## Selected Form Review Requirements

| **Company Name:** | | **SERFF Tracking #:** | |
|---|---|---|---|
| **NAIC#** | | | |
| **Form #'s:** | | | |

## Instructions:

1. Applicable to Ohio Revised Code Title 39 Student Major Medical **Blanket** ACA compliant products. Please contact the department if you need a checklist for Title 39 Major Medical Non-Employer Group ACA compliant products.
2. Only one checklist must be completed for policy forms that are included in the filing submission.
3. 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 in the form, please confirm compliance with the requirement in the "Page # or Confirmation" 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 accompanying explanation must be submitted under the Supporting Documentation Tab in SERFF.
6. Check the Plan Management Tool Kit on the Ohio Department of Insurance website (www.insurance.ohio.gov) for additional information.

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| **Eligibility** | | | |
| **Special Enrollment Period**<br>60 days from qualifying event. | ORC §3924.03(E)(3);<br>PHSA §2702, as amended by PPACA;<br>HIPAA §2701(f);<br>45 CFR §147.104(b)(3)&(4) | | |
| **Guaranteed Availability**<br>May restrict enrollment to open and special enrollment periods. | PHSA §2702,<br>(42 USC § 300gg-1); 45 CFR §148.104;<br>45 CFR 147.145(b)(1)(ii) | | |
| **Guaranteed Renewability**<br>Coverage is guaranteed renewable unless canceled for non-payment of premiums, fraud, discontinuation of plan, or eligibility status. | ORC §3923.57; PHSA §2703,<br>(42 USC § 300gg-2 45 CFR §147.104<br>45 CFR 147.145(b)(1)(iii) | | |
| **Cancellation and/or Termination Provisions**<br>May non-renew or discontinue for failure to pay premiums, fraud, or intentional misrepresentation, no longer eligible. | ORC §3923.57(C) | | |
| **Rescission**<br>▪ Rescission is permitted only if the insured (or person acting on their behalf) does any of the following:<br>○ Commits fraud.<br>○ Makes an intentional misrepresentation of material fact.<br>▪ Insurers must provide at least 30 calendar days' notice before rescinding coverage.<br>▪ Insureds have the right to request both internal and external appeals. | PHSA §2712,<br>(42 USC § 300gg-12); 45 CFR §147.128 | | |
| **Incarcerated Insured**<br>Cannot exclude coverage because incarcerated. | ORC §3924.53 | | |
| **Availability of Medicaid**<br>Cannot exclude coverage because eligible for Medicaid. | ORC 3924.41 | | |

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| **Dependent Child Eligibility—When Dependents are Covered** | | | |
| **Dependent Children Eligibility**<br>▪ Coverage must be available up to age 26.<br>▪ Eligible children are defined based on their relationship with the insured.<br>▪ Insurer shall provide certain information to child's custodial parent and pay claims submitted if child has coverage through insurer of non-custodial parent. | ORC §3923.24; ORC §3924.46; ORC §3924.47<br>PHSA §2714, as added by PPACA;<br>45 CFR §147.120 | | |
| **Court Ordered Coverage of Children**<br>▪ Either parent must be permitted to enroll court ordered children without any enrollment period restrictions.<br>▪ Employers must enroll court ordered children when parent does not. | ORC § 3924.41 ORC §3924.48 ORC §3924.49 | | |
| **Disabled Dependent Children**<br>Coverage may be continued after the limiting age for disabled children who are:<br>▪ incapable of self-sustaining employment by reason of physical handicap or intellectual disability.<br>▪ primarily dependent on the insured for support or maintenance | ORC §3923.24 | | |

