

ACA Form Filing Checklist – Title 39 Major Medical Products Selected Form Review Requirements

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

Select the type of Market: <input type="checkbox"/> Individual <input type="checkbox"/> Small Employer Group <input type="checkbox"/> Non-employer (Association Type) Group	Plan Intended for Issuance: <input type="checkbox"/> Both on and off the Exchange <input type="checkbox"/> Off the Exchange Only
Select the type(s) of plan(s) (as applicable): <i>Note type of plan selection(s) must agree with TOI/Sub-TOI selection for filing.</i>	
<input type="checkbox"/> Traditional <input type="checkbox"/> Catastrophic <input type="checkbox"/> PPO <input type="checkbox"/> High Deductible Health Plan <input type="checkbox"/> POS	

Instructions:

1. Applicable to Ohio Revised Code Title 39 Individual, Non-Employer Group and Small Employer Group Non-Grandfathered ACA compliant products effective January 1, 2017 or later. There are separate checklists for Health Insuring Corporations (“HICs”) 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 in the applicable column. If a provision is applicable but is not required to be a policy provision, please confirm compliance with the requirement
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 accompanying 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.

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
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 Insurers must provide a 30-day open enrollment period each year for late enrollees.	ORC § 3923.571(E)				√	
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 <ul style="list-style-type: none"> ▪ Issuers may restrict enrollment to open and special enrollment periods. ▪ For off exchange, coverage availability is statewide; limitations related to residency or place of employment do not apply to those within Ohio 	ORC 3924.03(E) PHSA §2702, as amended by PPACA, 45 CFR § 147.104		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<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 § 3924.03(B) ORC § 3923.57; ORC § 3923.571 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"> ▪ Insureds may terminate coverage with 14 days prior notice to QHP. <p>Insurers may terminate an insured’s coverage if:</p> <ul style="list-style-type: none"> ▪ The insured is no longer eligible for coverage through the exchange. ▪ The insured obtains other minimum essential coverage. ▪ Payment of premiums cease. ▪ The insured’s coverage is rescinded for non-prohibited reason. ▪ QHP is terminated or decertified. ▪ The insured changes from one plan to another through open/special enrollment. 	<p>45 CFR §§ 155.430 & 156.270</p>		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<p>Rescission</p> <ul style="list-style-type: none"> ▪ Rescission is permitted only if the insured (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 ▪ Insurers must provide at least 30 calendar days' notice before rescinding coverage. ▪ Insureds have the right to request both internal and external appeals. 	<p>ORC § 3923.14 PHSA § 2712, as added by PPACA; 45 CFR §147.128</p>		√	√	√	
<p>Incarcerated Insured</p> <p>Insurers may not exclude or limit coverage because the insured 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>ORC § 3923.24(A); PHSA §2714, as added by PPACA; 45 CFR §147.120</p>		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<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. 	ORC § 3923.26; ORC § 3924.46; ORC § 3924.51		√	√	√	
<p>Court Ordered Coverage for Children</p> <p>If required by court order to provide health coverage:</p> <ul style="list-style-type: none"> ▪ Insurers must permit either parent to enroll eligible children without any enrollment period restrictions. ▪ Employers must enroll eligible children when parent does not. 	ORC §3924.48; ORC § 3924.49		√	√	√	
<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 insured for support or maintenance 	ORC § 3923.24		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
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 ▪ Insured'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 	<p>PHSA § 2707(b), as added by PPACA; 45 CFR § 156.130; 45 CFR § 147.130; I.R.C. § 223; Rev. Proc. 2014-30 ORC 1751.02(F) 45 CFR §147.126 80 FR 10750</p>		√	√	√	
<p>Reimbursement Rate for In-Network Providers</p> <p>After benefits have been exhausted, the amount payable by the insured cannot exceed the negotiated amount between the insurer and the provider.</p>	<p>ORC 3923.81</p>		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<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 insured 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 Rule 3901-8-01		√	√	√	
<p>Policyholder's Right to Cancel Policy</p> <p>The policyholder's right to cancel the policy within 10 days of receipt must be printed prominently on the first page.</p>	ORC § 3923.31		√			
<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 insurance 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; ORC § 3923.03		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
Accessing Care						
<p>Access to Providers</p> <ul style="list-style-type: none"> ▪ Insurers 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; PHSA 2719(A), as added by PPACA; 45 CFR 147.138(a)(2) and (a)(3)		√	√	√	
<p>Prior Authorization</p> <p>To ensure that insureds know their financial responsibility, all penalties must have a flat dollar limit.</p>	ORC § 3923.03(A)		√	√	√	
Benefits (also complete EHB Locator)						
<p>Preventive Benefits</p> <ul style="list-style-type: none"> ▪ Required preventive benefits provided in network 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"> ▪ Insurers must comply with DOL's FAQs about Affordable Care Act Implementation (Part XIX) (May 2, 2014) regarding tobacco cessation. ▪ Insurers must comply with DOL's FAQs about Affordable Care Act Implementation (Part X XIX) (October 23, 2015) regarding lactation counseling, weight management services, genetic counseling and BRCA testing. ▪ Insurers must provide 60 day prior notification if a benefit is removed 	PHSA §2713, as added by PPACA; 45 CFR §147.130; CCIIO ACA Implementation FAQs - Set 18		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<p>Emergency Services</p> <p>Insurers must provide coverage for emergency services for an emergency medical condition in compliance with state and federal laws.</p> <p>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 ▪ Out of network services must be paid at network cost sharing levels. Approved amount must be the greatest of <ul style="list-style-type: none"> ○ The median in-network rate ○ The usual customary and reasonable rate (or similar rate determined using the plan’s or issuer’s general formula for determining payments for out-of-network services) ○ The Medicare rate 	<p>ORC § 3923.65; PHSA §2719A, as added by PPACA; 45 CFR §147.138(b)</p>		√	√	√	
<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 ▪ Insurers 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 § 3923.28; ORC § 3923.281; ORC § 3923.29; PHSA § 2726; 45 CFR § 146.136 (e)(4) brings in individual and small group through EHB requirement</p>		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<p>Alcohol/Drug Related Injury</p> <p>Insurers may not exclude or limit coverage for a loss or expense otherwise covered, that results from the insured's use of alcohol and/or drugs.</p>	ORC § 3923.82		√	√	√	
<p>Maternity</p> <ul style="list-style-type: none"> ▪ Insurers must provide coverage for inpatient care including routine nursery care for at least 48 hours for a normal delivery and 96 hours for a cesarean delivery. ▪ Insurers must provide coverage for 72 hours of follow-up care for discharges prior to 48/96 hours. ▪ Prior authorization is only permitted when inpatient stays exceed the 48/72 hours. <p>Surrogacy - Insurers may not exclude coverage for prenatal or maternity services for an insured.</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>	ORC § 3923.63		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<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 insured 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 § 3923.52		√	√	√	
<p>Child Health Supervision</p> <p>Coverage must include child health supervision benefits. Benefits included in the Federal preventive care mandate must be provided with no cost sharing; the remaining benefits may require cost sharing.</p>	ORC § 3923.55		√	√	√	
<p>Women’s Health and Cancer Rights Act</p> <p>Insurers 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		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
<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 § 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. Insurers 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 § 3923.85</p>		√	√	√	
<p>Off label use of prescription drugs</p> <ul style="list-style-type: none"> ▪ Insurers 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. ▪ Insurers must address this benefit in the covered services section of the policy or certificate. 	<p>ORC § 3923.60</p>		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
Prescription Drug Exception Process <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		√	√	√	
Pharmacy Network Requirements <ul style="list-style-type: none"> ▪ 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. 	45 CFR Section 156.122		√	√	√	
Essential Health Benefits (Ohio Benchmark Benefits) (also complete EHB Locator)						
Refer to the EHB Resource Document for a complete list.						
Dental Services for accidental injury: Benefits are limited to \$3000 per accident	Ohio Benchmark Plan		√	√	√	
Durable Medical Equipment/Prosthetics includes the following benefit previously described as vision correction: <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		√	√	√	

