

ACA Compliant Form Filing Guidance

(Individual,
Non-Employer Group
and Small Group Products)

Revised 04/26/2014

OPRAS - Ohio Department of Insurance

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I Forward

This document provides important information regarding ACA compliant **Individual, Non-Employer Group, and Small Employer Group**, non-grandfathered health products filed with the Ohio Department of Insurance (Department). Specifically, this guidance provides health plan issuers with “how to use” information, significant guidance and checklists that vary depending on market type. These resources also will be available on SERFF, making it easily accessible during a health plan issuer’s submission process. Additionally, Department staff from the Office of Product Regulation and Actuarial Services will be available to answer questions pertaining to this guidance.

ODI strongly urges all health plan issuers to consult this training packet throughout the submission process. Failure to follow this guidance could result in delay or disapproval during the intake process.

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II Authority

This guidance has been developed in conjunction with the regulatory authority provided to the Department by the Ohio Revised Code. Excerpts of the specific provisions that provide this authority are shown below.

- Accident and Sickness coverage, Title 39 of the Ohio Revised Code

Ohio Revised Code Section 3923.02 Policy forms

...No such policy, certificate, i(e)ndorsement, rider or application shall be delivered, issued for delivery, or used until the expiration of **thirty days** after the form of such policy, certificate, i(e)ndorsement, rider or application has been filed with the superintendent, unless he has previously given the insurer his written approval thereto. If the superintendent finds that any such form of policy, certificate, indorsement, rider, or application which has been filed with him by an insurer contains any provision which is contrary to the law of this state, or contains inconsistent provisions, or contains any question, provision, title, heading, backing, or other indication of its contents, which is ambiguous, misleading, or deceptive, or likely to mislead or deceive the policyholder, certificate holder or applicant, he shall give written notice of his finding to the insurer which has filed such form, and thereafter no insurer which has filed such form shall deliver, issue for delivery, or use such form in this state.

- Health Insuring Corporation coverage, Title 17 of the Ohio Revised Code

Ohio Revised Code Section 1751.11 (C), (D) (1) Evidence of coverage

(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within **sixty days** after it is filed it shall be deemed approved...

(D)(1) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used ...If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive...

Ohio Revised Code Section 1751.31 (A) Solicitation

(A) Any changes in a health insuring corporation's solicitation document shall be filed with the superintendent of insurance thirty days prior to use for informational purposes, and shall comply with the requirements of this section. If the superintendent finds that any solicitation document fails to comply with the requirements of this section, the superintendent may disapprove any solicitation document or require amendment to it on any of the grounds stated in this section. Such disapproval shall be effected by written notice to the health insuring corporation. The notice shall state the grounds for disapproval and shall be issued in accordance with Chapter 119 of the Revised Code.

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III Definitions

The following terms and definitions are applicable specifically to the context of this guidance.

Standard Benchmark Plan	A complete policy/certificate that provides, at a minimum, all benefits and services necessary for compliance with the Ohio Essential Health Benefits (EHB) Benchmark Plan requirements and otherwise complies with all applicable requirements of Ohio and federal law. This form can be used as the basis for Standard Plan Variations that include distinct actuarially equivalent EHB substitutions and/or additional coverage.
Standard Plan Variation	<p>A complete policy/certificate that is a unique variation of a Standard Benchmark Plan. Variations can include distinct actuarially equivalent EHB substitutions, higher benefit levels (i.e., higher quantitative limits or less restrictive exclusions than the Standard Benchmark Plan), and coverage for additional treatments or services.</p> <p>A Standard Plan Variation can also be used to provide the contraceptive coverage exemption in group health plans sold to eligible religious employers and non-profit religious organizations.</p> <p>Each unique Standard Plan Variation must have its own form number.</p>
Standard Plan Rider	<p>A separate form that can only be used as follows:</p> <ol style="list-style-type: none">1) in combination with the Standard Benchmark Plan, to construct a unique plan variation with increased benefit levels (e.g., higher quantitative limits or less restrictive exclusions than the Standard Benchmark Plan), and/or coverage for additional treatments or services; or,2) in combination with a Standard Plan Variation, to provide additional “stand alone” types of coverage (e.g., dental coverage). <p>A Standard Plan Rider cannot be used to reduce coverage provided in a Standard Benchmark Plan unless it is used to provide the contraceptive coverage exemption in group health</p>