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| **General Information** | | | |
| **Cost Sharing**<br>▪ The annual out of pocket limit may not exceed federal limits.<br>▪ All network cost sharing for EHBs must be applied to the out of pocket limit; cost sharing includes deductibles, coinsurance, copayments or similar charges.<br>▪ For family coverage, the ACA self-only out of pocket maximum applies to each individual family member.<br>▪ HDHP deductibles and out of pocket limits must comply with IRS requirements.<br>▪ No cost sharing for preventive services.<br>▪ Insured's coinsurance or copayments may not exceed 60% (to ensure the plan is not a closed panel).<br>▪ No annual or lifetime dollar limits on EHBs in and out- of-network. | PHSA §2707(b), as added by PPACA;<br>45 CFR §156.130;<br>45 CFR §147.130;<br>I.R.C. §223;<br>Rev. Proc. 2014-30;<br>45 CFR §147.126 | | |
| **No Surprises Act**<br>Forms must comply with State and Federal restrictions on charging out-of-network cost shares and balance billing for certain services. | ORC §§3902.50 et. seq., OAC 3901-8-17;<br>PHSA §§ 2799A-1,<br>2799A-2 added by division BB of the Consolidated Appropriations Act, 2021 | | |
| **Reimbursement Rate for In-Network Providers**<br>After benefits have been exhausted, the amount payable by the insured cannot exceed the negotiated amount between the insurer and the provider. | ORC § 3923.81 | | |
| **Coordination of Benefits**<br>▪ Include COB notice on the first page of the policy/certificate in all caps in 12-point type.<br>▪ Include the text of Appendix A of the rule. | OAC 3901-8-01; OAC 3901-8-01(C)(8)<br>(blanket) | | |
| **Subrogation**<br>If less than the full value of the tort action is recovered for comparative negligence, subrogee's claim shall be diminished in the same proportion. | ORC § 2323.44(B)(1)<br>Revised 2017 (HB64, SB223) | | |

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| **Language and Format Requirements**<br>▪ Text must have a minimum Flesch score of 40; certification must be attached.<br>▪ Text must be printed in at least 10-point type.<br>▪ Table of contents or index must be included.<br>▪ The effective date of the insurance policy must be included.<br>▪ Each policy form must have a unique form number in the lower left-hand corner of the first page. | ORC § 3902.04;<br>ORC § 3923.03 | | |
| **Inquiry into and effect or sexual orientation or AIDS or related condition.**<br>Limitations on questions insurer may ask applicants and limitations on certain benefits prohibited. | ORC § 3901.45 | | |
| **Medicare Notice** | OAC 3901-8-08(S)(5) | | |

<table>
<tr><th>Requirement Description</th><th>Authority</th><th>Page # or Confirmation</th><th>ODI Use Only</th></tr>
<tr><td colspan="4">Accessing Care</td></tr>
<tr><td>Access to Providers<br>Insurers may not discriminate against providers acting within the scope of their own licensure or certification.<br>▪ When a PCP is required:<br>a. Pediatricians may be designated as the PCP for children.<br>b. Women must have direct access to network ob/gyn; no referrals required.</td><td>PHSA Section 2706 PHSA 2719(A),<br>45 CFR 147.138<br>(a)(2) & (3)</td><td></td><td></td></tr>
<tr><td>Continuity of Care<br>Extended coverage must be provided for Continuing Care Patients after the provider terminates its network contract.<br>The term ‘continuing care patient’ means an individual who, with respect to a provider or facility:<br>▪ Is undergoing a course of treatment for a serious and complex condition from the provider or facility;<br>▪ Is undergoing a course of institutional or inpatient care from the provider or facility;<br>▪ Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;<br>▪ Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or<br>▪ Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.<br>Protections apply for patients who are receiving covered services from a provider or facility, and such provider or facility experiences a change in network status due to one of the following:<br>▪ The provider or facility’s contract with the issuer is terminated.<br>▪ The provider or facility’s terms of participation change resulting in a termination of benefits with respect to the provider or facility.<br>▪ A group health plan’s contract with an issuer is terminated.</td><td>PHSA §§ 2799A-3<br>and 2799B-8, as added by section 113 of division BB of the Consolidated Appropriations Act, 2021</td><td></td><td></td></tr>
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| **Telehealth**<br>Insurers must provide Telehealth Services provided by Health Care Professionals within their scope of practice at no greater cost share.<br>Contract must include “Telehealth Services” which are health care services provided through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located:<br>a. The patient receiving the services;<br>b. Another health care professional with whom the provider of the services is consulting regarding the patient. | ORC § 3902.30,<br>4739.09(A)(3) & (5) | | |
| **Prior Authorization – General Requirements**<br>▪ ORC § 3923.041 applies to electronic required prior authorization requests.<br>▪ The statute only applies if the plan contains prior authorization requirements.<br>▪ At a minimum, the certificate should provide a general description with examples and include instructions on how to access a complete list. | ORC § 3923.041<br>Effective 2016 (SB 129);<br>Revised 2017 (HB 505) | | |
| **Medication Synchronization**<br>Prescription drug coverage shall provide for medication synchronization if all the following are met:<br>The enrollee elects to participate.<br>▪ the enrollee, prescriber and pharmacist at a network pharmacy agree MS is in the enrollee's best interest.<br>▪ the prescription drug meets all of the requirements of 3923.602(C).<br>▪ the prescription drug subject to MS must be dispensed in a quantity that is less than a 30-day supply. This requirement only applies once for each drug subject to MS except if:<br>a. the prescriber changes the dosage or frequency of administration or,<br>b. the prescriber prescribes a different drug.<br>▪ See 3923.602(E) and (F) for cost-sharing requirements. | ORC § 3923.602 | | |

