Department of Consumer and Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Group or Individual Intensive Care, Organ and Tissue Transplant, and Prescription Drug

This product standard checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2).

The standards are summaries and review of the entire statute or rule will 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. Filings that do not include required information or policy provision will result in delays of the filing.

Insurer name: _____ **Date:** _____

TOI (type of insurance): ☐ **H08I Individual** ☐ **H08G Group Intensive Care - Limited Benefit**
Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits do not exceed a stated dollar amount per day.

Sub TOI ☐ **H08I.000** ☐ **H08G.000 Intensive Care - Limited Benefit**

TOI (type of insurance) ☐ **H09I Individual** ☐ **H09G Group Organ & Tissue Transplant - Limited Benefit**
Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day

Sub TOI ☐ **H09I.000** ☐ **H09G.000 Organ & Tissue Transplant - Limited Benefit**

TOI (type of insurance) ☐ **H17I Individual** ☐ **H17G Group Prescription Drug**
Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered

Sub TOI: ☐ **H17I.000** ☐ **H17G.000 Prescription Drug**

Note: If any of the forms you are submitting are considered a "Prescription Drug Plan" whether it is a stand alone policy or a rider, please complete the "Prescription Drug Plans" section.

Review requirements	Reference	Description of review standards requirements	Answer Yes or N/A
GENERAL REQUIREMENTS FOR ALL FILINGS			
Submission package requirements	**SERFF or Oregon Division of Financial Regulation website:** OAR 836-010-0011	Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx. These must be submitted with your filing to be accepted as complete: 1. Filing description or cover letter. 2. Third party filer's letter of authorization. 3. Certificate of compliance form signed and dated by authorized persons. 4. Readability certification. 5. Product standards for forms (this document). 6. Forms filed for approval. (If filing revised forms, include a ***highlighted/redline form version*** of the revised form to identify the modification, revision, or replacement language.) 7. Statement of Variability (see "Variability in forms" section).	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Filing description	OAR 836-010-0011(4), ORS 731.296	The filing description (cover letter) includes the following: 1. Changes made to previously-approved forms or variations from other approved forms. 2. Summary of the differences between previously-approved-like forms and the new form. 3. The differences between in-network and out-of-network, if applicable. **Note:** If filing through SERFF, DFR recommends that the cover letter be included in a separate document under the Supporting Documentation tab rather than in the General Information tab. If the filing description under the General Information tab is used, post submission changes to this language are not allowed.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
Purpose of filing	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and certificate, if applicable. Includes related advertising material ORS 742.009, OAR 836-020-0200 2. Changes to previously-approved forms include ***highlighted/redline version***. 3. Endorsements and/or amendments modify the policy by changing the coverage afforded under the previously approved policy. 4. Riders provide for additional or greater benefits than those in the base policy and no part of the rider revises the policy to reduce benefits or provide less favorable terms than in the policy. Riders must be applicable to the TOI filed under this standard 5. If the base policy was approved over 5 years, please submit a complete filing that includes all amendment and/or riders. The revised filing needs to include the highlighted/redline version.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Review requirements	Reference	Description of review standards requirements	Answer Yes or N/A
Clear policy language	ORS 742.005(2)	The policy provisions and benefit descriptions are clear and not ambiguous, abstruse, unintelligible, uncertain, or likely to mislead.	Yes ☐ N/A ☐
	ORS 742.106(1)(c)(d)	The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text. The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words	Yes ☐ N/A ☐
	ORS 743.104(2), ORS 743.106(1)(b)	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. The font is not less than 12-point type.	Yes ☐ N/A ☐
Cover page	**Disclosure** ORS 742.005, OAR 836-010-0011, OAR 836-020-0305	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer's logo, if used on the policy, must not mislead as to the identity of the insuring company and may not be bracketed. 3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. 4. The signature of at least one company officer appears on the first page of the policy. 5. A form-identification number appears in the lower left-hand corner of all forms. 6. All pages are numbered. 7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage. 8. The policy includes a right-to-examine provision that appears on the cover page. 9. The first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language: **"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."**	1. Yes ☐ N/A ☐ 2. ☐ ☐ 3. ☐ ☐ 4. ☐ ☐ 5. ☐ ☐ 6. ☐ ☐ 7. ☐ ☐ 8. ☐ ☐ 9. ☐ ☐
	Medicare Supplement OAR 836-052-0160 (5)(a)(b), Exhibit 1, Appendix C		
	Outline of Coverage OAR 836-020-305	Summarizes important features of the policy, provisions that exclude, eliminate, restrict, limit, delay or in any way operate to qualify payment of benefits.	Yes ☐ N/A ☐