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	<p>plans sold to eligible religious employers and non-profit religious organizations.</p> <p>Each Standard Plan Rider must have its own form number.</p>
<p>Amendment or Endorsement</p>	<p>A separate form that can be used to make Permitted Revisions to a Standard Benchmark Plan or a Standard Plan Variation.</p> <p>An Amendment or Endorsement cannot be used to reduce coverage provided in a Standard Benchmark Plan. Each Amendment or Endorsement must have its own form number.</p>
<p>Permitted Revisions</p>	<ol style="list-style-type: none"> 1) Administrative revisions necessary to contract language or content that do not change benefit levels or treatments and services covered under a plan (e.g., a change to contact information or name due to an assumption); or 2) For plans that will be offered <u>only</u> outside of the federal health insurance exchange, changes to benefit levels or treatments and services that will be effective only for newly issued plans or at renewal; or 3) For plans approved to be offered on the federal health insurance exchange, changes to benefit levels or covered treatments and services that will be effective for plans issued on or after January 1 of the next calendar year benefit period. 4) To provide the contraceptive coverage exemption in group health plans sold to eligible religious employers and non-profit religious organizations. Please see Section IV 9 for additional information.
<p>Permitted Variable Content</p>	<p>Variable content is limited to cost sharing options and alternative language or content that does not determine the treatments or services covered, or the benefit levels (quantitative limits and/or exclusions) applicable to treatments or services covered by a plan, except as provided in Section IV 9 for contraceptive coverage exemption.</p> <p><i>(cont'd...)</i></p>

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<i>Permitted Variable Content (cont'd)</i>	To support identification of covered benefits and services at a plan level, optional variations in treatments or services covered and/or applicable benefit levels must be offered as a <i>Standard Plan Variation</i> or a <i>Standard Plan Rider</i> . All variable content must be clearly identified and indexed to a Statement of Variability as described later in this guidance.
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IV General Filing Guidelines

These guidelines only apply to ACA compliant **Individual, Non-Employer Group, and Small Employer Group**, non-grandfathered health products filed with the Department and should be used in conjunction with requirements under Ohio and federal law.

1. **SERFF Coding Instructions** - in accordance with Ohio Bulletin 2009-11, all product filings must be submitted through SERFF (the System for Electronic Rate and Form Filing). Please contact the SERFF Marketing Team at serffmktg@naic.org for more information about the SERFF system. Specific instructions regarding the SERFF filing format required by Ohio are below:
 - a. **Type of Insurance (TOI)** – All products that must comply with ACA must use the appropriate TOIs and sub-TOIs as defined in the “TOI and Sub-TOI Coding Instructions” table. The table is attached to this guidance as Appendix A. Please note small and large group filings can no longer be combined in one filing. The “Any Size Group” sub-TOI is restricted to non-employer group plans only.
 - b. **Filing Type** – To enable a quick turnaround of filings, it is strongly recommended that the “Advertising/Solicitation” filing type be used for HIC advertising only filings and the “Form” filing type be used for all other required form filings. The “Form/Rate” filing type is NOT recommended because both the form and rate portions of the filing will need to be completed prior to approval of the filing.
 - c. **PPACA Indicator** – All products that must comply with ACA will include the PPACA indicator. Please indicate whether the product will be available to Grandfathered plans or Non-Grandfathered plans. To ensure appropriate compliance requirements, Grandfathered and Non-Grandfathered plans can no longer be combined in one filing. The “Not PPACA Related” option may ONLY be utilized when the filing contains only applications, application amendments, a name change or an assumption. ACA reforms applicable to grandfathered and non-grandfathered plans are detailed in the attached appendices. The “Individual Market Reforms” table is attached as Appendix B; the “Group Market Reforms” table is attached as Appendix C.
 - d. **Include Exchange Intentions Indicator** – Please select “YES” if any portion of the filing is intended for sale through the federal health insurance exchange. A text box will be provided to allow for specific details on the particular forms.
 - e. **Implementation Date Requested** – Please indicate the initial effective date of plans sold for this product. Be sure to indicate January 1, 20XX for any plan to be used in the upcoming open enrollment period.

