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**ACA COMPLIANT FORM FILING GUIDANCE**  
**FOR INDIVIDUAL, NON-EMPLOYER GROUP AND SMALL GROUP**  
**PRODUCTS**

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Written by

The Office of Product Regulation and Actuarial Services

Ohio Department of Insurance

## INTRODUCTION

The Ohio Department of Insurance has developed this manual to provide guidance for the development of Affordable Care Act compliant filings in the individual, non-employer group, and small group markets. The manual identifies important terms and provides filing instructions and information about document development. Failure to follow the instructions in this manual may result in delay or disapproval of a filing.

This manual provides the following information to help you with your form filings:

- Definitions of important terms
- Instructions on completing SERFF fields
- Identification of appropriate checklists
- Instructions on preparing acceptable forms
- Instructions on responding to objections

## ONLINE RESOURCES

Additional information is available on the Department's website under "Plan Management Toolkit" including:

- Ohio Essential Health Benefit Benchmark Plan
- Ohio Essential Health Benefit Resource Document
- Required Supporting Documentation for Form Filings
- QHP Binder and Rate Submission Guidance
- Frequently Asked Questions

## 2017 PLAN YEAR FILING DEADLINES

- April 15: Individual and Small Group new and amendatory form filings for On and Off Exchange; Pediatric Stand Alone Dental Plan (SADP) form filings
- April 27: On and Off Exchange Rate Filings for Individual, Small Group and SADP plans; QHP Binders
- September 2: ACA Compliant Large Group form and rate filings

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## IMPORTANT TERMS

### **OHIO ESSENTIAL HEALTH BENEFIT (EHB) BENCHMARK PLAN**

The plan selected for Ohio that is the model for all Standard Benchmark Plans.

### **ESSENTIAL HEALTH BENEFIT RESOURCE DOCUMENT**

A chart that identifies the essential health benefits required in Ohio. This chart should be used in conjunction with the Ohio EHB Benchmark Plan for complete descriptions of the Ohio EHBs.

### **ESSENTIAL HEALTH BENEFITS LOCATOR**

A form completed by insurers and submitted with individual and small group filings that confirms the inclusion of required EHBs, provides the page numbers of required EHBs and identifies benefits that are Substantially Equal to the Benchmark Plan, Actuarially Equivalent Substitutions, or above the EHB. Insurers also list any optional benefits that have been added to its plans.

### **STANDARD BENCHMARK PLAN**

The insurer's policy or certificate that includes all of the EHBs required in Ohio. This plan must be consistent with the Ohio EHB Benchmark Plan and meet all of the requirements of the Affordable Care Act (ACA). Standard Benchmark Plans may include benefits that are not included in the Ohio EHB Benchmark Plan; however this would mean the Standard Benchmark Plan exceeds the Ohio EHB Benchmark Plan.

Policies and certificates must be one complete form; they may not consist of matrix elements.

### **STANDARD PLAN VARIATION**

A complete policy or certificate that is a unique variation of the Standard Benchmark Plan. Each unique Standard Plan Variation must have a unique form number. Standard Plan Variations may:

- Increase the benefit level by increasing quantitative (*e.g.* visit) limits
- Increase the benefit level by revising or deleting exclusions
- Substitute actuarially equivalent essential health benefits
- Exclude contraceptives for eligible religious groups

### **STANDARD PLAN RIDER**

Standard Plan Riders are used to add new benefit provisions that will be used to construct one or more additional plans (each having unique Plan Identification Numbers). More than one new optional provision may be filed with a filing but each must be on a separate form with unique form numbers unless the intent is to always sell them together.

Except for the contraceptive exemption, Standard Plan Riders must add coverage rather than reduce coverage.

Standard Plan Riders may:

- Increase the benefit level by increasing quantitative (*e.g.* visit) limits
- Increase the benefit level by revising or deleting exclusions
- Add optional benefits including stand-alone benefits such as dental coverage
- Exclude contraceptives for eligible religious groups

**AMENDMENT OR ENDORSEMENT (AMENDATORY FORMS)**

A separate form, with a unique form number, used to revise previously approved Standard Benchmark Plans and Standard Plan Variations forms.

Amendments and endorsements may not reduce coverage unless the issuer is excluding contraceptive benefits for eligible religious groups.

