



INTRODUCTION

The Ohio Department of Insurance has developed this manual to provide guidance for the development of Affordable Care Act compliant filings for Student Health Insurance sold through Blanket policies (SBHI). Guidance for Student Health Insurance not sold through Blanket policies can be found in the Ohio ACA Compliant Form Filing Guidance for Individual, Non-Employer Group and Small Group Products. This manual identifies important terms and provides filing instructions and information about document development. Failure to follow the instructions in this manual may result in delay or disapproval of a filing.

This manual provides the following information to help you with your form filings:

- Definitions of important terms
- Instructions on completing fields in SERFF
- Identification of appropriate checklists
- Instructions on preparing acceptable forms
- Instructions on responding to objections

ONLINE RESOURCES

Additional information is available from the Plan Management Toolkit located on the Department's website, including:

- Ohio Essential Health Benefit Benchmark Plans
- Essential Health Benefits Resource Document
- Required Supporting Documentation for Form Filings
- Rate Submission Guidance

SCHOOL YEAR FILING DEADLINES

Refer to the Plan Management Tool Kit on the Department's website

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IMPORTANT TERMS

OHIO ESSENTIAL HEALTH BENEFIT (EHB) BENCHMARK PLAN

The plan selected for Ohio is the model for all Standard Benchmark Plans.

ESSENTIAL HEALTH BENEFITS RESOURCE DOCUMENT

A chart that identifies the essential health benefits required in Ohio. This chart should be used in conjunction with the Ohio EHB Benchmark Plan for complete descriptions of the Ohio EHBs.

ESSENTIAL HEALTH BENEFITS LOCATOR

A form completed by insurers and submitted with SBHI filings that confirms the inclusion of required EHBs, provides the page numbers of required EHBs and identifies benefits that are Substantially Equal to Benchmark Plan, Actuarially Equivalent Substitutions, or above the EHB. Insurers also list any optional benefits that have been added to their plans.

STANDARD BENCHMARK PLAN

The insurer's policy or certificate that includes all the EHBs required in Ohio. This plan must be consistent with the Ohio EHB Benchmark Plan and meet all requirements of the Affordable Care Act (ACA). Standard Benchmark Plans may include benefits that are not included in the Ohio EHB Benchmark Plan; however, this would mean the Standard Benchmark Plan exceeds the Ohio EHB Benchmark Plan.

Policies and certificates must each be one complete form; they may not consist of matrix elements.

STANDARD PLAN VARIATION

A complete policy or certificate that is a unique variation of the Standard Benchmark Plan. Each unique Standard Plan Variation must have a unique form number. Standard Plan Variations may:

- Increase the benefit level by increasing quantitative (e.g. visit) limits.
- Increase the benefit level by revising or deleting exclusions.
- Substitute actuarially equivalent essential health benefits.
- Exclude contraceptives for eligible religious groups. Contraceptives may be bracketed, and a new plan variation would not be required.

STANDARD PLAN RIDER

Standard Plan Riders are used to add new benefit provisions that will be used to construct one or more additional plans (each having unique Plan Identification Numbers). More than one new optional provision may be filed with a filing, but each must be on a separate form with unique form numbers unless the intent is to always sell them together.

Except for the contraceptive exemption, Standard Plan Riders must add coverage rather than reduce coverage. Standard Plan Riders may:

- Increase the benefit level by increasing quantitative (e.g. visit) limits.
- Increase the benefit level by revising or deleting exclusions.
- Add optional benefits including stand-alone benefits such as dental coverage.
- Exclude contraceptives for eligible religious groups.

AMENDMENT OR ENDORSEMENT (AMENDATORY FORMS)

A separate form, with a unique form number, used to revise previously approved Standard Benchmark Plans and Standard Plan Variations forms.

Amendments and endorsements may not reduce coverage unless the issuer is excluding contraceptive benefits for eligible religious groups.

WHAT SUPPORTING DOCUMENTS DO I NEED TO FILE?

