EXHIBIT 3

Amendment to Agreement

This Amendment ("Amendment"), dated January 1, 2016, is to that certain Agreement, dated September 30, 2013, between the Connecticut Health Insurance Exchange, d/b/a Access Health CT, a quasi-public agency created by the State of Connecticut (the "State"), with an office at 280 Trumbull Street, Hartford, Connecticut 06103 (the "Exchange") and ConnectiCare Benefits, Inc., a Connecticut corporation, with an office at 175 Scott Swamp Road, Farmington, Connecticut 06032 (the "Issuer") (the "Agreement").

WHEREAS, the Parties entered into the Agreement to establish the terms and conditions upon which the Exchange would make Issuer's Qualified Health Plans available to eligible individuals and eligible small groups through the Exchange's individual and small group marketplaces;

WHEREAS, the Parties desire to amend the Agreement as follows, including, without limitation, to update the Agreement pursuant to new regulations issued pursuant to the ACA;

NOW THEREFORE, the Parties agree as follows:

1. Any defined terms used, but not defined, herein shall have the meaning ascribed to such defined term in the Agreement.

2. The term of the Agreement is hereby extended to December 31, 2017.

3. For the Individual Marketplace 2016 Benefit Year, the Open Enrollment Period is November 1, 2015 – January 31, 2016. For future Benefit Years, the enrollment period for the Individual Marketplace will be at set in accordance with 45 C.F.R. §155.410(e), as it may be amended from time to time.

4. Notwithstanding Section 3.2 of the Agreement, Issuer acknowledges and agrees that plan requirements may be set on an annual basis by the Exchange in its Solicitation/Application for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace. The current minimum offering requirements for the Individual Marketplace are: (a) One standard Gold Plan; (b) One standard Silver Plan; and (c) Two standard Bronze Plans (one Standard Bronze Plan and one Standard HSA compatible Bronze Plan). The standard Silver plan must be the lowest cost Silver plan offered by the Issuer in the AHCT Individual Marketplace. The current minimum offering requirements for the AHCTSB Marketplace are: (a) One standard Platinum Plan; (b) One standard Gold Plan; (c) Two standard Silver Plans (one Standard Silver Plan and one Standard HSA compatible Silver Plan); and (d) Two standard Bronze Plans (one Standard Bronze Plan and one Standard HSA compatible Bronze Plan).

5. In accordance with Section 3.3 of the Agreement, Issuer acknowledges and agrees that network adequacy requirements may be updated periodically by the Exchange. Issuer acknowledges that its provider network for the Standard plan designs offered for sale in the Marketplace must include at least 85% of those unique providers and unique entities that are in Issuer's network for its largest plan (representing a similar product) that is marketed, sold and has active

enrollees outside of the Marketplace ("the benchmark plan"). If Issuer has an affiliated company that is active outside of the Marketplace, but in the State of Connecticut, the Exchange will look to the larger of Issuer's network for its largest plan or the network of Issuer's affiliated company's largest plan (representing a similar product) that is marketed, sold and has active enrollees outside of the Marketplace, but in the State of Connecticut, as the "benchmark plan" for the purposes of such network adequacy calculations. In order to determine whether Issuer's provider network(s) meet the 85% requirement, the Exchange will require Issuer to provide quarterly in accordance with a schedule established by the Exchange current network information for both its Standard Plan design network and for the benchmark plan network. If the Exchange determines that Issuer does not satisfy the 85% requirement, the Exchange may require the Issuer to submit a proposed corrective action plan ("CAP") to remedy such deficiency within 15 days of notice from the Exchange. In the event that Issuer and the Exchange fail to agree to a CAP within thirty (30) days thereafter, or Issuer fails to comply with the terms of such CAP, the Exchange may deem Issuer to be in breach of its obligations under this Agreement.

6. Issuer acknowledges and agrees that the ECP list described in Section 3.4 of the Agreement is subject to periodic updates by CMS and the Exchange.

