AMENDATORY RIDER
Century Preferred
Century Preferred Comprehensive
Century Preferred Comprehensive HSA
MEHIP Century Preferred

I. The Certificate of Coverage to which this Amendatory Rider is attached, is clarified based on Anthem Blue Cross Blue Shield's existing administration of benefits, as follows:

(1) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"DEFINITIONS"** section, "**MAXIMUM ALLOWABLE AMOUNT**" definition is clarified **with the deletion of**:

4. Non-Participating Hospital: except as otherwise required by law, an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Member, or in the absence of a negotiated amount, a Non-Participating Hospital's charge reduced by Cost-Shares for Covered Services. It is the Member's obligation to pay Cost-Shares and amount in excess of this Maximum Allowable Amount.

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"DEFINITIONS"** section, "**MAXIMUM ALLOWABLE AMOUNT**" definition is clarified **with the addition of**:

4. Non-Participating Hospital: except as otherwise required by law, a reasonable amount as determined by Anthem BCBS, after consideration of such industry cost, reimbursement and utilization data and indices, as Anthem BCBS deems appropriate in its sole discretion, which is assigned as reimbursement for Covered Services provided to a Member or an amount negotiated with a Non-Participating Hospital for Covered Services provided to a Member. The amount Anthem BCBS will pay for Covered Services will be the Maximum Allowable Amount or the billed charges, whichever is lower. It is the Member's obligation to pay Cost-Shares and amount in excess of this Maximum Allowable Amount.

(2) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES"** subsection is clarified **with the addition of**:

Anthem BCBS will consider purchase of such durable medical equipment if the cost would be less than rental. In either case, the total benefit will not exceed the cost of the least expensive equipment necessary to meet the medical condition.

(3) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES"** subsection is clarified **with the deletion of**:

Reasonable and necessary lodging and meal expenses, not to exceed $150 total per day ($200 total if two companions are accompanying a minor child), are payable for the individual accompanying the patient.

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES"** subsection is clarified **with the addition of**:

Reasonable and necessary lodging expenses, not to exceed $150 total per day ($200 total if two companions are accompanying a minor child), are payable for the individual accompanying the patient.

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 Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"ELIGIBILTY"** 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 Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section, **"MATERNITY/FAMILY PLANNING SERVICES"** subsection is amended **with the deletion of**:

In accordance with Ct. General Statute 38a-530c Inpatient care for a female Member and newborn will be provided for a minimum of 48 hours following a vaginal delivery, and for a minimum of 96 hours following a cesarean delivery, unless otherwise agreed upon by the Member and the Physician. If the Member and the Physician agree to an earlier discharge time, benefits for Covered Services shall be provided for a follow-up home visit within 48 hours of discharge and an additional follow-up visit within 7 days. The time period shall commence at the time of delivery.

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section, **"MATERNITY/FAMILY PLANNING SERVICES"** subsection is amended **with the addition of**:

In accordance with Ct. General Statute 38a-530c Inpatient care for a female Member and newborn will be provided for no less than 48 hours following a vaginal delivery; and for a minimum of 96 hours following a cesarean delivery; unless a shorter stay is agreed upon by the Member and the attending Provider. The attending Provider is restricted to an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The term attending Provider does not include a plan, hospital, managed care organization, or other issuer.

If the Member and the attending Provider agree to an earlier discharge time, benefits for Covered Services shall be provided for a follow-up home visit within 48 hours of discharge and an additional follow-up visit within 7 days. The time period shall commence at the time of delivery.

(3) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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.

(4) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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.

(5) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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 Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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. 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.

(6) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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 Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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 Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred 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.

(10) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"PLAN DESCRIPTION INFORMATION"** section **"MEDICAL LOSS RATIO"** subsection is amended **with the deletion of**:

For Anthem BCBS's managed care products (non-HMO), the **2007** loss ratio is **76.4%**.

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"PLAN DESCRIPTION INFORMATION"** section **"MEDICAL LOSS RATIO"** subsection is amended **with the addition of**:

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and shall other wise be calculated in accordance with the requirements of Connecticut state law. The medical loss ratio for Anthem Blue Cross and Blue Shield in Connecticut for calendar year **2008** is **85.0%**.

III. Effective January 1, 2010 the Certificate of Coverage to which this Amendatory Rider is attached is amended as follows:

(1) (A.) If your plan is based on a Calendar Year, as to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES"** subsection is amended **with the addition of**:

Wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician. Payment of such services will not be applied against any durable medical equipment Calendar Year dollar maximums or against the maximum lifetime limits specified in this Benefit Program.

(2) (A.) If your plan is based on a Plan Year, as to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES"** subsection is amended **with the addition of**:

Wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician. Payment of such services will not be applied against any durable medical equipment Plan Year dollar maximums or against the maximum lifetime limits specified in this Benefit Program.

(3) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"OTHER PROVISIONS"** subsection is amended **with the deletion of**:

Services from birth to age three for early intervention Covered Services for a Member and his/her family Members provided as part of an individualized family service plan.

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"COVERED SERVICES"** section **"OTHER PROVISIONS"** subsection is amended **with the addition of**:

Birth to Three Program: Services from birth to age three for early intervention Covered Services for a Member and his/her family members provided as part of an individualized family service plan. A maximum of $6,400 over a three year period per child, up to a lifetime maximum of $19,200. Payment of such services shall not be applied against the maximum lifetime limits specified in this Benefit Program.

(4) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"PLAN DESCRIPTION INFORMATION"** section **"MEMBER SATISFACTION INFORMATION"** subsection is amended **with the deletion of**:

Overall, **93.1%** of Anthem BCBS Members have a positive rating regarding their health plan.

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"PLAN DESCRIPTION INFORMATION"** section **"MEMBER SATISFACTION INFORMATION"** subsection is amended **with the addition of**:

Overall, **92.4%** of Anthem BCBS Members have a positive rating regarding their health plan.

(5.) (A.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"PLAN DESCRIPTION INFORMATION"** section **"UTILIZATION REVIEW DETERMINATIONS"** subsection is amended **with the deletion of**:

During **2007**, Anthem BCBS's utilization review department determined the following, based on its review of each case relative to Medical Necessity and Covered Services parameters (for Connecticut enrollees only):

Requests for certification:	**94,092**
Number of certification denials:	**7,432**
Number of appeals of denials:	**1,064**
Number of denials reversed or negotiated upon appeal:	**483**

(B.) As to the Century Preferred, Century Preferred Comprehensive, Century Preferred Comprehensive HSA, MEHIP Century Preferred the **"PLAN DESCRIPTION INFORMATION"** section **"UTILIZATION REVIEW DETERMINATIONS"** subsection is amended **with the addition of**:

During **2008**, Anthem BCBS's utilization review department determined the following, based on its review of each case relative to Medical Necessity and Covered Services parameters (for Connecticut enrollees only):

Requests for certification:	**104,833**
Number of certification denials:	**5,878**
Number of appeals of denials:	**1,122**
Number of denials reversed or negotiated upon appeal:	**581**

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.