CONNECTICARE, INC.
PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)
AMENDATORY RIDER

For the purposes of this Rider, the Plan and Membership Agreement, including any applicable Riders, are amended as described herein.

This Rider is to be attached to and form a part in your Membership Agreement, including any applicable Riders. All the terms and conditions in your Membership Agreement 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/PPACAARider 01 (10/2010)

Approved for use for 2010

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The "Eligibility And Enrollment" section in your Membership Agreement is revised as follows.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY RULES

Effective for Plan renewals or new Plans on or after June 1, 2010, paragraph 4 of the "General Rules" provisions of the "Eligibility Rules" subsection of the "Eligibility And Enrollment" section in your Membership Agreement is revised as follows.

General Rules

4. Your children under age 26 may be eligible for coverage under this Plan until they become covered as an employee under a group health plan.

   This means that your Eligible Dependent children may now include married dependents who are under age 26. In addition, all residency requirements that may have existed for those children under the Plan have been removed.

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

CHANGES AFFECTING ELIGIBILITY

Effective for Plan renewals or new Plans on or after June 1, 2010, paragraph 1 of the "Changes Affecting Eligibility" subsection of the "Eligibility And Enrollment" section in your Membership Agreement is deleted and replaced with the following.

You must notify us immediately of any change that may affect you or your dependents covered under this Plan. These changes include, but are not limited to:

1. Your marriage;

Except for these changes, all of the remaining provisions in the "Eligibility And Enrollment" section in your Membership Agreement remain unchanged.

MANAGED CARE RULES AND GUIDELINES

The "Managed Care Rules And Guidelines" section in your Membership Agreement is revised as follows.

COST-SHARES YOU ARE REQUIRED TO PAY

Maximums

Benefit Maximum

Effective for Plan renewals or new Plans on or after September 23, 2010, any annual benefit maximum under your Plan that applies to Essential Benefits is deleted.

Lifetime Maximum

Effective for Plan renewals or new Plans on or after September 23, 2010, a Lifetime Maximum no longer applies to any Plans.

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

BENEFITS

The "Benefits" section in your Membership Agreement is revised as follows.

IMPORTANT NOTICE
ABOUT PREVENTIVE AND WELLNESS

Effective for Plan renewals or new Plans on or after September 23, 2010, some Participating Provider preventive and wellness services, as defined by the United States Preventive Service Task Force and that are listed in your Benefit Summary, are exempt from all Member Cost-Shares (Deductible, Copayment and Coinsurance) under the Patient Protection and Affordable Care Act (PPACA). These services are identified by the specific coding your Participating Provider submits to ConnectiCare. Service coding must match ConnectiCare's coding list to be exempt from all Cost-Sharing.

EMERGENT/URGENT CARE

When you or one of your covered dependents need treatment due to a sudden or unexpected illness or injury, or

because of a Medical Emergency, this Plan provides coverage as follows.

Effective for Plan renewals or new Plans on or after September 23, 2010, the "Emergency Room" provisions of the "Emergent/Urgent Care" subsection of the "Benefits" section in your Membership Agreement is deleted and replaced with the following.

Emergency Room

An Emergency is defined as: "the sudden and unexpected onset of an illness or injury with severe symptoms whereby a Prudent Layperson, acting reasonably, would believe that emergency medical treatment is needed."

For mental health care, an Emergency also exists when a Member is at risk of suffering serious physical impairment or death; or of becoming a threat to himself/herself or others; or of significantly decreasing his/her functional capability if treatment is withheld for greater than 24 hours.

Determination of whether a condition is an Emergency rests exclusively within our discretionary authority.

Emergency Services rendered both within and outside of the Service Area are **covered at the In-Network Level Of Benefits for Cost-Sharing**, whether rendered in a Participating Hospital or Non-Participating Hospital emergency room. Non-Participating Hospital emergency rooms may balance bill the Member for their charges over and above a reasonable amount paid by us, as defined by federal law. In the event of an Emergency, medical assistance should be obtained as soon as possible. It is strongly urged that you seek care:

- From the closest emergency room; or
- From a Participating Hospital emergency room (and if possible you or your representative should contact your Primary Care Provider (PCP) or, for mental health care or alcohol and substance abuse Emergencies, your practitioner or our Behavioral Health Program, at the appropriate telephone number listed in the "Important Telephone Numbers And Addresses" subsection of the "Important Information" section of this Membership Agreement, prior to obtaining care so the PCP, your practitioner or our Behavioral Health Program can be involved in the management of your health care);
- By telephoning 911, if necessary and where this medical response system is available.

Except for these changes, all of the remaining provisions in the "Benefits" section in your Membership Agreement remain unchanged.

