

## Ohio Essential Health Benefits Filing Worksheet

Company Name:		HIOS Issuer ID:	NAIC #:
SERFF Tracking Number:		Policy Form Number(s):	
Product Name:	HIOS Product ID:	Plan intended for issuance: <input type="checkbox"/> Inside the Exchange Only <input type="checkbox"/> Outside the Exchange Only <input type="checkbox"/> Inside and Outside the Exchange	
Plan Name(s):	HIOS Plan ID(s):		

**Instructions:**

1. One Essential Health Benefits (EHB) Filing 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. Consequently, this worksheet may include multiple HIOS Plan ID's that represent the same benefits and services covered, but with different cost sharing variations.
2. Any exceptions to Ohio EHB Benchmark plan coverage must be explained and documented as applicable. Please refer to the [Ohio EHB Benchmark Plan Template document](#) and the [Essential Health Benefits Filing Guidance Checklist](#) for specific compliance and Ohio Benchmark Plan information.
3. The completed worksheet(s) must be attached to the EHB Checklist Requirement on the Supporting Document tab along with any applicable supplemental documentation listed as required on the worksheet (e.g., actuarial documentation).

\*Required Documentation Includes: 1) [EHB-Substituted Benefit \(Actuarial Equivalent\) Supporting Documentation and Justification form](#) (includes Actuarial Certification) and 2) Actuarial Memorandum.

**PART 1: PLAN COVERAGE OF OHIO EHB BENCHMARK PLAN BENEFITS AND SERVICES**

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Primary Care Visit to Treat an Injury or Illness	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Specialist Visit	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other Practitioner Office Visit (Nurse, Physician Assistant)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hospice Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Non-Emergency Care When Traveling Outside the U.S.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Routine Dental Services (Adult)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Infertility Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Long-Term/Custodial Nursing Home Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Private-Duty Nursing	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Routine Eye Exam (Adult)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Urgent Care Services in an Urgent Care Center or Facility	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Home Health Care Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Emergency Room Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Emergency Transportation/Ambulance	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Inpatient Hospital Services (e.g., Hospital Stay)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Inpatient Physician and Surgical Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bariatric Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cosmetic Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Skilled Nursing Facility	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prenatal and Postnatal Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Delivery and All Inpatient Facility and Professional Services for Maternity Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Mental/Behavioral Health Outpatient Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mental/Behavioral Health Inpatient Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Substance Abuse Disorder Outpatient Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Substance Abuse Disorder Inpatient Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Generic Prescription Drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preferred Brand Prescription Drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Non-Preferred Brand Prescription Drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Specialty Prescription Drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Outpatient Rehabilitation Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Habilitation Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spinal manipulation and manual medical intervention services (e.g., Chiropractic/Osteopathic care)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Durable Medical Equipment and Supplies	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing Aids	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Diagnostic Test (X-Ray and Lab Work)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Advanced Diagnostic Imaging Services (CT/PET Scans, MRIs)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Routine Foot Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Acupuncture	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Weight Loss Programs	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Routine Eye Exam and Refraction for Children	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Eye Glasses for Children	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Routine Dental Services for Children	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Radiation Therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chemotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Infusion Therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Renal Dialysis/Hemodialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alternative Medicine Services other than Acupuncture	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Injectable drugs and other drugs administered in a provider's office or other outpatient setting	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vision Correction After Surgery or Accident	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Medical supplies, equipment, and education for diabetes care for all diabetics	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dental Services for Accidental Injury and Other Related Medical Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

Benefit / Service	Coverage Matches Benchmark Plan (Including Not Covered Benefits/ Services)  <b>IF NO, CHECK COLUMN (A), (B), OR (C) AS APPROPRIATE</b>	(A)	(B)	(C)	Policy Form(s) and Page Number(s) Describing The Benefit/Service (Must Include Pages Describing All Applicable Limitations and/or Exclusions)	Explanation/Comments
		Coverage Is Substantially Equal to Benchmark Plan (Explanation Required)	Actuarial Equivalent Substitution (Explanation and Actuarial Documentation Required*)	Coverage Exceeds Benchmark Plan (Explanation Required)		
Human Organ and Tissue Transplant Services	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Human Organ and Tissue Transplant Services - Transportation and Lodging	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Human Organ and Tissue Transplant Services - Unrelated donor search	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Physical Rehabilitation Facilities Including Room & Board Charges, Physician Fees, Imaging, Testing, and Supplies	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Temporomandibular or Craniomandibular Joint/Jaw Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Non-Routine Dental Services for Specified Conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

\*Required Documentation Includes: 1) EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification form (*includes Actuarial Certification*) and 2) Actuarial Memorandum.