**WHAT SUPPORTING DOCUMENTS DO I NEED TO FILE?**

**MAJOR MEDICAL**

<i>Scenario</i>	<i>Form Filing Checklist</i>	<i>EHB Locator</i>	<i>Are Rates Required?<sup>1</sup></i>
I plan NO changes to my existing ACA compliant forms (no form filing required)	N/A	Yes, with the Rate Filing	Yes
I want to use an Amendment, Endorsement, or Standard Plan Rider to make changes to my existing Standard Benchmark Plan or Standard Plan Variation	No	Yes	Yes
I want to make changes by creating a new Standard Benchmark Plan or Standard Plan Variation	Yes	Yes	Yes

**DENTAL**

<i>Scenario</i>	<i>Form Filing Checklist</i>	<i>Are Rates Required?<sup>1</sup></i>
I plan NO changes to my existing ACA compliant forms (no form filing required)	N/A	Yes
I want to use an Amendment, Endorsement, or Standard Plan Rider to make changes to my existing ACA compliant forms	No	Yes
I want to create a new ACA compliant form	Yes	Yes

<sup>1</sup> All rates are filed under the rate filing type. Rates are not required if trend was not used in developing rates, and there are no changes to currently approved rates. See the “Plan Management Toolkit,” located on the Department’s website, for rate filing instructions.

# SERFF FILING INSTRUCTIONS

## TOI/SUB TOI

- Use the Type of Insurance Code (TOI) and Sub-TOI specified in Appendix A. Filings submitted under the incorrect TOI or Sub-TOI will be rejected.
- Do not combine small and large group forms in one filing.
- The any size group code may be used only for non-employer group plans.

## FILING TYPE

The filing type must accurately describe the submitted forms.

- If policy/certificate forms and rates are submitted separately use the Filing Type, **Form**, for the forms filing and the Filing Type, **Rate**, for the rate filing.
- If policy/certificate forms and rates are submitted together in one filing, use the Filing Type, **Form/Rate**.
- The **Advertising/Solicitation** filing type should be used for HIC solicitation filings only.

## PPACA INDICATOR

- All products that must comply with the ACA will include the PPACA indicator.
- The “Not PPACA Related” option may be used only for applications, amendments to applications, name changes and assumption filings.
- Identify the filing as either grandfathered or non-grandfathered. Do not combine grandfathered forms and non-grandfathered ACA forms in one filing.

## EXCHANGE INTENTIONS INDICATOR

Select YES if any portion of the filing is intended to be sold through the federal health insurance exchange. Include additional information, if any, in the text box that is provided.

## IMPLEMENTATION DATE

Indicate January 1, 2017 for any plan to be used for the upcoming open enrollment period.

## SUBMISSION TYPE

Indicate whether the filing is a new submission or a resubmission of a previously disapproved or withdrawn form. If it is a resubmission, please see the additional requirements under “Filing Description” section below.

## MARKET TYPE

Select the appropriate market type. Please refer to Appendix A for guidance in identifying the correct market type.

## CORRESPONDING FILING TRACKING NUMBER

Provide the SERFF Tracking Numbers for the corresponding rate filing and other related form filings (e.g. Standard Plan Variations, Standard Plan Riders, and Amendatory Forms) in this field.

## FILING DESCRIPTION

Provide a complete and accurate description of the filing in the Filing Description section of the General Information tab. Required information is specified below.

- Indicate if this is a new form or a revision of an existing form; revisions must include the SERFF tracking number and approval date of the previous form.
- Indicate if this filing represents a new use of an existing form.
- Indicate if the form will be offered to existing insureds, new applicants or both.
- Describe in detail how the Amendatory Forms and Standard Plan Riders will be used with the underlying base form. Examples of necessary information are shown below:
  - Indicate if the Amendatory Form will always be used with the base form.
  - Indicate if the base form will remain unchanged and the Amendatory Form will be issued attached to the base form.
- Describe how the form will be marketed (*e.g.* direct sales or sales agent).
- Indicate if the form is a resubmission of a previously disapproved or withdrawn ACA compliant form; include the SERFF tracking number(s), disposition date(s) of the previous form, and responses to all outstanding issues (as a supporting document)
- Identify all forms to be used with the submitted forms; include SERFF tracking number(s) and approval dates.
- Provide SERFF tracking numbers not included in Corresponding Filing Tracking Number Field for any related form or rate filings.
- For Health Insuring Corporation (HIC) advertising/solicitation filings describe the form related to the advertisement/solicitation and include the SERFF tracking number(s) and approval date(s). Please note, advertising and solicitation documents may be submitted only with the base form or after the base form has been approved.