STUDENT BLANKET MAJOR MEDICAL

<i>Scenario</i>	<i>Form Filing Checklist</i>	<i>EHB Locator</i>	<i>Are Rates Required?¹</i>
I plan NO changes to my existing ACA compliant forms. (no form filing required)	N/A	Yes, with the Rate Filing	Yes
I want to use an Amendment, Endorsement, or Standard Plan Rider to make changes to my existing Standard Benchmark Plan or Standard Plan Variation.	No	Yes	Yes
I want to create a new plan or make changes by creating a new Standard Benchmark Plan or Standard Plan Variation	Yes	Yes	Yes

STUDENT DENTAL

<i>Scenario</i>	<i>Form Filing Checklist</i>	<i>Are Rates Required?¹</i>
I plan NO changes to my existing ACA compliant forms. (no form filing required)	N/A	Yes
I want to use an Amendment, Endorsement, or Standard Plan Rider to make changes to my existing ACA compliant forms.	No	Yes
I want to create a new ACA compliant form.	Yes	Yes

Please review the checklist for any changes or new requirements even if you are only submitting an amendment/endorsement or rider.

¹ All rates are filed separately under the “Rate” filing type. See the Plan Management Toolkit, located on ODI’s website, for rate filing instructions.

SERFF FILING INSTRUCTIONS

TOI/SUB TOI

- Use the Type of Insurance Code (TOI) and Sub-TOI specified in Appendix A.
- Filings submitted under the incorrect TOI or Sub-TOI will be rejected.

FILING TYPE

The filing type must accurately describe the submitted forms.

- Use the Filing Type, **Form**, for policy/certificate forms.
- Use the Filing Type, **Rate**, for the rate filing.
- Policy/certificate forms and rates are filed separately.

PPACA INDICATOR

- All products that must comply with the ACA will include the PPACA indicator.
- The “Not PPACA Related” option may be used only for applications, amendments to applications, name changes, and assumption filings.
- ACA compliant student health insurance plans will be identified as non-grandfathered.

EXCHANGE INTENTIONS INDICATOR

Select NO for student blanket health insurance.

IMPLEMENTATION DATE

Indicate the date of the upcoming open enrollment period.

SUBMISSION TYPE

Indicate whether the filing is a new submission or a resubmission of a previously disapproved or withdrawn form. If it is a resubmission, please see the additional requirements under “Filing Description” section below.

MARKET TYPE

Select the market type as specified in Appendix A.

CORRESPONDING FILING TRACKING NUMBER

Provide the SERFF Tracking Numbers for the corresponding rate filing (if available), and other related form filings (e.g. Standard Plan Variations, Standard Plan Riders, and Amendatory Forms) in this field.

FILING DESCRIPTION

Provide a complete and accurate description of the filing in the Filing Description section of the General Information tab. Required information is specified below.

- Indicate if this is a new form or a revision of an existing form; revisions must include the SERFF tracking number and approval date of the previous form.
- Indicate if this filing represents a new use of an existing form.
- Indicate if the form will be offered to existing insureds, new applicants, or both.
- Describe in detail how the Amendatory Forms and Standard Plan Riders will be used with the underlying base form. Examples of necessary information are shown below:
 - Indicate if the Amendatory Form will always be used with the base form.
 - Indicate if the base form will remain unchanged and the Amendatory Form will be issued attached to the base form.
 - Describe how the form will be marketed (e.g. direct sales or sales agent).
- Indicate if the form is a resubmission of a previously disapproved or withdrawn ACA compliant form; include the SERFF tracking number(s), disposition date(s) of the previous form, and responses to all outstanding issues (as a supporting document)
- Identify all forms to be used with the submitted forms; include SERFF tracking number(s) and approval dates.
- Provide SERFF tracking numbers not included in Corresponding Filing Tracking Number Field for any related form or rate filings.

DOCUMENT FORMAT

All attachments to the Form Schedule and Supporting Document tabs must be provided in a searchable PDF format. For the EHB Locator, submit the locator in both its original Excel format and in a searchable PDF format.

FORM DESIGN

FORMAT

Forms must comply with the following requirements:

- Policies and Certificates must be complete documents.
- Matrix formats are not permitted.
- Each form must include a unique form number on the lower 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.
- Amendatory Forms and Riders content cannot be embedded into a previously approved form. Changing language within a previously approved form can only be done by submitting the revised form with a new form number.

