

**Exhibit A**  
**Ohio Requirements for PPACA Expedited Review Status**

**Overview**

A. Filings that meet the requirements specified below will be considered eligible for expedited review status. Request for expedited review status may be denied for any filing that does not meet all applicable requirements.

B. Some PPACA Immediate Reform filings that were submitted and pending review in SERFF on or before July 31, 2010, may be modified to be eligible for expedited review status. Please see the section titled “Special Instructions for Post-Submission Expedited Review Status” later in this document for more information.

C. Exhibits B1-B4 are form template versions for use in constructing riders, endorsements, or amendments, as applicable, (PPACA Riders), to implement health care reform requirements of PPACA that will be effective September 23, 2010, (“Immediate Reforms”). Each form template version contains standard language that is applicable to a specific PPACA-eligible market and plan type: Individual Grandfathered, Individual Non-Grandfathered, Group Grandfathered, or Group Non-Grandfathered.

**Please note that individual coverage includes sickness and accident insurance made available in the individual market to individuals, with or without family members or dependents, through group policies issued to one or more associations or entities. Group coverage applies to only employer sponsored plans.**

D. Filings that include rates or forms other than PPACA Riders (e.g., applications or other benefit contract changes), will not be eligible for expedited review status.

E. Filings eligible for expedited review status will be given priority, however, companies may not issue PPACA Riders until an approved filing Disposition is received from ODI in SERFF.

**Expedited Review SERFF Filing Requirements Checklist (for use in filing preparation – do not include checklist in filing submission)**

**1. General Requirements:**

- (a) Submit a separate filing for each company. Grandfathered and Non-Grandfathered plans for the same product may be combined in a filing.

- (b) Do not combine different SERFF TOIs in the same filing. For example, PPO and POS products must be filed separately under their respective TOIs.
- (c) All applicable market information fields on the General Information tab (Market Type, Group Market Type, Group Market Size, and Explanation For Other Group Market Type) must be completed accurately.
- (d) PPACA filing indicator field must be completed accurately.
- (g) Filer must indicate **in the Filing Description field** that PPACA Rider expedited review is requested for the filing.
- (h) The PPACA Uniform Compliance Summary submission requirement is not required for an expedited PPACA Rider filing, and should be bypassed.

## 2. **Forms and Supporting Documents:**

- (a) Attach each PPACA Rider under the Form Schedule – **do not** attach as Supporting Documentation.
- (b) PPACA Rider(s) must comply with the format and content of the applicable version of Exhibit B. The content of the PPACA Rider(s) must be verbatim to the Exhibit B language, except for the application of variable (bracketed) language or information, and the omission of Drafting Notes.
- (c) Filing must include a compliant Statement of Variability (see Submission Requirement in SERFF).
- (d) Attach a list of the contract forms for which the PPACA Rider will be used, including the form number, form name/description, ODI filing number and ODI approval date for each contract form listed.
- (e) Attach a copy of any previously approved form(s) that cannot be fully documented with regard to filing number and/or approval date, **as Supporting Documents** – do not attach to the Form Schedule.

## 3. **Special Instructions for Matrix Filers**

Matrix product filings may be eligible for expedited review, only if the following requirements are met:

(a) Filing must be made in compliance items (a) – (c) of the General Requirements section above.

**(b) A SAMPLE BASE BENEFIT CONTRACT MUST BE PROVIDED THAT DEMONSTRATES THE MINIMUM LEVEL OF BENEFITS THAT COULD BE INCLUDED IN A BENEFIT CONTRACT ISSUED FOR THE MATRIX PRODUCT. A LIST MUST ALSO BE PROVIDED THAT IDENTIFIES THE INDIVIDUAL MATRIX ELEMENTS (INCLUDING ELEMENT NAMES OR DESCRIPTIONS, APPROVAL DATES, AND FILE NUMBERS) THAT WERE USED TO CONSTRUCT THE SAMPLE BENEFIT CONTRACT.**

Attach the sample benefit contract, including the list of matrix elements, to the Form Schedule (do not attach as a Supporting Document). Enter the **Form Type as OTH** (Other) and the **Form Name as “Matrix Sample Contract.”**

(c) Provide a list of all matrix elements and other forms (applications, riders, etc.) that could be used in issuing coverage under the matrix product. Include for each element/form listed, form number (if applicable), name or description, ODI filing number and ODI approval date.

#### **4. Special Instructions for Post Submission Expedited Review Status**

(a) PPACA Immediate Reform filings that were submitted in SERFF prior to July 31, 2010, may be eligible for expedited review status if the filing is compliant, as originally filed, with the requirements specified in items (a) – (d) of the General Requirements section above. A filing that does not meet these requirements (e.g., multi-company filings) cannot be eligible for post submission expedited review status.

