

Department of Consumer & Business Services

Oregon Insurance Division - 5

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Standard Provisions for Large Group Health Benefit Plans

This checklist must be submitted with your filing in compliance with OAR 836-010-0011(2). This list includes national standards, relevant statutes, rules, and other documented positions to enforce ORS 731.016. The standards are summaries and review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed. Any line left blank will cause this filing to be considered incomplete. Not including required information or policy provisions may result in disapproval of the filing. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

Insurer name: _____

Date: _____

TOI (type of insurance): H16G Group health - Major medical
 H15G Hospital/surgical/medical expense

Sub-TOI

<input type="checkbox"/> H16G.001A	or	<input type="checkbox"/> H16G.002A	Group Health – Major Medical - PPO
<input type="checkbox"/> H16G.001B	or	<input type="checkbox"/> H16G.002B	Group Health – Major Medical - POS
<input type="checkbox"/> H16G.001C	or	<input type="checkbox"/> H16G.002C	Group Health – Major Medical - Other
<input type="checkbox"/> H15G.001	Hospital/Surgical/Medical Expense - Any Size Group (440-3136B may be required)		
<input type="checkbox"/> H15G.002	Hospital/Surgical/Medical Expense - Large Group Only		

Type of coverage: Indemnity Health Care Service Contractor
() Indicates standard does not apply per ORS 750.055)*

NOTE: Forms filed using this document must meet the definition for a Health Benefit Plan in ORS 743.730(19)(a).

Review requirements	Reference	Description of review standards requirements	Location of standard in filing (or check box)	
GENERAL REQUIREMENTS (FOR ALL FILINGS)				
Submission package requirements	OAR 836-010-0011 As required on SERFF or our Web site	Required forms are located on SERFF or on our Web site: http://www.insurance.oregon.gov/docs/serff/filing_requirements.html . These must be submitted with your filing for your filing for it to be accepted as complete: 1. NAIC transmittal form(paper filings only). 2. Filing description in SERFF or attach a cover letter. 3. Third party filer's letter of authorization. 4. Certificate of compliance form signed by authorized person. 5. Readability certification. 6. Product standards for forms (this document). 7. Forms filed for approval. (If filing revised forms, include a highlighted copy of the revised form to identify the modification, revision, or replacement language.) 8. For mailed filings, two self-addressed stamped envelopes, one in which the Insurance Division can return approved forms.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
	Filing description on transmittal form	The filing description (cover letter) includes the following: 1. Exceptions used to modify the mandated design. 2. Changes made to prior approved plan or variations from other approved plans. 3. Summary of the differences between prior approved like form and the new form. 4. The differences between in-network and out-of-network. 5. An explanation of the variability of any information appearing in the forms that is noted as variable.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Review requested	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and/or certificate. 2. Amendment of an approved form.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Application	OAR 836-053-0510	No application with medical questions is used to enlist new enrollees and the Oregon Health Statement. Exhibit 1 of OAR 836-053-0510 is used for late enrollees.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Associations/ Trusts, Discretionary groups	ORS 731.486, ORS 743.522, ORS 743.524	Does filing include an association, trust, union trust or discretionary group? If yes, additional filing requirements apply. Use Form 440-2441A, transmittal and standards for qualifying an Association, Union Trust or Trust Group. Use Form 440-2441D for discretionary group filings.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>

