

**ACA Form Filing Checklist – Title 17 HIC Products
Selected Form Review Requirements Ohio**

Company Name:		SERFF Tracking #:	
NAIC #:			
Form #'s:			

Select the type of Market:	Plan Intended for Issuance:
<input type="checkbox"/> Individual <input type="checkbox"/> Small Employer Group <input type="checkbox"/> Non-employer (Association Type) Group	<input type="checkbox"/> Both on and off the Exchange <input type="checkbox"/> Off the Exchange Only
Select the type of plan:	
<input type="checkbox"/> Catastrophic <input type="checkbox"/> High Deductible Health Plan	

Instructions:

1. Applicable to Ohio Revised Code Chapter 1751 Health Insuring Corporation (“HIC”) Individual, Non-Employer Group and Small Employer Group Non-Grandfathered ACA compliant products effective January 1, 2017 or later. There are separate checklists for Ohio Revised Code Title 39 products and pediatric stand-alone dental plans.
2. Only one checklist must be completed for all plan variations that are included in the filing submission.
3. In the applicable column, identify the form and page number where the provision is located. If a provision is applicable to that plan but is not required to be a policy provision, please confirm compliance with the requirement in the applicable column.
4. Any exceptions to compliance with the checklist requirements must be noted on the checklist and explained in a separate document referencing the specific form numbers.
5. The completed checklist and any exception explanation must be submitted under the SERFF Supporting Documentation Tab.
6. This checklist is intended only as guide to be used for the preparation of ACA form filings. The checklist identifies and summarizes relevant statutes, rules and bulletins but is not an exhaustive or complete statement of all applicable requirements and provisions. Please refer to the Ohio Revised Code, Ohio Administrative Code and other applicable law for complete information.

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Eligibility						
Actively at work A group health plan may not refuse to provide benefits because an individual is not actively at work due to a health status reason on the day that individual would otherwise become eligible for benefits.	ORC § 3901.21(T); 29 CFR § 2590.702				✓	
Waiting Periods Service waiting periods imposed by an employer may not exceed 90 days.	ORC § 3924.03(E)(2); PHSA § 2708, as added by PPACA; 45 CFR § 147.116				✓	
Small Group Eligible employee—An employee who works a normal work week of 30 hours or more	ORC § 3924.01(G)				✓	
Open Enrollment for Late Enrollees HICs must provide a 30-day open enrollment period each year for late enrollees.	ORC § 1751.58(D)				✓	
Special Enrollment Period - Individual /Non-Employer Group Coverage 60 days from qualifying event	ORC § 3924.03; PHSA § 2702, as amended by PPACA; HIPAA §2701(f); 45 CFR § 147.104(b)(3)&(4)		✓	✓		
Special Enrollment Period - Group 30 or 60 days depending on the qualifying event	PHSA § 2702, as amended by PPACA; 45 CFR § 147.104(b); (3)&(4); 45 CFR §155.725(j)(1),(2), (3)				✓	
Guaranteed Availability of Coverage Issuers may restrict enrollment to open and special enrollment periods.	ORC 3924.03(E) PHSA §2702, as amended by PPACA; 45 CFR §147.104		✓	✓	✓	

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<p>Guaranteed Renewability and Eligible Reasons for Non-renewal</p> <ul style="list-style-type: none"> ▪ Coverage is guaranteed renewable unless one of the following occurs: <ul style="list-style-type: none"> ○ non-payment of premiums, ○ fraud, ○ violation of participation or contribution rules (applicable to group policies), ○ discontinuation of plan, ○ market exit, ○ enrollee’s movement outside of the service area, (on exchange) ○ association membership ceases ▪ Guarantee issue coverage is provided to small employers that enroll during open enrollment regardless of any minimum participation or employer contribution requirements. 	<p>ORC § 1751.18, 1751.57 & 1751.58 PHSA § 2702, as amended by PPACA; 45 CFR §147.106</p>		√	√	√	
<p>Cancellation and/or Termination Provisions for QHP plans</p> <ul style="list-style-type: none"> ▪ Enrollees may terminate coverage with 14 days prior notice to QHP. <p>HICs may terminate an enrollee’s coverage if:</p> <ul style="list-style-type: none"> ▪ The enrollee is no longer eligible for coverage through the exchange. ▪ The enrollee obtains other minimum essential coverage. ▪ Payment of premiums cease. ▪ The enrollee’s coverage is rescinded for non-prohibited reason. ▪ QHP is terminated or decertified. ▪ The enrollee changes from one plan to another through open/special enrollment. 	<p>45 CFR §§155.430 & 156.270</p>		√	√	√	

