

**CONNECTICARE, INC.
AND
CONNECTICARE INSURANCE COMPANY, INC.
GROUP AMENDATORY RIDER
FOR JANUARY, 2012**

For the purposes of this Rider, the Plan and Membership Agreement or Certificate of Coverage (“**member document**”), including any applicable Riders, are amended as described herein.

This Rider is to be attached to and form a part in your member document, including any applicable Riders. All the terms and conditions in your member document and applicable Riders apply to the benefits and administration of coverage described in this Rider.

This Rider is not available to any person who does not have coverage under the Plan.

This Rider is effective as noted.
--

CCI and CICI/ARider GRP 01 (1/2012)

Approved for use for 2012

s:\gmas\cci and cici group ariders\2012\cci cici group amendatory rider for january 2012-v2.doc

TABLE OF CONTENTS

ELIGIBILITY AND ENROLLMENT	2
ELIGIBILITY RULES	2
<i>General Rules</i>	2
<i>Adding New Children</i>	3
MANAGED CARE RULES AND GUIDELINES	3
SERVICES REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION	3
COST-SHARES YOU ARE REQUIRED TO PAY	7
<i>Copayments</i>	7
<i>Maximums And 90 Day Lookback Period</i>	8
Coinsurance Maximums	8
HMO Plan Coinsurance Maximum.....	8
POS Plan Coinsurance Maximums	8
In-Network Level Of Benefits Coinsurance Maximum	8
Out-Of-Network Level Of Benefits Coinsurance Maximum	8
Combination In-Network and Out-of-Network Level Of Benefits Coinsurance Maximum	9
Cost-Share Maximums	9
HMO Plan Cost-Share Maximum	9
POS Plan Cost-Share Maximums	9
In-Network Level Of Benefits Cost-Share Maximum	9
Out-Of-Network Level Of Benefits Cost-Share Maximum	10
Combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum	10
INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE	10
BENEFITS	11
PREVENTIVE SERVICES	11
<i>Adult Preventive Care Services</i>	11
<i>Infant/Pediatric Preventive Care Services</i>	11
<i>Blood Lead Screening And Risk Assessments</i>	11
Lead Screenings:	11
Risk Assessments:	11
<i>Gynecological Preventive Exam Office Services</i>	11
Cervical Cancer Screening	11
<i>Mammogram Screenings</i>	11
<i>Routine Vision Exams</i>	12
OTHER PREVENTIVE SERVICES	12
<i>Colorectal Cancer Screenings</i>	12
<i>Hearing Screenings</i>	12
<i>Immunizations</i>	12
<i>Newborn Care</i>	12
<i>Prostate Screening</i>	12
EMERGENT/URGENT CARE	13
<i>Ambulance/Medical Transport Services</i>	13
Non-Emergency Services	13
HOSPITAL SERVICES	13
<i>Semi Private Room And Board</i>	13
Solid Organ Transplants And Bone Marrow Transplants	13
Donor Benefits	13
Transportation, Lodging, And Meal Expenses For Transplants	14
MENTAL HEALTH SERVICES	14

<i>Inpatient Mental Health Services</i>	14
ADDITIONAL SERVICES	14
<i>Clinical Trials</i>	14
<i>Health Management Programs</i>	15
<i>Other Outpatient Services</i>	15
Birth To Three Program (Early Intervention Services)	15
<i>Prescription Drugs</i>	16
Specialty Drugs:	16
EXCLUSIONS AND LIMITATIONS	17
CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS	17
CLAIMS FILING.....	17
TERMINATION AND AMENDMENT	17
GROUP TERMINATION	17
<i>Termination Of Your Coverage</i>	17
NON-GROUP TERMINATION	18
<i>Termination Of A Non-Group Member's Coverage</i>	18
COBRA AND CONTINUATION OF COVERAGE.....	18
<i>Your Right To Continue Benefits</i>	18
<i>Notification Requirements</i>	19
<i>Election Period</i>	19
<i>Payments</i>	19
<i>Termination Of Continuation Coverage</i>	19
<i>Special Termination Of Continuation Coverage Conditions</i>	19
DEFINITIONS	20
PLAN DESCRIPTION ADDENDUM	21

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY RULES

Effective July, 1, 2011 for all Plans, paragraph 4 of the “General Rules” provisions of the “Eligibility Rules” subsection of the “Eligibility And Enrollment” section in your member document and Patient Protection and Affordable Care Act Amendatory Rider is revised as follows.

General Rules

Subject to your Employer’s rules for participation in this Plan, you and your Eligible Dependents are eligible for coverage under this Plan as follows.

4. Your children may be eligible for coverage until the end of the last day of this Plan’s Contract Year that is after their 26th birthday that does not coincide with the first day of the Contract Year. If their 26th birthday does coincide with the first day of this Plan’s Contract Year, eligibility for coverage will end on that day.

In addition, your children must also meet one of the eligibility criteria described in your member document for **Natural Children, Adopted Children, Step-Children, Guardianship, or Handicapped Children** to be eligible for coverage under the Plan.

Effective for Plan renewals or new Plans on or after January 1, 2012, the “Adding New Children” provisions of the “Eligibility Rules” subsection of the “Eligibility And Enrollment” section of your member document is deleted and replaced with the following.

Adding New Children

You and your covered spouse’s newborn natural children receive coverage for the first 61 days after birth. Coverage for these children will end at the earlier of your termination of coverage or the end of this 61-day period, unless you have submitted a notice to us to add such child(ren) and paid the additional applicable Premium, if any. If your newborn natural children are not added to this Plan within the 61 day period, any services received after that 61 day period are not covered and you must wait until the next Annual Enrollment Period or the “Special Enrollment Period” to add them to this Plan, if additional Premium was required.

All the rules of this Plan apply to benefits payable for newborn children, even if they are only covered for the first 61 days after birth.

If you are enrolled in our non-group plan, you only have 61 days from the beginning of the Contract Year or the “Special Enrollment Period” to add your newborn natural children to this Plan.

If your female Eligible Dependent children are covered by this Plan, then their newborn children may receive coverage **ONLY** for the first 61 days after their birth, unless you or your covered spouse become the children’s legal guardian and you are enrolled in the Plan.

Newly adopted children, children for whom you become the legal guardian, and step-children must be enrolled within 61 days of the date of the adoption (or the date on which you or your spouse become at least partially legally responsible for the adopted children’s support and maintenance), or the date of your marriage to the step-children’s parent, or the date you became the legal guardian. If you do not add these children within the 61-day period, you must wait until the next Annual Enrollment Period or the “Special Enrollment Period” to add them to this Plan. In addition, we may require health underwriting for children legally placed for adoption if any required Premium and completed Enrollment Forms are not received by us within 61 days of the placement for the adoption.

If you are enrolled in our non-group plan, you only have 61 days from the beginning of the Contract Year or the “Special Enrollment Period” to add these children to this Plan.

Except for these changes, all of the remaining provisions in the “Eligibility And Enrollment” section of your member document remain unchanged.

MANAGED CARE RULES AND GUIDELINES

The “Managed Care Rules And Guidelines” section of your member document is revised as follows.

Effective January 1, 2012 for all Plans, the list of services and drugs requiring Pre-Authorization listed in the “Services Requiring Pre-Authorization Or Pre-Certification” subsection of the “Managed Care Rules And Guidelines” section of your member document is deleted and replaced with the following.

SERVICES REQUIRING PRE-AUTHORIZATION OR PRE-CERTIFICATION

You Need Pre-Authorization Or Pre-Certification For The Following:

Admissions:

- Hospital admissions that are elective or not the result of an Emergency, including: Acute Hospitals admissions*
Partial Hospitalizations Programs (PHP)*
Rehabilitation Facility admissions* Residential Treatment Facilities*
- Skilled Nursing Facility admissions
- Sub-acute care admissions

Ambulance/Medical Transportation:

- Land or air ambulance/medical transport that is not due to an Emergency

Durable Medical Equipment (DME) And Prosthetics

- Pre-Authorization will only be required for the following items: insulin pumps, wound vacs, real time continuous blood glucose monitors, customized wheelchairs and scooters, osteogenic stimulators (including spinal, non-spinal and ultrasound).
Electronic or Myoelectric prosthetics /artificial limbs, including the purchase, replacement and repair of whole limb or part of limb

Elective Services & Procedures:

- Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD) (if a covered benefit)*
- Artificial Intervertebral Disc
- Clinical trials
- Cardiac monitoring with Mobile Cardiac Outpatient Telemetry or continuous computerized daily monitoring with auto-detection (no Pre-Authorization is required for standard Holter monitors or loop event recording devices)
- Chondrocyte Implantation or Transplantation
- Corneal Pachymetry, repeat testing only
- Craniofacial treatment
- Dental anesthesia/procedures
- Extended outpatient behavioral health treatment visits beyond 45 – 50 minutes in duration with or without medication management*
- Gastric bypass surgery, including laparoscopic (if a covered benefit)
- Genetic testing, except for standard cystic fibrosis screening, routine chromosomal analysis (e.g., peripheral blood or tissue culture, chorionic villus sampling, amniocentesis), and FISH testing for lymphoma or leukemia
- Hospital clinics, non-contracted or out of the Service Area
- Mammoplasty (breast augmentation or reduction)
- Oncotype DX breast cancer test