Category	Reference	Description of review standards requirements	Answers	
Assumption certificates	Form 440-3637	File under checklist of standards for <u>Changes to Business Operations that Require a Filing</u> , Form 440-3637.		
Multiple Employer Welfare Arrangement (MEWA)	ORS 750.301 to 341	File under checklist of standards for <u>Standard Provisions for Multiple Employer Welfare Arrangements Group Health Benefit Plans</u> , Form 440-2448m.		
Applicability	Health care service contractors (HCSC)	(Statute references followed by an asterisk (*), may be marked "N/A" in the location column. These standards do not apply to HCSC per ORS 750.055.)		
	ORS 743.730(19)(b)	Health benefit plan does not include coverages specifically listed in ORS 743.730(19)(b). (See Form 440-3172A, B, or C for filing those coverages.)	Confirm <input type="checkbox"/>	
	ORS 743.565*, OAR 836-052-0800 to 0860	A separate notice of cancellation is mailed 10 days prior to the end of the grace period.	Yes <input type="checkbox"/>	
	ORS 743A.088	Health coverage is not denied or canceled because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.	Yes <input type="checkbox"/>	
	ORS 743A.110(2)(3)	The enrollee is provided a written notice at time of enrollment and annually thereafter describing the coverage for all mastectomy-related services including reconstruction of the breast by obtaining a single authorization.	Yes <input type="checkbox"/>	
	45 CFR, Part 160 & Subparts A & E of 164	Policy meets all HIPAA privacy requirements and all HIPAA related statements are solely supported by HIPAA requirements.	Yes <input type="checkbox"/>	
	ORS 743A.012	Health benefit plans are required to provide information to enrollees regarding coverage for emergency services and appropriate use of 9-1-1.		
	OAR 836-053-0001	Submit transmittal and requirements for <u>Modification and Discontinuance of Health Benefit Plans</u> , Form 440-2896, when eliminating or adding benefits, decreasing or increasing benefits payable or deductibles and co-payments, or establishing new conditions or requirements.		
Clarity/ Readability	ORS 742.005(2)	Forms are clear and understandable in their presentation of premiums, labels, description of contents, title, headings, backing, and other indications (including restrictions) in the provisions. The information is clear and understandable to the consumer and is not ambiguous, abstruse, unintelligible, uncertain, or likely to mislead.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Clarity/ Readability, continued	ORS 743.106(1)(d), ORS 743.103	Policy and certificate contain a table of contents or index of the principal sections if longer than three pages or over 3,000 words.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
	ORS.743.104(2)	A non-English language policy will be deemed to comply with ORS 743.106 if the insurer certifies that the policy is translated from an English language policy that complies with ORS 743.106, reading ease standards.		

Category	Reference	Description of review standards requirements	Answers	
Form numbers	ORS 743.405(7)	The policy and certificate are filed under one form number if both are required to complete the contract, and the form provides core coverage with all basic requirements. If the policy and certificate are “free standing” documents they must have their own unique form number. Optional benefits to the policyholder are riders or endorsements with separate form numbers. (See guidelines on our Web site: www.oregoninsurance.org/docs/healthun/health6.htm)	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Rates	Form 440-4872	If filing individual or small group health benefit plan rates in conjunction with this filing please include Product Standards 440-4872 with your filing.		
Variable text	ORS 742.005(2)	Variable data is indicated by brackets and all variable ranges or options are identified. (<i>Variable data may be included within the policy and certificate or may be submitted as an attachment. A separate document must also refer to the form it applies to, the form page number, and the paragraph and line if necessary for clarity.</i>)	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>

GENERAL FORM REQUIREMENTS

Category	Reference	Description of review standards requirements	Answers	
Cover page	ORS 742.023, ORS 743.405, OAR 836-010-0011, ORS 743.405(7)	<ol style="list-style-type: none"> The full corporate name of the insuring company appears prominently on the first page of the policy. A marketing name or insurer’s logo, if used on the policy, must not mislead as to the identity of the insuring company. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. The signature of at least one company officer appears on the first page of the policy. The individual certificate includes a right-to-examine provision that appears on the cover page of the certificate. A form-identification number appears in the lower left-hand corner of the forms. The form number is adequate to distinguish the form from all others used by the insurer. ORS 743.405(7) The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage. The policy includes a table of contents that easily identifies where to locate the provisions. ORS 743.106(1)(d) 	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>