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<p>Rescission</p> <ul style="list-style-type: none"> ▪ Rescission is permitted only if the enrollee (or person acting on their behalf) does any of the following <ul style="list-style-type: none"> ○ Commits fraud ○ Makes an intentional misrepresentation of material fact ▪ HICs must provide at least 30 calendar days' notice before rescinding coverage. ▪ Enrollees have the right to request both internal and external appeals. 	<p>ORC § 1751.18 PHSA § 2712, as added by PPACA; 45 CFR §147.128</p>		√	√	√	
<p>Incarcerated Enrollee</p> <p>HICs may not exclude or limit coverage because the enrollee is incarcerated except as permitted under state law.</p>	<p>ORC § 3924.53</p>		√	√	√	
<p>Pediatric Age</p> <ul style="list-style-type: none"> ▪ Pediatric vision and dental services must be covered until at least the end of the month the covered person turns 19 years of age. 	<p>45 CFR 156.110(a)(10) 45 CFR 156.115(a)(6)</p>		√	√	√	
Dependent Child Eligibility—when Dependents are covered						
<p>Dependent Children Eligibility</p> <ul style="list-style-type: none"> ▪ Eligible children are defined based on their relationship with the enrollee. No other factors can apply. ▪ Coverage for dependent children must be available up to age 26 if dependent coverage is provided. ▪ Terms of the policy for dependent coverage cannot vary based on the age of a child. <p align="center">○</p>	<p>ORC § 1751.14(A); ORC § 1751.141; ORC § 3924.46; ORC § 3924.51 PHSA §2714, as added by PPACA; 45 CFR §147.120</p>		√	√	√	

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<p>Adding Newborn and Adopted Children</p> <ul style="list-style-type: none"> ▪ Newborns of enrollees must be covered at no cost for the first 31 days. <ul style="list-style-type: none"> ○ Plans may require notification of birth to continue coverage after 31 days. ▪ Adopted children must be covered on the same basis as other dependents. ▪ Adopted children must be covered from the date of placement for adoption 	<p>ORC § 1751.61; ORC § 1751.59;</p>		√	√	√	
<p>Court Ordered Coverage for Children</p> <p>If required by court order to provide health coverage:</p> <ul style="list-style-type: none"> ▪ HICs must permit either parent to enroll eligible children without any enrollment period restrictions. ▪ Employers must enroll eligible children when parent does not. 	<p>ORC § 3924.48; ORC § 3924.49</p>		√	√	√	
<p>Disabled Dependent Children</p> <p>Parents can continue coverage after the limiting age for disabled children who are:</p> <ul style="list-style-type: none"> ▪ incapable of self-sustaining employment by reason of mental retardation or physical handicap ▪ primarily dependent on the enrollee for support or maintenance 	<p>ORC § 1751.14(B)</p>		√	√	√	

