

Exhibit A

[INSURANCE COMPANY]
ILLINOIS

PPACA Endorsement Template

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

[Grandfathered/Non-grandfathered] [GROUP/INDIVIDUAL] [POLICY/CERTIFICATE] **RIDER**

The [Policy/Certificate], to which this rider is attached and becomes a part, is amended as stated below.

A new section titled "Patient Protection and Affordable Care Act" is hereby added to the [Policy/Certificate] as follows:

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

Effective [mm/dd/yyyy], some of the benefits, terms, conditions, limitations, and exclusions contained in Your [Policy/Certificate] will change as a result of the Patient Protection and Affordable Care Act of 2010. Notwithstanding any other provision of Your [Policy/Certificate], the provisions below shall apply. In the event of a conflict between the provisions of any other Section of Your [Policy/Certificate] and the provisions of this Rider, the provisions of this Rider shall prevail, except to the extent the provisions of Your [Policy/Certificate] are more beneficial to You than are the provisions of this Rider.

Definitions

For the purposes of this Rider, the following definitions shall apply:

"Emergency services" means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

(COMPANY DRAFTING NOTE – HMOs: To maintain compliance with State law, the definition of "emergency services" shall be deleted from this Rider when modifying an individual or group HMO plan.)

"Essential health benefits" means benefits covered under the [Policy/Certificate], in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

"Patient Protection and Affordable Care Act of 2010" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“Stabilize” means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(COMPANY DRAFTING NOTE – HMOs: To maintain compliance with State law, the definition of “stabilize” shall be deleted from this Rider when modifying an individual or group HMO plan.)

Lifetime Dollar Limits

If Your [Policy/Certificate] contains a lifetime dollar maximum on the value of all benefits, such lifetime dollar maximum no longer applies. If Your [Policy/Certificate] contains a lifetime dollar maximum(s) on the value of specific benefits that are Essential Health Benefits, such lifetime dollar maximum(s) no longer apply.

If coverage under this [Policy/Certificate], for You or another person in Your family, ended by reason of reaching a lifetime dollar maximum, and You or Your family member are eligible for benefits under this [Policy/Certificate], You will receive written notice that You or Your family member are once again eligible for benefits under this [Policy/Certificate]. If Your family member is no longer enrolled under this [Policy/Certificate], he or she will be given an opportunity to re-enroll. We must provide You this written notice and, if applicable, the opportunity to re-enroll, by [mm/dd/yyyy].

Annual Dollar Limits

Essential Health Benefits provided within Your [Policy/Certificate] [are subject to an annual dollar maximum that is the greater of: 1) \$750,000 (for the year beginning [mm/dd/yyyy]), \$1,250,000 (for the year beginning [mm/dd/yyyy]), \$2,000,000 (for the year beginning [mm/dd/yyyy]); or 2) the amount(s) shown on [page # and/or Section]] [or [are not subject to any annual dollar maximum(s)]].

[Coverage for benefits that are not Essential Health Benefits will not be taken into account when determining whether You have met or exceeded the annual dollar maximum, if any, as described above.]

(COMPANY DRAFTING NOTE – GRANDFATHERED PLANS: Pursuant to Section 1251 of the Patient Protection and Affordable Care Act of 2010 (PPACA), the Annual Dollar Limits section may be deleted when modifying an individual grandfathered policy.)

Rescissions

We may not rescind Your [Policy/Certificate] based on a misrepresentation by You unless You have performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact, as prohibited by the terms of Your [Policy/Certificate]. We must provide at least 30 days advance written notice before Your [Policy/Certificate] may be rescinded. You have the right to appeal any such rescission.

Preventive Services

In addition to the [Covered Services] listed in [Section] of Your [Policy/Certificate], the following services shall be covered without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply:

- (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
- (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- (3) with respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) with respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For purposes of this section, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current. No recommendation of the United States Preventive Service Task Force shall serve to reduce the mammogram benefits required by Illinois law [215 ILCS 356g(a)] and described on [Page # and/or Section] of your [Policy/Certificate].

(COMPANY DRAFTING NOTE – GRANDFATHERED PLANS: Pursuant to Section 1251 of PPACA, the Preventive Services section may be deleted when modifying an individual or group grandfathered policy.)

Extension of Coverage to Dependents

Notwithstanding the eligibility requirements described in [Section] of Your [Policy/Certificate], a child in Your family is eligible to become a Covered Person if the child: 1) is under age 26, and 2) is related to You by one of the relationships listed in [Section] of Your [Policy/Certificate].