Review requirements	Reference	Description of review standards requirements	Answer Yes or N/A
Form numbers	OAR 836-010-0011	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. **Note:** if the policy and certificate are free-standing documents, they must each have their own unique form number. Optional benefits to the policyholder are riders or endorsements with separate form numbers.	Yes ☐ N/A ☐
Variability in forms	ORS 742.003, ORS 742.005	Variable material in forms will only be permitted if it is clearly identified by brackets along with an explanation of when each would be used. • Variable text includes all optional text, changes in language, and choices in terms or provisions. • Variable numbers are limited to numerical values showing all ranges(minimum to maximum benefit amounts). • Explanation must be clear and complete. • The filing includes a certification that any change outside the approved ranges will be submitted for prior approval • Variability in forms may be described either through embedded Drafter's Notes or a separate Statement of Variability form. In general, Drafter's Notes are preferred. **Note:** detailed variability instructions can be found at: https://dfr.oregon.gov/rates-forms/health/Pages/health.aspx	Yes ☐ N/A ☐

(*Skip to "Requirements for Rates" if filing only a new rate or rate change.*)

APPLICABILITY

Category	Reference	Description of review standards requirements	Answer Yes or N/A
Advertising material	ORS 742.009, OAR 836-020-0200	Related advertising material to be used with **new** policy form filings are included or filed separately prior to use. Use Form No. 440-3308H Transmittal and Product Standards for Health Advertisements.	☐ ☐
Application	Form 440-22442H	If filing includes an application form, please also submit Form 440-2442H *Standards for Health Applications*	☐ ☐
Associations/ trusts/ discretionary groups	ORS 731.098, ORS 731.486(7)*, ORS 743.522, ORS 743.524	If filing includes an association, trust, union trust, or discretionary group, additional filing requirements apply. Use Form 440-2441A *Transmittal and Standards for Group Health Coverage to be issued to an Association or Trust Group* or Form 440-2441D *Transmittal and Standards for Group Health Coverage to be issued to a Discretionary Group*.	Yes ☐ N/A ☐

POLICY PROVISIONS			Page and paragraph
Alternation of Application for health insurance	ORS 743.039	No alteration of any written application for any health insurance policy shall be made by any person other than the applicant without the written consent of the applicant, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant	
	ORS 746.650	Any adverse decision made in accepting or not accepting an applicant, including preliminary questions prior to filling out an application, are subject to the notification under ORS 746.650.	
Limited Benefit Coverage	ORS 731.114	"Limited benefit coverage" means: (1) Health insurance that provides: (a) Coverage for accident only, specific disease or condition only, credit or disability income; (b) Dental only coverage; or (c) Vision only coverage; and (2) Independent, non-coordinated, hospital-only indemnity insurance or other fixed indemnity insurance.	
Group health insurance policy	**Summary of essential features of coverage** ORS 743.406(2)	Policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable.	
	Applicable rights and conditions ORS 743B.340, ORS 743B.341 and ORS 743B.343 to ORS 743B.347	Policy shall provide the rights and conditions relating to premium contributions, continuation of benefits after termination and availability of continued coverage under group policy for surviving, divorced or separated spouse 55 or older as prescribed.	
	Adding employees/ members ORS 743.406(3)	A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.	