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General Information						
<p>Cost Sharing</p> <ul style="list-style-type: none"> ▪ The annual out of pocket limit may not exceed federal limits. ▪ All network cost sharing for EHBs must be applied to the out of pocket limit; cost sharing includes deductibles, coinsurance, copayments or similar charges. ▪ HDHP deductibles and out of pocket limits must comply with IRS requirements. ▪ For family coverage, the ACA self-only out of pocket maximum applies to each individual family member. ▪ HDHP deductibles and out of pocket limits must comply with IRS requirements. <ul style="list-style-type: none"> ○ HDHP's have minimum deductibles ○ Individuals must meet the self-only minimum deductible before any payment is made (except for eligible preventive services). ▪ No cost sharing for preventive services ▪ Enrollee's coinsurance or copayments may not exceed 60% (to ensure the plan is not a closed panel) ▪ No annual or lifetime dollar limits on EHBs ▪ Copayments, cost sharing, and deductibles must be reasonable and must not be a barrier to the necessary utilization of services by enrollees. 	<p>PHSA § 2707(b), as added by PPACA; 45 CFR § 156.130; 45 CFR § 147.130; I.R.C. § 223; Rev. Proc. 2014-30</p> <p>ORC § 1751.02(F) ORC § 1751.12(D) 45 CFR §147.126 80 FR 10750</p>		√	√	√	

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<p>Catastrophic Plans</p> <p><i>Eligibility</i> Individuals must meet one of the following:</p> <ul style="list-style-type: none"> ▪ be under age 30 on the first day of the plan or policy year ▪ have received a certificate of exemption because of hardship or lack of affordable coverage <p><i>Cost Sharing</i> No benefits are payable until the enrollee reaches the deductible except for:</p> <ul style="list-style-type: none"> ▪ Preventive services payable with no cost sharing ▪ 3 primary care office visits 	45 CFR § 156.155		√	√		
<p>Coordination of Benefits</p> <ul style="list-style-type: none"> ▪ Include COB notice on the first page of the policy/certificate in all caps in 12 point type. ▪ Mirror the language in the Appendix of the rule. 	OAC § 3901-8-01		√	√	√	
<p>Identification Cards ID cards must include:</p> <ul style="list-style-type: none"> ▪ Corporate name of the HIC in the same size print as used in any d.b.a. or product name ▪ Toll-free telephone number 24/7 for information regarding how and where health care services may be obtained ▪ Toll-free telephone number during normal business hours for access to information on coverage and the internal and external review process ▪ The name of any network(s) applicable to the coverage ▪ Whether the coverage is provided through the Exchange 	ORC § 1751.20(C) ORC § 1751.11(B) ORC § 1751.11(D)(2)(d) OAC 3901-8-16(D)(3)		√	√	√	
<p>Language and Format Requirements</p> <ul style="list-style-type: none"> ▪ Text must have a minimum Flesch score of 40; certification must be attached ▪ Text must be printed in at least 10 point type ▪ Table of contents or index must be included ▪ The effective date of the policy must be included ▪ Each policy form must have a unique form number in the lower left hand corner of the first page 	ORC §3902.04;		√	√	√	

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Accessing Care						
<p>Access to Providers</p> <ul style="list-style-type: none"> ▪ HICs may not discriminate against providers acting within the scope of their own licensure or certification ▪ When a PCP is required: <ul style="list-style-type: none"> ○ Pediatricians may be designated as the PCP for children ○ Women must have direct access to network ob/gyn; no referrals required 	PHSA Section 2706, as added by PPACA; PHSAs 2719(A), as added by PPACA; 45 CFR 147.138(a)(2) and (a)(3)		√	√	√	
<p>Network Issues</p> <ul style="list-style-type: none"> ▪ EOC must include a statement indicating that when a HIC is unable to provide a covered service from a contracted provider, the service must be provided by a non-contracting provider consistent with the terms of the contract at no additional cost to the enrollee ▪ Notification to the subscriber regarding provider PCP/Hospital termination 	ORC § 1751.13(A)(2); ORC § 1751.13(I)		√	√	√	
<p>Enrollees and Subscribers Not Liable to Providers or Facilities:</p> <p>EOC must include a provision requiring the provider to seek compensation for covered services solely from the HIC, except for co-payments and/or deductibles</p>	ORC § 1751.60		√	√	√	
<p>Accessing Health Care</p> <p>EOC must include a toll-free telephone number during business hours for access to information on coverage available and the HIC's internal and external review processes.</p>	ORC § 1751.11(D)(2)(d)		√	√	√	
<p>Provider Provision</p> <p>EOC must include a provision advising enrollees that if they are receiving a course of treatment when the plan becomes insolvent, services will continue to be provided under certain circumstances. A telephone number must be provided to enrollees for obtaining additional information.</p>	ORC § 1751.13(C)(3)		√	√	√	