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| **Pharmacy Benefits Prohibited Practices**<br>Pharmacy benefits:<br>▪ Cannot directly or indirectly restrict informing insureds about less expensive ways to purchase prescription drugs.<br>▪ Cannot require a cost share that is greater than the amount an individual would pay for the prescription drug if the drug were purchased without coverage under a health benefit plan. | ODI Bulletin 2018-02, http://insurance.ohio.gov/Legal/Bulletins/Documents/2018-02.pdf | | |
| **Pharmacy Benefits Prohibited Practices**<br>Insurers may not:<br>▪ Require or direct pharmacies to collect cost sharing beyond:<br>a. The amount an individual would pay for the drug if the drug were purchased without coverage.<br>b. The net reimbursement paid to the pharmacy for the drug by the insurer, PBP or administrator.<br>▪ Retroactively adjust pharmacy claims except as a result of billing errors and pharmacy audits<br>▪ Charge claim-related fees unless those fees can be determined at the time of claim adjudication. | ORC § 3959.20 | | |
| **Step Therapy Protocol**<br>Requirements for Insurer's Review of a Request for Exemption from a Step Therapy Exemption Request and Internal Appeal deadlines. | ORC § 3901.832(A)<br>Applies to Contracts issued, modified, or renewed after 1/1/2020 (Ohio SB 265, 132nd G.A.) | | |

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| **Benefits – Refer to the EHB Resource Document for the complete list of Essential Health Benefits and complete the EHB Locator.** | | | |
| **Preventive Benefits**<br>Policy/certificate includes at a minimum a summary of the four required categories of preventive benefits and appropriate link to website: https://www.healthcare.gov/coverage/preventive-care- benefits/<br>▪ Insurers must comply with DOL's FAQs about Affordable Care Act Implementation (Part XIX) (May 2, 2014) regarding tobacco cessation.<br>▪ Insurers 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. | PHSA 2713<br>(42 USC § 300gg-13) 29<br>CFR 2590.715 - 2713; 45<br>CFR 147.130; CMS ACA<br>Implementation FAQ Set XVIII (Coverage of Preventive Services) CMS FAQ XXVI | | |
| **Preventive Contraceptive Exception Process**<br>An exception process is 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. | CMS ACA<br>Implementation FAQ Set XXVI (Coverage of FDA- approved Contraceptives) | | |
| **Emergency Services**<br>Insurers must provide coverage for emergency services for an emergency medical condition in compliance with the Ohio Benchmark Plan and state and federal law.<br>▪ Prior authorization cannot be required.<br>▪ Services must be covered out of network.<br>▪ Out of network services must be paid at network cost sharing levels. Approved amount must be the greatest of:<br>○ The median in-network rate.<br>○ The usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services).<br>○ The Medicare rate.<br>▪ Must specify when the insured may be balance billed for out-of-network services. | PHSA §2719A, as added by PPACA;<br>45 CFR §147.138(b) OAC<br>3901-8-16(D)(2)(a) | | |

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| **Urgent Care Services**<br>Services must be covered in an Urgent Care center for an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. | Ohio Benchmark Plan | | |
| **Mental Health and Substance Abuse**<br>▪ Coverage must be provided for treatment of mental health and substance abuse.<br>▪ Insurers must comply with the federal Mental Health Parity and Addiction Equity Act.<br>o Mental health and substance abuse disorder benefits must be provided in parity with medical/surgical benefits within the same classification or sub classification.<br>o Intermediate levels of care such as residential treatment, partial hospitalization and intensive outpatient services must be covered.<br>o The filing must contain a statement of compliance with federal mental health parity and addiction equity requirements. | ORC §3923.281;<br>PHSA §2726<br>(42 USC § 300gg-26); 45 CFR 146.136 (e)(4)<br>45 CFR 147.160<br>Ohio Benchmark Plan | | |
| **Opioid Abuse Requirements**<br>Ohio requires the inclusion of the following provisions to combat the opioid crisis:<br>▪ Include information in the policy/certificate/EOC forms to direct insureds to opioid education options.<br>▪ Include in the policy/certificate/EOC forms case management tools to coordinate care of high-risk insureds with opioid-use disorder.<br>▪ Process opioid treatment as an expedited service for prior authorizations, pursuant to applicable state and federal regulations. | Insurers Task Force on Opioid Reduction recommendations (effective 1/1/2020 PY) | | |