POLICY PROVISIONS			Page and paragraph
Individual health insurance policy	ORS 743.405(1) through (8)	An individual health insurance policy **must** meet the following requirements: 1. Include a statement of money and considerations due; 2. Define the start and stop date; 3. Define who is covered under the plan; 4. May not be used to separate an individual from a group product under which they are eligible for coverage; 5. The policy may not give undue prominence to any provision, the style must be consistent and uniform throughout, and must be in 12 point font; 6. Exclusions and limitations must be clearly stated; 7. Each policy forms must be identified by a unique form number in the lower left portion of each page; 8. No portion of the insurers' internal corporate regulations may be made part of the policy. 9. Include a statement of money and considerations due; 10. Define the start and stop date; 11. Define who is covered under the plan; 12. May not be used to separate an individual from a group product under which they are eligible for coverage; 13. The policy may not give undue prominence to any provision, the style must be consistent and uniform throughout, and must be in 12 point font; 14. Exclusions and limitations must be clearly stated; 15. Each policy forms must be identified by a unique form number in the lower left portion of each page; 16. No portion of the insurers' internal corporate regulations may be made part of the policy.	
Arbitration	ORS 36.600 to 36.740	Voluntary arbitration is permitted by the Oregon Constitution and statutes. Please see additional details below: • Either party may elect arbitration at the time of the dispute (after the claimant has exhausted all internal appeals if applicable); • Unless there is mutual agreement to use an arbitration process, the decision will only be binding on the party that demanded arbitration; • Arbitration will take place in the insured's county or at another agreed upon location; • Arbitration will take place according to Oregon law, unless Oregon law conflicts with Federal Code. • The process may not restrict the injured party's access to other court proceedings; • Restricting participation in a class action suit is permissible	N/A ☐

Review requirements	Reference	Description of review standards requirements	Page and paragraph
Beneficiaries	ORS 743.444 (individual)	Policy states that unless the insured makes an irrevocable designation of beneficiary, the right to change beneficiary is reserved to the insured and the consent of the beneficiary shall not be requisite to surrender or assignment of this policy.	
Benefit reimbursement	ORS 743A.020 Acupuncturist	A health insurance policy that covers acupuncture services performed by a physician shall cover acupuncture performed by an acupuncturist.	
	ORS 743A.160 **Alcoholism treatment**	A health insurance policy providing coverage for hospital or medical expenses (not limited to expenses from accidents or specified sicknesses) shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism.	
	ORS 743A.024 **Clinical social worker**	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 **Dentist**	Coverage provides reimbursement for any surgical service that is within the lawful scope of practice of a licensed dentist, if policy provides benefits when a physician performs the service.	
	ORS 743A.028 **Denturist**	Coverage provides reimbursement for any service that is within the lawful scope of practice of a licensed denturist, if policy provided benefits when a physician performed the service.	
	ORS 743A.034 **Expanded practice dental hygienist**	Any policy covering dental health that provides for a dentist must also provide coverage for an expanded practice dental hygienist.	
	ORS 743A.164 **Injuries resulting from alcohol and controlled substances**	A health insurance policy other than a disability income policy shall provide coverage or reimbursement of expenses for the medical treatment of injuries or illnesses caused in whole or in part by the insured's use of alcohol or a controlled substance to the same extent as and subject to limitations no more restrictive than those imposed on coverage or reimbursement of expenses arising from treatment of injuries or illnesses not caused by an insured's use of alcohol or a controlled substance.	
	ORS 743A.036 **Nurse practitioner**	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 743A.040, ORS 750.065 **Optometrist**	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.	
	ORS 743A.044 **Physician assistant**	Claims submitted directly by physician assistants, practicing in keeping with ORS 677.515(4), to be paid as if submitted by the supervising physician.	