POLICY PROVISIONS

Category	Reference	Description of review standards requirements	Page & paragraph
Ambulance	ORS 743A.014*	If ambulance care and ground transportation to the nearest hospital is covered, coverage payments are either made directly to the provider or jointly to the insured and the provider.	
Benefit reimbursement	ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405	Group health insurance coverage for treatment of chemical dependency and mental or nervous conditions are at the same or substantially similar level as treatment of other medical conditions and are not subject to treatment limitations that are more restrictive than those imposed for other medical conditions.	
	ORS 743A.110	Coverage provides reimbursement for mastectomy-related services that are part of the enrollee's course of treatment including all stages of reconstruction with a single determination of prior authorization. Include the definition of mastectomy in the contract.	
	ORS 743A.080	Coverage provides reimbursement for expenses associated with pregnancy care, as defined by ORS 743.845, and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled spouses, and enrolled dependents.	
	ORS 743A.140	Any plan providing coverage for cochlear implants must cover bilateral implants.	
	ORS 743A.068	Any plan covering cancer chemotherapy must provide coverage for oral anticancer medications on a basis no less favorable than IV or injected medications.	
	ORS 743A.190	A plan must provide medically necessary covered services for children less than 18 years old diagnosed with pervasive developmental disorder.	
	ORS 743A.144	Coverage must be provided for prosthetics and orthotic devices that are medically necessary to restore or maintain activities of daily living.	
	OAR 836-052-1000	Prosthetic and orthotic coverage is based on Medicare's fee schedule for DME.	
	ORS 743A.020	Plans providing coverage for acupuncture services performed by a physician must also provide coverage when performed by an acupuncturist.	
	ORS 743A.070	Coverage must be provided for non-prescription elemental enteral formula for home use subject to physicians' orders and the formula comprises the sole or essential source of nutrition.	
	ORS 743A.184	Coverage provides reimbursement for supplies, equipment, and diabetes self-management programs associated with the treatment of diabetes prescribed by a health care professional.	
	ORS 743A.010	Policy pays benefits for covered services when provided by any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program.	
	ORS 743A.040*	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed optometrist, if the policy provides benefits when a physician performed the service.	

Category	Reference	Description of review standards requirements	Page & paragraph
Benefit reimbursement, continued	ORS 743A.148	Coverage provides for coverage of maxillofacial prosthetic services necessary for adjunctive treatment.	
	ORS 743A.048	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed psychologist, if the policy provided benefits when a physician performed the service.	
	ORS 743A.036	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed and certified nurse practitioner, if the policy provided benefits when a physician performed the service.	
	ORS 743.845(2)	Every health insurance policy that covers hospital, medical, or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women's health care provider as defined in 743.845(1)(b).	
	ORS 743A.024*	Coverage provides reimbursement for any service that is within the lawful scope of practice of a licensed clinical social worker and a physician or psychologist referred the insured to the licensed clinical social worker, if the policy provided benefits when a physician or psychologist performed the service.	
	ORS 743A.032*	Coverage provides reimbursement for any service that is within the lawful scope of practice of a licensed dentist, if policy provided benefits when a physician performed the service.	
	ORS 743A.044*	Claims submitted directly by physician assistants, practicing in keeping with ORS 677.515(4), to be paid as if submitted by the supervising physician.	
	ORS 743A.188	Coverage includes treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism.	
	ORS 743A.100	Coverage provides for annual mammogram reimbursement for the purpose of early detection and any time if high risk for women over 40; more frequent reimbursement if the health care provider determines a woman is at high risk for breast cancer.	
	ORS 743A.104	Coverage provides reimbursement for pelvic and Pap-smear exams provided annually for women 18 to 64 and any time upon referral of the woman's health care provider.	
	ORS 743A.108*	Coverage provides reimbursement for exam of the breast, not limited to clinical breast exam.	
	ORS 743A.120*	Coverage provides reimbursement for prostate cancer screening examinations, age 50+ biennially or as determined by physician or high risk medical history.	
ORS 743A.124*	Coverage provides colorectal cancer screening examinations and lab tests.		

Category	Reference	Description of review standards requirements	Page & paragraph
Benefit reimbursement, continued	ORS 743A.192	Coverage for routine costs of care for patients enrolled and participating in qualifying clinical trials. Coverage not liable for any adverse effects of trial. Effective 1/1/2010.	
	ORS 743A.058	Coverage for telemedical services via two-way video communication. Coverage of telemedical health services such as hospital, rural health clinic, doctor's office, community mental health, etc. Coverage equal to contract covered services Effective 1/1/2010.	
	Senate Bill 787	Coverage for telemedical services via two-way electronic communication, that allows health professionals to interact with a patient, a parent or guardian of a patient in connection with the treatment of with diabetes.	
	ORS 743A.175	Coverage for medically necessary therapy and services for the treatment of traumatic brain injury. Effective 1/1/2010.	
	ORS 743A.170	Coverage to provide payment or reimbursement of at least \$500 for tobacco use cessation programs for persons aged 15 years or older who is enrolled in the benefit plan. Effective 1/1/2010.	
	ORS 743A.141	Coverage for one hearing aid per impaired ear to enrollees under the age of 18 or dependents of enrollees over the age of 18 if the dependent is enrolled in an accredited educational institution. Maximum benefit required is \$4,000 per 48-month period; however, the \$4,000 must be adjusted 1/1 of each year following Consumer Price Index for all urban consumers for medical care. Effective 1/1/2010.	
	ORS 743A.105	Coverage of human papilloma virus (HPV) vaccine for female beneficiaries of the plan/policy who are at least 11 years of age but no older than 26. Effective 1/1/2010.	
	ORS 743A.052	Provide coverage for services of nurse practitioner or clinical social worker, also provide coverage for the services of licensed professional counselors or licensed marriage and family therapists when the counselors or therapists are acting within the scope of their practices and providing covered benefits under the policy. Effective 1/1/2010.	
	ORS 743A.070	Coverage for severe intestinal malabsorption, written order for the use of the formula and formula is at least an essential source of nutrition. Reinstated ORS 743A.070 on 1/1/2010.	
	Senate Bill 860	An insurer offering a health benefit plan that provides coverage for prescription eye drops shall provide coverage for one early refill of a prescription for eye drops to treat glaucoma under certain conditions provided in statute.	
ORS 743.823, OAR 836-053-1000(10)	Coverage provides 48 hours of care for vaginal delivery and 96 hours for caesarian and insurer compliance with the Federal Newborns' and Mothers' Health Protection Act of 1996.		

