
ACA COMPLIANT FORM FILING GUIDANCE
FOR INDIVIDUAL, NON-EMPLOYER GROUP AND SMALL GROUP
PRODUCTS

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Written by

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Ohio Department of Insurance

INTRODUCTION

The Ohio Department of Insurance has developed this manual to provide guidance for the development of Affordable Care Act compliant filings in the individual, non-employer group, and small group markets. The 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 SERFF fields
- Identification of appropriate checklists
- Instructions on preparing acceptable forms
- Instructions on responding to objections

ONLINE RESOURCES

Additional information is available on the Department's website under ACA Plan Management Toolkit including:

- Ohio Essential Health Benefit Benchmark Plan
- Essential Health Benefits Resource Document
- Required Supporting Documentation for Form Filings
- QHP Binder and Rate Submission Guidance
- Frequently Asked Questions

2016 PLAN YEAR FILING DEADLINES

- April 17: **Individual and Small Group** new and amendatory form filings for On and Off Exchange; Pediatric Stand Alone Dental Plans (SADP) Form Filings
- April 29: On and Off Exchange Rate Filings for Individual, Small Group and SADP plans
- May 1: QHP Binders
- September 4: ACA Compliant **Large Group** form and rate filings

TABLE OF CONTENTS

Introduction.....	2
Online Resources.....	2
2016 Plan Year Filing Deadlines	2
Important Terms.....	5
Ohio Essential Health Benefit (EHB) Benchmark Plan.....	5
Essential Health Benefits Resource Document	5
Essential Health Benefits Locator	5
Standard Benchmark Plan.....	5
Standard Plan Variation	5
Standard Plan Rider	5
Amendment or Endorsement (Amendatory Forms).....	6
What Supporting Documents Do I Need to File?.....	6
SERFF Filing Instructions	7
TOI/Sub TOI.....	7
Filing Type	7
PPACA Indicator	7
Exchange Intentions Indicator	7
Implementation Date.....	7
Submission Type	7
Market Type.....	7
Corresponding Filing Tracking Number.....	7
Filing Description	7
Document Format.....	8
Form Design.....	8
Format.....	8
Form Organization	8
Use of Variable Content.....	9
Requirements For Revisions to the Standard Benchmark Plan or a Standard Variation	9
Requirements For Adding Optional Benefits	10
Requirements For Contraceptive Coverage Exemption.....	10
Form Filing Checklist and EHB Locator.....	10
Filing Tips	10
Selected Benefit Issues	11

Understanding the Essential Health Benefits in Ohio Plans	11
Recurring Issues	11
New Requirements	13
Appendix A.....	15
Coding Instructions (TOI, Sub-TOI, Market Type) for ACA Compliant Filings.....	15
Ohio Title 39 Indemnity Insurers	15
Ohio Title 17 Health Insuring Corporations (HICs, commonly called HMOs).....	16
Appendix B.....	17
ACA Market Reforms.....	17
Individual Grandfathered Plans	17
Individual Non-Grandfathered Plans	17
Group Grandfathered Plans	18
Group Non-Grandfathered Plans	18

IMPORTANT TERMS

OHIO ESSENTIAL HEALTH BENEFIT (EHB) BENCHMARK PLAN

The plan selected for Ohio that 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 individual and small group 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 the optional benefits that have been added to its plans.

STANDARD BENCHMARK PLAN

The insurer's policy or certificate that includes all of the EHBs required in Ohio. This plan must be consistent with the Ohio EHB Benchmark Plan and meet all of the 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 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

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?

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 make changes by creating a new Standard Benchmark Plan or Standard Plan Variation	Yes	Yes	Yes

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 create a new ACA compliant form	Yes	Yes

¹ All rates are filed under the rate filing type. Rates are not required if trend was not used in developing rates, and there are no changes to currently approved rates. See the ACA Health 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.
- Do not combine small and large group forms in one filing.
- The any size group code may be used only for non-employer group plans.

FILING TYPE

The filing type must accurately describe the submitted forms.

- If policy/certificate forms and rates are submitted separately use the Filing Type, **Form**, for the forms filing and the Filing Type, **Rate**, for the rate filing.
- If policy/certificate forms and rates are submitted together in one filing, use the Filing Type, **Form/Rate**.
- The **Advertising/Solicitation** filing type should be used for HIC solicitation filings only.

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.
- Identify the filing as either grandfathered or non-grandfathered. Do not combine grandfathered forms and non-grandfathered ACA forms in one filing.

EXCHANGE INTENTIONS INDICATOR

Select YES if any portion of the filing is intended to be sold through the federal health insurance exchange. Include additional information, if any, in the text box that is provided.

IMPLEMENTATION DATE

Indicate January 1, 20XX for any plan to be used for 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 appropriate market type. Please refer to Appendix A for guidance in identifying the correct market type.

CORRESPONDING FILING TRACKING NUMBER

Provide the SERFF Tracking Numbers for the corresponding rate filing 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.
 - Indicate if the revisions will be inserted into the base form to create a new, amended base form.