Oral surgery (if a covered benefit)
 Reconstructive surgery
 Septoplasty (surgery of the nose), except when requested by an Ear, Nose and Throat Specialist
 Sleep apnea surgery or oral appliance treatment for sleep apnea
 Solid organ transplants (except cornea) and bone marrow transplants (all transplant Pre-Authorizations must be done at least ten business days prior to services being rendered)
 Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy (**see Radiation Oncology**)
 TMJ surgery (if a covered benefit)
 Varicose vein surgery
 Ventricular Assist Devices

Home Health Care:

Home health services
 Home infusion therapy
 Hospice care

Infertility Services

Intensive Outpatient Treatment Programs (IOP*)

Injectable Drugs & Nutritional Supplements:

Nutritional supplements and food products, including modified food products for inherited metabolic diseases and specialized formulas (if a covered benefit)

Neuropsychological Testing (behavioral health* and medical purposes)

Outpatient Radiological Services (except when such radiological services are done in conjunction with a biopsy or other surgical procedure):

Radiation Therapy for Breast, Lung, Prostate, Colon and Rectal Cancer
 Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy for all diagnosis
 Bone mineral density exams ordered more frequently than every 23 months
 CT scans (all diagnostic exams)
 MRI/MRA (all examinations)
 Nuclear cardiology
 PET scans
 Stress echocardiograms

Outpatient Rehabilitative Services Pediatric Only (except for the treatment of autism):

Occupational therapy
 Physical therapy
 Speech therapy (including specialty Hospitals, acute care Hospitals and providers of rehabilitation services)

Outpatient Electro-Convulsive Treatment (ECT)*

Outpatient Behavioral Health Treatment Provided in a Member's Home*

Outpatient Treatment of Opioid Dependence*

Psychological Testing Over 4 Hours*

***Pre-Authorization is conducted by OptumHealth Behavioral Solutions – 1-888-946-4658**

Prescription medications (only applies to certain medications)

Here's a list of the medications and supplies that also require Pre-Authorization.

You Need Pre-Authorization For The Following Prescription Drugs:

Abstral
 Aciphex
 Actemra
 Acthar Gel
 Actos
 Actoplus Met
 Acne-Brand Name Oral Agents; Doryx, Dynacin, Adoxa, Myrac, Solodyn, Minocin PAC
 Actiq
 Actonel
 Adcirca
 Adoxa
 Affinitor
 Agrylin
 Aldurazyme
 Alimta
 Allegra D (Rx)
 AlleRx
 Aloxi
 Alpha 1-Proteinase Inhibitors (All)
 Altace tabs
 Altoprev
 Ambien CR
 Amevive
 Ampyra
 Amrix
 Amturnide
 Androderm
 Androgel
 Antarra
 Anzemet
 Aplenzin
 Apokyn
 Aralast
 Aranesp
 Arcalyst
 Aricept
 Arthrotec
 Arzerra
 Ascensia Test Strips
 Astepro
 Atacand
 Atelvia
 Avalide
 Avandamet
 Avandaryl
 Avandia
 Avapro
 Avastin
 Avidoxy
 Avinza
 Avodart
 Avonex
 Axert
 Axiron
 Azor
 Beconase AQ
 Benicar/Benicar HCT

Benlysta
Betaseron
Bexxar
Blood Clotting Factors (All)
Boniva Injection
Boniva Tablets
Botox
Bravelle
Brovana
Buphenyl
Byetta
Cabergoline (Dostinex)
Cambia
Campral
Cardura XL
Cayston
Celebrex
Cerezyme
Cesamet
Cetrotide
Chantix
Cholesterol Lowering Drugs: Altoprev, Lescol/XL,
 Vytorin
Cimzia
Cinryze
Cladribine
Clarinex / D
Clindagel
Clobex
Clolar
Clomid
CNL Nail kit
Coartem
Compounded Medications
Contraceptives
Copaxone
Coreg CR
Crinone
Cymbalta
Dacogen
Daliresp
Detrol / LA
Dexilant (formerly Kapidex)
Differin
Diovan/Diovan HCT
Doryx
Dostinex
Duetact
Duexis
Dynacin
Dysport
Edarbi
Edluar
Effexor XR
Egrifta
Elaprase
Elidel
Enablex
Enbrel
Endometrin
Eloxatin

Erbitux
Euflexxa
Evoclin
Exalgo
Exelon/Exelon patch
Exforge/Exforge HCT
Exjade
Extavia
Extina
Fabrazyme
Fentanyl citrate oral
Fentora
Fexmid
Fexofenadine-D (Rx)
Fibrocor
Flector Patch
Flolan Flu Mist
Fluoxetine 40mg capsules
Follistim AQ
Folotyng
Food Supplements
Fortamet
Forteo
Fortesta
Fosamax plus D
Frova
Fuzeon
Ganirelix
Gastrocrom
Gelnique
Genotropin
Gilenya
Glassia
Gleevec
Glumetza
Gonal-F
Growth Hormones (All)
Halaven
HCG (chorionic gonadotropin)
Herceptin
Hizentra
Horizent
Humatrope
Humira
Hyalgan
Hycamtin
Ilaris
Implanon
Increlex
Infergen
Infertility Medications (All)
Injectable Drugs (All): excluding insulin
Interferons (All)
Intron-A
Intuniv
Iressa
Istodax
IV Immune Globulin (IVIG)
Ixempra
Jevtana
Kalbitor

Kadian	Olux E
Kapvay ER	Omnaris
Keppra XR	Omnitrope
Kineret	One Touch Test Strips
Klonopin Wafers	Onglyza
Kombiglyze XR	Onsolis
Krystexxa	Oracea
Kuvan	Orencia
Kytril	Orfadin
Lamictal ODT	Orthovisc
Lamictal XR	Ovidrel
Lamisil Oral Granules	Oxandrin
Lansoprazole	Oxytrol
Lescol/XL	Patanase
Letairis	Paxil CR and CR generic
Lexapro	Pegasys
Livalo	Peg-Intron
Lotronex	Pennsaid
Lovaza (formerly Omacor)	Pexeva
Lucentis	Ponstel
Lumigan	Pradaxa
Lumizyme	Prevacid (Rx)
Lunesta	Prevacid Naprapac
Luveris	Prialt
Luvox CR	Prilosec (Rx)
Luxiq	Pristiq
Lyrica	Prolastin
Macugen	Proleukin
Makena (17P)	Prolia
Marinol	Promacta
Maxalt/Maxalt MLT	Protonix (brand)
Menopur	Protopic
Mepron	Provence
Metozolv	Provigil
Micardis/Micardis HCT	Prozac Weekly
Minocin Combo Pack	Qualaquin
Mirena	Qutenza
Mozobil	Rapaflo
Myobloc	Razadyne
Myozyme	Rebetol (ribavirin)
Myrac	Rebetron
Naglazyme	Rebif
Namenda	Reclast
Nasacort AQ	Relistor
Nasarel	Relpax
Neulasta	Regranex
Nexavar	Remicade
Nexium	Remodulin
Nimotop	Repronex
Niravam	Retisert
Norditropin	Revatio
Novarel	Revlimid
Novoseven	Rhinocort AQ
Noxafil	RiaStap
NPlate	Ribavirin
Nuedexta	Rituxan
Nutropin/AQ	Rybix ODT
Nuvigil	Ryzolt ER
Oforta	Saizen
Oleptro	Sanctura
Olux	Sancuso

Sarafem
 Silenor
 Simponi
 Smoking Cessation Medications
 Solodyn
 Soliris
 Solzira
 Somavert
 Sporanox
 Sprix
 Sprycel
 Steroids, Anabolic
 Stavzor
 Stelara
 Striant
 Stratterra
 Suboxone Film
 Sucraid
 Sumavel Dosepro
 Supartz
 Sutent
 Sylatron
 Symlin
 Synagis
 Synarel
 Synvisc (hyaluronate sodium)
 Tassigna
 Tarceva
 Tekamlo
 Tekturna
 Telaprevir
 Temodar
 Testim
 Testosterone (All)
 Tevetan/Tevetan HCT
 TevTropin
 Thalomid
 Thyrogen
 Tofranil PM
 Torisel
 Toviaz
 Tracleer
 Travatan/Travatan Z
 Travel Medication: including Malarone, Larium and Aralen
 Treanda
 Tretin X
 Treximet
 Triglide
 Tribenzor
 Trospium
 Twynsta
 Tykerb
 Tysabri
 Tyvaso
 Uloric
 Ultram ER
 Uroxatral
 Valtorna
 Vandetanib
 Vectibix

Velcade
 Venlafaxine ER
 Ventavis
 Verdeso
 Vesicare
 Victoza
 Victrelis
 Vidaza
 Viibryd
 Vimovo
 Vivaglobin
 Vivitrol
 Voltaren Gel
 Votrient
 Vpriv
 Vusion
 Vytorin
 Weight Loss Medication (if covered by your plan); Meridia, Xenical, Ionamin, Tenuate, etc
 Welchol
 Xalatan
 Xeloda
 Xenazine
 Xeomin
 Xgeva
 Xiaflex
 Xolair
 Xyntha
 Xyrem (Sodium Oxybate)
 Xyzal
 Yervoy
 Zanaflex Caps
 Zantac gel dose
 Zavesca
 Zegrid
 Zemaira
 Zevelin
 Zolinza
 Zolpimist
 Zomig
 Zortress
 Zuplenz
 Zyban
 Zyclara
 Zyflo CR

COST-SHARES YOU ARE REQUIRED TO PAY

Effective for Plan renewals or new Plans on or after October 1, 2010, the “Copayments” provisions of the “Coast-Shares You Are Required To Pay” subsection of the “Managed Care Rules And Guidelines” section of your member document are revised as follows.