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<p>Referrals</p> <p>EOC must include:</p> <ul style="list-style-type: none"> ▪ A description of a policy and procedure for a standing referral to a specialist ▪ A description of the procedure for approval of a specialist to act as a PCP 	<p>ORC § 1753.14(A); ORC § 1753.14(B)</p>		√	√	√	
<p>HIC Discontinued</p> <p>EOC must include:</p> <ul style="list-style-type: none"> ▪ A provision explaining HIC’s method of extending health care services to enrollees if the HIC is discontinued prior to the expiration date of their contract. ▪ A HIC is not a member of the guaranty fund – A provision advising enrollee they are protected only to the extent of the hold harmless provision required by 1751.13(C)(2) ▪ A provision stating that in the event of the HIC’s insolvency, enrollee may be financially responsible for health care services rendered by a provider or a facility that is not under contract with the HIC, even if the HIC authorized the service. 	<p>ORC § 1751.05(B)(5); ORC § 1751.11(D)(4)</p>		√	√	√	
Benefits (also complete EHB Locator)						
<p>Basic Health Care Services</p> <p>HICs must provide coverage for all basic health care services.</p>	<p>ORC § 1751.01(A)</p>		√	√	√	

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<p>Preventive Benefits</p> <ul style="list-style-type: none"> ▪ Required preventive benefits must be provided at no cost sharing <p>The policy/certificate must include a summary of required preventive benefits and appropriate link to website: www.healthcare.gov/center/regulations/prevention.html.</p> <ul style="list-style-type: none"> ▪ HICs must comply with DOL’s FAQs about Affordable Care Act Implementation (Part XIX) (May 2, 2014) regarding tobacco cessation. ▪ HICs must comply with DOL’s FAQs about Affordable Care Act Implementation (Part XXIX) (October 23, 2015) regarding lactation counseling, weight management services, genetic counseling and BRCA testing. ▪ HICs must provide 60 day prior notification if a benefit is removed 	<p>PHSA §2713, as added by PPACA; 45 CFR §147.130; CCIO ACA Implementation FAQs - Set 18</p>		√	√	√	
<p>Emergency Services</p> <p>HICs must provide coverage for emergency services for an emergency medical condition in compliance with state and federal laws. Contract provision must include:</p> <ul style="list-style-type: none"> ▪ Statutory definitions of emergency medical condition, emergency services and stabilize ▪ Scope of Coverage ▪ Appropriate use of emergency services, including the use of the 911 system ▪ Any cost sharing requirements <p>To comply with requirements:</p> <ul style="list-style-type: none"> ▪ Prior authorization cannot be required ▪ Services must be covered out of network ▪ Enrollees are NOT responsible for balance bills. HICs must consider billed charges as allowed amount. This includes services provided by non-network providers. 	<p>ORC § 1751.01(I); ORC § 1753.28; PHSA §2719A, as added by PPACA; 45 CFR §147.138(b)</p>		√	√	√	