Category	Reference	Description of review standards requirements	Page & paragraph
Cancellation and non-renewal	ORS 743.560(4), OAR 836-052-0800 to 0860	Notice upon termination if coverage is not replaced by the policyholder. This requirement includes an employer's participation in or the termination of a multiple-employer trust policy.	
	ORS 743.560(3)	Notification of non-replacement rights is sent to the policyholder no later than 10 days after the termination date.	
	ORS 743.565	The policy provides that an insurer seeking to terminate a policy for nonpayment of premium will notify the policyholder at least 10 days prior to the end of the grace period.	
Grievance and appeals,	Senate Bill 89	The insurer must provide for a grievance process which includes complaints, internal appeals and external review. The process is triggered when an enrollee files a grievance regarding an adverse benefit determination.	
	ORS 743.801(1)(a-e), ORS 743.801(2), ORS 743.801(8), OAR 836-053-1030	<p>Include the statutory definition of:</p> <p>A. Adverse Benefit Determination:</p> <ul style="list-style-type: none"> • Denial of eligibility for or termination of enrollment in a health benefit plan; • Rescission or cancellation of a policy or certificate; • Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services; • Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or • Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854., <p>B. Authorized Representative: An individual who by law or by the consent of a person may act on behalf of the person.</p> <p>C. Grievance: A request submitted by an enrollee or an authorized representative of an enrollee:</p> <ul style="list-style-type: none"> • In writing, for an internal appeal or an external review; or In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or • A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the: <ul style="list-style-type: none"> ○ Availability, delivery or quality of a health care service; ○ Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or ○ Matters pertaining to the contractual relationship between an enrollee and an insurer. 	

Category	Reference	Description of review standards requirements	Page & paragraph
Grievance and appeals, continued	ORS743.804(1)(a)(C)(D), ORS 743.804(1)(b)(A)(B)(C)(D), ORS 743.804(2)(a)(c-e)(A-B), OAR 836-053-1030, OAR 836-053-1100	<p>Internal Appeals</p> <p><u>The following must be disclosed:</u></p> <ul style="list-style-type: none"> • Receipt of an initial grievance or the first or second appeal will be acknowledged in writing within seven days. • The insurer must make a decision on the grievance or internal appeal within 30 days but may take an additional 15 days if they provide notice of delay within the first 30 days. • The insurer will expedite internal appeal(s) when required by clinical urgency and provide a clear explanation of the procedure for requesting expedited review. • When an insurer provides two levels of internal appeal, a person involved in the initial denial or the first level of appeal may not be involved in the second level. • When an insurer provides one level of internal appeal, a person involved in the initial denial may not be involved in the internal appeal. • An enrollee may authorize a representative to act on the enrollee's behalf during the appeal. • An enrollee or their authorized representative has the right to submit additional comments, documents, records and other material relating to the adverse benefit determination for consideration. • An enrollee may receive, free of charge, reasonable access to documents used in the adverse benefit determination. • For adverse benefit determinations that qualify for external review, the insurer can waive its internal appeals process and move straight to external review. • An enrollee has the right to file a complaint with or seek assistance from the Department of the Consumer and Business Services. Contact information, including the phone number and address for the division, must also be included. • That the enrollee is entitled to receive continued coverage of the disputed item or service pending the conclusion of the appeal and review process, but that if the insurer's denial is not reversed, that the enrollee will be responsible to pay for the disputed item or service. • 	
	ORS 743.804(2)(g)	The enrollee must be allowed to receive continued coverage pending the conclusion of the internal appeal process.	

