under consideration, under the authority of a Connecticut licensed practitioner.

For level one appeals, we will respond in writing to you or your representative and the provider of record with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). If more time or information is needed to make a preservice or concurrent coverage 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 function 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. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision to you and your representative or provider within the lesser of: (a) 72 hours after the appeal is received or (b) two working days after the required information is received, followed up in writing.

For level one appeals, we will respond in writing to you or your representative and the provider of record with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

For postservice claim or administrative appeals, your request must be received before the 14th calendar day following our certified mailing of the level one determination. All postservice claim or administrative appeals will be reviewed and the decision made by someone who was not involved in either the initial or level one appeal decision.

Most requests for second reviews of Medical Necessity or clinical appropriateness issues will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. The Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your level two postservice claim or administrative appeal. For level two appeals involving Medical Necessity, we will write to you to schedule a Committee review.

If the level two appeal involves preservice and concurrent care coverage determinations, the level two review will be completed within 15 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 to complete the review.

For postservice claim or administrative appeals, the level two appeal review will be completed no later than 60 calendar days after receipt of your original level one request for appeal, unless you request an extension. If we receive a request for a level two postservice claim appeal on or after the 14th calendar day following our certified mailing of the level one determination: (a) it will be deemed as a request by you for an extension; and (b) the 60-day review period will be suspended on the 14th day we receive no level two appeal, then resume on the day we receive your level two appeal.

You or your representative and the provider of record will be notified in writing of the level two appeal review decision within five business days after the decision is made, and within the Committee review time frames above if the requested coverage is not approved.

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 function 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. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond to you and your representative or provider orally with a decision within the lesser of: (a) 72 hours after the appeal is received or (b) 2 working days after the required information is received, followed up in writing.

Appeal to the State of Connecticut

If you are dissatisfied with the decision of CG's level two appeals review regarding Medical Necessity or clinical appropriateness, you, or your provider with your consent, may file a written appeal for review with the State of Connecticut, within 60 days of receipt of the final denial letter. External appeals must be submitted within 60 days of receipt of the final denial letter on a prescribed state form with fee of $25, which is refundable to the prevailing party upon completion of a full review and which may be waived in cases of financial hardship. Your submission must also include an executed medical release form, an evidence of coverage, and evidence that the internal appeal process was exhausted.

The Connecticut Insurance Department will assign an impartial external review entity to make a determination within 30 days (or longer, if a review extension is granted by the Department and communicated to you). The external review decision is binding on CG.

The external review program is a voluntary program.

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: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) a statement describing: (a) the procedures to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant's right to bring an action under ERISA section 502(a); (5) 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.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the level two appeal decision (or with the level one appeal decision if expedited). 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.

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Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or 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 CG 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.

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Accident and Health Provisions

The section entitled "Physical Examination" under the **Accident and Health Provisions** section in your medical certificate is replaced as follows:

Claims

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

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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.

All references in this section to "Employee" shall be deemed to mean "Eligible Person".

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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.

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Eligibility for Medicare

This plan will assume the amount payable under Part A and/or Part B of Medicare for a person who is eligible for but is not currently enrolled in that Part(s), or Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract. A person is considered to be eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

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