(b) Amend the filing:

1) Revise the Form Schedule and Supporting Document Schedule, “removing” originally submitted schedule items.

2) Build an Amendment and add PPACA Rider(s) and other documents to the Form Schedule and Supporting Document Schedule as necessary to meet all requirements of the Forms and Supporting Documents section above. **Clearly indicate in the Comments field of the Amendment that you are requesting post submission expedited review status for the filing.**

**Exhibit B1 – For Use With Non-Grandfathered Group Contracts**

**PPACA AMENDMENT/ENDORSEMENT/RIDER TEMPLATE FOR EXPEDITED REVIEW**

*Drafting Note: To be eligible for expedited review status, language provided in this template must be used verbatim, except for variable text, indicated in this template by **red text enclosed in square brackets** ([ ]). A Statement of Variability must be provided that includes all variable text items.*

*When optional language, indicated by **green text enclosed in braces** ( { } ), is applicable for a specific type of plan (e.g., network plans, Health Insuring Corporations (HMOs), or plans that require selection of a primary care provider), it must also be inserted verbatim.*

*The heading text above this note and all “Drafting Notes” must be removed from this form prior to submission.*

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*[Name of Insurance Company]*

**Patient Protection and Affordable Care Act of 2010**

**[AMENDMENT/ENDORSEMENT/RIDER]**

**This [Rider] amends your health benefit plan (Plan), and becomes a part of your Plan as of [mm/dd/yyyy], the Effective Date. Please place this [Rider] with your [policy/evidence of coverage] for future reference.**

On the Effective Date of this [Rider], certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this [Rider] will control.

**The following Definition is added to your Plan:**

**“Essential Health Benefits”** is defined under federal law (PPACA) as including benefits 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. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **[Rider]**.

## **Emergency Services**

*Drafting Note: Insert the following Emergency Services language for Health Insuring Corporation (HMO) plans:*

**{Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department.}**

*Drafting Note: Insert the following definition for all types of plans other than Health Insuring Corporation (HMO) plans (e.g., traditional/fee for service, PPO, POS, etc.).*

**{“Stabilize” means, to provide such medical treatment of an Emergency Medical 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.}**

*Drafting Note: Insert the following Emergency Services language for network plans that provide out of network benefits (i.e., PPO and POS plans).*

**{Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an **[out of network provider]**. However, an **[out of network provider]** of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called “balance billing”).**

**Except where your Plan provides a better benefit, your Plan will apply the same copayments and coinsurance for **[out of network]** Emergency Services as it generally requires for **[in network]** Emergency Services. A deductible may be imposed for **[out of network]** Emergency Services, only as part of the deductible that generally applies to **[out of network]** benefits. Similarly, any out-of-**

pocket maximum that generally applies to [out of network] benefits will apply to [out of network] Emergency Services.

Your Plan will calculate the amount to be paid for [out of network] Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to [in network providers] for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with [in-network providers] for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for [out of network] services (such as the usual, customary and reasonable charges), but substituting [in network] copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any [in network] copayments or coinsurance.}

### **Lifetime Dollar Limits**

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan's terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

*Drafting Note: All Health Insuring Corporation (HMO) plans- As required in Ohio Revised Code Chapter 1751, under separate cover, please file for ODI approval, the PPACA required Notice Lifetime Limit No Longer Applies and Enrollment Opportunity.*

### **Annual Dollar Limits**

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than \$750,000.

For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than \$1.25 million.

For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than \$2 million.

For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

### **Rescission of Coverage**

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded.

You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

### **Preventive Health Benefits**

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible **{when these services are delivered by a [network provider]}**❶. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations

- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at **[insert website or email address]** or **[insert telephone number]**, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html).

*Drafting Note: ① Language should be EXCLUDED when a network plan is NOT available.*

**Dependent Coverage (for plans that make dependent coverage available)**

This Plan will cover your married or unmarried child as defined in **[section]** of this Plan until your child reaches age 26.