Review requirements	Reference	Description of review standards requirements	Page and paragraph
Benefit reimbursement	ORS 743A.010 **State hospital**	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.	
Cancellation and nonrenewal	ORS 743.495, ORS 743.498	A non-cancelable or guaranteed renewable policy includes the statement required by ORS 743.498 or similar language explaining the guaranteed or cancelable periods.	
	ORS 743B.320, ORS 743B.323 (group)	If policy provides benefits for hospital or medical expenses, other than accident or specific diseases, notification of non-replacement rights is sent to the policyholder no later than 10 days after the termination date.	
Claim forms	ORS 743.426	The "claim forms" statement in ORS 743.426, or a similar statement, is included in the policy, providing that, if claim forms are required and are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirement of the policy	
Claim notice	ORS 743.423(1)	The "notice of claim" statement in ORS 743.423(1), or a similar statement, is included in the policy, explaining that written notice of claim is given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible.	
Claim payment	ORS 743.432	A "time payment of claims" statement similar to that in ORS 743.432 is included in the policy, stating that indemnities payable will be paid immediately upon receipt of due written proof of loss or stating the intervals of periodic payment of benefits.	
	ORS 743.435	Policy states that benefits paid for loss of life are payable in accordance with the beneficiary designation. If no such designation or provision is in effect, such payments shall be payable to the estate of the insured.	
Claim procedures	OAR 836-080-0230 and -0235	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	
Discretionary clauses	OAR 836-010-0026	Prohibition on the use of discretionary clauses. Discretionary clause means a policy provision that purports to bind the claimant, or to grant deference to the insurer, in proceedings subsequent to the insurer's decision, denial or interpretation of terms, coverage or eligibility for benefits.	
Discrimination	**Domestic partners** (The Oregon Family Fairness Act) ORS 106.300 to ORS 106.340, Bulletin 2008-2	A domestic partnership is defined in ORS 106.310 as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." **Any time that coverage is extended to a spouse it must also extend to a domestic partner, requirements beyond this are not allowed for same sex domestic partners.**	

Review requirements	Reference	Description of review standards requirements	Page and paragraph
Discrimination (continued)	ORS 746.015	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.	
	Unmarried women and their children ORS 743A.084	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	
	Physical disability ORS 746.015(2)	This contract complies with ORS 746.015(2) by not discriminating in its underwriting standards and or rates solely on an individual's physical disability.	
	Age 65 ORS 746.015(3	This contract complies with ORS 746.015(3) by not discriminating against a person who attains or exceeds age 65, unless such discrimination is based on clear and sound actuarial principals as well as anticipated experience.	
	Domestic violence ORS 746.015(4)	This contract complies with ORS 746.015(4) by not cancelling, refusing to issue or renew this policy on the basis of the fact that an insured or prospective insured is or has been a victim of domestic violence.	
	Diethylstilbestrol use by mother ORS 743A.088	No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.	
	Gender Dysphoria Bulletin 2016-1 ORS 742.005(4), ORS 746.015(1)	• Health insurance plans cannot discriminate against people on the basis that the treatment is for gender identity issues. • Gender Dysphoria is a condition defined in the DSM-V and must be covered incompliance with Oregon Bulletin 2016-1.A health insurer may not categorically exclude coverage for a particular gender-affirming treatment, if the treatment is the only medically necessary treatment available for the person. A health insurer may not categorically exclude coverage for a particular gender affirming treatment, if the treatment is the only medically necessary treatment available for the person. This includes categorical exclusions such as an exclusion for cosmetic surgery if the treatment is deemed medically necessary for the mental condition of gender dysphoria. Nor may the insurer establish such a broad categorical exclusion or impose utilization controls so there is no viable treatment covered for the insured's condition.	
	Genetic information 45 CFR §146.122, ORS 746.135	Issuers may not discriminate on the basis of genetic information.	