Copayments

There are no Copayments for the following services, when no other services are provided:

- ♥ All pre-natal visits for routine care until the baby is born **after an initial visit**
- ♥ Chemotherapy administration (no matter where it is rendered)

- ♥ Immunizations
- ♥ Mammography (when noted on your Benefit Summary)

Except for this change, all of the remaining provisions in the “Copayments” provisions remain unchanged.

If you are enrolled in one of our **ConnectiCare, Inc. Plans**, effective for Plan renewals or new Plans on or after **January 1, 2012**, the following “Coinsurance Maximums” provisions are added to the “Maximums And 90 Day Lookback Period” subsection of the “Managed Care Rules And Guidelines” section of your member document.

Maximums And 90 Day Lookback Period

Coinsurance Maximums

HMO Plan Coinsurance Maximum

If you are enrolled in one of our **ConnectiCare, Inc. HMO Plans** and that Plan has a **Coinsurance Maximum**, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid to Participating Providers, including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

Once the Coinsurance Maximum is met in a year, the Coinsurance no longer applies for the remainder of the year. However, Members are still required to pay any other applicable Cost-Share amounts.

The Coinsurance Maximum is considered to be met for a Member if his or her individual Coinsurance Maximum is met by the Coinsurance amounts paid by that Member for services paid to Participating Providers. The family Coinsurance Maximum is met by the total Coinsurance amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid to Participating Providers, whereby no one member exceeds the individual amount for services paid to Participating Providers.

Even when the Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts.

POS Plan Coinsurance Maximums

If you are enrolled in one of our **ConnectiCare, Inc. or ConnectiCare Insurance, Inc. POS Plans** that Plan may have an In-Network Level Of Benefits Coinsurance Maximum, an Out-Of-Network Level Of Benefits Coinsurance Maximum, or a combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum.

In-Network Level Of Benefits Coinsurance Maximum

When this Plan has an In-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid at the In-Network Level Of Benefits (paid to Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

Once the In-Network Level Of Benefits Coinsurance Maximum is met in a year, the In-Network Level Of Benefits

Coinsurance no longer applies for the remainder of the year. However, Members are still required to pay any other applicable Cost-Share amounts.

The In-Network Level Of Benefits Coinsurance Maximum is considered to be met for a Member if his or her individual In-Network Level Of Benefits Coinsurance Maximum is met by the Coinsurance amounts paid by that Member for services paid at the In-Network Level Of Benefits. The family In-Network Level Of Benefits Coinsurance Maximum is met by the total Coinsurance amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the In-Network Level Of Benefits, whereby no one member exceeds the individual amount for services paid at the In-Network Level Of Benefits Coinsurance Maximum.

Even when the In-Network Level Of Benefits Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts.

Out-Of-Network Level Of Benefits Coinsurance Maximum

When this Plan has an Out-Of-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid at the Out-Of-Network Level Of Benefits (paid to Non-Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

Once the Out-Of-Network Level Of Benefits Coinsurance Maximum is met in a year, the Out-Of-Network Level Of Benefits Coinsurance no longer applies for the remainder of the year. However, Members are still required to pay any other applicable Cost-Share amounts.

The Out-Of-Network Level Of Benefits Coinsurance Maximum is considered to be met for a Member if his or her individual Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the Coinsurance amounts paid by that Member for services paid at the Out-Of-Network Level Of Benefits. The family Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the total Coinsurance amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the Out-Of-Network Level Of Benefits, whereby no one member exceeds the individual amount for services paid at the Out-Of-Network Level Of Benefits Coinsurance Maximum.

Even when the applicable Out-Of-Network Level Of Benefits Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Coinsurance Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members a Benefit Reductions, and
- ♥ Deductibles or any Copayments.

Combination In-Network and Out-of-Network Level Of Benefits Coinsurance Maximum

If your Plan has a combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum, that Coinsurance Maximum includes all Coinsurance amounts paid by the Member in a year for benefits paid at the In-Network Level Of Benefits (paid to Participating Providers) or the Out-Of-Network Level Of Benefits (paid to Non-Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan).

Once the combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum is met in a year, the Coinsurance no longer applies for the remainder of the year. However, Members are still required to pay any other applicable Cost-Share amounts.

The combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum is considered to be met for a Member if his or her individual Coinsurance Maximum is met by the Coinsurance amounts paid by that Member at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits. The family combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum is met by the total Coinsurance amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum, whereby no one member exceeds the individual amount for services paid at the combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum.

Even when the combination In-Network and Out-Of-Network Level Of Benefits Coinsurance Maximum is met, Members are still responsible for other applicable Cost-Share amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Coinsurance Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members a Benefit Reductions, and
- ♥ Deductibles or any Copayments.

Effective for Plan renewals or new Plans on or after January 1, 2012, the following “Cost-Share Maximum” provisions are added to the “Maximums And 90 Day Lookback Period” subsection of the “Managed Care Rules And Guidelines” section of your member document.

Cost-Share Maximums

HMO Plan Cost-Share Maximum

If you are enrolled in one of our **ConnectiCare, Inc. HMO Plans** and that Plan has a **Cost-Share Maximum**, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid to Participating Providers, including certain prescription drug programs (if one of our prescription drug

programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

Once the Cost-Share Maximum is met in a year, Copayment and Coinsurance no longer apply for the remainder of the year. However, Members are still required to pay any Deductible amounts.

The Cost-Share Maximum is considered to be met for a Member if his or her individual Copayment Maximum and Coinsurance Maximum are met by that Member for services paid to Participating Providers. The family Cost-Share Maximum is met by the total Copayment and Coinsurance amounts paid by a Member and all of the members in his or her family who are covered by the Plan for services paid to Participating Providers, whereby no one member exceeds the individual amount for services paid to Participating Providers.

Even when the Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts.

POS Plan Cost-Share Maximums

If you are enrolled in one of our **ConnectiCare, Inc. or ConnectiCare Insurance, Inc. POS Plans**, that Plan may have an In-Network Level Of Benefits Cost-Share Maximum, an Out-Of-Network Level Of Benefits Cost-Share Maximum, or a combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum.

In-Network Level Of Benefits Cost-Share Maximum

When this Plan has an In-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid at the In-Network Level Of Benefits (paid to Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

Once the In-Network Level Of Benefits Cost-Share Maximum is met in a year, the In-Network Level Of Benefits Copayment and Coinsurance amounts no longer apply for the remainder of the year. However, Members are still required to pay any other applicable Deductible amounts.

The In-Network Level Of Benefits Cost-Share Maximum is considered to be met for a Member if his or her individual In-Network Level Of Benefits Cost-Share Maximum is met by the Copayment and Coinsurance amounts paid by that Member for services paid at the In-Network Level Of Benefits. The family In-Network Level Of Benefits Cost-Share Maximum is met by the total Copayment and Coinsurance amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the In-Network Level Of Benefits, whereby no one member exceeds the individual amount for services paid at the In-Network Level Of Benefits Cost-Share Maximum.

Even when the In-Network Level Of Benefits Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts.

Out-Of-Network Level Of Benefits Cost-Share Maximum

When this Plan has an Out-Of-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid at the Out-Of-Network Level Of Benefits (paid to Non-Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

Once the Out-Of-Network Level Of Benefits Cost-Share Maximum is met in a year, the Out-Of-Network Level Of Benefits Copayments and Coinsurance no longer apply for the remainder of the year. However, Members are still required to pay any other applicable Deductible amounts.

The Out-Of-Network Level Of Benefits Cost-Share Maximum is considered to be met for a Member if his or her individual Out-Of-Network Level Of Benefits Copayment Maximum and Coinsurance Maximum are met by the Copayment and Coinsurance amounts paid by that Member for services paid at the Out-Of-Network Level Of Benefits. The family Out-Of-Network Level Of Benefits Cost-Share Maximum is met by the total Copayment and Coinsurance amounts paid by that Member and all of the members in his or her family who are covered by the Plan for services paid at the Out-Of-Network Level Of Benefits, whereby no one member exceeds the individual amount for services paid at the Out-Of-Network Level Of Benefits Cost-Share Maximum.

Even when the applicable Out-Of-Network Level Of Benefits Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Cost-Share Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members a Benefit Reductions, and
- ♥ Deductibles.

Combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum

If your Plan has a combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum, that Cost-Share Maximum includes all Copayment and Coinsurance amounts paid by the Member in a year for benefits paid at the In-Network Level Of Benefits (paid to Participating Providers) or the Out-Of-Network Level Of Benefits (paid to Non-Participating Providers), including certain prescription drug programs (if one of our prescription drug programs has been selected as part of this Plan). It **DOES NOT** include any Deductible amounts the Plan may have.