Please note that this requires a submission of a new base form with a new form number.
- 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.
- For Health Insuring Corporation (HIC) advertising/solicitation filings describe the form related to the advertisement/solicitation and include the SERFF tracking number(s) and approval date(s). Please note, advertising and solicitation documents may be submitted only with the base form or after the base form has been approved.

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 limitation that apply to the entire form should be located 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**.

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, websites).
 - Reduce the dependent eligibility from 28 years of age to 26 as permitted by Ohio HB 201 of the 130th General Assembly
 - Increase the number of hours for an eligible employee normal work week to 30 hours as permitted by Ohio HB 201 of the 130th General Assembly

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."

The statement of variability must:

- Clearly describe the use of the 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 VARIATION

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 red-lined version of the new form showing all revisions under Supporting Documentation tab.
- Include a certification that all changes are identified in the red-lined 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 located in the lower left hand corner of the first page.

REQUIREMENTS FOR CONTRACEPTIVE COVERAGE EXEMPTION

Contraceptive coverage may be excluded only for groups eligible for the ACA religious exemption. To provide this exemption:

- Use a Standard Plan Variation, Standard Plan Rider or Amendment or Endorsement.
- Clearly state exactly what contraceptive benefit is removed from coverage.
- Explain any variability in a statement of variability as described under USE OF VARIABLE CONTENT section.

Note: The ACA religious exemption does not apply to coverage of therapeutic abortions. Coverage for therapeutic abortions is required for consistency with the Ohio EHB Benchmark Plan.

FORM FILING CHECKLIST AND EHB LOCATOR

The Department has developed a form checklist and an EHB Locator that must be completed and submitted with each filing. The checklist and EHB Locator will be populated in SERFF under the Supporting Documentation tab and is available on the Department's website: www.insurance.ohio.gov under **ACA Plan Management Toolkit** (found in **Featured Links**).

FILING TIPS

Please adhere to the following:

- Include all forms for one market type (individual, non-employer group, or small group) in one filing.
- Provide a red-lined version of each revised form. Include a certification that the red-lined version is accurate and shows *all* changes made to the original form.
- 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.

SELECTED BENEFIT 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 on the Department’s website: www.insurance.ohio.gov under ACA Plan Management Toolkit (found in Featured Links).
- 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
- The Ohio EHB Benchmark Plan was not a HIC and does not meet all of the **Ohio HIC requirements**. HICs must cover all basic health care services as defined in ORC 1751.01(A). For example, complications from non-covered services must be covered.

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.
- **Off label use of drugs** must comply with ORC 3923.60 or 1751.66.
- **Habilitative Service** must comply with the Governor’s Letter, dated 12/26/12.
- 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.

DEPENDENT ELIGIBILITY

ORC sections 3923.24(A) and 1751.14(A) have been revised to change the mandatory age for continuing coverage for eligible dependents from 28 to 26.

ELIGIBILITY REQUIREMENTS FOR SMALL GROUPS

The definition of eligible employee in ORC 3924.01 has been changed to an employee who works a normal work week of 30 hours or more (previously the number of hours was 25).

ORALLY ADMINISTERED CANCER MEDICATION

Review ORC sections 3923.85 and 1751.69 for required coverage for orally administered cancer medication. Orally administered cancer medication may not be provided on a less favorable basis than intravenously or injected cancer medication. A safe harbor option that limits cost sharing for orally administered cancer medication to no more than \$100 is permitted. The safe harbor option for high deductible health plans applies after the deductible has been met. For catastrophic plans, it should be paid the same as any other benefit.

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.
- Certain specialty drugs may be provided only by specialty pharmacies. Specialty drugs must be defined.

PEDIATRIC DENTAL

Pediatric dental benefits must match the MetLife Federal Dental Plan-High Option 2012 Plan. A few guidelines are listed below:

- All age limitations (even those in the original plan) must be deleted.
- No lifetime maximums (even those in the original plan) are permitted.
- A 2 year waiting period is permitted for orthodontia only.
- Pediatric dental benefits may be embedded in the medical plan or sold as a stand-alone-plan.

PEDIATRIC VISION

Pediatric vision must be embedded in the medical plan. Benefits must match the FEP BlueVision High option 2012 plan. Mandated coverage includes:

- Eye exam
- Lenses (All lenses and treatments identified in FEP plan must be covered)
- Frames
- Contact Lenses
- Low Vision Benefits

In-network dollar maximums are **not** permitted on any services.

PREVENTIVE 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.

STANDARD PROVISIONS

INSURANCE COMPANIES

Review the required standard provisions for the type of product submitted. For individual products refer to ORC 3923.04. For group products refer to ORC 3923.12 and 3923.20. All required provisions must be included; optional provisions must be consistent with Ohio law.

HICs

Review ORC 1751.11 for standard provisions for HICs.

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. It is also a basic health care service for HICs. 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.

NEW REQUIREMENTS

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)
- Include the coverage provided in Governor Kasich's letter dated December 26, 2012. This letter can be accessed in the ACA 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
 - Out-patient 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).