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- f. Submission Type – Please indicate if this is a new submission or a resubmission of a previously disapproved or withdrawn form. If the form is a resubmission, please include the ODI/SERFF tracking number and disposition date of the previous submission along with responses to all questions and inquiries of the previous submission under the Supporting Documentation tab.
- g. Market Type – Select the type of market where the product will be sold. Additional selection criteria will appear to detail the market size and individual or group market type. Please reference the “SERFF Market Type Options” table attached as Appendix D. Non-employer group plans must select the “Individual” market type.
- h. Corresponding Filing Tracking Number – To accurately tie the appropriate rate filing to the form filing, filers are required to provide the corresponding rate filing SERFF tracking number when applicable in the Corresponding Filing Tracking Number field. Rates must be on file for most filings EXCEPT for applications, name changes, assumptions, health statements and application amendments. If the corresponding rate filing has not yet been submitted, the anticipated submission date for the rate filings must be included in the Filing Description portion of the General Information tab.

PLEASE NOTE: the Corresponding Filing Tracking Number field should also be used to provide the tracking numbers of **Standard Benchmark Plans** or **Standard Plan Variations** when submitting subsequent **Standard Plan Riders, Amendments, Endorsements** or other related form filings.

- 2. **Filing Description** - Include pertinent filing information in the Filing Description portion of the General Information tab. This information should at a minimum:
 - a. Indicate if this is a new form or a revision to an existing form.
 - b. Indicate if this filing represents a new use of an existing form.
 - c. Indicate if the form will be offered to existing insureds, new applicants or both, and explain with how the form will interact with existing forms.
 - d. When submitting an amendatory form (**Amendment or Endorsement, or a Standard Plan Rider**) detail how the form will be used with the base form. For example, will the base form remain unchanged and the amendatory form be issued with the base form, or will the amendatory form only be used for existing forms and the changes to language be included in a new amended base form, or will the new language be added to the existing base form in all cases.

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- e. For advertisement/solicitation filings, describe the form being advertised and include the ODI/SERFF tracking number(s) and approval date(s). Advertising and solicitation material can only be submitted with the advertised form or after the advertised form has been approved for use in Ohio.
 - f. Describe how the form will be marketed (direct sales, agent sales, etc.).
 - g. List all forms to be used with the submission, including ODI/SERFF tracking number(s) and approval date(s) or refer to a separate list under the Supporting Documentation tab.
 - h. When submitting **Permitted Revisions** to an approved ACA compliant form, include the previous version's ODI/SERFF tracking number(s) and approval date(s).
 - i. Indicate the ODI/SERFF tracking number for the approved or pending rate filing(s) applicable to the form submission as indicated in the Corresponding Filing Tracking Number section of Item IV 1. When **rates have not already been submitted** and the Corresponding Filing Tracking Number cannot be completed, **an indication of when rates will be filed must be provided**. Amendatory form filings for previously approved forms must also include corresponding rate filing information. If the addition of the rider, amendment or endorsement will not result in a rate change, please provide a statement to that effect in the Filing Description.
- 3. Attachment Format** - All attachments to the Form Schedule and Supporting Document tabs must be provided in a searchable PDF format. For documents that reasonably must be submitted in MS Excel format (e.g., actuarial calculations/data), a PDF format copy must also be provided, except for the EHB Data Worksheet and the EHB Rx Worksheet. Those documents must be submitted in their original MS Excel format and do not require submission of a PDF format copy.

4. Form Design

- a. Matrix filing types will NOT be accepted for ACA compliant plan filings.
- b. Every form filed must display a unique form number on the bottom 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.
- c. The form must comply with all form-related specifications found in the appropriate checklist(s), the Ohio Revised Code and the Ohio Administrative Code.

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- d. The form must meet the qualifications stated in ORC 3902.04 (A) including, but not limited to, printing in no less than ten-point type, one point leaded (unless stated otherwise in the Ohio Revised Code or Ohio Administrative Code).
- 5. Form Organization** - Coverages, limitations, exclusions and other terms and conditions are to be organized in logical, reasonable, understandable, and rational order and set forth in such a way that is clear and unambiguous to the average consumer.
- a. Format and organization must be consistent throughout the form.
 - b. A table of contents must be included in all policies and certificates.
 - c. Coverage must be clearly explained with a clear distinction between what is and is not covered.
 - d. All important terms that affect the coverage must be defined. The term must be distinguished, wherever used, as a defined term (e.g. in quotes, bolded, underlined, capitalized, etc.)
 - e. The definition of a term cannot include a restriction (exclusion or limitation) that alters coverage unless the restriction is also clearly described in the applicable coverage or restriction provision(s).
 - f. Titles, labels or headings for restrictions should reflect the type of restriction contained in the provision or section, i.e. limitations are identified as limitations, NOT exclusions.
 - g. Restrictions need to be indicated as such. The format must alert the reader that both coverage and restrictions are present if combined in the same sentence, paragraph or section.
 - h. Restrictions need to be in close proximity to the coverage, i.e., immediately following the description of coverage. General Restrictions that apply to the entire form should be located in a separate, clearly identified section.
- 6. Permitted Variable Content** – must be documented as follows:
- a. All variable form content (with the exception of Health Plan Issuer specific values) must be bracketed AND indexed for reference to a separate Statement of Variability (SOV) for each form.