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<p>Mental Health and Substance Abuse</p> <ul style="list-style-type: none"> ▪ Coverage must be provided for treatment of mental health, alcoholism, and substance use disorders ▪ HICs must comply with the federal Mental Health Parity and Addiction Equity Act. <ul style="list-style-type: none"> ○ Mental health and substance use disorder benefits must be provided in parity with medical/surgical benefits within the same classification or sub classification. ○ Intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services must be covered. ○ The filing must contain a statement of compliance with federal mental health parity and addiction equity requirements. 	<p>ORC § 1751.01(A); PHSA § 2726; 45 CFR § 146.136 (e)(4) brings in individual and small group through EHB requirement</p>		√	√	√	
<p>Maternity</p> <ul style="list-style-type: none"> ▪ HICs must provide inpatient care including routine nursery care for at least 48 hours for a normal delivery and 96 hours for a cesarean delivery. ▪ HICs must provide 72 hours of follow-up care for discharges prior to 48/96 hours. ▪ Prior-authorization is not permitted on inpatient stays that do not exceed the 48/72 hours. <p>Surrogacy – HICs may not exclude coverage for prenatal or maternity services for an enrollee.</p> <p>Coverage for therapeutic abortions is included in the Benchmark plan; it is not subject to the ACA religious exemption.</p> <p><i>On Exchange coverage cannot be provided for non-therapeutic abortions.</i></p>	<p>ORC § 1751.67 ORC § 3901.87</p>		√	√	√	

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<p>Mammography</p> <ul style="list-style-type: none"> ▪ Ohio requires coverage for a screening mammogram for women between ages 35 and 40 that is in addition to the Federal preventive care mandate. ▪ In cases where a mammogram is not a federally mandated preventive care service but is a service required under Ohio law, the enrollee may be responsible for cost sharing. ▪ The mammography provision must clearly indicate that: <ul style="list-style-type: none"> ○ The total benefit paid (including any cost sharing) for a screening mammography cannot exceed 130% of the Medicare Reimbursement amount. ○ Providers may bill only for approved deductibles and copayments; balance billing is not permitted. <p>Note: Cost sharing is permitted for ACA mandated screenings performed by out of network providers; however the cost sharing is subject to the Ohio limits specified above.</p>	ORC § 1751.62		√	√	√	
<p>Infertility Treatment</p> <ul style="list-style-type: none"> ▪ Diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct diagnosed diseases or conditions must be provided. ▪ Procedures such as IVF, GIFT and ZIFT, which are not essential to the protection of an individual's life are not mandated 	ORC § 1751.01(A)(1); Bulletin 2009-7		√	√	√	
<p>Women's Health and Cancer Rights Act</p> <p>HICs covering mastectomies must also cover reconstructive surgery.</p> <p>Any annual deductibles and coinsurance provisions must be consistent with those for other medical/surgical benefits under the coverage.</p> <p><i>Specific Benchmark mandate: Coverage must be provided for a minimum of 4 post-mastectomy surgical bras per benefit period as covered under the EHB benchmark plan.</i></p>	PHSA §2727; ERISA § 713		√	√	√	

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<p>Clinical trials</p> <p>Benefits for coverage of routine care for a cancer clinical trial must comply with both ORC 3923.80 and federal requirements. In general, the federal law covers all clinical trials. Ohio law is broader for cancer clinical trials than federal law in the following cases:</p> <ul style="list-style-type: none"> ▪ Coverage is not limited to a “qualified individual” as defined in federal law. ▪ Participant is not required to have a referral from a participating health professional or provide medical and scientific information establishing the appropriateness of participation. 	<p>ORC § 1751.01; ORC § 3923.80 PHSA § 2709, as added by PPACA</p>		√	√	√	
<p>Orally Administered Cancer Medication</p> <p>Prescribed orally administered cancer medication must be covered on no less favorable basis than coverage for intravenously administered or injected cancer medications. HICs may comply in one of the following ways:</p> <ul style="list-style-type: none"> ▪ Limit the cost sharing to no more than \$100 (safe harbor) ▪ Include a provision affirmatively stating, "All orally administered cancer medications will be covered on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication." <p>For HDHPs and catastrophic plans, the \$100 cost share safe harbor is after the deductible.</p>	<p>ORC § 1751.69</p>		√	√	√	
<p>Off label use of prescription drugs</p> <ul style="list-style-type: none"> ▪ HICs may not exclude coverage for a prescription drug because it hasn’t been approved for the indication for which it was prescribed if it meets the specified criteria. ▪ HICs must address this benefit in the covered services section of the policy or certificate. 	<p>ORC § 1751.66</p>		√	√	√	
<p>Non-Formulary Drugs</p> <p>If the plan uses a restricted formulary, there must be a procedure for an enrollee to obtain a non-formulary drug at no extra cost when appropriate</p>	<p>ORC § 1753.21</p>		√	√	√	