## DOCUMENT FORMAT

All attachments to the Form Schedule and Supporting Document tabs must be provided in a searchable PDF format. For the EHB Locator, submit the locator in both its original Excel format and in a searchable PDF format.

## FORM DESIGN

### FORMAT

Forms must comply with the following requirements:

- Policies and Certificates must be complete documents.
- Matrix formats are not permitted.
- Each form must include a unique form number on the lower left hand corner of the first page of the form. The form number must be identical to the form number shown on the Form Schedule tab in SERFF.
- Amendatory Forms and Riders content cannot be embedded into a previously approved form. Changing language within a previously approved form can only be done by submitting the revised form with a new form number.

## **FORM ORGANIZATION**

The form must be organized in a logical, reasonable, and rational order and presented in a manner that is clear and easy to understand for the average consumer. Specific requirements are identified below:

- The format must be consistent throughout the form.
- A table of contents must be included in all policies and certificates.
- Covered benefits must be clearly explained.
- There must be a clear distinction between what is covered and what is not covered.
- All important terms must be defined and when used, must be differentiated from the remaining text in some way (*e.g.* capitalized, bolded).
- Definitions may not be used to describe limits or exclusions of benefits.
- Benefit specific limitations and exclusions must be provided directly after description of the covered benefit. General limitations that apply to the entire form should be located in a separate, clearly identified section.
- Limitations and exclusions must be labeled appropriately. For example, exclusions should be listed under the heading, ***Exclusions***, while limitations should be listed under the heading, ***Limitations***.
- Covered benefits must be described in the benefit section and not included as an exception in the exclusion section.

## **USE OF VARIABLE CONTENT**

***Alternative provisions are not permitted in individual policies.***

Permitted variable content is limited to:

- Cost sharing options including deductibles, coinsurance and copayments.
- Contraceptive coverage alternatives for groups eligible for the ACA religious exemption.
- Options in a group policy/certificate that have been added by rider or amendatory form may be bracketed in the Schedule of Benefits.
- Alternative language that does not affect covered benefits (*e.g.* eligibility options, addresses, websites).

To ensure that the use of variability is clear, please adhere to the following:

- Bracket each variable.
- Include a statement of variability in the Forms Schedule as a separate form identified by a unique form number. Please use the Form Type "OTH."

The statement of variability must:

- Clearly describe the use of each bracketed item.
- Include specific options; vague statements such as "variables will always comply with applicable laws" are not acceptable.
- Include all alternative language with an explanation of why and when the language will be substituted.
- Include all values and ranges of values; value ranges must be reasonable and consistent with filed rates.

***Any changes to an approved statement of variability must be filed and approved before use.***

## **REQUIREMENTS FOR REVISIONS TO THE STANDARD BENCHMARK PLAN OR A STANDARD PLAN VARIATION**

Insurers may update Standard Benchmark Plans by revising the previously approved policy or certificate or by submitting an amendment to be used in conjunction with the previously approved form. If insurers want to submit an amendment to be used for current insureds and a new policy or certificate for new insureds, they must submit both the amendment and the policy or certificate for review. These forms should be filed in the same SERFF filing.

The following requirements apply to the submission of revisions to previously approved forms:

- Assign a new unique form number for each filed form.
- Attach the previously approved form under Supporting Documentation tab on SERFF.
- Attach a red-lined version of the new form showing all revisions under Supporting Documentation tab.
- Include a certification that all changes are identified in the red-lined version under Supporting Documentation tab.

Please note that if the Department determines that an amendment or endorsement contains too many changes we may request an entirely new version of the base form.

## **REQUIREMENTS FOR ADDING OPTIONAL BENEFITS**

The following requirements apply to adding optional benefits:

- Add new benefits via a Standard Plan Rider.
- Specify in the filing if the optional benefits will always be sold as a package or if each optional benefit may be sold separately. If optional benefits are to be sold as a package they may be included in one Standard Plan Rider. If optional benefits are to be sold separately, each benefit must be on a separate Standard Plan Rider.
- Assign a unique form number to each Standard Plan Rider. The form number must be located in the lower left hand corner of the first page.