CLAIMS FILING, QUESTIONS AND COMPLAINTS, AND APPEAL PROCESS

Effective September 23, 2010 for all Plans, the "Appeal Process" subsection of the "Claims Filing, Questions, And Complaints, And Appeal Process" section in your Membership Agreement is deleted and replaced with the following.

APPEAL PROCESS

If you are not satisfied with a decision we or our Delegated Programs have made regarding Health Services, benefits, Pre-Authorization, Pre-Certification or claims, then you or your legal representative may request an Appeal on your behalf.

Of course, before pursuing the Appeal process, you should always consider seeking immediate assistance from our Member Services Department, as described in the "Questions And Complaints" subsection of the Membership Agreement. Often, questions and complaints can be resolved quickly and informally by speaking with one of our representatives. However, if you choose to make use of the Appeal process, we will not subject you to any sanctions or impose any penalties on you.

The Appeal process is divided into two categories.

1. One category deals with the **Medical Necessity Appeal** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain surgical procedure.
2. The other category deals with the **Administrative (Non-Medical Necessity) Appeal**, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity.

In either case, the Appeal request may be initiated orally, electronically or by mail by calling, faxing or writing us as follows:

Telephone: 1-800-251-7722

Facsimile: 1-800-319-0089 or (860) 674-2866

ConnectiCare
Member Appeals
PO Box 4061
Farmington, Connecticut 06034-4061

For urgent or expedited behavioral health reviews, contact our behavioral health Delegated Program at:

Telephone: 1-888-946-4658

Facsimile: 1-800-322-9104

OptumHealth Behavioral Solutions / UBH
Attention: Complaints and Appeals Department
1900 East Golf Road, Suite 300
Schaumburg, IL 60173

When contacting us or our behavioral health Delegated Program, you should explain why you feel the original decision should be overturned and submit any other information you think is relevant.

The Appeal must be made as soon as possible after you receive the original decision, but no later than six months after the Pre-Authorization request was denied or six months after the claim for benefits was denied, whichever comes first. If you fail to submit your request within the six months, you lose your right to your Appeal.

You may contact the Insurance Department for assistance or with any complaints at:

State of Connecticut Insurance Department
Insurance Commissioner
PO Box 816
Hartford, Connecticut 06142-0816

860-297-3910

For assistance with completing an Appeal, or if you believe you have been given erroneous information contact the Office of the Health Care Advocate at the following address and telephone number:

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT. 06114

or

(Toll Free) 1-866-466-4446

Medical Necessity Appeal

Internal Appeal Process

If you disagree with a decision regarding the **Medical Necessity** of a particular Health Service, such as a denial of a request for Pre-Certification of an inpatient admission or the Pre-Authorization of a certain surgical procedure, you may Appeal that decision.

Our *internal* Appeal process is designed to resolve Appeals quickly and impartially through the use of an independent review organization of medical practitioners (except for behavioral health expedited and urgent reviews, which are reviewed by an appropriately licensed specialist through our behavioral health Delegated Program).

1. We will investigate your Appeal request. If during this investigation, we acquire new or additional evidence that will be reviewed as part of your Appeal, we will provide that information to you or your representative for review. You will have two business days to respond to the new or additional information before we send your Appeal to the independent physician reviewer.
2. The independent review organization will arrange to have the Appeal reviewed by a board-certified physician specialist in the field related to the condition that is the subject of the Appeal who was not involved in the original decision. If the physician reviewer agrees with ConnectiCare's decision to deny coverage, but uses new or additional rationale for their decision, then you or your authorized representative will be provided with the new or additional rationale and will have an opportunity to respond before the decision is issued.
3. You or your authorized representative and your practitioner will be sent a written decision no later than 30 calendar days after we receive your Appeal request, unless your request meets the definition of "urgent" (see the "Urgent Care Appeals" provision explained later in this subsection). If you have an urgent care Appeal, a decision will be made and you will be notified within the time frames outlined below.
4. If you are not satisfied with the decision made by the independent review organization, then you or your legal representative or any provider with your consent, may request a utilization review external appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

For all ongoing treatment, when you file an Appeal with us, coverage will remain in effect through the end of our internal Appeal process.

Urgent Care Appeals

You may file an Appeal on an urgent basis with us if we have issued an Adverse Determination for coverage, and any of the following circumstances exist:

- You or your covered dependent have an Emergency or life-threatening situation,
- A delay in treatment could seriously jeopardize your or your covered dependent's life or health or ability to regain maximum function
- In the opinion of a physician with knowledge of the condition, you or your covered dependent would be subject to severe pain that could not be adequately managed without the services related to the Appeal.
- You are receiving ongoing care for which ConnectiCare has issued an Adverse Determination. In this case, you may file an expedited external review at the same time as the internal appeals process. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

Your Appeal will be reviewed by a board-certified physician specialist in the field related to the condition that is the subject of the Appeal who was not involved in our original decision.