7. Section 3.5 of the Agreement is amended and restated in its entirety as follows:
   A. Issuer shall submit a provider directory that is compliant with the information and accessibility requirements established under 45 C.F.R. §156.230(b) for each of its Qualified Health Plans in electronic format to the Exchange for publication online in accordance with guidance from the Exchange and HHS and shall provide a hard copy to the Exchange, Enrollees and prospective Enrollees upon request. The Exchange shall impose deadlines that are consistent with those in the Notice of Benefit Payment Parameters. The provider directory shall note which providers are not accepting new patients to the extent practicable.

   B. Issuer shall submit to the Exchange provider directories for each QHP in a PDF format with updates submitted to the Exchange no less often than on a monthly basis. Issuer shall provide URL links to the portion of the Issuer's webpage where Enrollees and prospective Enrollees can review or perform automated searches of provider directories for each QHP. For the avoidance of doubt, it is understood and agreed to by the Exchange and the Issuer that the Issuer prints its provider directories once per year and that any revisions to said directories once directories for that year have been printed are made and disseminated electronically. Nothing in this Section 3.5(B) shall require Issuer to deviate from this procedure and standard.

   C. Issuer must publish, in a document with a searchable format and with a direct URL, an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public, as required pursuant to 45 C.F.R. § 156.122(d) and in accordance with guidance from the Exchange and HHS. "Up-to-date" means the formulary drug list must accurately list all of the QHP's covered drugs at that time.

8. The requirements in Section 3.6(C) shall apply to each Contract Year.

9. With respect to Section 3.10 of the Agreement, Issuer agrees that it will provide to the Exchange within fourteen (14) days of rate approval from CID, but in no event later than October 1st of each year, preliminary copies of its marketing materials for the Exchange's review and comment. Copies of final marketing materials intended for public use (whether in connection with Open Enrollment or otherwise), including, without limitation, Issuer's proposed website pages, member renewal materials, brochures, fliers, guides and television and print advertisements, shall be provided to the Exchange as soon as practicable but in no event less than fifteen (15) business days in advance of Issuer's intended distribution of such materials to Enrollees and potential Enrollees. Materials must be submitted sufficiently in advance of their proposed distribution date to permit Issuer to make any changes required by the Exchange prior to distribution. Such final materials shall include a comparison version against any materials previously reviewed by the Exchange as part of the preliminary process. In addition to such materials, Issuer shall provide a short description to the Exchange of the contexts (e.g. Issuer's website, print advertisements, etc.) in which it intends to use each particular item. The same review requirement shall apply to any material revision to previously-approved marketing materials. For the 2016 Benefit Year, the Exchange shall review Issuer's marketing materials as currently provided in the Agreement; provided, however, the Exchange shall have fifteen (15) business days of receipt in all instances to review such materials. Without limiting the Exchange's discretion with respect to the guidelines described in Section 3.10(B), Issuer shall ensure that all marketing materials:

    - Clearly identify that APTCs and CSRs are only available through the Exchange, wherever the materials reference APTCs or CSRs;
    - Do not imply that the Exchange is only for Enrollees or potential Enrollees who are eligible for APTCs or CSRs;
    - Do not imply that the Exchange cannot or should not be used by Enrollees or potential Enrollees who are not eligible for APTCs or CSRs; and
    - If the materials include a calculator for the purpose of estimating a consumer's eligibility for APTCs, CSRs or other affordability programs, include the disclaimer provided by the Exchange with respect to such calculator.

    Notwithstanding anything to the contrary in Section 3.10 of the Agreement, the Exchange shall have ten (10) business days to review Issuer's proposed marketing materials and inform Issuer of any required changes.

10. With respect to Section 3.11 of the Agreement, in accordance with 45 C.F.R. §147.200 and 45 C.F.R. §147.136(e), Issuer must provide the SBC in a culturally and linguistically appropriate manner. In addition, the Issuer must conform with 45 C.F.R. §155.205(c)(2)(i)(A) which requires Issuer to provide telephonic interpreter services in at least 150 unique languages.

11. With respect to Section 3.17 of the Agreement, Issuer shall submit a plan to CID that details its process and methodology for complying with the segregation of funds requirements in accordance with CID Bulletin No. MC-21.

12. With respect to Section 3.19 of the Agreement, Issuer must not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs (45 C.F.R. §156.225). To ensure non-discrimination in QHP benefit design, the Exchange will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) for Issuer's plans as part of the QHP certification application process. QHPs identified as having potentially discriminatory benefit/cost-sharing structures may be given the opportunity to modify such cost sharing.