## **REQUIREMENTS FOR CONTRACEPTIVE COVERAGE EXEMPTION**

Contraceptive coverage may be excluded only for groups eligible for the ACA religious exemption. To provide this exemption:

- Use a Standard Plan Variation, Standard Plan Rider or Amendment or Endorsement.
- Clearly state exactly what contraceptive benefit is removed from coverage.
- Explain any variability in a statement of variability as described under USE OF VARIABLE CONTENT section.

Note: The ACA religious exemption does not apply to coverage of therapeutic abortions. Coverage for therapeutic abortions is required for consistency with the Ohio EHB Benchmark Plan.

## **FORM FILING CHECKLIST AND EHB LOCATOR**

The Department has developed form checklists and an EHB Locator for use with certain filings. See the *What Supporting Documents Do I Need to File* section. The checklists and EHB Locator will be populated in SERFF under the Supporting Documentation tab and are available on the Department's website: [www.insurance.ohio.gov](http://www.insurance.ohio.gov) under "*Plan Management Toolkit*" (found in *Featured Links*).

## FILING TIPS

Please adhere to the following:

- Include all forms for one market type (individual, non-employer group, or small group) in one filing.
- Provide a red-lined version of each revised form. The initial redline must be based on a prior **approved** form. Include the SERFF filing number for the prior approved form and a certification that the redlined version is accurate and shows *all* changes made to the original form. See *How to Prepare Redline Versions* for more information.
- Submit all Standard Benchmark Plan and Standard Plan Variation filings as complete policies, certificates and riders (i.e. not matrix type filings).

## HOW TO RESPOND TO OBJECTION LETTERS

- **Respond to each objection individually** using the response format in SERFF.
- Do not respond in a separate letter attached as a supporting document.
- If an objection has multiple parts, address all parts of the objection.
- Call the reviewer if you need clarification of any of the objections.
- Include (as a supporting document) a redline copy of each form showing changes only from the most recent form submitted and a certification that all changes have been redlined. Do not replace an old redline with a new redline.

## HOW TO PREPARE REDLINE VERSIONS

- Compare only two forms, the newest version to the last version. Redlines may not include accumulated changes from several versions of a form.
- Use a contrasting color such as red or blue. Underlines, gray or black print are not acceptable.
- Provide a complete form and include all of the changes that have been made. The redline version must match the newest version of the form.
- Review the redline version to ensure it is easy to understand.

## SELECTED COVERAGE AND FILING ISSUES

### UNDERSTANDING THE ESSENTIAL HEALTH BENEFITS IN OHIO PLANS

- Essential health benefits are outlined in the Essential Health Benefit Resource Document and the Ohio EHB Benchmark Plan. These can be found on the Department's website: [www.insurance.ohio.gov](http://www.insurance.ohio.gov) under "Plan Management Toolkit" (found in Featured Links).
- All EHBs included in the benchmark plan must be covered.
- No annual or lifetime dollar maximums are permitted. Some benchmark benefits have visit limitations or per service dollar maximums.

The Ohio EHB Benchmark Plan is not a HIC plan and does not meet all of the Ohio HIC requirements. Please refer to the section titled *Specific issues for HICs (HMOs) only*.

Some of the benefits in the Ohio EHB Benchmark Plan must be revised and other benefits added in order to comply with current state and federal requirements. These revisions are identified below:

- **Dental Services for accidental injury: limited to \$3000 per accident.**
- **Private duty nursing: limited to 90–110 visits per year.**

- **Unrelated donor searches for bone marrow/stem cell transplants for a covered transplant:** limited to \$30,000 per transplant.
- **Residential treatment centers** must be covered for mental health and substance abuse treatment.
- **Habilitative services:** refer to “HABILITATIVE SERVICES” subsection below.

Please refer to the Ohio Essential Health Benefit Resource Document, located in the “Plan Management Toolkit” on the Department’s website. Note that a few EHB benefits are no longer listed separately but referenced in the “Explanations” column text of a more general EHB benefit category. It is important to carefully review the “Explanations” column text for important EHB details.

### EXCLUSIONS AND LIMITATIONS

- Exclusions and limitations must be consistent with the Ohio EHB Benchmark Plan; benefits not excluded in the Ohio EHB Benchmark Plan may not be excluded in a Standard Benchmark Plan
- Exclusions or limitations broader than those in the OHIO EHB Benchmark Plan are not permitted.