Once the combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met in a year, Copayments and Coinsurance no longer apply for the remainder of the year. However, Members are still required to pay any Deductible amounts.

The combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is considered to be met for a Member, if his or her individual Copayment Maximum and Coinsurance Maximum are met by that Member for services paid at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits. The family combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met by the total Copayment and Coinsurance amounts paid by a Member and all of the members in his or her family who are covered by the Plan for services paid at the In-Network Level Of Benefits or the Out-Of-Network Level Of Benefits, whereby no one member exceeds the individual amount for services paid at the combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum.

Even when the combination In-Network and Out-Of-Network Level Of Benefits Cost-Share Maximum is met, Members are still responsible for other applicable Deductible amounts, as well as those amounts for covered Out-Of-Network Level Of Benefits in excess of the Maximum Allowable Amount.

Cost-Share Maximum amounts do not include:

- ♥ Charges by a provider in excess of the Maximum Allowable Amount,
- ♥ Amounts paid by Members a Benefit Reductions, and
- ♥ Deductibles.

Except for these additions, all of the remaining provisions in the "Maximums And 90 Day Lookback Period" provisions remain unchanged.

Effective for Plan renewals or new Plans on or after January 1, 2011, the "Insufficient Evidence Of Therapeutic Value" subsection of the "Managed Care Rules And Guidelines" section of your member document is deleted and replaced with the following.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Any service, supply, device, procedure or medication (collectively called "Treatment") for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered. There is insufficient evidence of therapeutic value when we determine, in our sole discretion, that either:

1. There is not enough evidence to prove that the Treatment directly results in the restoration of health or function for the use for which it is being prescribed, whether or not alternative Treatments are available; or
2. There is not enough evidence to prove that the Treatment results in outcomes superior to those achieved with reasonable alternative Treatments which are less intensive or invasive, or which cost less and are at least equally effective for the use for which it is being prescribed.

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when it has been approved by a regulatory body or recommended by a health care

practitioner. In that case, the Treatment will still not be covered.

We will monitor the status of a Treatment for which there is Insufficient Evidence Of Therapeutic Value and may decide that a Treatment for which at one time there was Insufficient Evidence Of Therapeutic Value may later be a covered Health Service under this Plan. Coverage will not become effective until we have made a determination that there is sufficient evidence of therapeutic value for the Treatment and we have decided to make the Treatment a covered Health Service. All Treatment with sufficient evidence of therapeutic value must also be Medically Necessary to treat or diagnose a Member's illness or injury in order to be covered.

Except for these changes, all of the remaining provisions in the "Managed Care Rules And Guidelines" section of your member document remain unchanged.

BENEFITS

The "Benefits" section is revised as follows.

Except as noted, effective for Plan renewals or new Plans on or after January 1, 2011, the "Preventive Services" and "Other Preventive Services" subsections of the "Benefits" section of your member document are deleted and replaced with the following.

PREVENTIVE SERVICES

Services provided in the doctor's office for routine and preventive care are **covered**.

Adult Preventive Care Services

Office visits for adult preventive care services (routine exams and preventive care) are **covered**.

The frequency of adult preventive care services is determined by the Member's physician.

Infant/Pediatric Preventive Care Services

Office visits for infant/pediatric preventive care services (routine exams and preventive care) are **covered**.

The following is a suggested schedule for infant/pediatric preventive care services:

<u>Infant/Pediatric Preventive Care Services</u>	
Under Age 3:	At months 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30
Ages 3 to 21:	Annually

The frequency is determined by the Member's physician.

Blood Lead Screening And Risk Assessments

Blood lead screening and risk assessments ordered by the Member's Primary Care Provider are **covered** as follows.

Lead Screenings:

- ♥ At least annually for a child from nine to 35 months of age; and
- ♥ For a child three to six years of age who has not been previously screened or is at risk.

Risk Assessments:

- ♥ For lead poisoning at least annually for a child three to six years of age; and
- ♥ At any time in accordance with state guidelines for a child age 36 months or younger.

Gynecological Preventive Exam Office Services

Office visits for gynecological preventive exam office services (routine exams and preventive care) are **covered**.

The frequency of periodic health evaluations and checkups is determined by the Member's physician.

Cervical Cancer Screening

Cervical cancer screenings (pap tests) for female Members are **covered**.

The following is a suggested schedule for cervical cancer screening:

Cervical Cancer Screenings

Cervical cancer screening should begin at age 21 years.

Cervical cytology screening is recommended every two years for women between the ages of 21 years and 29 years.

Women 30 years old and older who have had three consecutive negative cervical cytology screening tests results and who have no history of CIN 2 or CIN 3 are not HIV infected, are not immunocompromised, and were not exposed to diethylstilbestrol in utero may extend the interval between cervical cytology and examinations to every three years.

Mammogram Screenings

Mammogram screenings are **covered**.

The following is a suggested schedule for mammogram screenings:

Mammogram Screenings

Ages 35 to 39:	One baseline screening
Age 40 and over:	One screening mammogram per year

Mammogram screenings may be **covered** more often as determined by a physician.

Effective for Plan renewals or new Plans on or after January 1, 2012, in addition to the mammogram screenings noted above, comprehensive ultrasound screening or magnetic resonance imaging (MRI) of an entire breast or breasts are also **covered**, if:

- ♥ A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
- ♥ If a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's

physician or advanced practice registered nurse.

Some types of breast cancer screenings (e.g., when a Member has or is suspected of having a clinical genetic disorder) require Pre-Authorization. Please refer to the “Genetic Testing” subsection of the “Benefit” section of your member document for more information regarding genetic testing.

If a Member requires an ultrasound screening or MRI that is not considered routine, that ultrasound screening or MRI is **covered**, but it may not be exempt from any Plan Deductible your Plan may have. Please refer to your Benefit Summary to see if your Plan has certain services that are exempt from your Plan’s Deductible.

Routine Vision Exams

Routine eye care, including a refraction (a test to determine whether you are near-sighted or far-sighted), is not covered, unless:

- ♥ This Plan has our ***Vision Care Rider***.

If this Plan does have our ***Vision Care Rider***, annual routine eye exams and glasses are **covered** in accordance with the terms of the Rider.

If this Plan **DOES NOT** include our ***Vision Care Rider***, then screening exams for a Member who is under age 19 are **covered** unless he or she has been diagnosed with a refraction problem.

In addition, Members with diabetes are **covered** for a routine eye exam each year. These screenings and eye exams are **covered** under the terms of the ***Vision Care Rider***, if there is one. Otherwise, they are **covered** under this Agreement as a medical service.

- ♥ You are a Member in the ***CSEHRP HMO Open Access Plan***, in which case coverage is available if you are under age 17 or you have diabetes.

OTHER PREVENTIVE SERVICES

Colorectal Cancer Screenings

Colorectal cancer screenings, such as annual fecal occult blood testing (FOBT), fecal immunochemical test (FIT), and flexible sigmoidoscopy, colonoscopy, or radiologic imaging are **covered** in accordance with recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society and the American College of Radiology.

Colorectal cancer screenings may be **covered** more often as determined by a physician based on the Member’s medical history and/or risk factors.

There may be a Cost-Share that you will be required to pay for these screenings. The Cost-Share amount depends on where the procedure is rendered and your Plan. For example, if you have a procedure performed at a physician’s office, you may be required to pay an office services Copayment, but if the service is performed on an outpatient basis, whether in a Hospital or ambulatory surgery facility, you may be required to pay an ambulatory services Cost-Share amount.

Effective for Plan renewals or new Plans on or after January 1, 2012, repeat colonoscopies ordered by a physician in a benefit year will be **covered without any Cost-Sharing amount**, unless the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Please refer to your Benefit Summary to see the Cost-Share amount you are required to pay, if any, under your Plan and to see if the benefits of this Plan are administered per calendar year or per Contract Year.

Hearing Screenings

Hearing screenings are **covered** as follows:

- ♥ As a part of a physical examination are only covered if a Member is under age 19.
- ♥ If Medically Necessary to evaluate the sudden onset of severe symptoms of an injury or illness. No coverage is available if the Member is already diagnosed with a permanent hearing loss.

Immunizations

Immunizations (vaccine and injection of vaccine) are **covered**. Coverage for vaccines such as Hepatitis is limited.

The following immunizations are **NOT** covered:

- ♥ Immunizations obtained solely because they are required by a third party (such as job, travel, school, or camp).
- ♥ Immunizations obtained for travel.
- ♥ Immunizations and vaccinations for cholera, plague and yellow fever.
- ♥ Routine immunizations obtained at an Urgent Care Center.
- ♥ Vaccinations an employer is legally required to provide due to an employment risk.

Newborn Care

Effective for Plan renewals or new Plans on or after January 1, 2012, newborn children are **covered for the first 61 days following birth**.

Continued coverage for a newborn child requires the newborn to be enrolled in this Plan within 61 days of his or her birth for coverage to continue beyond this initial 61 days

There is no coverage beyond 61 days for a newborn who does not qualify as your dependent child.

Please refer to the “Adding New Children” subsection of the “Eligibility And Enrollment” section of your member document and this Rider for more information and rules regarding coverage for newborn children.