13. Section 3.23 of the Agreement is amended and restated as follows:

    A. Issuer is required to comply with the standards and requirements for data collection of quality rating information pursuant to 45 C.F.R. § 156.1120.

    B. Issuer is required to comply with the standards and requirements regarding the QHP Enrollee Survey pursuant to 45 C.F.R. § 156.1125. Issuer must collect and report validated data annually, on a timeline and in a standardized form and manner specified by HHS, to support the calculation of the quality-rating system ("QRS") scores and ratings for each QHP that has been offered in a Marketplace for at least one year. Issuer is also required to contract with and authorize an HHS-approved vendor to annually collect and submit QHP Enrollee Survey data on their behalf for each QHP. Issuer shall follow the specific requirements related to data collection, validation and submission, as well as minimum enrollment criteria, for the QRS and QHP Enrollee Survey as detailed in technical guidance issued by CMS. Issuer shall provide its Enrollee satisfaction results to the Exchange. The results may be posted on the Exchange's web site in a manner that allows individuals to easily compare Enrollee satisfaction levels between comparable plans. Before the posting of any results under the provisions of this Paragraph 13.B, the Issuer shall have the right to review for accuracy both the results to be posted and the Exchange's proposed posting.

    C. Consistent with 45 C.F.R.§156.200(b)(5), in order to demonstrate compliance with the quality reporting standards as part of the certification process for the 2016 Plan Year, Issuer is required to attest that it complies with the specific quality reporting and implementation requirements related to the QRS and QHP Enrollee Survey.

    D. The Exchange reserves the right to require Issuer to submit the following:

        (1) CAHPS data for the submitted QHP, or, if such data is not yet available because the plan is new, CAHPS data for the plan most comparable to the submitted QHP (whether that plan is offered by Issuer or an affiliated company);
        (2) NCQA star rating in the five core areas (i.e. "Access and Service," "Qualified Providers," "Staying Healthy," "Getting Better" and "Living with Illness") for the NCQA-accredited product most comparable to each submitted QHP; and
        (3) Medical Loss Ratio ("MLR") for the most recent year and projected MLR (based on the applicable federal standard) for the next Benefit Year, for non-group/small-group.

    E. Issuer shall in accordance with 45 C.F.R. § 156.1130, in the event it participates in the Exchange for two (2) or more consecutive years, implement and report on Quality

Improvement Strategy (QIS) on an annual basis: the required documentation outlining how it will attempt to better coordinate care and control costs, improve chronic illness management, reduce medical error, or otherwise promote health care delivery and payment reform for the benefit of the consumer, and the metrics Issuer intends to use to demonstrate program success. Issuer will be further required to submit data that has been validated in a manner and timeframe conforming to such standards on an annual basis to support the evaluation of the QIS in accordance with 45 C.F.R. § 155.200(d). As part of its annual QIS submission, Issuer shall also provide to the Exchange reports demonstrating success of its QIS in the previous Plan Year.

F. Issuer shall provide the information on health care quality and outcomes as described in Section 399JJ of the Public Health Service Act to the Exchange.

G. Issuer will report to HHS and the Exchange at least annually, the pediatric quality reporting measures described in Section 1139A of the Social Security Act.

H. If Issuer is accredited by the NCQA or the URAC, Issuer shall submit to the Exchange the portion of its most recent accreditation survey to Exchange that addresses the following criteria with respect to its QHP(s):

(1) A payment structure that provides increased reimbursement or other incentives for improving health outcomes through the implementation of activities that include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage.
(2) The implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional.
(3) The implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage.
(4) The implementation of wellness and health promotion activities.
(5) The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

I. If an Issuer is not accredited by the NCQA or the URAC or if Issuer does not sponsor a quality improvement program that substantially addresses the criteria set forth above, Issuer must develop a plan to institute such a quality assurance program and present its proposed program to Exchange. Issuer's program must include an implementation timeline and quality improvement milestones that are acceptable to Exchange. In all instances, an Issuer must obtain full accreditation by an organization recognized by HHS on or before January 1, 2018.

