AMENDATORY RIDER
Dental Expense Plan

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

(1) (A.) As to the "**GENERAL PROVISIONS**" section, the "**TERMINATION OF THE POLICY**" subsection is hereby **deleted in its entirety and replaced with**:

TERMINATION OF THE POLICY

1. This Policy may be terminated in accordance with applicable law at the option of the Policyholder without cause upon delivery of 15 days prior written notice to the other party, to be effective the first of the month following the expiration of the 15 day notice period.

2. This Policy will be terminated at Anthem BCBS's option for the Policyholder's non-payment of premiums. Termination will go into effect on the last to occur of the date to which such premiums have been paid by the Policyholder or the 30th day following the date when such premiums are due.

3. This Policy will be terminated at Anthem BCBS's option, in the event the Policyholder receives 30 days prior written notice from Anthem BCBS of the Policyholder's failure to perform any obligation required by this Policy. Such termination shall occur the first day of the month following such 30 day notice period.

4. Anthem BCBS may not renew this Policy in the event the Policyholder fails to meet the participation or contributory requirements stated in the Group Health Care Benefits Contract and as stated below: during the policy period for more than 60 continuous days.

   Anthem BCBS may not renew this Policy in the event the Policyholder fails to meet the participation or contributory requirements at the time of renewal.

   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. The termination, expiration, non-renewal or cancellation of the Policy by the Policyholder or Anthem BCBS will automatically result in the termination of each Covered Person's or Dependent's right to coverage and benefits under this Policy.

6. During the first two years following the effective date of the policy, Anthem BCBS may rescind, cancel or limit the Benefit Program if Anthem BCBS, determines after completing underwriting, there was information submitted by or omitted on behalf of the Employer Group during the initial application and enrollment process, and such information was material to the acceptance of the application at the time submitted to Anthem BCBS. Such information may include, but is not limited to, information regarding eligibility of the Employer Group or any Members to receive coverage under the Benefit Program. The date of rescission shall be the Effective Date of the Benefit Program.

7. The termination, expiration, non-renewals or cancellation of the Group Health Care Benefits Contract by the Contractholder or Anthem BCBS will automatically result in the termination of each Covered Person's or Dependent's right to coverage and benefits under this Benefit Program.

(2) (A.) As to the PPO Plus Preventive and PPO Preventive plans the "**TERMINATION OF THE EMPLOYER GROUP**" subsection is hereby **deleted in its entirety and replaced with**:

Termination of the Employer Group

1. The Benefit Program may be terminated in accordance with applicable law as follows:

   a. At the option of the Employer Group without cause upon delivery of 15 days prior written notice to the other party, to be effective the first of the month following the expiration of the 15 day notice period;

   b. By Anthem BCBS, at its option, in the event the Employer Group fails to pay all or any portion of the premium due Anthem BCBS. Such termination shall be effective on the last to occur of the date to which such premium has been paid by the Employer Group or the 30th day following the date when premium is due;

c. By Anthem BCBS, at its option, in the event the Employer Group receives 30 days prior written notice from Anthem BCBS of the Employer Group's failure to satisfy any other covenant or obligation contained in the Benefit Program or any underwriting requirement designated by Anthem BCBS. Such termination shall occur the first day of the month following such 30 day notice period.

d. Anthem BCBS may not renew the entire contract, in the event the employer groups fails to meet the participation or contributory requirements stated below during the policy period for more than 60 continuous days.

Anthem BCBS may not renew, in the event the employer group fails to meet the participation or contributory requirements at the time of renewal.

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.

PARTICIPATION REQUIREMENTS

A. 1-50 Eligible Employees

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.

2. During the first two years following the effective date of the Policy, Anthem BCBS may rescind, cancel, or limit the Benefit Program if Anthem BCBS, determines after completing underwriting, there was information submitted by or omitted on behalf of the Employer Group during the initial application and enrollment process, and such

information was material to the acceptance of the application at the time submitted to Anthem BCBS. Such information may include, but is not limited to, information regarding eligibility of the Employer Group or any Members to receive coverage under the Benefit Program. The date of rescission shall be the effective date of the Benefit Program.

3. The termination, expiration, non-renewals or cancellation of the Group Health Care Benefits Contract by the Contractholder or Anthem BCBS will automatically result in the termination of each Covered Person's or Dependent's right to coverage and benefits under this Benefit Program.

(3) (A.) The "**GENERAL PROVISIONS**" section "**TERMINATION OF MEMBER'S COVERAGE UNDER THE POLICY**" 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.

(4) (A.) The "**GENERAL PROVISIONS**" section "**TERMINATION OF MEMBER'S COVERAGE UNDER THE POLICY**" subsection 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.

(5) (A.) As to the PPO Plus Preventive and PPO Preventive plans the "**TERMINATION OF THE MEMBER**" subsection is hereby **deleted in its entirety and replaced with**:

Termination of the Member

The Member's enrollment in the Benefit Program shall terminate:

1. At the employee's option during an Employer Group's Open Enrollment Period and shall be effective as of the renewal date of the Benefit Program.

2. The day following the Covered Person's death. When a Covered Person dies, Dependents shall be terminated the first of the month following the Covered Person's death.

3. The first day of the month following the loss of eligibility due to:

   - Loss of employment with the Employer Group or a reduction in work hours; or
   - He or she no longer meets the eligibility requirements of the Benefit Program as defined in the Eligibility Section of this Certificate;

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.

4. The Benefit Program shall terminate immediately if:

   - The Member has permitted any other person to use his or her Identification Card to obtain services.

   - Following the effective date of the policy, Anthem BCBS may rescind, cancel or limit the Benefit Program; if the Member has submitted false information to Anthem BCBS, or omitted information during the application and enrollment process concerning eligibility, insurability or health status and such information was material to the underwriting of the application at the time submitted and acceptance by Anthem BCBS of that application for coverage.

     Anthem BCBS may also initiate and conduct a review on a post claim basis to obtain information when the information sought is:

     i) in relation to a medical condition not disclosed on the application, or;
     ii) when the information on the claim or the facts and circumstances of the medical treatment for which a claim is submitted clearly indicate the response or responses to the questions on the application, or the information provided on the application, might be suspect in any way.

In the event that Anthem BCBS failed to complete underwriting with respect to health status prior to the acceptance of the application for coverage by Anthem BCBS, Anthem BCBS must obtain prior approval from the Insurance Department to rescind, cancel or limit the policy.

The Benefit Program may not be rescinded, cancelled or limited more than 2 years after the effective date of the policy. The date of rescission shall be the Effective Date of the Benefit Program.

5. The Member's enrollment in the Benefit Program shall terminate on the first day of the month following 30 days written notice when:

   - Adequate medical treatment is jeopardized by an impaired relationship between a Member and Anthem BCBS, or a Member does not accept a prescribed course of treatment; or

- The Member fails to pay Cost-Shares as specified in the Benefit Program and which become due from the Member; or
- Where applicable, the Member fails to make the agreed upon employee contribution to the Benefit Program.

6. Termination of an enrolled Dependent's Coverage will terminate on the first day of the month following the occurrence of:

   - Divorce or legal separation of the spouse.
   - Other enrolled Dependent's criteria are no longer met by the spouse or enrolled Dependents as defined in the Eligibility section.
   - Enrollment in the Benefit Program shall be terminated on the day after the death of an enrolled Dependent.

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.

(6) (A.) 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.

(7) (A.) 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.) 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.

(8) (A.) 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.) 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.

(9) (A.) 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 of Coverage 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 of Coverage except as shown in this Rider.