A child in Your family who is age 26 or older is also eligible to become a Covered Person if the child: 1) is an Illinois resident; 2) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; 3) received a release or discharge other than a dishonorable discharge; 4) is under age 30; and 5) meets any additional eligibility requirements described in [Section] of Your [Policy/Certificate].

(COMPANY DRAFTING NOTE: This section may be deleted when modifying an individual or group policy that does not provide coverage for dependents.)

Right to Appeal

You have the right to appeal any decision or action taken by Us to deny, reduce or terminate the provision of or payment for health care services requested or received under Your [Policy/Certificate]. When We have denied, reduced, or terminated a requested service or payment for a service covered by Your [Policy/Certificate] based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, You have the right to have Our decision reviewed by an independent review organization not associated with Us.

We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeal rights and procedures, every time We make a determination to deny, reduce or terminate the provision of or payment for health care services requested or received under Your [Policy/Certificate].

Emergency Services

We shall cover Emergency Services without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a Participating Provider. Care provided by a Non-participating Provider will be paid at no greater cost to the Covered Person than if the services were provided by a Participating Provider.

Direct Access to Obstetricians and Gynecologists

In addition to the Woman's Principal Health Care Provider described in [Section] of Your [Policy/Certificate], a female Covered Person may see any available participating health care professional who specializes in obstetrics or gynecology without referral from her Primary Care Provider.

Obstetrical and gynecological care authorized or ordered by a health care professional who specializes in obstetrics or gynecology will be treated as authorized by the Primary Care Provider.

(COMPANY DRAFTING NOTE – GRANDFATHERED PLANS: PPACA allows, but does not require the inclusion of this provision when modifying an individual or group grandfathered policy.)

(COMPANY DRAFTING NOTE – The Direct Access to Obstetricians and Gynecologists section may be deleted when modifying an individual or group policy that does not require the selection of a Primary Care Provider.)

Selection of a Primary Care Provider

You may designate any available participating Primary Care Provider who is available to accept You to be Your Primary Care Provider as required under [Section] of Your [Policy/Certificate].

Your child's legal representative may designate a physician (allopathic or osteopathic) who specializes in pediatrics as his or her Primary Care Provider as required under [Section] of Your [Policy/Certificate].

(COMPANY DRAFTING NOTE – GRANDFATHERED PLANS: PPACA allows, but does not require the inclusion of this provision when modifying an individual or group grandfathered policy.)

(COMPANY DRAFTING NOTE – The Selection of a Primary Care Provider section may be deleted when modifying an individual or group policy that does not require the selection of a Primary Care Provider.)

Preexisting Condition Limitations

With respect to Covered Persons who are under [19] [26] years of age, notwithstanding the Preexisting Condition Limitations described in [Section] of Your [Policy/Certificate/Rider], no health care service or treatment will be denied, limited, or excluded based on the fact that a medical condition was present before the effective date of Your [Policy/Certificate], whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

With respect to Covered Persons who are under [19] [26] years of age, any provision previously attached to the [Policy/Certificate] excluding coverage for a specific condition is removed and shall be considered null and void.

(COMPANY DRAFTING NOTE – GRANDFATHERED PLANS: PPACA allows, but does not require the inclusion of this provision when modifying an individual grandfathered policy.)

(COMPANY DRAFTING NOTE – Companies may voluntarily extend the prohibition on preexisting condition exclusions to individuals who are older than age 19.)

Grandfathered Health Plan Disclosure Requirement

This [group health plan/health insurance issuer] believes this [plan/coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan/policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to [insert contact information]. You may also contact the Illinois Department of Insurance at (877) 527-9431 or <http://insurance.illinois.gov>.

(COMPANY DRATING NOTE – GRANDFATHERED PLANS: Pursuant to the Interim Final Rule on grandfathered health plans under PPACA [45 CFR 147.40], in order to maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary (in the individual market, primary subscriber), similar to the model statement above. This section may be deleted when modifying an individual or group policy that is not a grandfathered plan under PPACA.)

Questions/Contact Information

Questions regarding this Rider can be directed to [insert contact information]. You may also contact the Illinois Department of Insurance at (877) 527-9431 or <http://insurance.illinois.gov>.

This Rider takes effect on the [later of the] effective date [of the [Policy] [/] [Certificate] to which it is attached] [or [Month Day, Year]] [shown in the Certificate Schedule]. This Rider terminates concurrently with the [Policy] [/] [Certificate] to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the [Policy] [/] [Certificate] except as stated.

IN WITNESS WHEREOF:

[Name of company]

[Signature]
[President’s Name]
President