14. The following section is added as Section 3.28 of the Agreement regarding patient safety standards:

A. Issuer shall comply with 45 C.F.R §156.1110 regarding patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. Specifically, when Issuer contracts with a hospital with more than 50 beds, it must verify that the hospital, as defined in section 1861(e) of the SSA, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Conditions of Participation requirements for:

(1) A quality assessment and performance improvement program as specified in 42 C.F.R. §482.21; and
(2) Discharge planning as specified in 42 C.F.R. §482.43.

B. In addition, Issuer is required to collect and maintain documentation of the CCNs from its applicable network hospitals.

15. The following section is added as Section 3.29 of the Agreement regarding delegated and downstream entities:

A. As provided in 45 C.F.R. §156.340, Issuer maintains responsibility for the compliance of its delegated and downstream entities, including affiliated agents and brokers, as applicable, with all applicable standards, including, without limitation, those relating to licensure, registration and training, privacy and security, conflict(s) of interest, marketing and continuing education.

B. If any of the Issuer's activities or obligations are delegated to other parties, Issuer's agreement with any delegated or downstream entity must:

(1) Specify the delegated activities and reporting responsibilities;

(2) Provide for revocation of the delegated activities and reporting standards or specify other remedies in instances where the Exchange or Issuer determines that such parties have not performed satisfactorily;

(3) Specify that the delegated or downstream entity must comply with all applicable laws and regulations relating to the standards specified under 45 C.F.R. §156.340; and

(4) Specify that the delegated or downstream entity must permit access by HHS or its designee in connection with its right to evaluate through audit, inspection, or other means, the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the Issuer's obligations in accordance with Federal standards until 10 years from the expiration or earlier termination of such agreement.

16. The following section is added as Section 3.30 of the Agreement regarding Issuer's Compliance Plan:

A. Issuer is required to maintain a compliance program demonstrating compliance with applicable federal and Connecticut law as well as to prevent fraud, waste and abuse, and to submit documentation of such compliance plan to the Exchange. Such program shall contain at least the following elements:

(1) Designation of a compliance officer and compliance committee;
(2) Written policies and procedures and documentation of adherence to such requirements;
(3) Effective communication among all levels of the company ensuring a shared responsibility for compliance;
(4) A record retention policy of not less than 10 years for any information related to CSR or APTC;
(5) Compliance education and an effective training program;
(6) Compliance metrics as part of an employee performance appraisal process and compliance standards enforced through well-publicized disciplinary guidelines;
(7) An internal audit process;
(8) Corrective action plan initiatives to monitor and respond to detected offenses; and
(9) A statement of corporate philosophy and codes of conduct.

B. Issuers are further required to submit to the Exchange any subsequent material changes made to its compliance plan during any Plan Year.

C. The Exchange may perform compliance reviews of Issuer's Exchange business, including, without limitation, Issuer's compliance with Subpart C of 45 CFR part 156 and other key operational standards. The Exchange may review data at both the Issuer and the QHP level. The Exchange may conduct either a desk review or an on-site review. Issuer agrees that it will promptly provide relevant policies, procedures and any other applicable documentation as the Exchange may request, as part of the compliance review process, to show compliance with issuer standards.

17. With respect to Section 5.3(D)(4) of the Agreement, in accordance with 45 C.F.R. §156.425(c), if an Enrollee's assignment to a standard plan or plan variation of the QHP changes in accordance with 45 C.F.R. §156.425(a) and the Exchange's policies and procedures, Issuer must provide to that individual an SBC that accurately reflects the new plan variation (or standard plan variation without CSRs) in a manner consistent with 45 C.F.R. §147.200 as soon as practicable following receipt of notice from the Exchange, but not later than seven (7) business days following receipt of notice.

