AMENDATORY RIDER

All 2 and 3 Tier Managed Prescription Drug Plans and Riders (Including Standalone)
All Copayment Prescription Drug Riders (Including Standardized & Unstandardized)
Full and Copayment Prescription Drug Rider (Standardized)
Comprehensive Prescription Drug Rider
Copayment and Coinsurance Prescription Drug Rider
Point of Service Prescription Drug Rider
Coordinated Prescription Drug Rider
Managed Prescription Drug Rider

I. Amendments to the list below may have been sent throughout the year of 2009 via newsletter. This chart applies only to those Certificates of Coverage with the section entitled "**Covered Drugs Requiring Prior Authorization"**. If your Certificate does not have this section, this chart does not apply to you. The list below represents the current list of covered drugs for which Prior Authorization is required and has been amended as follows:

Accutane	Herceptin	Remodulin
Aciphex	HP Acthar Gel	Revatio
Actiq	Humira	Revlimid
Adcirca	Increlex	Rituxan
Afinitor	Infergen	Roferon A
Alamast	Infertility Drugs	Rozerem
Alocril	IntronA	Savella
Alomide	Iressa	Serevent
Ambien CR	Isotretinoin	Simponi
Amevive	IVIG Products	Sonata
Amphetamine/ Dextroamphetamine	Kineret	Sporanox
Androderm	Lamisil	Sprycel
AndroGel	Letairis	Suboxone
Android	Leukine	Subutex
Anorexiants	Lidoderm	Sutent
Aranesp	Lucentis	Synagis
Arthrotec	Lunesta	Synarel
Avastin	Lupron	Tarceva
Botox	Lyrica	Targretin
Botulinum toxin	Macugen	Tasigna
Byetta	Meridia	Temodar
Celebrex	Methitest	Testim
Ceredase	Myobloc	Testopel
Cerezyme	Nasal Corticosteroid	Testosterone Cream/Ointment
Chantix	Neulasta	Testred
Cimzia	Neumega	Thalomid
Crestor	Neupogen	Topomax
CSF category	Nexavar	Trelstar
Delatestryl	Nexium	Tykerb
Dihydroergot-amine mesylate inj (DHE)	Nicotrol Inhaler and Nasal spray	Tysabri
Elestat	Non-preferred diabetic test strips (any other than the preferred Accu-Check and Lifescan/One Touch Product lines)	Tyvaso
Elidel	Non-sedating Antihistamine	Vantas Implant

Eligard	Nuvigil	Vectibix
Emadine	Onsolis	Veramyst
Enbrel	Optivar	Vfend
Enteral Nutrition	Orencia	Viadur
Epogen	Pantoprazole	Vivitrol
Epoprostenol	Pegasys	Vytorin
Erbitux	Peg-Intron	Xeloda
Fentanyl, Fentora	Penlac	Xenical
Flolan	Prilosec	Xolair
	Procrit	Xylocaine IV
Foradil	Protopic	Zavesca
Forteo	Provigil	Zegerid
Fuzeon	Qualaquin	Zetia
Gleevec	Rebetron	Zoladex
GnRH category	Remicade	Zolinza
Growth Hormones		Zyban
		Zyvox

II. Effective October 1, 2009 the Certificate of Coverage to which this Amendatory Rider is attached is amended as follows:

(1) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"ELIGIBILITY SECTION"** section **"SPECIAL ENROLLMENT PERIODS"** subsection is amended **with the addition of**:

Eligible employees or Dependents may also enroll under two additional circumstances:

1. The employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

2. The employee or Dependent becomes eligible for a subsidy (state premium assistance program under Medicaid or CHIP.

The employee or Dependent must request special enrollment within 60 days of the loss of Medicaid/chip or of the eligibility determination. If Anthem BCBS receives an application to add a Dependent or an eligible person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

(2) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"TERMINATION"** section, **"TERMINATION OF THE MEMBER"** subsection is amended **with the addition of**:

However the Employer Group, upon a Covered Person's voluntary termination or termination of the Covered Person by the Employer Group, may elect to receive a credit for the portion of the premium paid for your coverage. As such, an earlier date of termination may apply if the Employer Group notifies Anthem BCBS within 72 hours of the date the Employer Group has terminated a Covered Person due to voluntary termination or termination by the Employer Group; in which case the date of termination shall be 72 hours following the date termination is issued by the Employer Group.

In the event that the Employer Group contacts Anthem BCBS after 72 hours from the date the Employer Group has terminated a Covered Person or due to the Covered Person's voluntary termination the standard termination date will apply without exception as described above.

Receipt of a credit for the portion of the premium paid for the Covered Person's coverage may trigger the need to return the portion of said premium contributed by the Covered Person whose coverage is being terminated. Accordingly, upon the Employer Group's election to receive a credit for the portion of the premium paid for the Covered Person's coverage, it is the Employer Group's responsibility to notify the Covered Person of the termination of the Covered Person's insurance coverage within 72 hours of the date the employment of the Covered Person has terminated due to voluntary termination or termination by the Employer Group.

(3) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"TERMINATION"** section, **"TERMINATION OF THE MEMBER"** section is amended **with the addition of**:

In the event of the termination of the Covered Person based on Anthem BCBS standard termination rules or the Employer Group's election of early termination in order to receive a credit against premium payment, coverage under the Benefit Program will also terminate for any and all Dependents enrolled under the Benefit Program.

(4) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"TERMINATION"** section, **"TERMINATION OF THE EMPLOYER GROUP"** section is amended **with the deletion of**:

- Anthem BCBS may not renew the entire contract in the event the Contractholder fails to meet the participation or contributory requirements stated in the Group Health Care Benefits Contract.