FORM ORGANIZATION

The form must be organized in a logical, reasonable, and rational order and presented in a manner that is clear and easy to understand for the average consumer. Specific requirements are identified below:

- The format must be consistent throughout the form.
- A table of contents must be included in all policies and certificates.
- Covered benefits must be clearly explained.
- There must be a clear distinction between what is covered and what is not covered.
- All important terms must be defined and when used, must be differentiated from the remaining text in some way (e.g. capitalized, bolded).
- Definitions may not be used to describe limits or exclusions of benefits.
- Benefit specific limitations and exclusions must be provided directly after description of the covered benefit. General limitations that apply to the entire form should be in a separate, clearly identified section.
- Limitations and exclusions must be labeled appropriately. For example, exclusions should be listed under the heading, **Exclusions**, while limitations should be listed under the heading, **Limitations**.
- Covered benefits must be described in the benefit section and not included as an exception in the exclusion section.

USE OF VARIABLE CONTENT

Alternative provisions are not permitted in individual policies.

Permitted variable content is limited to:

- Cost sharing options including deductibles, coinsurance, and copayments.
- Contraceptive coverage alternatives for groups eligible for the ACA religious exemption.
- Options in a group policy/certificate that have been added by rider or amendatory form may be bracketed in the Schedule of Benefits.
- Alternative language that does not affect covered benefits (e.g. eligibility options, addresses, and websites).

To ensure that the use of variability is clear, please adhere to the following:

- Bracket each variable.
- Include a statement of variability in the Forms Schedule as a separate form identified by a unique form number. Please use the Form Type “OTH” for this statement of variability.

The statement of variability must:

- Clearly describe the use of each bracketed item.
- Include specific options; vague statements such as “variables will always comply with applicable laws” are not acceptable.
- Include all alternative language with an explanation of why and when the language will be substituted.
- Include all values and ranges of values; value ranges must be reasonable and consistent with filed rates.

Any changes to an approved statement of variability must be filed and approved before use.

REQUIREMENTS FOR REVISIONS TO THE STANDARD BENCHMARK PLAN OR A STANDARD PLAN VARIATION

Insurers may update Standard Benchmark Plans by revising the previously approved policy or certificate or by submitting an amendment to be used in conjunction with the previously approved form. If insurers want to submit an amendment to be used for current insureds and a new policy or certificate for new insureds, they must submit both the amendment and the policy or certificate for review.

The following requirements apply to the submission of revisions to previously approved forms:

- Assign a new unique form number for each filed form.
- Attach the previously approved form under Supporting Documentation tab on SERFF.
- Attach a redlined version of the new form showing all revisions under Supporting Documentation tab.
- Include a certification that all changes are identified in the redlined version under Supporting Documentation tab.

Please note that if the department determines that an amendment or endorsement contains too many changes, they may request an entirely new version of the base form.

REQUIREMENTS FOR ADDING OPTIONAL BENEFITS

The following requirements apply to adding optional benefits:

- Add new benefits via a Standard Plan Rider.
- Specify in the filing if the benefits will always be sold together or if they may be sold separately.
- Assign a unique form number to each Standard Plan Rider. The form number must be in the lower left-hand corner of the first page.

FORM FILING CHECKLIST AND EHB LOCATOR

The Department has developed a specific form checklist for student blanket health insurance and an EHB Locator worksheet that must be completed and submitted with each filing. The checklist and EHB Locator will be provided as Filing Requirements in SERFF under the Supporting Documentation tab and are also available in the [Plan Management Toolkit](#) on the Department’s website. **Please review the checklist for any changes or new requirements even if you are only submitting an amendment/endorsement or rider.**

FILING TIPS

Please adhere to the following:

- Provide a redlined version of each revised form. Include a certification that the redlined version is accurate and shows all changes made to the original form. See How to Prepare Redline Versions for more information.
- Submit all Standard Benchmark Plan and Standard Plan Variation filings as complete policies, certificates, and riders (i.e. not matrix type filings).

HOW TO RESPOND TO OBJECTION LETTERS

- Respond to each objection individually using the response format in SERFF.
- Do not respond in a separate letter attached as a supporting document.
- If an objection has multiple parts, address all parts of the objection.
- Call the reviewer if you need clarification of any of the objections.
- Include (as a supporting document) a redline copy of each form showing changes only from the most recent form submitted and a certification that all changes have been redlined. Do not replace an old redline with a new redline.