18. With respect to Section 6.1 of the Agreement, in the event Issuer decides to offer QHPs through the AHCTSB Marketplace, the employer's plan year must consist of a Plan Year beginning with the qualified employer's effective date of coverage (45 C.F.R. §155.725(b)). Issuers offering QHPs through AHCTSB must also charge the same contract rate for each month of the applicable small employer's policy year in accordance with 45 C.F.R. § 156.285(a)(3). If participating in AHCTSB, Issuer must agree to fully participate in each of the AHCTSB's purchasing options. The three options are Issuer Bundle, Metal Tier Bundle, and Single Plan option. Each choice model has been defined below:

- Issuer Bundle (Vertical Choice): Allows an eligible employer to offer their eligible employees plan options from all available "metal tiers" from any one selected Issuer (i.e. any 'Issuer A' plan in any tier);
- Metal Tier Bundle (Horizontal Choice): Allows an eligible employer to offer their eligible employees plan options from all of participating Issuers, across any one selected "metal tier" (i.e. any silver plan from any of the Issuers);
- Single Plan (Single Choice): Allows an eligible employer to offer their eligible employees one plan design in any one metal tier from any one issuer for group offering.

19. Section 9.35 of the Agreement is amended and restated as follows:

Mediation.

A. Except for the pursuit of injunctive or other equitable relief, the Parties agree that they will not file any suit or seek any relief of any kind in court concerning any dispute that arises out of the Agreement or a breach thereof until they have endeavored to resolve the dispute by mediation, and failure to mediate will be a ground for dismissal of any such litigation.

B. Either Party may initiate mediation by providing the other with a written demand for mediation including a brief statement of the issue in dispute. The Parties shall select a mutually satisfactory mediator within fifteen (15) days of such notice. In the event the Parties are unable to select a mediator within such period, the Parties shall select a mediator in accordance with the American Arbitration Association Commercial Mediation Procedures (the "AAA Mediation Procedures"). The mediator shall be neutral and shall be required to disclose any conflicts of interest, including, but not limited to, past or present financial interests or employment.

C. The mediation shall take place at a neutral location in Hartford, Connecticut within thirty (30) days of selection of the mediator. The Parties shall not select a mediator unable to comply with this schedule. If the Parties cannot agree on the location, the location will be selected by the mediator. At least seven (7) days before the mediation, each Party shall provide the mediator and the opposing Party with a written statement of its position regarding the dispute. Each Party shall be represented at the mediation by a representative with authority to resolve the dispute and each Party may also be represented by counsel. The requirement to mediate will be satisfied if no resolution is reached after four hours of mediation; however, the Parties may, by agreement, extend the mediation beyond four hours.

D. Each Party will bear its own costs and attorney fees and the Parties will share equally the fees and expenses of the mediator and the mediation location.

E. The mediation shall be conducted according to the AAA Mediation Procedures. The mediator does not have the authority to impose a settlement on the parties but will attempt to help them reach a satisfactory resolution of their dispute. Subject to the discretion of the mediator, the mediator may make oral or written recommendations for settlement to a party privately or, if the parties agree, to all parties jointly.

20. The following Code of Federal Regulations sections were incorrectly cited in the Agreement and are corrected as follows:

    a. The reference in Section 3.4(A)(1) of the Agreement to 45 C.F.R. § 156.325 shall be 45 C.F.R. § 156.235.

    b. The reference in Section 3.6(G) of the Agreement to 45 C.F.R. § 156.430(a)(1) (i)-(ii) shall be 45 C.F.R. § 156.420(b)(1).

    c. The reference in Section 3.6(G) of the Agreement to 45 C.F.R. § 156.430(a)(2) and (2)(ii) shall be 45 C.F.R. § 156.420(b)(2).

    d. The reference in Section 3.7(A)(1) of the Agreement to 45 C.F.R. § 156.255 shall be 45 C.F.R. § 156.225.

    e. The reference in Section 5.2(B) of the Agreement to 45 C.F.R. § 156.260 shall be 45 C.F.R. § 155.260.

21. Any ambiguity in this Amendment and the Agreement shall be resolved in favor of a meaning that permits the Exchange and Issuer to comply with applicable federal and Connecticut law and regulation, including, without limitation, the ACA and its implementing regulations.

22. All terms, provisions, conditions, and covenants contained in the Agreement shall remain in full force and effect as amended and supplemented by the terms of this Amendment.

[*Signature page follows.*]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the date stated below.

THE CONNECTICUT HEALTH INSURANCE EXCHANGE

By: _____

Name:

Title:

Date: 3/10/16

CONNECTICARE BENEFITS, INC.

By: _____

Name: Michelle Zetterqren

Title: SVP, Chief Sales & Marketing Officer

Date: 2/15/16