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- b. **Permitted Variable Content** is limited to:
 - i. Cost sharing options – Deductible, copayment, coinsurance, out-of-pocket maximum and any similar charge.
 - ii. Alternate language – language or content such as domestic partner options, that do not determine treatments or services covered or benefit levels available.
 - iii. Health Plan Issuer specific values – addresses, websites, telephone numbers, officer names and similar information.
 - iv. Contraception coverage exemption alternatives as provided in Section IV 9.

- c. Structure of the SOV: The SOV must have its own unique form number in the bottom left hand of the document. This could be as simple as using the form number of the affected form and adding the suffix -SOV.
 - i. Every variable item in the form(s) must be bracketed. The SOV must include a clear description of the conditions for use of each variable (i.e., factors that determine when and how the value of a variable may change) AND the specific alternative language, values, range of values, or other content that can be inserted.
 - ii. When language is bracketed because it will either be included or excluded, then an explanation as to the circumstances of when it will be included or excluded must be provided.
 - iii. General and vague explanations, without specific page references, are insufficient. For example, a statement that it will change “as necessary to comply with statutory requirements” is too vague and is unacceptable.

- d. Submission requirements:
 - i. Each form must have a separate SOV.
 - ii. Each SOV must be submitted under the Form Schedule tab in SERFF. Please use the Form Type “OTH”.

- e. Only variable content that is approved by the Department can be used in a form. Department approval of variable content is limited to the conditions and alternatives specified in the filed SOV. Future changes in the conditions for use or the alternative values for variable content must be filed and approved by the Department prior to use.

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- 7. Permitted Filing Revisions** (see definition) –revisions to approved ACA compliant forms must be documented as follows:
- a. The filing must include, under the Supporting Document tab:
 - i. A reference copy of the ACA compliant base form as it has been approved to date; and
 - ii. A “red-lined” version showing all additions and/or deletions to the previously approved ACA compliant base form.
 - b. An updated SOV must be included in accordance with the standards established in the **Permitted Variable Content** section.
 - c. When revising, adding or deleting language in a form, the form must be refiled with a new unique form number.
 - d. The Department may require a company to file an entirely new version of the base form if there are numerous or significant changes made by an **Amendment or Endorsement**.
- 8. Requirements for Filing Standard Plan Riders** - when filing a new optional benefit provision(s) that will be offered in addition to a base form, the following instructions apply:
- a. All such additions are to be filed as a **Standard Plan Rider** form describing the additional coverage.
 - b. More than one new optional provision may be filed at a time, but each must be on separate forms with separate identifiers unless the intent is to always sell them together.
 - c. Each separate **Standard Plan Rider** must contain a unique form number at the bottom left-hand corner of the first page.
 - d. A **Standard Plan Rider** to be offered with an in-force base form cannot reduce benefits, delete benefits or provide less favorable terms except when effective at renewal or as provided in Section IV 9 for contraceptive coverage exemption.
- 9. Requirements for Contraceptive Coverage Exemption** – A Health Plan Issuer may offer the federal contraceptive coverage exemption to religious employers and eligible organizations.

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- a. The issuer may provide the coverage exemption through a **Standard Plan Variation, Standard Plan Rider, Amendment or Endorsement**. Any plan variation or amendatory form must do both of the following:
 - i. Clearly state the particular contraceptive coverage(s) that will be removed.
 - ii. Limit the availability of the variation or amendatory form to eligible religious employers and organizations in accordance with applicable federal law.
- b. Issuers are permitted to include all contraceptive coverage options in a single form. Optional variations in services to be covered must be clearly identified and indexed to a Statement of Variability as described in Item IV 6 above.