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

*Drafting Note: Please note that there are also federal and state requirements to provide notice of the opportunity to enroll older aged children.*

*Drafting Note: All Health Insuring Corporation (HMO) plans-- As required in Ohio Revised Code Chapter 1751, under separate cover, please file for ODI approval, the PPACA required Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26.*

## **Internal Claims and Appeals and External Review Process**

*Drafting Note: Please consult the “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Process under the Patient Protection and Affordable Care Act,” regarding specific requirements.*

*Internal Appeals Process: Please insert revised internal claims and appeals process language that complies with requirements of PPACA.*

*If you have previously approved internal claims and appeals language, please provide a redline copy indicating all changes, along with a letter certifying that there are no changes to the previously approved language other than those indicated in the redlined copy. Attach the redlined copy and the certification letter as Supporting Documents in SERFF.*

*External Review Process: The existing Ohio-mandated external review process will satisfy federal law for plan years beginning before July 1, 2011.*

*Drafting Note: The following language should be used only for plans that include preexisting condition limitations.*

### **{No Preexisting Condition Limitations for [Enrollees] under age 19**

**The Preexisting Condition Limitations described in [Section] of your Plan do not apply to [enrollees] who are under 19 years of age. With respect to [enrollees] who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means an [enrollee] under the age of 19 cannot be excluded from the plan if the exclusion is based on a preexisting condition.}**

*Drafting Note: Language should be included only for Plans that require the designation of a primary care provider.*

### **{Direct Access to Obstetricians and Gynecologists**

**You do not need prior authorization from us or any other person (including a [primary care provider]) to obtain access to obstetrical or gynecological care from a [health care professional] in our [network] who specializes in obstetrics or gynecology. The [health care professional], however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For**

a list of [participating health care professionals] who specialize in obstetrics or gynecology, contact [plan administrator or issuer] at [insert contact information].

Selection of a [Primary Care Provider]

We generally [require/allow] the designation of a [primary care provider]. You have the right to designate any [primary care provider] who participates in our [network] and who is available to accept you or your family members. For children, you may designate a pediatrician as the [primary care provider].}

*Drafting Note: If the plan or health insurance coverage designates a primary care provider automatically, insert:*

{Until you make this designation, [name of group health plan or health insurance issuer] designates one for you. For information on how to select a [primary care provider], and for a list of the [participating primary care providers], contact [plan administrator or issuer] at [insert contact information].}

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

IN WITNESS WHEREOF:

[Name of company]

[Signature]

[President's Name]

**Exhibit B2 – For Use With Non-Grandfathered Individual Contracts**

**PPACA AMENDMENT/ENDORSEMENT/RIDER TEMPLATE FOR EXPEDITED REVIEW**

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*[Name of Insurance Company]*

**Patient Protection and Affordable Care Act of 2010**

**[AMENDMENT/ENDORSEMENT/RIDER]**

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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. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **[Rider]**.

## **Emergency Services**

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*Drafting Note: All Health Insuring Corporation (HMO) plans- As required in Ohio Revised Code Chapter 1751, under separate cover, please file for ODI approval, the PPACA required Notice Lifetime Limit No Longer Applies and Enrollment Opportunity.*

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Please contact us at **[insert website or email address]** or **[insert telephone number]**, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit [www.healthcare.gov/center/regulations/prevention.html](http://www.healthcare.gov/center/regulations/prevention.html).

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*Drafting Note: Please note that there are also federal and state requirements to provide notice of the opportunity to enroll older aged children.*

*Drafting Note: All Health Insuring Corporation (HMO) plans-- As required in Ohio Revised Code Chapter 1751, under separate cover, please file for ODI approval, the PPACA required Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26.*

## **Internal Claims and Appeals and External Review Process**

*Drafting Note: Please consult the “Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Process under the Patient Protection and Affordable Care Act,” regarding specific requirements.*

*Internal Appeals Process: Please insert revised internal claims and appeals process language that complies with requirements of PPACA.*

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*External Review Process: The existing Ohio-mandated external review process will satisfy federal law for plan years beginning before July 1, 2011.*

*Drafting Note: The following language should be used only for plans that include preexisting condition limitations.*

### **{No Preexisting Condition Limitations for [Enrollees] under age 19**

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### **{Direct Access to Obstetricians and Gynecologists**

**You do not need prior authorization from us or any other person (including a [primary care provider]) to obtain access to obstetrical or gynecological care from a [health care professional] in our [network] who specializes in obstetrics or gynecology. The [health care professional], however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For**

a list of **[participating health care professionals]** who specialize in obstetrics or gynecology, contact **[plan administrator or issuer]** at **[insert contact information]**.