Prostate Screening

Laboratory and diagnostic tests to screen for prostate cancer are **covered** for a male Member who:

- ♥ Is 50 years of age or older; or
- ♥ Is any age and is also symptomatic; or
- ♥ Is any age and has a biological father or brother who

has been diagnosed with prostate cancer.

Effective for Plan renewals or new Plans on or after January 1, 2012, in addition to laboratory and diagnostic tests noted above, treatment for prostate cancer will also be **covered** in accordance with national guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

EMERGENT/URGENT CARE

Ambulance/Medical Transport Services

Effective for Plan renewals or new Plans on or after January 1, 2011, the “Non-Emergency Services” paragraphs of the “Ambulance/Medical Transportation Services” provisions of the “Emergent/Urgent Care” subsection of the “Benefits” section of your member document are deleted and replaced with the following.

Non-Emergency Services

Non-Emergency land ambulance/medical transport services for non-routine care visits will be covered as a medical service only when Medically Necessary and with Pre-Authorization if the Member’s medical condition is such that any other method of transport would result in injury or would be detrimental to the Member’s health as determined by us or if the Member is in-patient at an acute care facility and needs air transportation to another acute care facility because Medically Necessary services are not available in the facility where the patient is confined.

There is no coverage for non-Emergency land or air ambulance/medical transport services to and from a physician’s office for routine care or if it is for Member convenience.

HOSPITAL SERVICES

Semi Private Room And Board

Effective January 1, 2012 for all Plans, the “Solid Organ Transplants And Bone Marrow Transplants” paragraphs of the “Semi Private Room And Board” provisions of the “Hospital Services” subsection of the “Benefits” section of your member document is deleted and replaced with the following.

Solid Organ Transplants And Bone Marrow Transplants

Medically Necessary transplants, including the following, are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered.

The following organ transplants and bone marrow transplants are covered: cornea, heart, heart-lung, kidney, liver, lung, pancreas, pancreas-kidney, intestinal, and bone marrow transplants.

Bone marrow procedures such as autologous or allogeneic transplants, or peripheral stem cell rescue, or any procedure similar to these are considered “organ transplants” under this Plan and are subject to the provisions of this subsection.

Except for cornea transplants, all requests for transplants and related services require Pre-Authorization at the time of diagnosis not less than ten business days prior to any evaluative services to determine eligibility for the transplant.

If Pre-Authorization has not been obtained, payment for the transplant and related services, as well as for medical diagnosis and evaluation, will be reduced, or denied, as described in the “Benefit Reduction” provisions of the “Services Requiring Pre-Authorization Or Pre-Certification” subsection of the “Managed Care Rules And Guidelines” section of your member document, as applicable.

If you are enrolled in one of our ConnectiCare, Inc. Plans, requests for benefits for transplants will be Pre-Authorized only for Participating Providers, or other providers that we have existing contracts with (or through a subcontractor of ours), or other medical facilities with which we (or a subcontractor of ours) have contracted prior to the request for Pre-Authorization, for a predetermined negotiated rate applicable to us.

There are no benefits available under this Plan when transplants and related services are rendered by a Non-Participating Provider or by a Participating Provider without the required Pre-Authorization.

NOTE: If you are enrolled in one of our ConnectiCare Insurance Company, Inc. Plans, these provider restrictions DO NOT apply. However, to obtain the In-Network Level Of Benefits, you must use Participating Providers. By using Participating Providers you reduce your out-of-pocket expenses.

Donor Benefits

Medically Necessary expenses of the transplant donor, including Medically Necessary services and tests related to determining compatibility, are **covered after the applicable Cost-Share amount**. The Cost-Share amount depends on where the procedures are rendered. Coverage is only available if the transplant recipient is our Member and the Pre-Authorization for evaluation (described in the above paragraphs) has been obtained. This is true whether or not the donor is our Member.

In addition, expenses arising from human leukocyte antigen testing (also known as histocompatibility locus antigen testing) for A, B or DR antigens for use in bone marrow transplantation are **covered after the applicable Cost-Share** when the testing is performed in a facility both accredited by the American Society for Histocompatibility and Immunogenetics and certified under the Clinical Laboratory Improvement Act of 1967.

The Cost-Share for the testing depends on who ordered the procedures and where the procedures are rendered and shall not be more than 20% of the cost of such testing per year, unless the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs).

Coverage for the testing is limited as follows:

- ♥ To a Member who, at the time of the testing, completed and signed an informed consent form that also authorizes the results of the test to be used for

participation in the National Marrow Donor Program, and

- ♥ One testing per Member per lifetime.

Transportation, Lodging, And Meal Expenses For Transplants

Expenses for transportation, lodging, and meals for the transplant recipient and his or her companion are **reimbursable up to a maximum of \$10,000 per transplant episode.**

A “transplant episode” is the time from the initial evaluation for the transplant until 90 days after the recipient is discharged from the transplant facility or until the recipient is cleared to return home, whichever is sooner.

A transplant facility is a facility as described in the preceding “Solid Organ Transplants And Bone Marrow Transplants” provisions.

If additional transplants occur during the transplant episode, the additional transplants are considered a single transplant episode subject to \$10,000 overall benefit limit.

If readmission to the transplant facility is necessary for the transplant recipient within 90 days of the date of discharge, the readmission will be considered part of the same transplant episode and any remainder of the \$10,000 benefit not previously used will be available.

The transplant facility must be more than 300 miles from the transplant recipient’s home for this reimbursement to apply.

- ♥ Transportation costs incurred for travel to and from transplant facility for the transplant recipient and one other individual accompanying the recipient are **covered.**

If air transportation is chosen, coverage includes round trip transportation for the transplant recipient and one other individual accompanying the recipient **up to two round trips per person**

If travel occurs via automobile, mileage will be reimbursed based on the federal Internal Revenue Code mileage reimbursement rate at the time the travel was undertaken for **a maximum of one round trip from the transplant recipient’s home to the transplant facility.**

- ♥ Lodging and meal expenses are **covered up to \$150 total per day** for the transplant recipient and the individual accompanying the transplant recipient. Transportation, lodging, and meal receipts must be submitted to us at the appropriate address listed in the information you receive from us when authorizing this reimbursement.

There is no coverage for the following expenses:

- ♥ Any expenses for anyone other than the transplant recipient and the designated traveling companion.
- ♥ Any expenses other than the transportation, lodging and meals described in this provision.
- ♥ Expenses over the total per day limits for lodging and meals and the overall \$10,000 transplant episode

benefit limit.

- ♥ Local transportation costs while at the transplant facility.
- ♥ Rental car costs.

MENTAL HEALTH SERVICES

Effective for Plan renewals or new Plans on or after January 1, 2011, the “Inpatient Mental Health Services” provision of the “Mental Health Services” subsection of the “Benefits” section of your member document is deleted and replaced with the following.

Inpatient Mental Health Services

Medically Necessary inpatient mental Health Services, as defined in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”, rendered in an acute care Hospital or a Residential Treatment Facility, are **covered** just as they would be for any other illness or injury as described in the “Hospital Services” section of your member document.

ADDITIONAL SERVICES

Effective for Plan renewals or new Plans on or after January 1, 2012, the “Cancer Clinical Trials” provisions of the “Additional Services” subsection of the “Benefits” section of your member document are deleted and replaced with the following.

Clinical Trials

Certain routine care for a Member who is a patient in a disabling or life-threatening chronic diseases clinical trial is **covered** just as routine care would be covered under this Plan if the Member was not involved in a disabling or life-threatening chronic diseases clinical trial. All of the terms and conditions of your member document apply to these benefits in addition to the following.

In order for the Member to be eligible for coverage, the trial must be Pre-Authorized and:

- ♥ Conducted under an independent peer-reviewed protocol approved by one of the National Institutes of Health, a National Cancer Institute affiliated cooperative group, the federal Food and Drug Administration (FDA) as part of an investigational new medication or device application or exemption, or the federal Department of Defense or Veterans Affairs, or
- ♥ Qualified to receive Medicare coverage of its own routine costs under the Medicare Clinical Trial Policy.

The Connecticut Insurance Department has issued a standardized form for use when asking us to cover routine care costs in a clinical trial. When we receive this form we will approve or deny coverage within five business days of receipt of the materials reasonably needed to review the request, except that we may take ten business days when we use an independent expert to review the request. Denials are subject to the State of Connecticut utilization review external Appeal program as described in the “Appeal Process”

subsection of the “Claims Filing, Questions And Complaints, And Appeal Process” section of your member document.

We may require the following in order for the Member to be considered for coverage:

- ♥ Evidence that the Member meets all of the selection criteria for the trial, including clinical or pre-clinical data that shows that the trial is likely to benefit the Member commensurate with the trial’s risks;
- ♥ Evidence that the Member has given appropriate informed consent to the trial;
- ♥ Copies of any medical records, protocols, test results or other clinical information used to enroll the Member in the trial;
- ♥ A summary of how the anticipated routine care costs would exceed the costs for standard treatment;
- ♥ Information about any items or services (including routine care) that may be paid for by someone else, including the entity sponsoring the trial; and
- ♥ Any other information we may reasonably need to review the request.