(B.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"TERMINATION"** section, **"TERMINATION OF THE EMPLOYER GROUP"** section is amended **with the addition of**:

- Anthem BCBS may not renew the entire contract in the event the Contractholder fails to meet the participation or contributory requirements stated in the Group Health Care Benefits Contract and as described below.

  Contribution requirements do not apply to continuation of coverage under Connecticut Continuation Rights, C.G.S.38a-538 and 38a-554, or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) P.L.99-272.: esl.

PARTICIPATION REQUIREMENTS:

A. <u>1-50 Eligible Employees</u>

The Employer Group agrees to contribute at least 25% of the class I (single person) premium rate for all eligible employees, excluding Members covered under the provisions of COBRA or other applicable law.

If the Employer Group offers employees a choice of health plans, the Employer Group agrees to make equitable contributions on behalf of all eligible employees. Equitable contributions are defined as contributions that do not financially discriminate against eligible employees who select Anthem BCBS. Acceptable policies are: equal dollar or percentage contributions, reasonable amounts for salary or projected utilization differentials, designated amounts up to the maximums contributed by the Employer Group to the base plan, or reasonable maximums if Anthem BCBS would be offered at little or no cost, or any other formula that is mutually accepted by the Employer Group and Anthem BCBS.

Participation Requirement:

2-9 Eligible Employees – 100%*
10+ Eligible Employees – 75%*

*exclusive of employees waiving coverage due to spousal coverage

B. 51+ Eligible Employees

The Employer Group agrees to contribute at least 50% of the class I (single person) premium rate for all eligible employees, excluding Members covered under the provisions of COBRA or other applicable law.

Contribution levels below 50% (not less than 25%) will require proof that participation minimums are met and may require additional underwriting consideration and/or approval. Anthem BCBS will not accept contribution levels less than 25%.

Participation Requirement:

75% of net eligible lives less valid credits (waivers) and 50% of total eligible employees. Eligible lives is the total eligible employees prior to credits (waivers) given for each eligible employee that has coverage elsewhere as determined by Anthem BCBS.

(5) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"MEMBER APPEAL PROCESS"** section is amended **with the addition of**:

An external appeal process administered by the State of Connecticut Insurance Department is available to Members of a fully insured health plan or self-insured governmental plan. A Member may utilize the external appeal process directly, and would not need to exhaust all internal appeals in order to file for an external appeal if it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. Please see the Other Member's Rights section for addition information regarding the external appeals process.

(6) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"MEMBER APPEAL PROCESS"** section **"APPEAL PROCESS FOR ADVERSE UTILIZATION REVIEW DETERMINATION", "Second Level Appeal"** subsection is amended **with the deletion of**:

Any request for an external appeal regarding an adverse utilization review determination must be received by the Insurance Department within sixty (60) days from the date of the receipt of the final Appeal determination.

(B.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"MEMBER APPEAL PROCESS"** section **"APPEAL PROCESS FOR ADVERSE UTILIZATION REVIEW DETERMINATION", "Second Level Appeal"** subsection is amended **with the addition of**:

Any request for an external appeal regarding an adverse utilization review determination must be received by the Insurance Department within sixty (60) days from the date of the receipt of the final Appeal determination, unless the Member is eligible for an expedited external appeal. Please see Other Member Rights for additional information regarding the external appeal process.

(7) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"MEMBER APPEAL PROCESS"** section **"APPEAL PROCESS FOR ADVERSE NON-UTILIZATION REVIEW DETERMINATION", "Second Level Appeal"** subsection is amended **with the deletion of**:

A Second Level Appeal review request should include copies of any additional documentation supporting the Second Level Appeal.

(B.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"MEMBER APPEAL PROCESS"** section **"APPEAL PROCESS FOR ADVERSE NON-UTILIZATION REVIEW DETERMINATION", "Second Level Appeal"** subsection is amended **with the addition of**:

A Second Level Appeal review request should include copies of any additional documentation supporting the Second Level Appeal. Please see Other Member Rights for additional information regarding the external appeal process.

(8) (A.) As to the 3 Tier Managed Prescription Drug Plan (**Standalone**), the **"MEMBER APPEAL PROCESS"** section **"OTHER MEMBER RIGHTS"** subsection is amended **with the addition of**:

- To be eligible for an external appeal, the Member must first exhaust all of the utilization review company's internal appeal mechanisms unless it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life threatening situation, the enrollee, or provider acting on behalf of the enrollee with the enrollee's consent, would not need to exhaust all internal appeals in this situation in order to file for an external appeal. The expedited appeal application must be filed with the Insurance Department immediately following receipt of the utilization review company's initial adverse determination or at any level of adverse appeal determination. If the expedited appeal is not accepted on an expedited basis, and the enrollee has not previously exhausted all internal appeals, the enrollee may resume the internal appeal process until all internal appeals are exhausted and then may file for a standard external appeal within 60 days following receipt of the final denial letter. If all internal appeals were previously exhausted, the enrollee's rejected expedited external appeal will automatically be eligible for consideration for standard external appeal. The enrollee is not required to submit a new application.

- The external appeals process is not available to enrollees who are covered under a non-governmental self-insured plan or to denials regarding workers compensation.

This Rider is to be attached and form a part of your Certificate and any riders; changes; or endorsements to it. This Rider does not extend, vary, change, or waive any of the terms, benefits, exclusions, limitations, or conditions in the Certificate except as shown in this Rider.