Category	Reference	Description of review standards requirements	Page & paragraph
Grievance and appeals, continued	ORS 743.857, ORS 743.859, ORS 743.861, OAR 836-053-1030, OAR 836-053-1342 OAR 836-053-1325 OAR 836-053-1340	<p>External Review</p> <p>The insurer must have a process in place for an external review with an Independent Review Organization (IRO) chosen by the director. The insurer must provide an explanation of when external review is available and how to request external review. In addition the following must be disclosed:</p> <ul style="list-style-type: none"> • The insurer must notify the division of an enrollee’s request for external review no later than the second business day after receipt of the request. • An IRO must complete their review within: <ul style="list-style-type: none"> ○ 3 days for expedited reviews (notification is immediate) ○ 30 days when not expedited (notification with within 5 days) • An external review must be provided when there is a dispute on an adverse benefit determination regarding whether a course or plan of treatment is: <ul style="list-style-type: none"> ○ medically necessary ○ experimental or investigational ○ an active course of treatment for purposes of continuity of care under ORS 743.854. ○ delivered in an appropriate health care setting and with the appropriate level of care. • The insurer shall pay the cost of the external review. • When an enrollee requests external review, the enrollee must authorize release of medical records needed by the IRO. • The enrollee may submit additional information to the independent review organization no later than 5 business days after the appointment of the IRO or 24 hours in the case of an expedited review.. • The insurer and the director shall expedite the external review in the case of clinical urgency and the insurer must explain the circumstances in which external review can be expedited. • A description of the circumstances in which the enrollee can move to external review and bypass internal appeals. • The following in boldface type or otherwise emphasized: <ul style="list-style-type: none"> ○ The enrollee has the right to external review. ○ The insurer is bound to follow the decision of the IRO, and may be penalized by DCBS if it fails to do so. ○ The enrollee has the right to sue the insurer if the decision of the IRO is not implemented. 	

Category	Reference	Description of review standards requirements	Page & paragraph
Grievance and appeals, continued	ORS 743.804(5); OAR 836-053-1030(12)	Insurers must disclose that the following additional information is available upon request: <ul style="list-style-type: none"> • Annual summary of grievance and appeals; • An annual summary of utilization review policies; • An annual summary of quality assessment activities; • The results of all publically available accreditations surveys; • An annual summary of the insurer's health promotion and disease prevention activities; • An annual summary of scope of network and accessibility of services. 	
Continuation of coverage	ORS 743.854(9)(10)	Continuity of care is provided under managed health insurance or preferred-provider-organization insurance. A copy of the notice to enrollees is provided.	
	ORS 743.527(1)(a)	Provides continuation of coverage for strike or lockouts.	
	ORS 743.529(1), OAR 836-082-0055	Provides continuation of coverage for a covered hospitalized individual if policy is canceled and replaced by another insurance carrier.	
	ORS 743.529(2), OAR 836-082-0050 to 0055	Provides uninterrupted coverage when the existing policy is replaced.	
	ORS 743.530*	Provides continuation of coverage after injury or illness claim filed for workers' compensation.	
	ORS 743.600, ORS 743.601, ORS 743.602	Provides continuation of coverage for surviving, divorced, or separated spouse 55 or older for employers with 20 or more employees.	
	ORS 743.760(1)(12), ORS 743.610, OAR 836-053-0750	Includes state and federal eligibility requirements to obtain an individual portability plan.	
Coordination of benefits	ORS 743.549, ORS743.552, OAR 836-020-0770 to 0806, and Exhibits	If policy applies coordination of benefits, it complies with ORS 743.549, ORS 743.552, and OAR 836-020-0770 to 0805 and Exhibits.	
		Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	
Credibility	ORS 742.005(2)(3)	If plan includes a discretionary clause, it does not give the insurer full and final discretion in interpreting its insurance contract. (Such a clause is considered to be inequitable, deceptive, and misleading to consumers.)	
Definitions	ORS 743.801(5)*, OAR 836-053-1060	Definition of "grievance" as it applies to the grievance procedures.	
	ORS 743.730(3)	Terms identify the eligibility date for coverage and define affiliation period for health care service contractors.	