The federal exemption does **not** exempt the religious employer or eligible organization from any applicable state law.

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V Ohio Essential Health Benefits (EHB) Benchmark Plan and Submission Requirements

As background, Ohio's EHB benchmarks are as follows:

1. Medical – [Essential Health Benefit Certificate of Coverage \(Anthem Blue 6.0 – Blue Access PPO – Medical Option #D4/Rx Option G\)](#)
 - a. [Prescription Drug EHB-Benchmark Plan Benefits by Category and Class](#)
 - b. Habilitative Services - [Governor's Habilitative Services Letter](#)
2. Pediatric Dental - [The MetLife Federal Dental Plan](#)
3. Pediatric Vision - [Federal Employee Dental and Vision Benefits Enhancement](#)

The Ohio [Essential Health Benefits Resource Document for 2015 Plan Year](#) includes important corrections to the information currently provided on the CMS website. Health Plan Issuers should refer to this document to ensure compliant EHB benefits.

The above documents can be found in the [Plan Management Toolkit](#) on the Ohio Department of Insurance website.

The following filing requirements apply to all EHB Benchmark Plans, whether the plan will be offered through the federal health insurance exchange or in the outside market:

1. To expedite the review process, a **Standard Benchmark Plan** and one or more **Standard Plan Variations** and/or **Standard Plan Riders** (see Definitions) for the same market type (Individual, Non-Employer Group, or Small Group) may be included in the same filing.
2. Provide a “red-lined” comparison between each **Standard Plan Variation** and the **Standard Benchmark Plan**, along with a certification that the “red-lined” comparison is accurate and shows all changes made to the **Standard Benchmark Plan**.
3. All EHB Benchmark plans must be filed as complete policies, certificates and riders, as applicable (no matrix filings).
4. Initial EHB Benchmark plan submissions cannot be filed as revisions, amendments, or endorsements to forms approved *for use prior to January 1, 2014*. Each **Standard Benchmark Plan** and **Standard Plan Variation** must have its own unique form number.
5. To assist in form/plan identification, the form number should appear on the bottom left hand corner of each page.

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6. The [EHB Data Worksheet](#) and the [EHB Rx Worksheet](#) must be completed and included for all 2015 ACA compliant form filings. If a form filing is not required for the 2015 plan year because **no** changes are going to be made to the forms previously approved for a 2014 plan(s), both of these EHB worksheets must still be completed and submitted with the applicable rate filing(s) for the 2015 plan year.

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VI Form Filing Guidance and Checklists

These filing assistance documents are attached to the Supporting Documentation tab and serve as SERFF submission requirements. The specific document(s) attached to a particular filing are determined by the Filing Type, the TOI and the sub-TOI selected. A filing submitted under an incorrect Filing Type, TOI or sub-TOI will be REJECTED. Some additional filing assistance documents are attached to all filings regardless of Filing Type or TOI. A description of each document and its use are shown below.

1. Form Review Requirements

- a. Guidance - This guidance was created to provide a list and the text of Ohio Revised Code and Ohio Administrative Code sections with form requirements. Additionally, the Federal Requirements guidance provides a list of federal law that impacts the form content for all market types.
- b. Checklists - The form checklists are submitted with the filing and identify the location of selected federal and state requirements in the forms.
 - i. The checklists must be submitted for each policy/certificate being filed. The checklists do not need to be submitted with a rider, amendment or endorsement to previously approved form filings unless substantive changes are made to the **Standard Benchmark Plan** or the **Standard Plan Variation**.
 - ii. On each checklist, provide
 1. the appropriate TOI and sub-TOI,
 2. the form name and form number to be reviewed,
 3. whether the Review Requirement applies by responding in the “Included” column, and
 4. the location of the Review Requirement by noting the page number and if applicable, the document where it can be found.A comment section has been provided to include the reason a requirement was bypassed or any additional detail on a particular requirement. “Not applicable” can be used only if the item does not apply to the form being filed.
 - iii. Submit the checklist under the Supporting Documentation tab in SERFF.

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- iv. By submitting the checklists, the Health Plan Issuer is confirming that the form complies with applicable requirements. Any line left blank on a checklist will cause the filing to be considered incomplete. Not including required information or form provisions may result in disapproval of the filing.
- c. [EHB Data Worksheet](#) - the Essential Health Benefits worksheet (EHB Data Worksheet) must be completed and included for all 2015 ACA compliant form filings. If a form filing is not required for the 2015 plan year because **no** changes are going to be made to the forms previously approved for a 2014 plan(s), the EHB Data Worksheet must still be completed and submitted with the applicable rate filing(s) for the 2015 plan year.