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
Habilitative Services <ul style="list-style-type: none"> ▪ Must define 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 § 3923.38				√	
Continuation of Coverage during Military Service Rights of reservists to extend coverage upon being called to active duty	ORC § 3923.381				√	
COBRA Federal requirements for coverage continuation, for groups with 20 or more employees	29 U.S.C. § 1161				√	
Individual—Option For conversion: There must be a provision to allow conversion by the spouse upon death of the subscriber, divorce, dissolution or annulment or by children upon reaching the limiting age.	ORC § 3923.32		√			

**ACA Form Filing Checklist – Title 39 Major Medical Products
Selected Form Review Requirements**

Requirement Description	Authority	Page # or Confirmation	Individual	Non-Emp. Group	Small Group	ODI Use Only
Standard Provisions						
Entire Contract	ORC § 3923.04(A)		√			
Time Limit on Certain Defenses	ORC § 3923.04(B)		√			
Grace Period	ORC § 3923.04(C)		√			
Reinstatement	ORC § 3923.04(D)		√			
Notice of Claim	ORC § 3923.04(E) ORC § 3923.20		√	√	√	
Claim Forms	ORC § 3923.04(F)		√	√	√	
Proofs of Loss	ORC § 3923.04(G) ORC § 3923.20		√	√	√	
Time of Payment of Claims Except for periodic payments, claims must be paid immediately or within 30 days of receipt of proof of loss.	ORC § 3923.04(H) ORC § 3923.20		√	√	√	
Payment of Claims	ORC § 3923.04(I)		√			
Physical examination and autopsy	ORC § 3923.04(J)		√			
Legal Actions Legal actions are permitted 60 days after written proof of loss has been submitted and up to 3 years after written proof of loss is required to be submitted.	ORC § 3923.04(K) ORC § 3923.20		√	√	√	
Cancellation by the Insured	ORC § 3923.04(M)		√			
Mandated Group Provisions	ORC § 3923.12(C)			√	√	
Claims Procedures and Appeal Process						
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 <i>Only one level of internal review is permitted for individual coverage. Two levels of internal review are permitted for employer group coverage.</i>	PHSA § 2719, as added and amended by PPACA		√	√	√	
External Review	ORC Chapter 3922; PHSA § 2719, as added and amended by PPACA		√	√	√	