**Selection of a [Primary Care Provider]**

We generally **[require/allow]** the designation of a **[primary care provider]**. You have the right to designate any **[primary care provider]** who participates in our **[network]** and who is available to accept you or your family members. For children, you may designate a pediatrician as the **[primary care provider].**

*Drafting Note: If the plan or health insurance coverage designates a primary care provider automatically, insert:*

**{Until you make this designation, [name of group health plan or health insurance issuer] designates one for you. For information on how to select a [primary care provider], and for a list of the [participating primary care providers], contact [plan administrator or issuer] at [insert contact information].}**

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

IN WITNESS WHEREOF:

[Name of company]

[Signature]

[President's Name]

**Exhibit B3 – For Use With Grandfathered Group Contracts**

**PPACA AMENDMENT/ENDORSEMENT/RIDER TEMPLATE FOR EXPEDITED REVIEW**

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*When optional language, indicated by **green text enclosed in braces** ( { } ), is applicable for a specific type of plan (e.g., network plans, Health Insuring Corporations (HMOs), or plans that require selection of a primary care provider), it must also be inserted verbatim.*

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*[Name of Insurance Company]*

**Patient Protection and Affordable Care Act of 2010**

**[AMENDMENT/ENDORSEMENT/RIDER]**

**This [Rider] amends your health benefit plan (Plan), and becomes a part of your Plan as of [mm/dd/yyyy], the Effective Date. Please place this [Rider] with your [policy/evidence of coverage] for future reference.**

On the Effective Date of this [Rider], certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this [Rider] will control.

**Grandfathered Health Plan Disclosure**

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a

grandfathered health plan means that your **[plan or policy]** may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plan must comply with certain other consumer protections in PPACA, 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 the **[plan administrator]** at **[insert contact information]**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**The following Definition is added to your Plan:**

**“Essential Health Benefits”** is defined under federal law (PPACA) as including benefits 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. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **[Rider]**.

**Lifetime Dollar Limits**

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan’s terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

*Drafting Note: All Health Insuring Corporation (HMO) plans- As required in Ohio Revised Code Chapter 1751, under separate cover, please file for ODI approval, the PPACA required Notice Lifetime Limit No Longer Applies and Enrollment Opportunity.*

### **Annual Dollar Limits**

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than \$750,000.

For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than \$1.25 million.

For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than \$2 million.

For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

### **Rescission of Coverage**

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

### **Dependent Coverage (for plans that make dependent coverage available)**

This Plan will cover your married or unmarried child as defined in [section] of this Plan until your child reaches age 26 {, unless your child is eligible to enroll in an employer sponsored health plan, other than a group health plan of a parent. For plan years beginning after January 1, 2014, this Plan will cover your child up to age 26 even if your child has employer sponsored coverage available}. ❶

*Drafting Note: ❶Language to be used when the optional adult child exclusion is included.*

Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

*Drafting Note: Please note that there are also federal and state requirements to provide notice of the opportunity to enroll older aged children.*

*Drafting Note: All Health Insuring Corporation (HMO) plans-- As required in Ohio Revised Code Chapter 1751, under separate cover, please file for ODI approval, the PPACA required Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26.*

*Drafting Note: The following language should be used only for plans that include preexisting condition limitations.*

**{No Preexisting Condition Limitations for [Enrollees] under age 19**

**The Preexisting Condition Limitations described in [Section] of your Plan do not apply to [enrollees] who are under 19 years of age. With respect to [enrollees] who are under 19 years of age, your Plan covers any condition that may have been previously excluded by name or specific description as a pre-existing condition. This also means an [enrollee] under the age of 19 cannot be excluded from the plan if the exclusion is based on a preexisting condition.}**

This [Rider] takes effect on the {later of the} effective date of the Plan to which it is attached {or [Month Day, Year]} {shown in the Certificate Schedule}. This [Rider] terminates concurrently with

the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

[Name of company]

[Signature]

[President's Name]

**Exhibit B4 – For Use With Grandfathered Individual Contracts**

**PPACA AMENDMENT/ENDORSEMENT/RIDER TEMPLATE FOR EXPEDITED REVIEW**

*Drafting Note: To be eligible for expedited review status, language provided in this template must be used verbatim, except for variable text, indicated in this template by **red text enclosed in square brackets** ([ ]). A Statement of Variability must be provided that includes all variable text items.*

*When optional language, indicated by **green text enclosed in braces** ( { } ), is applicable for a specific type of plan (e.g., network plans, Health Insuring Corporations (HMOs), or plans that require selection of a primary care provider), it must also be inserted verbatim.*

*The heading text above this note and all “Drafting Notes” must be removed from this form prior to submission.*

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*[Name of Insurance Company]*

**Patient Protection and Affordable Care Act of 2010**

**[AMENDMENT/ENDORSEMENT/RIDER]**

**This [Rider] amends your health benefit plan (Plan), and becomes a part of your Plan as of [mm/dd/yyyy], the Effective Date. Please place this [Rider] with your [policy/evidence of coverage] for future reference.**

On the Effective Date of this [Rider], certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this [Rider] will control.

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IN WITNESS WHEREOF:

[Name of company]

[Signature]

[President's Name]