Review requirements	Reference	Description of review standards requirements	Page and paragraph
Discrimination Continued	**Medicaid** ORS 743B.470(2)	Eligibility for benefits is not determined based on eligibility for Medicaid.	
	Children out of wedlock ORS 743B.470(6)	Policy covers children not residing with the parent, not claimed as dependents on parents' federal tax return, born out of wedlock, or residing in the insurer's service area.	
	Same-sex marriages performed in other states OAR 836-010-0150	Oregon recognizes the marriages of same-sex couples validly performed in other jurisdictions to the same extent that they recognize other marriages validly performed in other jurisdictions.	
Entire contract	ORS 742.016 (all), ORS 743.411	The "entire contract" statement in ORS 743.411 or similar statement is included in the policy, explaining that the contract, including the endorsements and attached papers, if any, constitutes the entire contract of insurance.	
Examination of contract	ORS 743.492	There is a provision printed on the face of the policy or attached thereto entitling the prospective insured to a 10-day period in which to examine and return the policy for a refund of any premium paid, including any policy fees or other charges. If returned, the policy is considered void from the beginning and the parties are in the same position as if no policy had been issued.	
Exclusions	ORS 743B.470	Eligibility for benefits is not determined based on eligibility for Medicaid.	
Grace period	ORS 743.417, ORS 743B.320	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.	
Incontestability	ORS 743.414(3)(4)	The "incontestable" statement in ORS 743.414(3) and (4) or a similar statement is included that states after two years from the date of issue of this policy, no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim, and losses after two years are covered.	
Inducements	ORS 746.035	Inducements must be specified in policy. Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon.	
Fraud warnings	ORS 742.013, Bulletin 2010-03	Fraud or misstatement warnings that mention criminal or civil penalties must avoid definite statements of the criminal nature of an act, guilt, or possible penalties. A warning that specifies that knowingly providing false information "may be" a crime, which "may be" grounds for criminal or civil penalties is appropriate.	
Legal action	ORS 743.441	Provision states that no action at law or in equity is brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of three years after the time written proof of loss is required.	

Review requirements	Reference	Description of review standards requirements	Page and paragraph
Physical examination/ autopsy	ORS 743.438	The “physical examinations and autopsy” statement in ORS 743.438 or a similar statement is included in the policy, explaining that the insurer at its own expense shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim is pending.	
Pre-existing conditions	ORS 742.023	Pre-existing condition is a defined period prior to the effective date of coverage.	
Proof of loss	ORS 743.429	The "proof of loss" statement in ORS 743.429 or a similar statement that proof of loss is due to the insurer within 90 days of the loss or, in the case of continuing loss for which the insurer is obligated to make periodic payments, 90 days after the end of the period of insurer liability. (*If it is not reasonably possible for the policyholder to meet this requirement, the claim shall not be invalidated or reduced if proof of loss is provided as soon as is reasonably possible and not later than one year after the date proof is otherwise required, except in the absence of legal capacity*.)	
Rebates	ORS 746.045	No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy, which is not specified in the policy.	
Reinstatement	ORS 743.420	A provision states that if the renewal premium has not been paid within the time granted but an insurer or authorized agent subsequently accepts a premium the policy shall be reinstated. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the insurer.	
Renewability	ORS 742.023, ORS 743.018	A premium change or renewability provision provides for premium changes only when such changes apply to all policies of this form, are issued to persons in the same class in this state, and have been approved by the Oregon Division of Financial Regulation.	
Representations not warranties	ORS 743.406(1)	A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person.	
Time limit on certain defenses	ORS 743.414(1)	A provision states that after two years from the date of issue of the policy no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim.	
	ORS 743.414(2)	The policy provision does not affect any legal requirement for avoidance of a policy or denial of a claim during the first two-year period or limit the application of ORS **743.450 to 743.462** in the event of misstatement with respect to age or occupation or other insurance.	

Review requirements	Reference	Description of review standards requirements	Page and paragraph
Alcoholism	ORS 743A.160	A health insurance policy providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism.	
Chemical dependency, alcoholism, mental or nervous conditions treatment	ORS 743A.168	Policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.	
Inborn errors of metabolism	ORS 743A.188	All health insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases shall include coverage for treatment of inborn errors of metabolism.	
Injuries resulting from alcohol, cannabis and controlled substance	ORS 743A.164	Requires that an individual health insurance policy, other than disability income, provide coverage for medical treatment of injuries or illnesses caused in whole or in part by the insured's use of alcohol or a controlled substance that is equivalent to coverage for other injuries or illnesses	
Maxillofacial prosthetic services	ORS 743A.148	If policy provides benefits for hospital, medical, or surgical expenses, other than limited benefit coverage, coverage includes maxillofacial prosthetic services necessary for adjunctive treatment.	
Non-prescription enteral formula for home use	ORS 743A.070	All policies providing health insurance, as defined in ORS 731.162, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.	