HOW TO PREPARE REDLINE VERSIONS

- Compare only two forms, the newest version to the last version. Redlines may not include accumulated changes from several versions of a form.
- Use a contrasting color such as red or blue. Underlines, gray or black print are not acceptable.
- Provide a complete form and include all the changes that have been made. The redline version must match the newest version of the form.
- Review the redline to ensure it is easy to understand.

SELECTED COVERAGE AND FILING ISSUES

UNDERSTANDING THE ESSENTIAL HEALTH BENEFITS IN OHIO PLANS

- Essential health benefits are outlined in the Essential Health Benefits Resource Document and the Ohio EHB Benchmark Plan. These can be found in the Plan Management Toolkit on the Department's website.
- All EHBs included in the benchmark plan must be covered.
- No annual or lifetime dollar maximums are permitted. Some benchmark benefits have visit limitations or per service dollar maximums.
- Exclusions must be consistent with the Ohio EHB Benchmark Plan; benefits not excluded in the Ohio EHB Benchmark Plan may not be excluded in a Standard Benchmark Plan.

Some of the benefits in the Ohio EHB Benchmark Plan must be revised to comply with current ACA requirements. These revisions are identified below:

- **Mental health or substance abuse:** No visit limitations are permitted.
- **Dental Services for accidental injury:** limited to \$3000 per accident.
- **Private duty nursing:** limited to 90–110 visits per year.
- **Transportation and lodging for transplants:** limited to \$10,000 per transplant.
- **Unrelated donor searches for bone marrow/stem cell transplants for a covered transplant:** limited to \$30,000 per transplant.

Other changes have been made to the benchmark plan to be consistent with state and federal mandates. These changes are:

- **Residential treatment centers** must be covered for mental health and substance abuse treatment.
- **Habilitative Service** must comply with the Governor's Letter, dated 12/26/2012.

Covered benefits must be described in the benefit section and not included as an exception in the exclusion section.

RECURRING ISSUES

CLINICAL TRIALS

Benefits for coverage of routine care for a clinical trial must comply with ORC 3923.80 and federal requirements. In general, the federal law is more expansive and covers all clinical trials. However, Ohio requirements for cancer clinical trials are broader than federal law:

- Coverage is not limited to a "qualified individual" as defined in federal law.
- The participant is not required to have a referral from a participating health professional.
- The participant is not required to provide medical and scientific information establishing the appropriateness of participation.

CONTRACEPTIVE EXCEPTION PROCESS

Filings must include a contraceptive exception process compliant with the ACA FAQ Part XXVI. This process must clearly indicate that the plan must defer to the determination of the attending provider regarding medical necessity.

HABILITATIVE SERVICES

Standard Benchmark Plans must cover habilitative services:

- Must define as health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. 45 CFR 156.115(a)(5).
- Must include the coverage provided in Governor Kasich's letter dated December 26, 2012. This letter can be accessed in the Plan Management Toolkit on the Department's website.
- Coverage must include, but not be limited to, services to children (0 to 21) with a medical diagnosis of Autism Spectrum Disorder.
- Outpatient physical habilitation services must include 20 speech and language therapy visits and 20 occupational therapy visits per year.
- Services include 20 hours per week of Clinical Therapeutic Intervention, including but not limited to, Applied Behavioral Analysis.
- Mental and Behavioral Health Outpatient Services must include no less than 30 visits – this minimum must be increased when necessary to comply with Mental Health Parity Act (MHPA).

OUT OF NETWORK COVERAGE FOR COMPANIES LICENSED UNDER TITLE 39

Insurers must provide out of network benefits for all services with the following exceptions:

- Transplants may be limited to centers of excellence.
- Mail order prescription drugs
- Certain specialty drugs may be provided only by specialty pharmacies. Specialty drugs must be defined.