If we need any additional information to determine coverage, we will request it within five business days of receiving a request for clinical trial coverage. We will not cover routine costs that are eligible for reimbursement by another entity.

There is no coverage for the following:

- ♥ The cost of Experimental Or Investigational medications or devices not approved for sale by the FDA;
- ♥ Costs for non-Health Services;
- ♥ Facility, ancillary, professional services and medication costs paid for by grants or funding for the trial;
- ♥ Costs that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or costs for services that are performed specifically to meet the requirements of the trial;
- ♥ Costs that would not be covered by your Plan for a non-Experimental Or Investigational treatment; and
- ♥ Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member.

Coverage includes Hospitalization at a Non-Participating Hospital, if the treatment is not available at a Participating Hospital and is not paid for by the clinical trial sponsor. Payments made to a Non-Participating Hospital for cancer clinical trials will be available at no greater cost to the Member than if the treatment was provided at a Participating Hospital.

Effective for Plan renewals or new Plans on or after January 1, 2011, the “Health Management Programs” provisions of the “Additional Services” subsection of the “Benefits” section of your member document are deleted and replaced with the following.

Health Management Programs

Health management programs are designed to help the Member stay in control of his or her chronic health conditions, so that the Member can maintain his or her functional status and quality of life.

Members in this Plan may be eligible to enroll in one or more of our health management programs. In addition, Members may be contacted and managed by our High Risk Member Outreach Program.

Depending on the programs that are available at that time, a Member may receive items or services (e.g., educational mailings or visits; nicotine replacement therapy (NRT); pillboxes; special medical equipment such as a blood pressure monitor/cuff, a peak flow meter, a glucose monitor or a scale to assist during convalescence or to monitor a special medical condition) as value added services or covered benefits in our discretion. When these items are covered benefits, they will not be subject to standard claim processing and Cost-Sharing rules. If you are enrolled in one of our HSA-compatible high deductible health plans (HDHPs), the health management program items or services that are covered benefits are subject to the Plan Deductible. However, those items or services may not be subject to the other Cost Share amounts that do apply after the Plan Deductible is satisfied. Please refer to your Benefit Summary to see if your Plan is one of our HSA-compatible high deductible health plans (HDHPs) and to find out which Cost-Shares apply to your Plan after the Plan Deductible is met.

Please call our Member Services Department at the appropriate telephone number listed in the “Important Telephone Numbers And Addresses” subsection of the “Important Information” section of your member document to find out more about our current health management programs.

Other Outpatient Services

Effective for Plan renewals or new Plans on or after January 1, 2012, the “Birth To Three Program (Early Intervention Services)” paragraphs of the “Other Outpatient Services” provisions of the “Additional Services” subsection of the “Benefits” section of your member document are deleted and replaced with the following.

Birth To Three Program (Early Intervention Services)

Early intervention services consist of care as part of an Individualized Family Service Plan as prescribed by State law and are available for a Member from birth until the child's third birthday. These services are **covered as provided by the Connecticut Early Intervention Services program up to the amount as required by Connecticut State law.**

For children with autism spectrum disorders who are receiving early intervention services, the maximum benefit payable under the birth to three early intervention benefit shall be \$50,000 per Member per year, with a combined benefit of \$150,000 per Member over the three year early intervention period. The amount of coverage provided in the “Autism Services” section of your member document does not increase over the amounts already provided. That means

any coverage provided for autism spectrum disorders through early intervention Individualized Family Service Plan is credited toward the coverage amounts described in the "Autism Services" section of your member document.

The Cost-Share amount depends on where the procedures are rendered and will only apply, if the Member is enrolled in one of our HSA-compatible high deductible health plans (HDHPs). Any benefit amount does not apply to the application of any maximum lifetime or annual limits described in your member document.

Prescription Drugs

Effective January 1, 2012 for all Plans, the list specialty drugs requiring Pre-Authorization listed in the "Prescription Drugs" provisions of the "Additional Services" subsection of the "Benefits" section of your member document is deleted and replaced with the following.

Specialty Drugs:

Growth Hormone including:

- Accretropin
- Genotropin
- Humatrope
- Increlex
- Norditropin
- Nutropin
- Nutropin AQ
- Saizen
- Serostim
- TevTropin

Blood Clotting Factors including:

- Advate
- Alphanate
- Benefix
- Helixate
- Humate P
- Kogenate FS
- Monarc M
- NovoSeven
- Recombinate
- Xyntha

Hepatitis C Treatments including:

- Copegus
- Infergen
- Peg Intron
- Pegasys
- Rebetol
- Rebetron
- Ribavirin
- Telaprevir
- Victralis

LHRH Agonists including:

- Eligard
- Lupron
- Trelstar
- Viadur
- Vantas
- Zoladex

Multiple Sclerosis Treatments including:

- Avonex

- Betaseron
- Copaxone
- Extavia
- Gilenya
- Rebif
- Tysabri

Other Drugs including:

- Acthar
- Actimmune
- Apokyn
- Aralast
- Botox (botulinum toxin type A)
- Cayston
- Cerezyme
- Cinryze
- Exjade
- Fabrazyme
- IVIG (Immunoglobulin)
- Kuvan
- Lucentis
- Naglazyme
- Nplate
- Prolastin
- Promacta
- Riastap
- Soliris
- Synagis
- Thyrogen
- Xenazine
- Xolair
- Zavesca
- Zemaira

Oral Oncology Agents Including:

- Afinitor
- Gleevec
- Hycamtin
- Iressa
- Nexavar
- Oforta
- Revlimid
- Sprycel
- Sutent
- Tarceva
- Tasigna
- Temodar
- Thalomid
- Torisel
- Tykerb
- Vandetanib
- Votrient
- Xeloda
- Zolinza

Psoriasis/Rheumatoid Treatments including:

- Actemra
- Amevive
- Cimzia
- Enbrel
- Humira
- Orencia
- Remicade

Arthritis/Crohn's

Disease

Rituxan RA
Simponi
Stelara

Pulmonary Hypertension Drugs including:

Flolan
Letairis
Remodulin
Tracleer
Ventavis

Infertility Drugs including:

Bravelle
Chorionic Gonadotropin (HCG)
Follistim AQ
Ganirelix
Gonal-F
Menopur
Novarel
Ovidrel
Repronex

Viscosupplements including:

Euflexxa
Hyalgan
Orthovisc
Supartz
Synvisc
Synvisc One

Except for these changes, all of the remaining provisions in the “Benefits” section of your member document remain unchanged.

EXCLUSIONS AND LIMITATIONS

NOTE: There are some exclusions that have been revised in your member document since you received it and some others that have been deleted. As a result, please read through this section carefully.

The following is a list of services, supplies, etc., that are excluded and/or limited under this Plan. These exclusions and limitations supersede and override the “Benefits” section of your member document, so that, even if a health care service seems to be covered in the “Benefits” section, the following provisions, if applicable, will exclude or limit it.

Effective for Plan renewals or new Plans on or after January 1, 2011, the following exclusions in the “Exclusions And Limitations” section are added or revised.

Any Treatment for which there is Insufficient Evidence Of Therapeutic Value for the use for which it is being prescribed is not covered.

Smoking cessation products are excluded, except to treat nicotine addiction. When that occurs, the product must be obtained with a prescription and Pre-Authorized.

In addition, we may also cover smoking cessation products if:

- ♥ The Member is being actively case managed, and
- ♥ The use of the smoking cessation product is approved by us.

When those conditions are met, smoking cessation products may be provided as part of a health management program value-added service or as a benefit.

The following exclusion is deleted from the “Exclusions And Limitations” section effective for Plan renewals or new Plans on or after January 1, 2011.

Services rendered at Hospital-based clinics are excluded unless the Hospital clinics are contracted with us for specific services.

Except for these changes, all of the remaining exclusions and limitations in the “Exclusions And Limitations” section remain unchanged.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS

Effective for Plan renewals or new Plans on or after January 1, 2011, the first paragraph of the “Claims Filing” subsection of the “Claims Filing, Questions, And Complaints, And Appeal Process” section of your member document is revised and a second paragraph has been added.

CLAIMS FILING

Non-behavioral health claims for payment for Health Services must be received by us within 180 days from the date the services, medications, or supplies were received. Claims submitted more than 180 days after the date the services, medications, or supplies were received will not be reimbursed. You can check the status of your medical claims at any time by checking our web site at www.connecticare.com and logging in as described.

Behavioral health claims for payment for Health Services must be received by us within 90 days from the date the services were received. Claims submitted more than 90 days after the date the services were received will not be reimbursed. You can check the status of your behavioral health claims at any time by checking the OptumHealth Behavioral Solutions/UBH web site at www.liveandworkwell.com and logging in as described.

Except for these changes, all of the remaining provisions in the “Claims Filing, Questions, And Complaints, And Appeal Process” section remain unchanged.

TERMINATION AND AMENDMENT

Except as noted, effective for Plan renewals or new Plans on or after June 1, 2010, paragraphs 2 and 10 of the “Termination Of Your Coverage” provisions of the “Group Termination” subsection of the “Termination And Amendment” section of your member document are deleted and replaced with the following.

GROUP TERMINATION

Termination Of Your Coverage

This Agreement will terminate and coverage under this Plan will terminate on the earliest day that any of the following events occurs.