PRESCRIPTION DRUGS *Applicable to stand alone policies as well as prescription drug riders attached to any policy*.			
Review requirements	Reference	Description of review standards requirements	Page and paragraph
Prescription drugs	ORS 743A.060, ORS 743A.062	No health insurance policy providing coverage for a prescription drug shall exclude coverage because the drug is not Food and Drug Administration (FDA) approved for a prescribed medical condition if the Oregon Health Resources Committee determines the use is effective. HB 3340 (2017) prohibits prior authorization for cost of medication prescribed for treating opioid or opiate withdrawal during the first 30 days of treatment.	
Contraceptives	ORS 743A.066	The prescription drug benefit plan (stand-alone policies) provides payment or reimbursement for prescription contraceptives. Contraceptive is defined as a drug or device approved by the FDA to prevent pregnancy. Otherwise, this statute applies when the **prescription drug rider is attached to a health benefit plan**.	

REQUIREMENTS FOR RATES FOR INDIVIDUAL POLICIES *Information requested under this section is determined to be necessary to evaluate the filing for compliance.*			
Review requirements	Reference	Description of review standards requirements	Check compliance
Filing request	ORS 742.003(1)	The following review is requested: 1. New rate filing. 2. Rate change. 3. Informational.	Requested ☐ ☐ ☐
Class rating	ORS 742.005(6), ORS 743.018	If the insurer uses class for the purpose of rating, the policy includes a definition of class that is consistent with the actuarial basis.	Yes ☐
Combined classes	ORS 742.041	This filing includes classes of combined life and health insurance. (*No other classes are combined in this filing in which the liability of the insurer for unearned premiums or the reserve for unpaid, deferred, or undetermined-loss claims is estimated in a different manner*.)	Yes ☐
Loss ratios	OAR 836-010-0021(1)	**Rate changes.** Successive generic policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.	Yes ☐
Premium changes	ORS 742.005(6), ORS 743.018	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period.	Yes ☐

Review requirements	Reference	Description of review standards requirements	Check compliance
Ratemaking	ORS 743.018, OAR 836-010-0011	Appendix A (Form 440-2462) is included and all columns completed showing support of the rate change requested; it includes actual and projected experience and overall loss ratio from policy inception for Oregon and the company's national experience.	Yes ☐
		A complete actuarial memorandum, signed by an accredited actuary, is included containing a description of all policy benefits and the actuarial assumptions used to develop each of the benefits. Include a description of the risk and the assumptions used in developing the cost.	Yes ☐
		The expected experience of the new rate or existing rate for the projected calculating period over which the actuary expects the premium rates to remain adequate is based on estimated future experience without expected rate increases.	Yes ☐
	ORS 743.018, OAR 836-010-0011	The source of the data; information about new or experimental benefits; and explanation of the reliability of projections, abrupt changes in the experience, and substantial differences between actual and expected experience are included.	Yes ☐
		A statement that the grouping of policy forms has not changed or an explanation of the changes is included. Experience of forms must be grouped according to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders.	Yes ☐
		The premium structure, as defined by the classification of insured's in the policy, is not changed at the time of rate increase (e.g., changes from issue-age to attained-age basis).	Yes ☐
	ORS 733.030	Filing identifies how reserving assumptions (including specific company experience) take into account any expected adverse mortality and lapses that are reflected in the pricing.	Yes ☐
Underwriting	OAR 836-010-0011	Mark the type of health underwriting filed for the forms included in this rate request: 1. Full underwriting. 2. Simplified underwriting. 3. No underwriting.	Mark one ☐ ☐ ☐
	ORS 746.600(1)(a)(D) Adverse underwriting	No practices or procedures imply or provide for "adverse underwriting" by offering individuals insurance at higher-than-standard rates.	Yes ☐