A decision on an urgent Appeal will be made as soon as possible, taking into account your condition. If we receive all of the necessary information with your Appeal, you will receive a decision within 24 hours after we have received your Appeal. If we need additional information in order to make the decision, then we will contact you within 24 hours of our receipt of your Appeal to tell you specifically what information we need, and you will have 48 hours to provide us with that information. We will make the decision no later than 24 hours after receipt of the missing information. **Please note that a behavioral health urgent review is reviewed by an appropriately licensed specialist who was not involved in the original decision through our behavioral health Delegated Program, and not an independent review organization.**

If you are not satisfied with the urgent Appeal decision **made by us**, then you, your legal representative or any provider with your consent may request a utilization review external appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

If the time frame for completing the urgent Appeal described above may cause or exacerbate an Emergency or life-threatening situation for you or your covered dependent,

then you or your legal representative or your provider with your consent may request an expedited external Appeal through the State of Connecticut Insurance Department. Please refer to the "Utilization Review External Appeal" provision explained later in this subsection.

Utilization Review External Appeal

1. The utilization review external appeal must be submitted to the State of Connecticut Insurance Department in writing. The address and telephone number is:

State of Connecticut Insurance Department
Insurance Commissioner
PO Box 816
Hartford, Connecticut 06142-0816

860-297-3910

2. The Appeal must be made within 60 calendar days of your receipt of the final denial letter. However, an expedited external utilization review Appeal may be filed without receipt of our final denial letter if you decide to appeal because you feel the timeframe for completing our urgent Appeal may cause or exacerbate an Emergency or life-threatening situation.

NOTE: An expedited utilization review external Appeal is not available when the requested services have already been provided.

3. The Appeal will require a fee of $25 payable to the State of Connecticut Insurance Department. This fee will be waived if you are poor or unable to pay.
4. The State's external review organization will notify you and ConnectiCare of their decision in writing.

If you need help having ConnectiCare materials translated from English to a different language, please call 877 373-1206.

Administrative (Non-Medical Necessity) Appeal

If you disagree with an **Administrative (Non-Medical Necessity)** decision, such as a decision that interprets the application of Plan rules and that does not relate to Medical Necessity, you may Appeal that decision.

The Appeal request may be initiated orally, electronically or by mail by calling, faxing or writing us as follows:

Telephone: 1-800-251-7722

Facsimile: 1-800-319-0089 or (860) 674-2866

ConnectiCare
Member Appeals
PO Box 4061
Farmington, Connecticut 06034-4061

When contacting us or our behavioral health Delegated Program, you should explain why you feel the original decision should be overturned and submit any other information you think is relevant.

The Appeal must be made as soon as possible after you receive the original decision, but no later than six months after the service was rendered or the request was denied. If you fail to submit your request within the six months you lose your right to your Appeal. For all ongoing treatment, when you file an Appeal with us, coverage will remain in effect through the end of our internal Appeal process.

For assistance with completing an Appeal, or if you believe you have been given erroneous information contact the Office of the Health Care Advocate at the following address and telephone number:

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, Ct. 06114

or

(Toll Free) 1-866-466-4446

1. When the Appeal is submitted, it will be forwarded for review.
2. A staff member who was not involved in the original decision will review the Appeal.
3. You or your legal representative will be provided with a written decision within 30 calendar days after receipt of the request.

If you need help having ConnectiCare materials translated from English to a different language, please call 877 373-1206.

Except for these changes, all of the remaining provisions in the "Claims Filing, Questions, And Complaints, And Appeal Process" section in your Membership Agreement remain unchanged.

DEFINITIONS

Effective for Plan renewals or new Plans on or after September 23, 2010, the term Adverse Determination is added to the "Definitions" section in your Membership Agreement.

ADVERSE DETERMINATION

Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental Or Investigational or not Medically Necessary or appropriate.

Effective for Plan renewals or new Plans on or after September 23, 2010, the term Essential Benefit is added to the "Definitions" section in your Membership Agreement.

ESSENTIAL BENEFITS

Essential Benefits include those services set forth in regulations issued by the Department of Health and Human Services pursuant to the Patient Protection and Affordable Care Act (PPACA).

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) ADDENDUM

PRIMARY CARE PROVIDERS (PCP)S

ConnectiCare generally allows the designation of a Primary Care Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of the PCP Participating Providers, please call us at (860) 674-5757 or 1-800-251-7722.

For children, you may designate a pediatrician as the PCP.

You do not need Pre-Authorization from ConnectiCare or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Pre-Authorization or Pre-Certification for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating Providers who specialize in obstetrics or gynecology, please call us at (860) 674-5757 or 1-800-251-7722.

Except for these changes, your Membership Agreement, including any other Riders, remains unchanged.