2. On the last day of the month during which you cease to be an Employee or on the date established by your Employer's termination standards.

Your Eligible Dependent spouse's coverage will terminate on the last day of the month after the month which he or she ceases to be an Eligible Dependent; or on the date established by your Employer's termination standards if coverage continues under COBRA or Connecticut rules.

Effective July, 1, 2011 for all Plans, your Eligible Dependent children's coverage will terminate on their 26th birthday if it coincides with the first day of this Plan's Contract Year. Otherwise, their coverage will terminate at the end of the last day of the Contract Year in which they become 26 years old.

10. The date you no longer reside or work in the Service Area or your covered dependent spouse no longer resides with you or in the Service Area as described in the "Eligibility And Enrollment" section of your member document, as applicable.

Effective for Plan renewals or new Plans on or after June 1, 2010 if you are enrolled in one of our ConnectiCare, Inc. Plans, paragraph 8 of the "Termination Of A Non-Group Member's Coverage" provisions of the "Non-Group Termination" subsection of the "Termination And Amendment" section of your member document is deleted and replaced with the following.

NON-GROUP TERMINATION

Termination Of A Non-Group Member's Coverage

This Plan will terminate and coverage under this Plan will terminate on the earliest day that any of the following events occurs.

8. The date you no longer reside in the Service Area or your covered dependent spouse no longer resides with you or in the Service Area as described in the "Eligibility And Enrollment" section of your member document.

COBRA AND CONTINUATION OF COVERAGE

Effective May 5, 2010 for all Plans, the "COBRA And Continuation Of Coverage" subsection of the "Termination And Amendment" section of your member document is deleted and replaced with the following.

The following "COBRA And Continuation Of Coverage" provisions DO NOT APPLY TO YOU IF YOU ARE ENROLLED IN OUR NON-GROUP PLAN.

As the result of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and Connecticut State law, a "Qualified Beneficiary" is offered the ability to continue coverage under this group Plan when a "Qualifying Event" occurs.

THE FOLLOWING IS A SUMMARY ONLY of the circumstances under which a Member may be eligible for continued group coverage under the COBRA and Connecticut rules. The Employer is responsible for notifying the Member of these rights and for administering the COBRA and Connecticut rules. (However, certain Employers may have hired us to perform certain billing services for the Employer for continuation premiums.)

In addition, Trade Adjustment Assistance (TAA)-eligible individuals and their dependents, as well as those who receive benefits from the Pension Benefit Guaranty Corporation (PBGC) and their dependents, may be eligible for extended COBRA coverage. Have your Employer contact us if you are eligible for TAA or PBGA benefits.

Your Right To Continue Benefits

As described in COBRA and Connecticut law, if coverage under this Agreement were to terminate due to a "Qualifying Event," a "Qualified Beneficiary" (you or your covered dependents) may elect to continue coverage for up to 30, 36 months or longer, based on the Qualifying Event(s) which occurred:

1. You and your covered dependents may continue coverage **up to 30 months** when coverage terminates due to: layoff, reduction in your hours, leave of absence, or termination of your employment for reasons other than gross misconduct.
2. You and your covered dependents may continue coverage **until you experience an event listed in the "Special Termination Of Continuation Coverage Conditions" provision of the "Termination Of Continuation Coverage" subsection**, if you experience a reduction, leave of absence or termination of employment as a result of your eligibility to receive Social Security income.
3. Coverage may continue **for up to 36 months** for the following persons:
 - ♥ A covered child who ceases to be an Eligible Dependent.
 - ♥ A covered spouse and dependents if you die.
 - ♥ A covered spouse and dependents whose coverage ceases due to divorce or legal separation from you.
 - ♥ A covered spouse and dependents if coverage ceases due to your entitlement for Medicare.

A child who is born to or adopted by you during the continuation period is also a Qualified Beneficiary entitled to continuation. There is a special continuation period for you if you are retired and your Employer declares bankruptcy under Title 11 of the United States Code and you and your covered dependents lose substantial coverage within one year before or after the date the bankruptcy proceedings commenced.

If continuation is elected, coverage will continue as though a Qualifying Event had not occurred. Any accumulation of Deductibles, Coinsurance or benefits paid prior to the Qualifying Event, which had been credited toward any Deductible, Coinsurance or maximum benefits of this Plan, will be retained as they would have been had the Qualifying Event not occurred.

During Annual Enrollment Periods, an individual with continuation of coverage has the same rights as active Employees to change his or her coverage or to add or eliminate coverage for covered dependents covered by this Plan.

If, after the first Qualifying Event, another Qualifying Event occurs, coverage can be continued for an additional period, up to a total of 36 months from the date coverage under this Plan would have first stopped. If the Subscriber retires and becomes entitled to Medicare within 18 months after retirement, the Subscriber's dependent Qualified Beneficiaries are entitled to continuation for up to 36 months beginning with the date of retirement. If the Subscriber becomes entitled to Medicare and then later retires (or otherwise stops working or has reduced hours resulting in loss of coverage), the Subscriber's dependent Qualified Beneficiaries are entitled to continuation for the greater of:

- ♥ Up to 36 months from the date of Medicare entitlement; or
- ♥ Up to 30 months from the date of the retirement or layoff, leave of absence, reduction in hours or employment termination for reasons other than gross misconduct.

The Subscriber is entitled to continuation for up to 30 months from the date of retirement or layoff, leave of absence, reduction in hours or employment termination for reasons other than gross misconduct, or until he or she experiences an event listed in the "Special Termination Of Continuation Coverage Conditions" provision of the "Termination Of Continuation Coverage" subsection if the retirement, or reduction in hours results from eligibility to receive Social Security income.

These group continuation provisions do not apply to newborn children who are covered only for 31 days after birth, as described in the "Eligibility And Enrollment" section of your member document, unless the newborn children are properly enrolled in this Plan as covered dependents within 31 days of their birth.

Notification Requirements

In order to be eligible for continuation, you must provide notice to your Employer within 60 days of the date of the following Qualifying Events.

- ♥ Your marriage is dissolved.
- ♥ You become legally separated from your spouse.
- ♥ Your dependent child no longer qualifies as your Eligible Dependent.

Complete instructions on how to elect continuation will be provided by your Employer.

Election Period

The length of time during which a Qualified Beneficiary may decide whether or not to continue coverage extends until the later of 60 days after the date coverage would have stopped due to the Qualifying Event or 60 days after the date notice of the right to continue coverage is sent.

A special COBRA election period may be available if you become eligible for trade adjustment assistance (TAA) under the Trade Act of 2002. If you did not elect COBRA

previously for loss of coverage related to TAA, the special COBRA election period begins on the first day of the month in which you become eligible for TAA and lasts for 60 days, EXCEPT that you may not elect COBRA more than six months after your TAA-related loss of coverage. If you elect COBRA during this special election period, the COBRA coverage will begin on the first day of the special election period. However, the COBRA coverage will end on the same date it would have terminated if you had elected COBRA when you first became eligible for it.

Payments

The Qualified Beneficiary has 45 days from the date of the election to make the first payment of premium. The first payment will include any payment for the coverage before the date of the election. For example, if the election to continue coverage is made 60 days following the Qualifying Event and payment is made 45 days following the election, a total of three months premium must be paid on that date. The premium to continue coverage will be determined by your Employer in accordance with the law.

Termination Of Continuation Coverage

Continuation of coverage shall not continue beyond the day any of the following events happen:

- ♥ The date the person reaches the maximum period of continuation of benefits (30 or 36 months from the date of the Qualifying Event).
- ♥ The date this Agreement stops being in force for any of the reasons listed in the "Termination Of Your Employer's Coverage" or the "Termination Of Your Coverage" subsections of this section, except paragraph "2" of the "Termination Of Your Coverage" subsection. (If your Employer offers another group health plan, coverage may continue under that plan.)
- ♥ 30 days after the required payment for the coverage is due and not made.
- ♥ The date the person becomes, after electing continuation, covered under any other group health plan or becomes entitled to Medicare. This does not apply if the other group health plan excludes or limits coverage on a person's pre-existing condition. If you or your Eligible Dependents are already covered under any other group health plan or Medicare before electing continuation coverage, you may still elect continuation coverage under this Plan.

Special Termination Of Continuation Coverage Conditions

If your retirement, reduction in hours, or employment termination results from your eligibility to receive Social Security income, then continuation of coverage for you and your dependents ends on the earliest of the following to occur:

- ♥ This Plan is no longer in force with your Employer;
(NOTE: If your Employer offers another health plan, coverage may continue under that plan.)

- ♥ 30 days after the required payment for coverage has not been made;
- ♥ The date you become eligible for Medicare; or
- ♥ The date you become eligible for other group coverage.

Subject to our review and approval, some Employers may have continuation policies that provide for additional terms of continuation coverage.

Except for these changes, all of the remaining provisions in the “Termination And Amendment” section remain unchanged.

DEFINITIONS

If you are enrolled in one of our **ConnectiCare, Inc. Plans, effective for Plan renewals or new Plans on or after January 1, 2012**, the term Coinsurance Maximum is added to the “Definitions” section of your member document.