Instructions:

1. One EHB Data Worksheet must be completed for each plan variation included in a filing submission. For purposes of this worksheet, plan variations are not determined by cost sharing, only by differences in the benefits and services covered.
2. Any exceptions to Ohio EHB Benchmark plan coverage must be explained and documented as applicable:
 - a. Coverage is Substantially Equal to Benchmark Plan – an explanation must be provided in the Explanation/Comments field (or in a separate document if more space is required).
 - b. Coverage is an Actuarially Equivalent Substitution – the following supplemental materials must also be provided:
 - i. [EHB Substituted Benefit \(Actuarial Equivalent\) Supporting Documentation and Justification](#) form (includes Actuarial Certification); and
 - ii. Actuarial Memorandum.
3. The completed worksheet(s) must be attached in the original MS Excel format (do not change MS Excel format version or PDF) to the EHB Data Worksheet filing requirement on the Supporting Document tab in SERFF along with any applicable supplemental materials.

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- d. [EHB Rx Worksheet](#)- this worksheet must be completed for each and included for all 2015 ACA compliant form filings. If a form filing is not required for the 2015 plan year because **no** changes are going to be made to the forms previously approved for a 2014 plan(s), the EHB Rx Worksheet must still be completed and submitted with the applicable rate filing(s) for the 2015 plan year.

Instructions:

1. Complete only one worksheet for each distinct formulary that will be used for plans required to comply with ACA Essential Health Benefit (EHB) prescription drug (Rx) coverage requirements.
2. For purposes of this worksheet a distinct formulary is defined by the list of drugs covered. Application of utilization management or cost sharing features (preauthorization, coverage tiers, etc.) to the same list of drugs does not determine a separate formulary.
3. A copy of this worksheet must be attached to the appropriate Requirement in the Supporting Documentation tab in SERFF for all issuer form and rate filings (both) that include health plans that will utilize this formulary to provide EHB compliant Rx benefits. Submit this worksheet in its original MS Excel format. Do not change the MS Excel version or submit this worksheet in PDF format.
4. Note that for Rx categories/classes where the Ohio benchmark plan does not include coverage of any drugs, the minimum default EHB requirement of 1 drug per category and/or class is indicated.
5. Further information is available from the links to CMS EHB Rx resources provided below:

[CMS EHB Rx Crosswalk](#)

[USP Category and Class Count Service](#)

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2. Compliance Confirmation

- a. **Guidance** – [The Health Plan Issuer Compliance Guides](#) provide a description of additional Ohio requirements, along with corresponding Ohio Revised Code and Ohio Administrative Code sections, that should be considered for compliance by health plan issuers. In most cases the requirements listed should **not** be included in policy form documents.

The guides are not exhaustive and intended as a reference tool. Health plan issuers are responsible to review and comply with all applicable state and federal law.

- b. **Checklists** - A corresponding compliance confirmation checklist is also provided for each guide. Health plan issuers may use these checklists for internal purposes. At this time, the compliance confirmation checklists are not required to be filed with the Department.

3. Guidance, Worksheet and Checklists

- a. [Form Review Requirements Guidance and Checklists](#)

Health Insuring Company (HIC) - Individual Medical:

- EHB Data [WORKSHEET](#) and [GUIDANCE](#)
- EHB Rx [WORKSHEET](#)
- Federal Requirements [CHECKLIST](#)
- Individual HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- Pediatric Dental and Vision [GUIDANCE](#) and [CHECKLIST](#)

Health Insuring Company (HIC) – Non-employer Group Medical:

- EHB Data [WORKSHEET](#) and [GUIDANCE](#)
- EHB Rx [WORKSHEET](#)
- Federal Requirements [CHECKLIST](#)
- Non Employer Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- Pediatric Dental and Vision [GUIDANCE](#) and [CHECKLIST](#)

Health Insuring Company (HIC) – Small Group Medical:

- EHB Data [WORKSHEET](#) and [GUIDANCE](#)
- EHB Rx [WORKSHEET](#)
- Federal Requirements [CHECKLIST](#)

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- Small Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- Pediatric Dental and Vision [GUIDANCE](#) and [CHECKLIST](#)