### RECURRING ISSUES

#### CLINICAL TRIALS

Benefits for coverage of routine care for a clinical trial must comply with ORC 3923.80 and federal requirements. In general, the federal law is more expansive and covers all clinical trials. However, Ohio requirements for cancer clinical trials are broader than federal law:

- Coverage is not limited to a “qualified individual” as defined in federal law.
- The participant is not required to have a referral from a participating health professional.
- The participant is not required to provide medical and scientific information establishing the appropriateness of participation.

#### HABILITATIVE SERVICES

Standard Benchmark Plans must cover habilitative services as specified:

- Must define as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. 45 CFR 156.115(a)(5).
- Must include the coverage provided in Governor Kasich’s letter dated December 26, 2012. This letter can be accessed in the “Plan Management Toolkit” on the Department’s website.
  - Coverage must include, **but not be limited to**, services for children (0 to 21) with a medical diagnosis of Autism Spectrum Disorder.
  - Out-patient physical habilitation services must include 20 speech and language therapy visits and 20 occupational therapy visits per year.
  - Services include 20 hours per week of Clinical Therapeutic Intervention, including but not limited to, Applied Behavioral Analysis.
  - Mental and Behavioral Health Outpatient Services must include no less than 30 visits – **this minimum must be increased** when necessary to comply with Mental Health Parity and Addiction Equity Act (MHPAE).

## ORALLY ADMINISTERED CANCER MEDICATION

Review ORC sections 3923.85 and 1751.69 for required coverage for orally administered cancer medication. Orally administered cancer medication may not be provided on a less favorable basis than intravenously or injected cancer medication. A safe harbor option that limits cost sharing for orally administered cancer medication to no more than \$100 is permitted. The safe harbor option for high deductible health plans and catastrophic plans applies after the deductible has been met.

## OUT OF NETWORK COVERAGE FOR COMPANIES LICENSED UNDER TITLE 39

Insurers must provide out of network benefits for all services with the following exceptions:

- Transplants may be limited to centers of excellence.
- Certain specialty drugs may be provided only by specialty pharmacies. Specialty drugs must be defined.

## PEDIATRIC AGE

Standard Benchmark Plans must provide coverage for pediatric services until at least the end of the month in which the enrollee turns 19. 45 CFR 156.115(a)(6). "Pediatric services" means the pediatric services required under 45 CFR §156.110(a)(10), which includes the EHB-benchmark plan standards, specifically, "Pediatric services, including oral and vision care."

## PEDIATRIC DENTAL

Pediatric dental benefits must match the MetLife Federal Dental Plan-High Option 2014 Plan. A few guidelines are listed below:

- All benefits must be covered to the end of the month in which the enrollee reaches age 19. No other age limitations (including any in the benchmark plan) may be used.
- No lifetime maximums (even those in the original plan) are permitted.
- A 2 year waiting period is permitted for orthodontia only.
- Pediatric dental benefits may be embedded in the medical plan or sold as a stand-alone-plan.

## PEDIATRIC VISION

Pediatric vision must be embedded in the medical plan. Benefits must match the FEP BlueVision High Option 2014 Plan. Mandated coverage includes:

- Eye exam
- Lenses (All lenses and treatments identified in FEP plan must be covered)
- Frames
- Contact Lenses
- Low Vision Benefits

In-network dollar maximums are **not** permitted on any services.

## PRESCRIPTION DRUG EXCEPTION PROCESS

Beginning in plan year 2016, ACA compliant forms are required to include a prescription drug exception process so that an enrollee may request and gain access to a drug not on the plan's formulary under certain situations. Under this process, an insurer must notify the enrollee or the enrollee's designee and physician of its coverage decision no later than 72 hours following receipt of an exception request. The enrollee or the enrollee's designee/physician

may request an expedited exception based on exigent circumstances and receive notification no later than 24 hours after making the request. The process must include the right of the enrollee or enrollee's designee physician to request that a denied exception request be reviewed by an Independent Review Organization with a response time of 72 hours for regular requests and 24 hours for expedited requests. If an exception request is granted, the plan must treat the drug as an EHB and count costs towards the annual EHB limitation on cost-sharing. 45 CFR 156.122.

#### PREVENTIVE CARE EDUCATION PROGRAMS

Coverage for preventive benefits must include all mandated interventions and counseling sessions.

#### STANDARD PROVISIONS

##### *INSURANCE COMPANIES*

Review the standard and optional provisions for individual products in ORC 3923.04 and 3923.05. For group products refer to ORC 3923.12 and 3923.20. Department approval is required to omit or substitute provisions. Substituted provisions must not be less favorable to the insured than the statutory provisions. See ORC 3923.07.