Category	Reference	Description of review standards requirements	Page & paragraph
Definitions, continued	ORS 743.730(8), OAR 836-053-0230 and 0060	Creditable coverage is defined.	
	ORS 743.730(13)	Definition of "enrollee" includes employee, dependent of the employee, or an individual otherwise eligible under the group.	
	ORS 743.730(15), OAR 836-053-0250	Describes exclusion period.	
	ORS 743.730(19)	The policy defines Health Benefit Plan.	
	ORS 743.730(24)	Defines "late enrollee" as an individual who enrolls in the group subsequent to the initial enrollment period during which the individual was eligible for coverage.	
	ORS 743.730(27)	Defines "pre-existing condition" as services, charges, or expenses incurred for pre-existing conditions for specified period immediately following enrollment. <i>(Pre-existing conditions do not include:</i> 1. <i>Pregnancy, except as provided in ORS 743.766.</i> 2. <i>Genetic information in the absence of a diagnosis.</i> 3. <i>A newborn child or adopted child who obtains coverage in accordance with ORS 743.707.)</i>	
	ORS 742.023(1)(d)	Stop-loss or out-of-pocket provisions define calendar year and contract year. The definition follows the administration of these provisions and clearly states how the crediting for previously satisfied deductibles, stop-loss, or out-of-pocket maximum is applied on mid-year contract renewal.	
Dependent coverage	ORS 743A.090	Policy covers newborn children of the insured and/or qualified eligible dependents from the moment of birth. Covers adopted children of the insured from the date of placement of the children with the insured for adoption.	
	ORS 106.305(4), Bulletin 2008-2	Same sex domestic partner should be included the same as a married spouse.	
	ORS 743.847(6)	Enrollment of a child shall not be refused on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal tax return, and the child does not reside with the child's parent or in the insurer's service area.	
	Section 2714 of the PHSA/Section 1001 of the PPACA	If a policy offers dependent coverage, it must include dependent coverage until age 26. Plans that provide dependent coverage must extend coverage to adult children up to age 26. Plans are not required to cover children of adult dependents.	
Discrimination	ORS 743A.084, ORS 746.015	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	

Category	Reference	Description of review standards requirements	Page & paragraph
Dollar Limits	Section 2711 of the PHS/Section 1001 of the PPACA	<p>Annual Limits A plan may not impose annual dollar limits on essential benefits, except for policy years beginning prior to January 1, 2014.</p> <p>Annual limits on essential benefits may be limited to: \$750,000 for plan years beginning 9/23/2010-9/23/2011 \$1.25 million for plan years beginning 9/23/2011-9/23/2012 \$2 million for plan years beginning 9/23/2012-12/31/2013mn</p>	
	Section 2711 of the PHS/Section 1001 of the PPACA	<p>Lifetime limits on essential benefits are prohibited.</p> <p>The essential health benefits cover the following general categories of services:</p> <ul style="list-style-type: none"> • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care 	
Eligibility	ORS 743.837, OAR 836-053-1200	Policy describes prior authorization and binding periods.	
Emergency care	ORS 743.801(1)(2)(3)*	Defines “emergency medical condition” as a medical condition that manifests itself by acute symptoms of sufficient severity including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person or fetus, in the case of a pregnant woman, in serious jeopardy.	
	ORS 743A.012	Emergency services are not subject to additional penalty or pre-authorization requirements.	
Exclusions	ORS 743.847(2)	Eligibility for benefits is not determined based on eligibility for Medicaid.	
Grace period	ORS 743.560(1)	Provision states that a minimum 10-day grace period is granted for the payment of each premium falling due after the first premium, during which the policy shall continue in force.	