Health Insuring Company (HIC) – Large Group Medical:

- Federal Requirements [CHECKLIST](#)
- Large Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)

Health Insuring Company (HIC) – Stand Alone Dental:

- HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- Stand-Alone Dental [GUIDANCE](#) and [CHECKLIST](#)

Major Medical – Individual:

- EHB Data [WORKSHEET](#) and [GUIDANCE](#)
- EHB Rx [WORKSHEET](#)
- Federal Requirements [CHECKLIST](#)
- Individual Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- Pediatric Dental and Vision [GUIDANCE](#) and [CHECKLIST](#)

Major Medical – Non Employer Group:

- EHB Data [WORKSHEET](#) and [GUIDANCE](#)
- EHB Rx [WORKSHEET](#)
- Federal Requirements [CHECKLIST](#)
- Non Employer Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- Pediatric Dental and Vision [GUIDANCE](#) and [CHECKLIST](#)

Major Medical – Small Group:

- EHB Data [WORKSHEET](#) and [GUIDANCE](#)
- EHB Rx [WORKSHEET](#)
- Federal Requirements [CHECKLIST](#)
- Small Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- Pediatric Dental and Vision [GUIDANCE](#) and [CHECKLIST](#)

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Major Medical – Large Group:

- Federal Requirements [CHECKLIST](#)
- Large Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)

Major Medical – Stand Alone Dental:

- i. Stand-Alone Dental [GUIDANCE](#) and [CHECKLIST](#)

b. [Health Plan Issuer Compliance Guides and Checklists](#)

The guides are not exhaustive; and insurers are expected to comply with all federal and state law.

- HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- Individual HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Individual Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Non Employer Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Non Employer Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Small Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Small Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- Large Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- Large Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)

TOI and Sub-TOI Coding Instructions: For ACA Compliant Filings

The table identifies the appropriate TOIs and Sub-TOIs that must be utilized when filing 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, including requirements relative to recent federal health care reform regulations.

Please implement this coding structure for all ACA compliant form or rate filing submissions.

Ohio Title 39 Indemnity Issuers

TOI	SUB-TOI	DESCRIPTION AND USE
H16G <u>Group</u> Health - Major Medical ANY SIZE GROUP	H16G.001A	Any Size Group – PPO: <u>ONLY</u> for Non-Employer Group* plans
	H16G.001B	Any Size Group – POS: <u>ONLY</u> for Non-Employer Group* plans
	H16G.001C	Any Size Group – Other: <u>ONLY</u> for Non-Employer Group* plans
H16G <u>Group</u> Health – Major Medical LARGE GROUP ONLY	H16G.002A	Large Group Only – PPO
	H16G.002B	Large Group Only – POS
	H16G.002C	Large Group Only – Other
H16G <u>Group</u> Health – Major Medical SMALL GROUP ONLY	H16G.003A	Small Group Only – PPO
	H16G.003D	Small Group Only – POS
	H16G.003G	Small Group Only – Other
H16I <u>Individual</u> Health – Major Medical INDIVIDUAL ONLY**	H16I.005A	Individual – PPO
	H16I.005B	Individual – POS
	H16I.005C	Individual – Other
H10G <u>Group</u> Health - Dental	H10G.000	All Groups – Large, Small or Non-Employer Group*
H10I <u>Individual</u> Health – Dental	H10I.000	Individual Only

TOI and Sub-TOI Coding Instructions:
For ACA Compliant Filings

Ohio Health Insuring Corporations (HMOs)

TOI	SUB-TOI	DESCRIPTION AND USE
HOrg02G <u>Group</u>	HOrg02G.002C	HMO Any Size Group – Restricted Network plan <u>ONLY</u> for Non-Employer Group plans
	HOrg02G.003C	HMO Large Group – Restricted Network plan
	HOrg02G.004F	HMO Small Group – Restricted Network plan
		
HOrg02I <u>Individual</u>	HOrg02I.005C	HMO Individual – Other <u>ONLY</u> for grandfathered Conversion or Ohio Basic and Standard Restricted Network plans
	HOrg02I.005D	HMO Individual – Restricted Network plan
		
Supplemental/Specialty Product – Health Insuring Corporation	Dental Care Services	All Individual and Group Plans

*Non-Employer Group plans are those sold to Individuals through associations, trusts or other entities

**Only for use with true Individual plans not sold through associations, trusts or other entities

ACA Market Reforms

Individual Market Reforms

Individual Market = Individual plans and plans marketed to Individuals through associations, trusts or other entities (Non-Employer).