##### *HICs*

Review ORC 1751.11 for standard provisions for HICs.

#### SURROGATE PREGNANCY

If a covered person is pregnant, coverage must be provided even if the person is acting as a surrogate. Maternity coverage is a required benefit of the benchmark plan. It is also a basic health care service for HICs. Coverage may be excluded if the surrogate is not a covered person.

#### **SPECIFIC ISSUES FOR HICs (HMOs) ONLY**

Health Insuring Corporations must provide all basic health care services at all times (refer to ORC 1751.01). To comply with this requirement, some exclusions in the benchmark plan may not be included in a HIC form. For example:

- HICs must cover complications of non-covered services.
- HICs may not exclude services based on events such as participation in a riot.
- HICs must cover diagnostic testing and treatment related to infertility (please refer to ORC 1751.(A)(1)(h) and Bulletin 2009-07.

HICs must file for approval any ID cards that need to be updated to comply with OAC 3901-8-16(D)(3).

#### **NEW ISSUES AND REQUIREMENTS**

##### CONTRACEPTIVE EXCEPTION PROCESS

Filings must include a contraceptive exception process compliant with the FAQs about Affordable Care Act Implementation (Part XXVI) issued jointly by DOL, HHS and CMS on May 11, 2015. This process must clearly indicate that the plan must defer to the determination of the attending provider in regard to medical necessity.

## ID CARD REQUIREMENTS

OAC 3901-8-16(D)(3) requires an issued ID card to clearly and conspicuously denote the name of any network(s) applicable to the coverage and whether the coverage is provided through the exchange. HICs must file any ID cards that need to be revised to comply with this requirement.

## REHABILITATION SERVICES

The CMS 2017 EHB Summary presents benefits for rehabilitation services in a different manner than in the previous summary. However, the benefits have not changed. The EHB rehabilitation quantitative benefits limits are:

- Combined inpatient rehabilitation and day rehabilitation 60 days
- Outpatient physical therapy 20 visits
- Outpatient occupational therapy 20 visits
- Outpatient pulmonary rehabilitation (unless rendered as part of physical therapy) 20 visits
- Outpatient Cardiac Rehabilitation 36 visits

*Note: Outpatient therapy visits may be combined to total 116 or be provided separately as shown above.*

## VISION CORRECTION

The CMS Summary Information Form no longer identifies vision correction as a separate EHB benefit; however this benefit is still required and is referenced under Durable Medical Equipment.

- Intraocular lens implantation for the treatment of cataracts or aphakia.
- Contact lenses or glasses following lens implantation.
- The first pair of contact lenses or eyeglasses which replace the function of the human lens for conditions caused by cataract surgery or injury; a donor lens is not the first lens.

## APPENDIX A

### CODING INSTRUCTIONS (TOI, SUB-TOI, MARKET TYPE) FOR ACA COMPLIANT FILINGS

The tables below identify the appropriate TOIs and Sub-TOIs and Market Types for ACA compliant filings. This coding structure will be used to display applicable Filing Requirements in SERFF, and will also help us to collect data necessary for a variety of tracking and reporting activities.

#### OHIO TITLE 39 INDEMNITY INSURERS

##### MAJOR MEDICAL

<b>TOI</b>	<b>SUB-TOI</b>	<b>Description and Use</b>
H16G Group <sup>2</sup> Health–Major Medical Any Size Group	H16G.001A	Any Size Group-PPO; Only for Non-Employer Group Plans
	H16G.001B	Any Size Group-POS; Only for Non-Employer Group Plans
	H16G.001C	Any Size Group-Other; Only for Non-Employer Group Plans
H16G Group Health–Major Medical Large Group Only	H16G.002A	Large Group Only-PPO
	H16G.002B	Large Group Only-POS
	H16G.002C	Large Group-Other
H16G Group Health–Major Medical Small Group Only	H16G.003A	Small Group Only-PPO
	H16G.003B	Small Group Only-POS
	H16G.003C	Small Group-Other
H16I Individual <sup>3</sup> Health–Major Medical Individual Only	H16I.005A	Individual-PPO
	H16I.005B	Individual-POS
	H16I.005C	Individual-Other
H22 Student Health Insurance	H22.000A	Blanket
	H22.000B	Non-Blanket / Indemnity
	H22.000C	Non-Blanket / Health Insuring Corp (HMO)

<sup>2</sup> Non-employer group plans are those sold to individuals through associations, trusts or other entities.