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<p>Prescription Drug Exception Process</p> <ul style="list-style-type: none"> ▪ 72 hour/24 hour decision notification ▪ Process for denial review by independent review organization ▪ Drugs provided through the exception process are considered EHBs and count toward the annual out of pocket limit ▪ An exception process is also required for specific methods of contraception. The provision must indicate that the plan must defer to the determination of the attending provider’s determination of medical necessity. 	45 CFR 156.122(c); 2016 Letter to Issuers		√	√	√	
<p>Pharmacy Network Requirements</p> <p>Effective 1-1-17 enrollees must have option to access prescription drug benefits at in network retail pharmacies, with certain exceptions. Mail order only plans not permitted.</p>	45 CFR 156.122		√	√	√	
<p>Essential Health Benefits (Ohio Benchmark Benefits) (also complete EHB Locator)</p> <p>Refer to the EHB Resource Document for a complete list.</p>						
<p>Dental Services for accidental injury:</p> <p>Benefits are limited to \$3000 per accident</p>	Ohio Benchmark Plan		√	√	√	
<p>Durable Medical Equipment/Prosthetics includes the following benefit previously described as vision correction:</p> <ul style="list-style-type: none"> ▪ 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 	Ohio Benchmark Plan		√	√	√	

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Habilitative Services <ul style="list-style-type: none"> ▪ Must be defined as “health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.” ▪ Must comply with benefits identified in the governor’s letter. In addition, mental health visit limits must comply with Mental Health Parity. 	45 CFR 156.115(a)(5) Governor’s Letter, 12/26/12		√	√	√	
Private Duty Nursing Private duty nursing provided through home health care limited to 90–110 visits per year	Ohio Benchmark Plan		√	√	√	
Transplant Benefits <ul style="list-style-type: none"> ▪ Live donor benefits ▪ Transportation and lodging for transplants—\$10,000 per transplant ▪ Unrelated donor searches for bone marrow/stem cell transplants for a covered transplant—\$30,000 per transplant 	Ohio Benchmark Plan		√	√	√	
Continuation						
State Continuation Rights of certain employees to continue coverage for 12 months	ORC § 1751.53				√	
Continuation of Coverage during Military Service Rights of reservists to extend coverage upon being called to active duty.	ORC § 1751.54				√	
COBRA Federal Continuation for groups with 20 or more employees	29 U.S.C. § 1161				√	

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Claims Procedures and Appeal Process						
Utilization Review <ul style="list-style-type: none"> ▪ Description of utilization review procedures ▪ Toll-free telephone number to utilization review staff 	ORC § 1751.11(D)(2)(g) ORC § 1751.81		√	√	√	
Reconsiderations, Complaints, and Grievances <ul style="list-style-type: none"> ▪ Right to reconsiderations of adverse determinations including information about expedited reconsiderations and applicable time periods ▪ Complaint/grievance procedure for non-claim related/administrative complaints must comply with statute ▪ If complaints are referred to a professional peer review organization, provide organizations name and address ▪ Address and telephone number to which enrollees may direct complaints (enrollees must be able to complain by telephone or in person) 	ORC § 1751.82; ORC § 1751.11(D)(2)(f); ORC § 1751.19		√	√	√	
Claims procedures, including applicable time frames	45 CFR §147.136; 29 CFR §2560.503-1		√	√	√	
Internal appeals of adverse benefit determinations - processes, rights and required notices Only one level of internal review is permitted for individual coverage. Two levels of internal review are permitted for employer group coverage.	PHSA § 2719, as added and amended by PPACA		√	√	√	
External Review	ORC § 3922; PHSA § 2719, as added and amended by PPACA		√	√	√	