Category	Reference	Description of review standards requirements	Page & paragraph
Grandfathered Plans		<p>1. Plan Materials- Plan Materials provided to a participant or beneficiary of a grandfathered plan describing the benefits must include a statement indicating:</p> <ul style="list-style-type: none"> • the insurer believes the plan is a grandfathered plan under PPACA. • grandfathered plans preserve certain basic health coverage that was already in effect. • a grandfathered health plan may not include certain consumer protections. • the grandfathered plan complies with PPACA consumer protections. • customer service contact information. 	
		<p>2. ERISA Plans include verbiage:</p> <ul style="list-style-type: none"> • You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. • For individual market policies and non federal governmental plans insert: <ul style="list-style-type: none"> ○ You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov. 	
Managed care	ORS 743.845(1)	Provision allows for the designation of a women's health care provider as the primary care physician, if a primary care physician is required.	
	ORS 743.845(2)	Provision permits a female enrollee to designate a women's health care provider as her primary care provider.	
	ORS 743.845(3)	Provision permits a female enrollee to have direct access to a women's health care provider for at least one annual preventive women's health examination and for pregnancy care.	
Access to Pediatricians	Section 2719A of the PHS/Section 10101 of the PPACA	Requires a non-grandfathered plan that mandates designation of a primary care physician to allow the policyholder to designate any willing in-network pediatrician as a child's primary care physician.	
Pre-existing conditions	ORS 742.005(2)	Pre-existing condition is a defined period prior to the effective date of coverage.	
	ORS 743.754(1)(2)	The pre-existing-condition provisions apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 month period prior to enrollment; they terminate on the earlier of 6 months following effective date for new enrollees or 12 months for late enrollees.	
	ORS 743.754(3), OAR 836-053-0230	Credit for covered time reduces the pre-existing-condition period when creditable coverage did not end more than 63 days after enrollment.	
	ORS 743.737(3)	The policy describes any affiliation period for health care service contractors.	

Category	Reference	Description of review standards requirements	Page & paragraph
Pre-existing conditions, continued	Sections 2704 of the PHSA/Section 1201 of the PPACA	A plan may not impose any preexisting condition exclusions. Plans may not impose any exclusion of benefits (including a denial of coverage) limit coverage based upon a preexisting condition, for an individual under age 19.	
Prescription drug	ORS 743A.062	If prescription drug coverage is offered, it does not exclude coverage of a drug because the drug is not FDA approved for a prescribed medical condition if the Oregon Health Resources Commission determines the use is effective.	
	ORS 743A.066	Health benefit plans, student health and prescription drug benefit programs that cover outpatient prescription drugs must cover contraceptives drugs and devices. (There is a religious employer exemption provision.)	
Preventive Services	Section 2713 of the PHSA/Section 1001 of the PPACA	For non-grandfathered plans, requires coverage and prohibits the imposition of cost-sharing for specified preventative services. Non-grandfathered plans must provide coverage without cost-sharing for: <ul style="list-style-type: none"> • Services recommended by the US Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration Preventive care and screenings for women supported by the Health Resources and Services Administration	
Proof of loss	OAR 836-080-0230 and 0235	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	
Requirements not part of a listed category	ORS 743A.084	Policy provides the same payments for costs of maternity to unmarried women that it provides to married women and the same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives.	
Required provisions for group health insurance plans	ORS 743.528	<ol style="list-style-type: none"> 1. Policy shall affirm that statements made by applicants, policyholder, or insured person shall be deemed representations and not warranties. 2. Policy shall contain provision that the insurer will furnish to policyholder a summary form of essential features of insurance coverage. 3. Policy shall contain provision that new employees or members or dependents may be added in accordance with the terms of the policy. 	
Renewability	ORS 743.754(6)	Describes renewal, modification, or discontinuance provisions.	

Category	Reference	Description of review standards requirements	Page & paragraph
Rescissions	Section 2712 of the PHSA/Section 1001 of PPACA	<p>Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. A plan must provide at least 30 days advance written notice to each participant who would be affected prior to rescinding coverage.</p> <p>Rescissions are defined as any retroactive cancellations of coverage, except for those attributable to failure to pay premiums or contributions. These requirements do not apply to prospective cancellations.</p>	
Usual, customary, or reasonable defined	ORS 743.878(1)(b)*	A written methodology of how allowable expenses are determined.	
Utilization review	ORS 743.807(2), OAR 836-053-1140	Utilization review requirements (prior authorization and appeal process).	
Vision	ORS 743.842	If the plan covers eye care services, the benefit includes emergency eye services.	
Waiting period	ORS 743.730(18)	Policy describes group eligibility waiting period.	
	ORS 743.754(3)(a)	Policy describes the affiliation period limitation for health care service contractors on pre-existing conditions.	
	ORS 743.754(3)(b), OAR 836-053-0250	Policy describes the exclusion period for specified covered services and its application to all individuals enrolling for the first time in the group health benefit plan.	
	ORS 743.754(4)	Policy defines late enrollee exclusion.	
	ORS 743.754(5)	Policy provides for special enrollment periods.	