Grandfathered Plans

PHS Section	Provision	Effective 2010	Effective 2014
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2714	Dependent to Age 26	✓	

Non-Grandfathered Plans

PHS Section	Provision	Effective 2010	Effective 2014
2704	No Pre-Existing Under Age 19	✓	
2711	Annual Dollar Limit	✓	
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2713	Preventive Services	✓	
2714	Dependent to Age 26	✓	
2719	Appeals Process	✓	
2719 A	Emergency Services	✓	
2719 A	Access to Pediatricians and OB/GYNs	✓	
2704	No Pre-Existing For All		✓
2705	Prohibit Discrimination Based on Health Status		✓
2706	No Discrimination Against Providers In Scope		✓
2707	Provide Essential Health Benefits Package		✓
2709	Coverage For Approved Clinical Trials		✓
2707	Out-of-Pocket Maximum		✓

ACA Market Reforms

Group Market Reforms

Group Market = Small and Large Group Employer plans

Grandfathered Plans

PHS §	Provision	Effective 2010	Effective 2014
2704	No Pre-Existing Under Age 19	✓	
2711	Annual Dollar Limit	✓	
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2714	Dependent to Age 26	✓	
2704	No Pre-Existing For All		✓
2708	Prohibit Excessive Waiting Periods		✓

Non-Grandfathered Plans

PHS §	Provision	Effective 2010	Effective 2014
2704	No Pre-Existing Under Age 19	✓	
2711	Annual Dollar Limit	✓	
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2713	Preventive Services	✓	
2714	Dependent to Age 26	✓	
2719	Appeals Process	✓	
2719 A	Emergency Services	✓	
2719 A	Access to Pediatricians and OB/GYNs	✓	
2704	No Pre-Existing For All		✓
2705	Prohibit Discrimination Based on Health Status		✓
2706	No Discrimination Against Providers In Scope		✓
2707	Provide Essential Health Benefits Package		✓ (Small Group Only)
2708	Prohibit Excessive Waiting Periods		✓
2709	Coverage for Approved Clinical Trials		✓
2707	Deductible Limits		✓ (Small Group Only)

ACA Market Reforms

PHS §	Provision	Effective 2010	Effective 2014
2707	Out-of-Pocket Maximums		✓
2713	Contraceptive Coverage Exemption		✓

SERFF Market Type Options

Market Type:		
Individual		Individual Market Type Options:
		Individual
		Non Employer Group – Individual
Franchise		
Group	Group Market Size Options:	
	Small	
	Large	
	Small and Large	
		Group Market Type Options:
		Employer
		Association
		Blanket
		Discretionary
		Trust
		Other

2015 ACA Compliant Plans

“What do I need to file?”

	Filing Type	Form To Be Filed ¹	Form Review Requirements Checklists	EHB Data and EHB Rx Worksheets	Rates ² Required?
I plan NO changes to my existing ACA compliant forms	n/a	NONE	NO	YES	YES ³
I want to make Cost Sharing (deductible, Out-of-Pocket Maximum) changes to my existing ACA compliant forms	FORM	Amendment, Endorsement	NO	YES	YES
I want to make Plan changes (increase or change benefits) to my existing ACA compliant forms	FORM	Various ⁴	NO ⁵	YES	YES
I want to create a Standard Plan Rider to sell with my existing ACA compliant forms	FORM	Standard Plan Rider	NO ⁵	YES	YES
I want to create a new Standard Plan Variation of my existing ACA compliant forms	FORM	Standard Plan Variation	YES	YES	YES
I want to create a new Standard Benchmark Plan	FORM	Standard Benchmark Plan	YES	YES	YES

¹ As defined in the Ohio [ACA Form Filing Guidance](#).

² All rates are filed under the RATE filing type and must include the [Rate Filing Checklist](#), the [EHB Data Worksheet](#), and the [EHB Rx Worksheet](#) (must be identical to the EHB Data Worksheet and EHB Rx Worksheet included with any corresponding Form filing(s)).

³ Changes in rating must be filed.

⁴ Depending on your intended use, the change can be accomplished through an Amendment, Endorsement, Standard Plan Variation or Standard Benchmark Plan. Details are found in the Ohio [ACA Form Filing Guidance](#).

⁵ May be required if changes are substantial.