PEDIATRIC AGE

Standard Benchmark Plans must provide coverage for pediatric services until at least the end of the month in which the enrollee turns 19. “Pediatric services” means the pediatric services required under §156.110(a)(10), which includes the EHB-benchmark plan standards, specifically, “Pediatric services, including oral and vision care.” 45 CFR 156.115(a)(6)

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

APPENDIX A

CODING INSTRUCTIONS (TOI, SUB-TOI, MARKET TYPE) FOR ACA COMPLIANT FILINGS

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

OHIO TITLE 39 INDEMNITY INSURERS

MAJOR MEDICAL

<i>TOI</i>	<i>SUB-TOI</i>	<i>Description and Use</i>
H16G Group Health–Major Medical Any Size Group	H16G.001A	Any Size Group-PPO; Only for Non-Employer Group Plans ²
	H16G.001B	Any Size Group-POS; Only for Non-Employer Group Plans ²
	H16G.001C	Any Size Group-Other; Only for Non-Employer Group Plans ²
H16G Group Health–Major Medical Large Group Only	H16G.002A	Large Group Only-PPO
	H16G.002B	Large Group Only-POS
	H16G.002C	Large Group-Other
H16G Group Health–Major Medical Small Group Only	H16G.003A	Small Group Only-PPO
	H16G.003B	Small Group Only-POS
	H16G.003C	Small Group-Other
H16I Individual ³ Health–Major Medical Individual Only	H16I.005A	Individual-PPO
	H16I.005B	Individual-POS
	H16I.005C	Individual-Other

DENTAL

H10G Group	H10G.000	Dental Any Size Group
H10I Individual	H10I.000	Dental Individual

² Non-employer group plans are those sold to individuals through associations, trusts or other entities.

³ Only for use with true individual plans not sold through associations, trusts or other entities.

OHIO TITLE 17 HEALTH INSURING CORPORATIONS (HICs, COMMONLY CALLED HMOs)

BASIC HEALTH CARE

<i>TOI</i>	<i>SUB-TOI</i>	<i>Description and Use</i>
HOrg02G Group	HOrg02G.002C	HMO Any Size Group–Restricted Network plan; Only for non-employer group plans
	HOrg02G.003C	HMO Large Group–Restricted Network plan
	HOrg02G.004F	HMO Small Group–Restricted Network plan
HOrg02I Individual	HOrg02G.005C	HMO Individual–Other; Only for Conversion or Ohio Basic and Standard Restricted Network Plans
	HOrg02G.005D	HMO Individual–Restricted Network Plan

DENTAL

Supplemental/Specialty Product Health Insuring Corporation	Dental Care Services	Dental Care Services
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MARKET TYPE (ALL FILINGS)

Individual		Individual Market Type Options <ul style="list-style-type: none"> • Individual • Non-employer Group
Group	Group Market Size Options <ul style="list-style-type: none"> • Small • Large 	Group Market Type Options <ul style="list-style-type: none"> • Employer • Associations • Blanket • Discretionary • Trust • Other

APPENDIX B

ACA MARKET REFORMS

The ACA mandated market reforms are shown below by type of coverage. The individual market includes individual plans and plans marketed to individuals through associations, trusts or other entities (non-employer groups). Group market applies only to employer related coverage.

INDIVIDUAL GRANDFATHERED PLANS

<i>PHS Section</i>	<i>Provision</i>
2711	No Lifetime Dollar Limit
2712	Prohibits Rescissions
2713	Dependent Coverage to Age 26

INDIVIDUAL NON-GRANDFATHERED PLANS

<i>PHS Section</i>	<i>Provision</i>
2704	No Pre-Existing Condition Exclusions
2705	Prohibits Discrimination Based on Health Status
2706	No Discrimination Against Providers In Scope
2707	Provide Essential Health Benefits Package
2709	Coverage For Approved Clinical Trials
2711	No Annual or Lifetime Dollar Limits
2712	Prohibits Rescissions
2713	Preventive Services
2714	Dependent to Age 26
2719	Appeals Process
2719 A	Emergency Service
2719 A	Access to Pediatricians and OB/GYNs

GROUP GRANDFATHERED PLANS

<i>PHS Section</i>	<i>Provision</i>
2704	No Pre-Existing Condition Exclusions
2708	Prohibit Excessive Waiting Periods
2711	No Annual or Lifetime Dollar Limits
2712	Prohibits Rescissions
2713	Dependent Coverage to Age 26

GROUP NON-GRANDFATHERED PLANS

<i>PHS Section</i>	<i>Provision</i>
2704	No Pre-Existing Condition Exclusions
2705	Prohibit Discrimination Based on Health Status
2706	No Discrimination Against Providers In Scope
2707	Provide Essential Health Benefits Package
2708	Prohibits Excessive Waiting Periods
2709	Coverage For Approved Clinical Trials
2711	No Annual or Lifetime Dollar Limits
2712	Prohibits Rescissions
2713	Preventive Services
2714	Dependent Coverage to Age 26
2719	Appeals Process
2719 A	Emergency Service
2719 A	Access to Pediatricians and OB/GYNs