<sup>3</sup> Only for use with true individual plans not sold through associations, trusts or other entities.

DENTAL

H10G Group	H10G.000	Dental Any Size Group
H10I Individual	H10I.000	Dental Individual

**OHIO TITLE 17 HEALTH INSURING CORPORATIONS (HICs, COMMONLY CALLED HMOs)**

BASIC HEALTH CARE

<i><b>TOI</b></i>	<i><b>SUB-TOI</b></i>	<i><b>Description and Use</b></i>
HOrg02G Group	HOrg02G.002C	HMO Any Size Group–Restricted Network plan; Only for non-employer group plans
	HOrg02G.003C	HMO Large Group–Restricted Network plan
	HOrg02G.004F	HMO Small Group–Restricted Network plan
	HOrg02G.002B <sup>4</sup>	POS Any Size Group
	HOrg02G.003B <sup>4</sup>	POS Large Group
	HOrg02G.004D <sup>4</sup>	POS Small Group
HOrg02I Individual	HOrg02G.002B	HMO Individual–Other; Only for Conversion or Ohio Basic and Standard Restricted Network Plans
	HOrg02G.005D	HMO Individual–Restricted Network Plan
	HOrg02I.005B	POS Individual

DENTAL

Supplemental/Specialty Product Health Insuring Corporation	Dental Care Services	Dental Care Services
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<sup>4</sup> For use only by HICs with a Title 39 license who issue one contract that includes in and out of network services.

## MARKET TYPE (ALL FILINGS)

Individual		<b>Individual Market Type Options</b> <ul style="list-style-type: none"><li>• Individual</li><li>• Non-employer Group</li></ul>
<b>Group</b>		
	<b>Group Market Size Options</b> <ul style="list-style-type: none"><li>• Small</li><li>• Large</li></ul>	<b>Group Market Type Options</b> <ul style="list-style-type: none"><li>• Employer</li><li>• Associations</li><li>• Blanket</li><li>• Discretionary</li><li>• Trust</li><li>• Other</li></ul>

## APPENDIX B

### ACA MARKET REFORMS

The ACA mandated market reforms are shown below by type of coverage. The individual market includes individual plans and plans marketed to individuals through associations, trusts or other entities (non-employer groups). Group market applies only to employer related coverage.

#### INDIVIDUAL GRANDFATHERED PLANS

<i><b>PHS Sections</b></i>	<i><b>Provision</b></i>
2711;1251	No Lifetime Dollar Limit
2712;1251	Prohibits Rescissions
2714;1251	Dependent Coverage to Age 26

#### INDIVIDUAL NON-GRANDFATHERED PLANS

<i><b>PHS Section</b></i>	<i><b>Provision</b></i>
2704	No Pre-Existing Condition Exclusions
2705	Prohibits Discrimination Based on Health Status
2706	No Discrimination Against Providers In Scope
2707	Provides Essential Health Benefits Package
2709	Coverage For Approved Clinical Trials
2711	No Annual or Lifetime Dollar Limits
2712	Prohibits Rescissions
2713	Preventive Services
2714	Dependent Coverage to Age 26
2719	Appeals Process
2719 A	Emergency Services
2719 A	Access to Pediatricians and OB/GYNs

**GROUP GRANDFATHERED PLANS**

<b><i>PHS Sections</i></b>	<b><i>Provision</i></b>
2704;1251	No Pre-Existing Condition Exclusions
2708;1251	Prohibits Excessive Waiting Periods
2711;1251	No Annual or Lifetime Dollar Limits
2712;1251	Prohibits Rescissions
;2714;1251	Dependent Coverage to Age 26

**GROUP NON-GRANDFATHERED PLANS**

<b><i>PHS Section</i></b>	<b><i>Provision</i></b>
2704	No Pre-Existing Condition Exclusions
2705	Prohibits Discrimination Based on Health Status
2706	No Discrimination Against Providers In Scope
2707	Provides Essential Health Benefits Package
2708	Prohibits Excessive Waiting Periods
2709	Coverage For Approved Clinical Trials
2711	No Annual or Lifetime Dollar Limits
2712	Prohibits Rescissions
2713	Preventive Services
2714	Dependent Coverage to Age 26
2719	Appeals Process
2719 A	Emergency Services
2719 A	Access to Pediatricians and OB/GYNs