COINSURANCE MAXIMUM

Generally, the Member’s maximum payment liability per year for Coinsurance for Health Services covered at the In-Network Level Of Benefits or separately at the Out-Of-Network Level Of Benefits, as listed in the Benefit Summary. Please refer to the “Managed Care Rules And Guidelines” section for more information about how the Coinsurance Maximum applies to your Plan.

Effective for Plan renewals or new Plans on or after January 1, 2012, the term Cost-Share Maximum is added to the “Definitions” section of your member document.

COST-SHARE MAXIMUM

Generally, the Member’s maximum payment liability per year for Copayment and Coinsurance as listed in the Benefit Summary. Please refer to the “Managed Care Rules And Guidelines” section for more information about how the Cost-Share Maximum applies to your Plan.

Effective for Plan renewals or new Plans on or after January 1, 2011, the term Insufficient Evidence Of Therapeutic Value in the “Definitions” section of your member document is deleted and replaced with the following.

INSUFFICIENT EVIDENCE OF THERAPEUTIC VALUE

Insufficient Evidence Of Therapeutic Value occurs when we determine in our sole discretion that either:

1. There is not enough evidence to prove that the service, supply, device, procedure or medication (collectively called “Treatment”) directly results in the restoration of health or function for the use for which it is being prescribed, whether or not alternative Treatments are available; or
2. There is not enough evidence to prove that the Treatment results in outcomes superior to those achieved with reasonable alternative Treatments which are less intensive or invasive, or which cost less and are at least equally effective for the use for which it is being prescribed.

There may be Insufficient Evidence Of Therapeutic Value for a Treatment even when it has been approved by a regulatory body or recommended by a health care practitioner, and the Treatment will not be covered.

Effective for Plan renewals or new Plans on or after April 1, 2011, the term Maximum Allowable Amount in the “Definitions” section of your member document is deleted and replaced with the following.

MAXIMUM ALLOWABLE AMOUNT

The amount on which we base our reimbursement for covered Health Services provided by Non-Participating providers, if you are enrolled in any of our **POS Plans**, which may be less than the amount billed for those covered Health Services. We calculate the Maximum Allowable Amount as the lesser of the amount billed by the Non-Participating Provider or where applicable, the amount determined by one of the methods described below. In addition, the Maximum Allowable Amount is not the amount that we pay for a covered Health Service. The actual payment will be reduced by applicable Deductible(s), Coinsurance, Copayment(s), Benefit Reduction amounts and other applicable adjustments described in your member document. In no case will our reimbursement exceed the maximum benefit described in your member document.

We have the sole authority to determine what we use for the Maximum Allowable Amount. The Maximum Allowable Amount can change from time to time, as well as the criteria we will use to determine the Maximum Allowable Amount.

Only charges that you are legally required to pay for a Health Service will count towards the Maximum Allowable Amount. So, if the physician or provider is not charging you for part or all of the Health Service and you are therefore not legally obligated to pay for that waived amount, we will not count that waived amount towards the Maximum Allowable Amount.

1. We may contract with vendors that have fee arrangements with Non-Participating Providers (Third Party Networks). If you utilize a Non-Participating Provider in a Third Party Network, the Maximum Allowable Amount will be determined based on our contract with the Third Party Network. Where the terms of our contract with the Third Party Network require, we will always use the contract fee between the Non-Participating Provider and the Third Party Network as the Maximum Allowable Amount. For other arrangements, we will determine the Maximum Allowable Amount as the lesser of the contract fee, or billed charges or the amount determined by one of the methods described below.
2. We may, at our option, refer a claim for the Out-Of-Network Level Of Benefits covered Health Service to a fee negotiation service to negotiate the Maximum Allowable Amount with the Non-Participating Provider. In that situation, if the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount, you will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible(s),

Coinsurance and/or Copayment(s) at the Out Of Network Level Of Benefits, as well as any Benefit Reduction amounts.

3. For physician and other professional covered Health Services, we may utilize a designated percentage of Resource Based Relative Value System (RBRVS) determined by us based on a percentage of Medicare. When no amount specified by the Centers for Medicare and Medicaid Services (CMS) at a percentage of RBRVS exists, a percentage of charges, as determined by us, will be used instead.

As applicable for group Plans, when the Employer chooses and pays the appropriate Premium for a higher percentage of Medicare than our standard described above, the percentage amount used to determine the Maximum Allowable Amount under this Plan will be specified in the Evidence Of Agreement.

4. For inpatient and outpatient Hospital covered Health Services, we may utilize a method developed by a company that uses Hospital cost to charge (C2C) ratio. This method analyzes charges based upon Hospital's: financial and statistical information as submitted to the Federal Government; cost of providing covered Health Services; and the median mark up by revenue center for Hospitals in that geographic area. These values are then compared to the actual billed charges. If the Hospital accepts the C2C determination it will become the Maximum Allowable Amount for the services rendered, at that time.
5. Where prescription drugs (e.g., IV therapy claims) are administered by a Non-Participating Provider, and covered as a medical benefit, we will determine the Maximum Allowable Amount using the Average Wholesale Price (AWP), as determined by us.
6. For a prescription drug or supply obtained at a pharmacy, the Maximum Allowable Amount will be the lesser of the actual charge for the medication or supply or the negotiated contracted rate for that medication or supply that we would have paid, if the medication or supply had been obtained at a Participating Pharmacy.

In the event that the billed charges for the Non-Participating Provider are more than the Maximum Allowable Amount, you are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Non-Participating Provider's fee is determined by references to a Third Party Network contract or the Non-Participating Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever you obtain covered Health Services from a Non-Participating Provider, you are responsible for applicable Deductibles(s), Coinsurance, Copayment(s) and/or Benefit Reduction Amounts.

For more information on the definition of Maximum Allowable Amount, you can contact us at the appropriate telephone number in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section your member document.

Effective for Plan renewals or new Plans on or after January 1, 2012, the term Primary Care Provider (PCP)s in the "Definitions" section of your member document is deleted and replaced with the following.

PRIMARY CARE PROVIDER OR PCP

A physician, advanced practice registered nurse (APRN), or a nurse practitioner who is a Participating Provider selected by or assigned to the Member, who is normally engaged in one of the following primary care specialties:

- ♥ Family medicine;
- ♥ Internal medicine; or
- ♥ Pediatrics; and

who is eligible to be listed as a PCP in the Provider Directory, as updated from time to time.

Effective for Plan renewals or new Plans on or after January 1, 2011, the term Wilderness Camp is added to the "Definitions" section.

WILDERNESS CAMP

A camp that provides behavioral health intervention for children and adolescents with emotional, addiction, and or psychological problems. The intervention typically involves immersion in the wilderness or wilderness like setting, group living with peers, the administration of individual and group therapy sessions, and educational/therapeutic curricula, including back country travel, wilderness living skills and horseback riding.

Except for these changes, all of the remaining definitions in the "Definitions" section of your member document remain unchanged.

PLAN DESCRIPTION ADDENDUM

Effective for ConnectiCare, Inc. Plan renewals or new Plans on or after January 1, 2012, the "Plan Description Addendum" section in your member document is deleted and replaced with the following.

This addendum, in conjunction with your member document, any applicable Rider and the Provider Directory constitutes compliance with the disclosure requirements of Connecticut law, "AN ACT CONCERNING MANAGED CARE," regarding Plan Descriptions.

We are a for-profit health care center, organized under the Connecticut Business Corporations Act. If our status should change, you will be notified in our member newsletter.

We are also accredited by the National Committee for Quality Assurance (NCQA).

The following information is a summary of our 2010 utilization review data with respect to the number of certifications requested; the number of admissions, services, procedures or extension of stays not certified; and the number of denials upheld or reversed on Appeals within our utilization review process. This information does not include review data for benefits managed or administered by an outside company under its own Connecticut utilization review license.

Utilization Review Data

Requests for Certification

35,946

Certification Denials

6,512, or approximately 18.0%

Number of Appeals of Denials

624, or 10.0%

Number of Denials Reversed Upon Appeal

279, or approximately 45.0%

Below are the ratios of medical and administrative costs to gross premium revenue for 2010.

State Medical Loss Ratio

78.7%

State Administrative Loss Ratio

17.0%

Federal Medical Loss Ratio

Not yet available

Satisfaction Results, HEDIS

1. Based on the *HEDIS (Healthcare Effectiveness Data and Information Set) CAHPS (Consumer Assessment of Healthcare Providers and Systems) Member Satisfaction* study for 2010, 58.1% of our Members gave us an 8 or above when they were asked to rate our health plan on a scale ranging from worst health plan (“0”) to the best health plan (“10”).
2. ConnectiCare makes information about its Quality Improvement Program available to all Members. This includes information about the quality information program, including goals, processes and outcomes as they relate to Member health and service. You may access this information at www.connecticare.com. If you would like a written copy, you should feel free to call our Member Services Department at the appropriate telephone number listed in the “Important Telephone Numbers And Addresses” subsection of the “Important Information” section of your member document.
3. Connecticut law requires the State of Connecticut Insurance Department to develop and distribute a consumer report card, which compares:
 - ♥ All applicable licensed managed care organizations, and
 - ♥ The 15 largest licensed health insurers that use provider networks not included above.

Except for these changes, your member document, including any other Riders, remains unchanged.