PRESCRIPTION DRUG EXCEPTION PROCESS

Beginning in plan year 2016, ACA compliant forms are required to include a prescription drug exception process so that an enrollee may request and gain access to a drug not on the plan's formulary under certain situations. Under this process, an insurer must notify the enrollee or the enrollee's designee and physician of its coverage decision no later than 72 hours following receipt of an exception request. The enrollee or the enrollee's designee/physician may request an expedited exception based on exigent circumstances and receive notification no later than 24 hours after making the request. The process must include the right of the enrollee or prescriber/physician to request that a denied exception request be reviewed by an Independent Review Organization with a response time of 72 hours for regular requests and 24 hours for expedited requests. If an exception request is granted, the plan must treat the drug as an EHB and count costs towards the annual limitation on cost sharing. 45 CFR 156.122

PREVENTATIVE CARE EDUCATION PROGRAMS

Coverage for preventive benefits must include all mandated interventions and counseling sessions.

PRIVATE DUTY NURSING

Private duty nursing is a benchmark benefit only when provided through home care. The dollar maximum has been converted to a visit limit. The standard number of visits is 90 to 110. This is separate from the home care visit visits.

REHABILITATION SERVICES

The EHB rehabilitation quantitative benefits limits are:

- Combined inpatient rehabilitation and day rehabilitation - 60 days
- Outpatient physical therapy - 20 visits

- Outpatient occupational therapy - 20 visits
- Outpatient pulmonary rehabilitation (unless rendered as part of physical therapy) - 20 visits
- Outpatient Cardiac Rehabilitation - 36 visits

Note: Outpatient therapy visits may be combined to total 116 or be provided separately as shown above.

STANDARD PROVISIONS

Please refer to the “ACA Form Filing Checklist – Title 39 Student Major Medical Blanket Plan Selected Form Review Requirements” for a partial list of required plan provisions.

SURROGATE PREGNANCY

If a covered person is pregnant, coverage must be provided even if the person is acting as a surrogate. Maternity coverage is a required benefit of the benchmark plan. Coverage may be excluded if the surrogate is not a covered person.

VISION CORRECTION

Coverage includes the following:

- 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.

TELEHEALTH SERVICES (EXPANDED)

Beginning in 2021, Health Benefit Plans were required to provide telehealth services on the same basis and to the same extent that the plan provides coverage for in-person health care services. No annual or lifetime benefit maximums are permitted. ORC 3902.30 The requirements in ORC 3902.30 were expanded effective March 23, 2022, and include a broader list of providers and description of covered services (Ohio HB 122, 134th General Assembly).

ADDITIONAL CONTINUITY OF CARE REQUIREMENT

The contracts must provide extended coverage for Continuing Care Patients after a provider terminates its network contract (PHSA §§ 2799A-3 and 2799B-8, as added by section 113 of division BB of the Consolidated Appropriations Act, 2021).

NEW ISSUES AND REQUIREMENTS

COST SHARING PARITY

The cost share on a per day basis for occupational therapy, physical therapy, and chiropractic services shall not be greater than the cost share for an office visit to a primary care physician (ORC 3902.63 effective 4/3/2025).

HEARING AID COVERAGE

Coverage for hearing aids and related services must be provided (ORC 3902.64 effective 4/3/2025).

APPENDIX A

CODING INSTRUCTIONS (TOI, SUB-TOI, MARKET TYPE) FOR ACA COMPLIANT STUDENT BLANKET HEALTH INSURANCE FILINGS

The tables below identify the appropriate TOIs and Sub-TOIs and Market Types for ACA compliant SBHI 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.

MAJOR MEDICAL

TOI	SUB-TOI	Description and Use
H22 Student Health Insurance	H22.000A	Blanket
	H22.000B	Non-Blanket / Indemnity
	H22.000C	Non-Blanket / Health Insuring Corp (HMO)

STAND ALONE DENTAL PLAN – INDEMNITY STAND ALONGE PLANS

TOI	SUB-TOI	Description and Use
H10G Group Health - Dental	H10G.000	Health Dental
	H10G.001	Health - Pediatric Dental

STAND ALONE DENTAL PLAN – HEALTH INSURING CORP (DHMO)

TOI	SUB-TOI	Description and Use
Supplemental/Specialty Product Health Insuring Corporation (HMO Only)	Dental Care Services	Dental Care Services

MARKET TYPE (ALL FILINGS)

Market Type	Group Market Size	Group Market Type
Group	Small and Large	Blanket