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| **Alcohol/Drug Related Injury**<br>Cannot exclude or limit coverage for injuries caused by use of alcohol or drugs. | ORC § 3923.82 | | |
| **Women's Health and Cancer Rights Act**<br>▪ Coverage for mastectomies must also cover reconstructive surgery.<br>▪ Any annual deductibles and coinsurance provisions must be consistent with those for other medical/surgical benefits under the coverage.<br>*Specific Benchmark mandate: Coverage must be provided for a minimum of four post-mastectomy surgical bras per benefit period as covered under the EHB benchmark plan.* | PHSA 2706<br>PHSA 2727<br>(42 USC § 300gg-27); ERISA §713<br>Ohio Benchmark Plan | | |
| **Clinical Trials**<br>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:<br>▪ Coverage is not limited to a "qualified individual" as defined in federal law.<br>▪ Participant is not required to have a referral from a participating health professional or provide medical and scientific information establishing the appropriateness of participation. | ORC §3923.80;<br>PHSA §2709, as added by PPACA<br>(42 USC 300gg-8) | | |

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| **Prescription Drug Exception Process**<br>Insurers must include a procedure to request access to clinically appropriate drugs not in the formulary.<br>▪ 72 hour/24 hour decision notification applies to both internal and external reviews.<br>▪ Process for denial review by independent review organization.<br>▪ Must apply to the out-of-pocket limit. | 45 CFR 156.122(c) & (e);<br>2016 Letter to Issuers | | |
| **Pharmacy Network Requirements**<br>Enrollees must have the option to access prescription drug benefits at retail pharmacies, with certain exceptions. Mail order only plans not permitted. | 45 CFR 156.122 | | |
| **Pediatric Dental/Vision Services**<br>▪ Must comply with MetLife Federal Dental and FEP Blue Vision benchmark plans.<br>▪ Covered until at least the end of the month the covered person turns 19 years old. | 45 CFR 156.110(a)(10);<br>45 CFR 156.115(a)(6);<br>Ohio Benchmark Plans | | |
| **Kidney Dialysis Benefit**<br>If provided in-patient, then must provide out-patient. | ORC 3923.25 | | |

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| **Specific Issues with Essential Health Benefits** | | | |
| **Dental Services for Accidental Injury**<br>Benefits must be at least $3000 per accident. | Ohio Benchmark Plan | | |
| **Habilitative Services**<br>▪ Must define as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.<br>▪ Must comply with benefits identified in the governor's letter. In addition, mental health visit limits must comply with Mental Health Parity<br>▪ Must include coverage for Habilitative Services for all causes separate from the coverage of autism spectrum disorder. | 45 CFR 156.115(a)(5);<br>Governor's Letter, 12/26/12 | | |
| **Private Duty Nursing**<br>Benefits must be at least 90-110 visits for private duty nursing provided through home health care. | Ohio Benchmark Plan | | |
| **Transplant Benefits**<br>▪ Live donor benefits.<br>▪ Transportation and lodging for transplants—at least $10,000 per transplant.<br>▪ Unrelated donor searches for bone marrow/stem cell transplants for a covered transplant—at least $30,000 per transplant. | Ohio Benchmark Plan | | |
| **Prosthetics includes the following vision correction benefit.**<br>▪ Intraocular lens implantation for the treatment of cataract or aphakia.<br>▪ Contact lenses or glasses following lens implantation.<br>▪ 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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| **Standard Provisions** | | | |
| **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**<br>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 | | |
| **Legal Actions**<br>Legal actions are permitted 60 days after written proof of loss has been submitted and no later than three years after written proof of loss is required to be submitted. | ORC §3923.04(K); ORC §3923.20 | | |
| **Claims Procedures and Appeal Process** | | | |
| **Claims Procedures, Including Applicable Time Frames** | 45 CFR § 147.136<br>29 CFR 2560.503-1(i)(2)(i) | | |
| **Internal Appeals of Adverse Benefit Determinations - Processes, Rights and Required Notices** | PHSA 2719,<br>(42 USC § 300gg-19) 45 CFR 147.136 | | |
| **Adverse Prior Authorization Determination Appeals** | ORC § 3923.041(B)(12) | | |
| **External Review** | ORC Chapter 3922;<br>PHSA 2719,<br>(42 USC § 300gg-19) 45 CFR 147.136 | | |